December 2021

Recommendations to increase the capacity of Sex Offense Treatment Providers who serve Less Restrictive Alternative (LRA) clients

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Sex Offender Policy Board
Report submitted to the Legislature
(Required by Chapter 236, Laws of 2021)

Prepared by
Whitney L. Hunt, MACRCJ, MSW, LICSWA
Megan Schoor, MPA, PhD, LSSBB

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Forecasting and Research Division
Office of Financial Management

Table of Contents

Sex Offender Policy Board membership

Brad Meryhew, SOPB Chair
Attorney | Washington Association of Criminal Defense Lawyers

Jedd Pelander, SOPB Vice-chair
Youth who have Sexually Offended program administrator | Department of Children, Youth, and Families, Juvenile Rehabilitation

Linda Farmer*
Lakewood City Council councilmember | Association of Washington Cities

David Flynn*
Chief executive officer | Special Commitment Center, Washington State Department of Social and Health Services

Jimmy Hung
Chief deputy prosecutor | Washington Association of Prosecuting Attorneys

Susan Marks
Executive director | Washington Coalition of Sexual Assault Programs

Maryann Moreno
Judge | Superior Court Judges Association

Michael O'Connell, Ph.D.
Board member | Washington Association for the Treatment of Sexual Abusers

Jeff Patnode
Board member | Indeterminate Sentence Review Board

Terrina Peterson
Program coordinator |Washington Association of Sheriffs and Police Chiefs

Mac Pevey*
Assistant secretary | Department of Corrections

Shawn Sant
Franklin County prosecutor | Washington Association of Prosecuting Attorneys

Richard Torrance
Managing director | Office of Crime Victims Advocacy

Jamie Weimer
Projects and programs manager |Washington Association of Sheriffs and Police Chiefs

*Members with Proxy Voters

Proxy for Linda Farmer (10/28/21):
Sharon Swanson, government relations advocate | Association of Washington Cities

Proxy for David Flynn:
Zainab Ghazal, M.D., chief of transition and program accountability | Special Commitment Center, Behavioral Health Administration

Proxy for Mac Pevey:
Donta Harper, Ed.D., regional administrator | Department of Corrections

Workgroup membership

ESSB2 5163 Workgroup

Workgroup Co-chairs

- **Joshua Choate**, section chief – Criminal Justice Division, Sexually Violent Predators (SVP) Unit |Office of the Attorney General

- **Shoshana Kehoe-Ehlers**, program managing attorney, 71.09 RCW Civil Commitment and Trial Level Programs | Washington State Office of Public Defense

Members:

- **David T. Flynn**, chief executive officer | Special Commitment Center, Department of Social and Health Services
- **Zainab A. Ghazal. M.D.**, chief of Transition and Program Accountability | Special Commitment Center, Department of Social and Health Services
- **Priscilla Hannon**, board member |Washington Association for the Treatment of Sexual Abusers
- **Sonja Hardenbrook**, attorney | Snohomish County Public Defender Association
- **Elena Lopez, Psy.D.**, director of sex offense treatment and programs | Department of Social and Health Services
- **Alex Mayo**, board member | Washington Voices
- **Brad Meryhew (SOPB Chair)**, attorney | Washington Association of Criminal Defense Lawyers
- **Jedd Pelander (SOPB Vice-chair)**, program administrator for Youth who have Sexually Offended | Department of Children, Youth, and Families
- **Jonathan D. Sherry**, chief of secure residential operations | Special Commitment Center, Department of Social and Health Services
- **Brandon Williams**, program manager | Department of Health
- **Devon Gibbs,** attorney | King County Department of Public Defense
- **Jennifer J. Williams,** corrections specialist | Department of Corrections
- **Erik Knudson,** Workforce Development Manager | Special Commitment Center, Department of Social and Health Services
- **Shawn Candella,** deputy chief executive officer | Special Commitment Center, Department of Social and Health Services

What we recommend

This is the Sex Offender Policy Board's (SOPB) final report in response to the Legislature's July 2021 request. We list our 8 recommendations below. This report also explores our Workgroup process, SOPB process, a brief current state analysis and applicable historical context.

Icon key
Next to each recommendation, you will see an icon that indicates:

 We need action from Legislature

 We need additional funds from Legislature

 We need internal agency action

 We had unanimous support

No. 1

Option A: For defense-proposed LRAs Sex Offender Treatment Providers (SOTPs) shall be required to contract with DSHS' Special Commitment Center prior to being Court Ordered to provide treatment for a Sexually Violent Predator under a Less Restrictive Alternative.

Option B: For defense-proposed LRAs Sex Offender Treatment Providers (SOTPs) should not be required to contract with DSHS' Special Commitment Center prior to being Court Ordered to provide treatment for a Sexually Violent Predator under a Less Restrictive Alternative.

No. 2

The SCC and DOC should conduct a comprehensive review of the implementation of SB 5163, in consultation with the Office of Public Defense, the Attorney General's Office, Treatment Providers, and other RCW 71.09 stakeholders, and report back to the SOPB in two years (24 months).

No. 3

The SCC and DOC should conduct a review of billing practices in other states and to consult with other stakeholders in Washington about these issues, in order to make recommendations regarding changes to LRA SOTP reimbursement rates and the scope of billable work. Those recommendations should be included in future budget requests to ensure adequate funding of any changes. An increase in pay rates has been identified by SOTPs and the SOPB as a necessary change to attract and retain qualified providers. An increase in pay rates should be adopted given the financial constraints identified by the SOTPs and the imminent need for more providers to serve LRA clients.

We need action from Legislature | We need additional funds from Legislature | We need internal agency action | We had unanimous support

No. 4

Annual or biannual trainings should not be mandatory for prospective and existing SOTPs who work with LRA clients. However, there is a need to expand the number of professional development trainings and CEU opportunities available for contracted providers.

No. 5

The SOPB recommends that a cost-of-living pay increase be considered as an incentive for providers who work with LRA clients.

No. 6

The SCC should incentivize providers who contract with them by paying for a portion of their continuing education units (CEUs) specific to their SOTP credential and/or trainings that may be necessary for treatment of LRA clients or the specialized population.

No. 7

Cover costs associated with traveling to McNeil Island while carrying out LRA treatment.

No. 8

The Legislature should create a temporary funding stream or grant to subsidize the cost of SOTP licensure fees for new and renewing providers who treat LRA clients. High costs of obtaining certification is cumbersome and a barrier.

Introduction

In Chapter 236, Laws of 2021,[1] the Legislature directed and provided funding for the Sex Offender Policy Board (SOPB), the Department of Social and Health Services (DSHS), and the Department of Health (DOH) to convene a workgroup to develop recommendations to increase the availability and quality of sex offender treatment providers in Washington. We know that more individuals are qualifying for conditional release to less restrictive alternatives (LRAs). As a result, we need additional sex offender treatment services to meet the demand. To better inform the expansion of treatment services in the state, this workgroup was instructed to provide data on:

1. Best practices in other states and make recommendations whether sex offender treatment providers should be required to contract with the department;
2. Whether annual or biannual trainings by the department should be mandatory for prospective and existing sex offender treatment providers;
3. Whether the department should provide competitive wages for services or pay that is commensurate with the years of experience or education level of the treatment provider; and
4. Whether the department should provide other incentives such as a cost-of-living pay increase or compensating providers for the cost of mandated trainings associated with the sex offender treatment provider license under chapter 18.155 RCW.

This report summarizes the workgroup's findings and recommendations on these four areas.

How we created the SB 5163 workgroup

On July 1, 2021, grant funding was secured to support this workgroup project. Shortly after, the interim SOPB coordinator, the SOPB chair, and SOPB vice-chair met with leaders from DSHS' Special Commitment Center (SCC) and DOH. They discussed workgroup expectations, developed a recruitment communication plan, and brainstormed prospective members to recruit. The interim SOPB coordinator invited representatives from the following organizations to participate in the workgroup:

- State Office of Public Defense
- Washington Association of Prosecuting Attorneys (WAPA)
- Attorney General's Office
- Washington Association for the Treatment of Sexual Abusers (WATSA)
- Disability Rights Washington
- Washington Association of Criminal Defense Lawyers (WACDL)
- Washington Voices

[1] https://lawfilesext.leg.wa.gov/biennium/2021-22/Pdf/Bills/Session%20Laws/Senate/5163-S2.SL.pdf?q=20211001155536

The workgroup expanded its membership in the following months to include additional representatives from the Department of Corrections (DOC), King County Department of Public Defense, and the SCC.

The workgroup officially launched July 29 and met twice a month until Oct. 8. Workgroup members participated in thoughtful discussions about the LRA process in Washington, reviewed the SCC's contract template and LRA caseload data, and gathered feedback from Sex Offense Treatment Providers (SOTPs) with experience working with LRA clients to understand potential challenges with the contracting process and any other barriers. Workgroup members also reached out to states with LRA programs and relayed that information for the workgroup's consideration. The workgroup proposed recommendations based on the insight gained from these efforts and then submitted their recommendations to the full SOPB for consideration.

We asked the workgroup to provide their final recommendations to the SOPB coordinator by Oct. 8. This gave board members time to review the recommendations before voting on their adoption at the Oct. 14 board meeting.

Response 1: Best practices and contract requirements

Our response to: "Best practices in other states and make recommendations whether sex offender treatment providers should be required to contract with the department;"

How the current system operates

SB 5163 clarifies that either the SCC or the respondent's defense team may develop and propose an LRA plan.[2] For existing and defense-proposed LRAs, a contract between SOTPs and the SCC is not a statutory requirement, though most SOTPs who currently provide services to LRA clients do establish contracts with the SCC. When the SCC develops an LRA plan, the SOTP must have a contract with the SCC. However, many SOTPs report that contracting with the SCC has been a barrier in the past. Per SB 5163, the SCC is now tasked with developing discharge plans and is using a Request for Proposal (RFP) process to recruit those treatment providers.

We have 97 certified SOTPs in the state, and 16 of them currently work with 70 LRA clients from the SCC.[3] RCW 71.09.092(1), treatment by a treatment provider who is qualified to provide such treatment in the state of Washington under chapter 18.155, requires that SOTPs who agree to work with individuals on a LRA must be certified. At the current time, and per the SCC contract, affiliate SOTPs may only provide services for a designated period when the primary provider is unavailable. Per WAC 246-930-075, an affiliate SOTP may be authorized to treat and evaluate Level III sex offenders if a qualified supervisor has ensured that the affiliate has completed 1,000 hours of supervised evaluation and treatment, and the qualified supervisor has submitted documentation of the hours within 30 days of completion. Currently, Pierce County and King County have the largest number of SOTPs who are contracted with the SCC to provide services to LRA clients. Some SOTPs provide LRA services to multiple counties. Please see Appendix B and F for further detail regarding current SOTPs and LRA clients.

What other states do[4]

The workgroup reached out multiple times to learn how other states handle LRA cases, particularly around provider contracting.[5] Although many states were contacted, only a few states provided information within the timeframe of this assignment. Not every state has a civil commitment program similar to Washington's program through the SCC.[6] The following states provided information on their LRA-type programs:

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[2] For more information, please see the SOPB's Fall 2020 report entitled *Recommendations and current practices for Special Commitment Center releases.*

[3] See Appendix F: SCC Current and Predicted Caseload Forecast Handout.

[4] For a brief overview from ATSA, please see: THE ASSOCIATION FOR THE (atsa.com)

[5] Including California, Colorado, Minnesota, Iowa, Missouri, Wisconsin, and others

[6] For a state comparison regarding LRAs, see Appendix K. Note: It is unclear as to when this information was last updated by Minnesota.

California

California contracts their entire LRA program through a private company, Liberty Healthcare. The state manages the contract closely for all elements of the program to include condition monitors (supervision), SOTPs, social work, and placements. DSHS Quality Assurance and contract management have close oversight and conduct periodic evaluations of the program for statutory and APA and Sex Offense Management Program (SOMP) standards of practice. Unlike Washington, providers are certified through California's sex offender management program instead of a health department.

Colorado

Colorado uses a community-based program based on risk, which is different from Washington's LRA process.[7] This state also requires lifetime supervision for most class 2, 3, and 4 felony sex offenses.[8] Colorado's treatment providers are state employees through the Colorado Department of Corrections.

Iowa

Iowa hires treatment providers as full-time employees, primarily psychologists and social workers, through its Department of Human Services (DHS). Although they used to contract with outside providers to deliver sex offense therapy services, the state now hires them as full-time employees through DHS. Additionally, Iowa's DHS also has one full-time employee who employs subcontractors that deliver penile plethysmograph (PPG) and polygraph exams.

Minnesota[9]

Minnesota uses a Request for Proposal (RFP) system that it sends to the public for responses. According to the reintegration program coordinator for the Minnesota Sex Offender Program:

> "The RFP outlines the services we are looking for, and treatment programs send in responses as to how they provide the services we are looking for. Proposals are then reviewed by myself [reintegration program coordinator] and a small team of folks. Any program that meets the requirements are then granted a contract for services. We only send our clients to treatment programs that have a contract with us. The Reintegration Team provides oversight to the contract and ensures that the services continue to meet the requirements and client need. We have a high level of oversight for the contracts. Invoices come to me for approval. In some very limited instances, we have allowed a client to receive services from a noncontracted provider when the court order requires services that do not fall under the normal outpatient sex offender treatment guidelines. In those situations, clients are responsible to pay for all services but we do require that the therapist maintains contact with the supervising agent for

[7] For a full review of Colorado's practices, please see the Lifetime Supervision of Sex Offenders Annual Report (November 2020).
[8] Overview of Sex Offender Management in Colorado | Division of Criminal Justice
[9] Minnesota is the only state that provided information on their provider fee schedule. For more details, see Appendix I.

> continuity of care. When a client gets ready to leave the total confinement treatment program (MSOP) and move into a community treatment program, we share quite a bit of documentation. There is also a transfer conference that is held with both treatment programs at the table. MSOP continues to be a resource for the community provider as the client attends their program but we have found that having both programs involved creates more problems so for the most part, the community provider takes over all aspects of treatment when a client is released. Our oversight of community treatment is in the form of the contract and the ongoing involvement of the MSOP supervising agent."[10]

Stakeholder perspectives on contract requirements

The SOPB and workgroup unanimously supported the recommendations in this report with one exception: whether SOTPs should be required to contract with the Department. Each stakeholder was asked to indicate their reasons for the position they took and that is what follows. This section captures the perspectives of key stakeholders who are involved in the LRA process regarding contract requirements for SOTPs:

Washington State Department of Social and Health Services (DSHS), Special Commitment Center (SCC)

Current law (RCW 71.09) allows defense attorneys to propose a discharge plan under certain circumstances without DSHS first having the chance to develop a plan. With so few qualified treatment providers in the state, existing providers will likely choose not to contract with the SCC and only take on LRA clients through the defense planning process since those plans do not have contract requirements and, therefore, cost limitations. This dynamic threatens the ability of SCC to execute discharge planning as E2SSB 5163 intended.

Additionally, without provider contracts in place, the SCC can't effectively project costs or work with community treatment providers on appropriate treatment. It is an inefficient use of taxpayer dollars to allow provider rates and, therefore, LRA placements, to increase without any cost control mechanisms. The SCC also recommends that the SCC does discharge planning first under all circumstances. The resident's attorney can then propose an LRA but only if the SCC has failed to produce a qualifying discharge plan within 90 days. The SCC plans to move forward with a proposal to make these changes in statute.

Washington State Department of Health (DOH)

We consulted with DOH on this topic. However, their jurisdiction scope falls outside of SOTP contracts with other government agencies so representatives did not believe they could appropriately weigh in on this topic.

[10] K. Esser (personal communication, October 6, 2021)

Treatment providers

There is an overall shortage of SOTPs across the state. Of those who practice in the state, very few providers are willing to treat RCW 71.09 clients due to a variety of factors. Since LRA individuals are identified to be the highest risk, SOTPs who treat them carry an additional responsibility to help ensure the community is safe. The SCC has required a contract in the past, and it is currently required for SCC-proposed LRAs but optional for defense-proposed LRAs. In August 2021, the SB 5163 Workgroup and interim SOPB coordinator organized a virtual listening session and online survey to gather feedback from SOTPs who have experience working with LRA clients in Washington.[11] Some providers said the challenges of the contracting process and working under previous contracts led them to discontinue working with 71.09 clients in the past. Increasing the pool of treatment providers in Washington starts by making the profession more accessible to pursue providers. Contracts can act as a barrier to recruitment, and SOTPs have reported that a perceived contract requirement with the SCC is enough to discourage them from treating LRA clients. Not requiring a contract would help providers gain experience working with LRA clients without a long-term commitment. It may also encourage SOTPs in underserved areas to provide services to a nearby individual on an LRA when they may not be willing or able to fully contract to serve other areas of the state.

Washington State Office of Public Defense (OPD), Washington Association of Criminal Defense Lawyers (WACDL) and Washington Defender Association (WDA)

Requiring all SOTPs who serve LRAs to contract with the SCC will only exacerbate the current shortage of experienced SOTPs who provide treatment for SCC residents and impede fair share distribution of LRAs. Past and current providers report that the SCC's contracting process is a disincentive to working with SCC residents, and has been an obstacle to provider recruitment and retention. Though the SCC is and always has been able to require contracts with SOTPs that it selects to develop SCC-proposed LRAs, there is no need to extend a blanket contracting requirement to all SOTPs for the following reasons:

1. **All LRAs incorporate a thorough vetting of an SOTP's qualifications and their individualized treatment plan through an adversarial court process, which includes:**
    - Vetting SOTPs by prosecution experts.
    - Depositions and cross-examination of SOTPs.
    - A jury and/or judicial determination that the proposed plan, including the SOTP's proposed treatment plan, is adequate for community safety.
2. **Multiple sources of oversight apply throughout the life of an LRA placement, regardless of contract status:**
    - Provider rates and frequency of treatment are in the individualized treatment plan submitted to the court for approval.
    - Ongoing Transition Team meetings ensure continual management of the SOTP's work.

[11] See Appendix G: Compiled Feedback from SOTPs with LRA Experience.

- SOTPs provide monthly reports to all parties, including the court, DOC, and SCC.
- SCC, DOC, and the prosecution have continuing authority to petition for an immediate hearing if they believe a person needs additional care or treatment.
- SOTPs are professionally licensed under the state, are required to obtain extensive credentialing to treat this population, and must follow the treatment guidelines from ATSA and the APA.

3. **There are limited SOTPs in the state, and the lack of a contract requirement allows SOTPs to experience working with LRA clients without entering a long-term commitment.**

    - New SOTPs and those in underserved areas are incentivized to explore LRA practice, without entering into protracted contract negotiations with the SCC.
    - Current SOTPs were previously recruited by the defense. Some of those providers chose to subsequently sign contracts with the SCC after that trial run.
    - Even SOTPs without a contract have rates and conditions set in advance by the court order.

4. **Current and previous SOTPs reported to the workgroup that past SCC contracts have included problematic provisions. These include:**

    - Clauses that require preapproval for therapeutic interventions (including phone calls).
    - Restrictions on how SOTPs can respond when a client is in crisis.
    - Provisions that let SCC override an SOTP's clinical decision, even when those community SOTPs are more professionally experienced and familiar with the client's needs.
    - Restrictions on an SOTP's ability to respond to conditions in the community with additional treatment sessions, when necessary.
    - Excessive limitations on the amount of support an SOTP can provide as well as work requirements that are uncompensated.
    - SOTPs described the culture and process of contracting as disrespectful and some characterized the SCC contract as a "hammer."
    - The SCC reported they are concerned that SOTPs will not contract with them unless it's a requirement. This concern speaks to why the current contracting process is a disincentive for providers and does not support the argument for extending that requirement.

5. **"Consistency" in LRAs is not the goal; the statute requires "individualized" treatment:**

    - While DSHS and DOC might find it convenient to have contracts with SOTPS – such that all people on LRAs are treated the same, with the same rules, treatment modalities, and restrictions on the types of treatment they are allowed to be given – this approach is often inconsistent with the purpose of community safety or the best interests of the released person.
    - Some individuals may need more treatment, interventions and/or more expensive treatments than others to keep the community safe. An SOTP should not be put in a position to choose between community safety and violating the restrictions of a cookie-cutter contract.
    - An individualized and narrowly-tailored discharge plan is part of the statute and underlies the legislative intent to prioritize community safety.

The provisions of SB 5163 are new, and the SCC's discharge and LRA practices are still in development. Whether the SCC's RFP process under SB 5163 will recruit adequate SOTPs is a critical piece of missing information. We also do not have current comprehensive data on other states' practices, nor do we know whether those states face a similar shortage of SOTPs. Enacting a blanket contract requirement seems premature given the need for additional knowledge. This topic should be studied and further discussed by the SOPB as this process moves forward.

Washington State Department of Corrections (DOC)

DOC would recommend a contract requirement. DOC corrections specialists are required to collaborate with the SOTP and the Residential Community Transitional Team (RCTT). Often, the treatment modalities for LRA clients vary across providers. A contract could provide a level of direction and treatment planning standards as set forth by the American Psychological Association (APA) and Association for the Treatment of Sexual Abusers (ATSA) standards. Examples of standards could include risk-needs-responsivity, dynamic risk mitigation, criminogenic need targeting, and response to underlying deficiencies/disorders. A contract would give corrections specialists expectation standards and stronger treatment-oriented, mitigation strategies for risky behavior other than a client's return to total confinement.

Disability Rights Washington (DRW)

Disability Rights Washington is class counsel for high-acuity SCC residents in the ongoing settlement monitoring in *R.R. v. DSHS*.[12] As part of the settlement, the SCC is responsible for individualized treatment planning, which includes discharge planning for residents with cognitive disabilities. The SCC is also obligated to facilitate LRA placements in the community when those residents are found releasable. As a result, DRW has closely monitored the SCC's work during the last four years to identify and contract with community providers and DRW has serious concerns regarding the current contracting process. Expanding the requirement to contract may only further limit the number of community providers who are willing to work with the SCC. This could undermine the facility's ability to meet its obligations under the *R.R. v. DSHS* settlement. Since the recent changes directed by SB 5163 will fundamentally change the way that the SCC engages in discharge planning and community placements, additional legislated contracting requirements should be postponed until that develops.

[12] https://www.disabilityrightswa.org/cases/r-r-v-dshs/

Recommendations to Response 1

No. 1

Recommendation

SOPB Voting Results

Option A: For defense-proposed LRAs Sex Offender Treatment Providers (SOTPs) shall be required to contract with DSHS' Special Commitment Center prior to being Court Ordered to provide treatment for a Sexually Violent Predator under a Less Restrictive Alternative.

Position statement in support of Option A

In some states with sex offender civil commitment programs, the entity of jurisdiction has the authority to decide all contracts with SOTPs and maintain oversight and accountability measures for SOTPs. Each state has its own set of requirements for contracting with SOTPs, if they contract. Requiring a contract allows the SCC to establish processes for selecting SOTPs that can best serve resident needs, offer a more successful transition, and guarantee continuity of care throughout the LRA process.

For SCC-developed LRA plans, SB 5163 already requires the SCC to use a Request for Proposal (RFP) process to recruit and contract with SOTPs. Contracting for all LRAs (SCC- and defense-proposed) would offer more accurate cost projections since these are all funded by the SCC, regardless of whether a contract is in place. Current compensation rates in SCC contracts for these SOTPs are on par with the rates that other DSHS entities use. (e.g., SOTPs rates for Eastern and Western State Hospital). There is concern that a lack of cost consistency and oversight among SOTPs that treat LRA clients could have Department-wide impacts.

A contracting requirement for all LRA SOTPs would promote consistency. Consistency helps create a systemic approach to community treatment for all SVPs statewide and standardizes the oversight of this piece of an LRA discharge plan. A contract requirement could encourage courts statewide to use the SB 5163 changes (effective July 25, 2021) that require the newly established SCC discharge team to create a release plan for cases where the SCC annual review recommends LRA placement. The SCC is working to resolve any contract issues or perceived barriers after the complete implementation of SB 5163.

Option B: For defense-proposed LRAs Sex Offender Treatment Providers (SOTPs) should not be required to contract with DSHS' Special Commitment Center prior to being Court Ordered to provide treatment for a Sexually Violent Predator under a Less Restrictive Alternative.

Position statement in support of Option B

Currently, there is no statutory requirement for SOTPs to contract with the state when treating LRA clients. The lack of this requirement allows treatment providers on respondent-proposed LRAs to try working with a particular LRA client without a commitment to serve LRAs. The current process incorporates a vetting of the SOTP's expertise and the individualized treatment plan they propose for each client. Multiple sources of oversight remain in place throughout an LRA regardless of contract status. This includes transition team[13] meetings and judicial oversight (which includes SOTPs reporting monthly to the courts). Washington's SOTP licensure and certification process ensures fidelity with the Association for the Treatment of Sexual Abusers (ATSA) and American Psychological Association (APA) without creating a barrier to SOTP recruitment.

Increasing the pool of treatment providers for LRAs in Washington starts by making the profession more accessible to pursue for prospective SOTPs. LRA SOTPs have given consistent feedback that the contract process is a disincentive to taking on LRA clients and sent correspondence to the SOPB regarding the SCC's problematic contracting practices.[14] SB 5163 changes, which have not yet been implemented, already address continuity of care and successful, collaborative transitions in the LRA process. These changes may be sufficient without imposing a contract requirement that may impede SOTP recruitment.

If a contract with the SCC is required, some providers have expressed concern that preapproval for off-schedule treatment sessions or clinical determinations may hinder adequate service of treatment needs which, in turn, may negatively impact public safety. The terms of the SCC's current contract focus solely on SCC LRA proposals with many provisions that are not possible on a defense-proposed LRA. Examples of these provisions in the contract that do not apply to defense-proposed LRAs include timelines for developing treatment plans, requirements for the treatment plan, and requirements for pre-treatment plan cooperation with the SCC.[15] Because of these discrepancies, the SCC would need to develop an entirely separate contract that applies to SOTPs who are involved in defense-proposed LRAs. Defense-proposed LRAs often occur where the SCC does not support a conditional release. Requiring a contact may well undermine this path to release and put the statutory scheme in constitutional jeopardy.

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[13] An LRA client's transition team is comprised of a Department of Corrections (DOC) Corrections Specialist, SCC representative, and the SOTP. The transition team is charged with working together to address issues collaboratively as they arise.

[14] See Appendix G for all compiled feedback from SOTPs.

[15] See Appendix C - SCC Provider Contract Terms and Conditions

No. 2

Recommendation

The SCC and DOC should conduct a comprehensive review of the implementation of SB 5163, in consultation with the Office of Public Defense, the Attorney General's Office, Treatment Providers, and other RCW 71.09 stakeholders, and report back to the SOPB in two years (24 months).

Background

Since July 2021, the SCC has started to implement various components of SB 5163, including additional funds from the Legislature to onboard 15 full-time social workers to the SCC. Five of these employees will manage LRA cases. Three of the 15 employees will serve as placement coordinators, working with the SCC's community program administrator to help develop contracts with SOTPs to work with LRA clients. Before this bill was passed, RCW 71.09 outlined that the Respondent's attorney(s) was solely responsible for developing the client's LRA and discharge planning resources through social workers and their defense attorney. As a result of SB 5163, now the SCC's placement coordinators are also responsible for developing these resources.

As of the date of this report, the SCC has created a handful of LRA plans pursuant to SB 5163. The SCC has contracted with one community housing provider since the law took effect in July 2021. Not enough time has passed between SB 5163's implementation and this legislative assignment to understand contract barriers and identify ways to improve the process for the SCC and SOTPs who contract with them. Analyzing potential bottlenecks in the contracting and recruiting process for the agency and prospective providers would be valuable to pursue once the SCC implements all key components of the bill. And, reviewing the bill implementation may identify the successes and challenges of this implementation.

Response 2: Training requirements

Our response to: "whether annual or biannual trainings by the department should be mandatory for prospective and existing sex offender treatment providers;"

In August 2021, the SB 5163 workgroup and interim SOPB coordinator organized a virtual listening session and online survey to gather feedback from SOTPs who have experience working with LRA clients in Washington.[16] SOTPs and the workgroup determined that existing training opportunities are insufficient to ensure providers incorporate the latest technologies and methods, while also meeting contract requirements. The SOPB proposes the following recommendations regarding SOTP trainings:

[16] See Appendix G for all compiled feedback.

Recommendations to Response 2

The following recommendations received unanimous support from the full board and the workgroup.

No. 3

Recommendation

Annual or biannual trainings should not be mandatory for prospective and existing SOTPs who work with LRA clients. However, there is a need to expand the number of professional development trainings and CEU opportunities available for contracted providers. The SOPB proposes the following types of opportunities:

a. **SCC Orientation/Workshop.** The SCC should develop a formal orientation and onboarding workshop for new SOTPs who contract with them. This should be compensated.

b. **Sex Offense Management Conference.** The Sex Offense Management Conference should be re-instated as it was held in the past. This will need to be funded from the Legislature.

c. **Optional BHA-sponsored Trainings.** Expand funding to DSHS' Behavioral Health Administration's (BHA) Agency Learning and Development Council (ALDC) to explore and encourage the possibility of providing new and/or offering existing applicable trainings on a variety of mental health and sexual offense issues to contracted SOTPs who work with LRA clients.

Background

SOTPs are already required to complete 40 continuing education units (CEUs) every two years to maintain their SOTP license (WAC 246-930-410). This statute requires that 30 of the 40 CEUs must be earned through attending courses, workshops, institutes, or conferences that are relevant to the provider's field of work. Additionally, the current SCC Contract Terms and Conditions state that any contracted SOTP must complete training related to SVPs as determined necessary by the Contract Manager.[17] Because of these requirements, we recommend that trainings should not be mandatory for providers.

We further recommend additional training opportunities be available to providers, and that providers be compensated or reimbursed for their participation. The current fee schedule of the SCC's contract template does not reimburse providers for their time in training, which imposes a financial burden on providers. Not reimbursing for training creates process barriers that act as disincentives for new providers and discourage current treatment providers from participating in key professional development opportunities.

[17] See Appendix C - SCC Provider Contract Terms and Conditions

SCC orientation/workshop. The SOPB and workgroup recognize the importance of multi-agency and cross-disciplinary teams collaborating to meet the treatment needs of LRA clients. This is also a high priority and current need for SOTPs who have experience working with these clients.[18] No formal orientation process or workshop exists to onboard providers who decide to contract with the SCC. Providing an orientation and/or workshop would help ensure that collaboration amongst the multi-disciplinary team begins at the start of the LRA process. An orientation would likely increase providers' knowledge and comfortability in working with LRA clients, DOC, the SCC, and vice versa. We recommend that providers should be compensated for attending this orientation and/or workshop.

Sex Offense Management Conference. The Office of Financial Management coordinated the annual Sex Offense Management Conference in 2017[19] and 2018[20]. The SOPB and the workgroup members agreed that the conference was an incredibly positive experience. Past attendees reported that the conference increased collaboration and networking with entities statewide, brought a more nuanced understanding and appreciation of different perspectives across disciplines[21], and offered attendees the chance to recruit new SOTPs (including providers to treat LRA clients). It also gave providers training opportunities to expand their knowledge and gain exposure to the latest methodologies and best practices. The SOPB and past attendees believe that re-instating the conference is a necessary and helpful tool to attract and retain SOTPs, along with the many other benefits to system- and statewide partnerships.

Funding for these conferences came from the Office of Sex Offender Sentencing, Monitoring, Apprehending, Registering, and Tracking (SMART) with the U.S. Department of Justice's Office of Justice Programs.[22] The SMART office was authorized in the Adam Walsh Child Protection and Safety Act of 2006 and provides assistance and funding to states "related to the registration, notification and management of sex offenders".[23] The SMART office participated and approved the funding requests for both years of the conferences. Funding was, and future funding currently still is, tied to further implementation of the federal Sex Offender Registration and Notification Act (SORNA)[24], which is Title I of the Adam Walsh Child Protection and Safety Act of 2006. In February 2020, the SMART office reported on the status of Washington's implementation of SORNA.[25] Additionally, previous recommendations that the SOPB made to the Legislature, and the SOPB's recent recommendations regarding minors who have committed sex offenses[26], also affect the extent of Washington's compliance with SORNA. The SMART office will likely continue denying

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[18] See Appendix G Compiled Feedback from SOTPs with LRA Experience for further feedback.
[19] https://sgc.wa.gov/sex-offender-policy-board/2017-sex-offender-management-conference
[20] https://sgc.wa.gov/sex-offender-policy-board/2018-sex-offender-management-conference
[21] Including law enforcement, state agencies, treatment providers, victim services and more
[22] https://smart.ojp.gov/
[23] Ibid
[24] 34 USC § 209
[25] https://smart.ojp.gov/sites/g/files/xyckuh231/files/media/document/washington-hny.pdf and https://smart.ojp.gov/sites/g/files/xyckuh231/files/media/document/sorna-progress-check.pdf
[26] See the SOPB's report entitled "Recommendations and Current Practices for Minors Who Have Committed Sex Offenses" submitted December 1, 2021, to the Senate Human Services, Reentry and Rehabilitation Committee for the full recommendations and supporting information.

Washington's requests for conference funding because of these deviations. Reinstating the Sex Offense Management Conference will require funding from the Legislature.

Optional BHA-sponsored trainings. The Behavioral Health Administration (BHA) values investing in employee development. Recently, the BHA created a project team to increase training opportunities for staff, as part of a continued effort to address employee feedback and agency goals. The project team identified specific tasks to increase opportunities for training and continuing education, focusing first on expanding trainings for BHA staff who have licensure requirements and need CEUs to maintain their licenses. However, many of the tasks also focus on the professional development of all staff. The BHA project team recently created an Agency Learning and Development Council (ALDC) to review agency survey data and coordinate the logistics to annually bring in expert trainers and entities as guest speakers. The ALDC is in the formation phase, so they may identify additional tasks to achieve BHA's goals and support employees' professional growth. Currently, the council's scope does not include offering potential trainings to any agency-contracted providers since the focus is on addressing employee feedback and making sure staff have what they need to do their jobs successfully. We recommend that the ALDC explore the possibility of extending invitations for future trainings to contracted providers who work with LRA clients. Expanding access would give additional opportunities for contracted SOTPs to obtain the necessary CEUs to maintain their license and positively impact relations between providers, DOC, BHA and the SCC.

Response 3: Competitive wages

Our response to: "Whether the department should provide competitive wages for services or pay that is commensurate with the years of experience or education level of the treatment provider"

The SCC's current pay rates are education-based according to whether the provider is a psychologist or non-psychologist.[27] Although the pay rates vary by type of service, psychologists generally earn a rate of pay that is $25 per hour higher than non-psychologists. Based on insight that the SB 5163 Workgroup gathered, the SCC's pay rates may be inconsistent with the market rate that is typically paid in private practice and by some civil commitment programs in other states. However, we need more information to determine the basis for wages earned by SOTPs who contract with the SCC.

[27] See Appendix D and E for a complete list of current provider rates of reimbursement by credential.

Recommendations to Response 3

The following recommendations received unanimous support from the full board and workgroup.

No. 4

Recommendation

The SCC and DOC should conduct a review of billing practices in other states and to consult with other stakeholders in Washington about these issues, in order to make recommendations regarding changes to LRA SOTP reimbursement rates and the scope of billable work. Those recommendations should be included in future budget requests to ensure adequate funding of any changes. An increase in pay rates has been identified by SOTPs and the SOPB as a necessary change to attract and retain qualified providers. An increase in pay rates should be adopted given the financial constraints identified by the SOTPs and the imminent need for more providers to serve LRA clients.

Background

The workgroup made multiple attempts to learn how other states handle LRA cases, including pay information for SOTPs. The workgroup received very few responses to its requests. And Minnesota was the only state that provided rate of pay information.[28] Reviewing billing practices in other states with SCC-like programs will increase the awareness of potential differences in the fee structure for contracted SOTPs, pinpoint similar barriers experienced across programs, and determine potential incentives that are meant to attract and retain SOTPs.

Treatment providers who participated in the workgroup's online survey and virtual listening session acknowledged low reimbursement rates as a critical factor in their decision not to contract with the SCC to serve LRA clients.[29] Issues with pay rates have been identified within the SCC's current contract template. In 2016, pay rates were made uniform across the SCC contract and became dependent on a provider's educational credentials (psychologist (Ph.D.) vs. non-psychologist (master's level).[30] As a result, pay rates for many providers decreased in 2016 from $150 per hour to $125 per hour. This reduction further complicated existing problems with recruiting and retaining treatment providers in Washington. The SCC has not increased the rate of pay for contracted providers in the last five years.

Providing treatment services to LRA clients is challenging for many reasons. This includes the increased burden on SOTPs to serve high-risk clients, the skills required to effectively collaborate in clinical transition teams, and the SOTPs' inherent role to promote community safety. RCW 71.09 cases are very complex and some of the most difficult cases to treat. LRA clients meet the definition of SVPs and are potentially more likely to reoffend than others. There are not enough SOTPs to work with LRA clients. Currently, a total of 16 SOTPs in Washington serve 70 LRA clients. We

[28] See Appendix I for Minnesota's rate of pay
[29] See Appendix G
[30] See Appendix D and E

recommend that contracted SOTPs who serve LRA clients get paid at a higher rate because these challenges warrant an increase in pay. Increasing reimbursement may increase the number of contracted providers. The SCC's review of billing practices in other states will inform future budget requests to make sure there is adequate funding for pay rate changes. This review will also help determine the wages of contracted SOTPs for treatment services. Once the SCC better understands how competitive their current rate is compared to states with similarly structured programs and cost of living rates, there may be opportunities to address these barriers by revising the pay rates and/or billable hours for SOTPs in the contract template. Setting pay rates based on states with a comparable cost of living, for example, could make the SCC a more competitive employer and enhance its ability to recruit more SOTPs as contracted providers to serve the growing number of LRA clients.

Response 4: Incentives

Our response to: "Whether the department should provide other incentives such as a cost-of-living pay increase or compensating providers for the cost of mandated trainings associated with the sex offender treatment provider license under chapter 18.155 RCW."

Given the small number of SOTPs in Washington who serve LRA clients and the SCC's expectation that LRA cases will increase over the coming years, it is important to offer additional incentives that encourage more providers to contract with the SCC to serve these clients. We make the following recommendations regarding potential incentives for interested and current SOTPs.

Recommendations to Response 4

The following recommendations received unanimous support from the full board and the workgroup.

No. 5

Recommendation

The SOPB recommends that a cost-of-living pay increase be considered as an incentive for providers who work with LRA clients.

Background

Due to the shortage of SOTPs who treat LRA clients, implementing a cost-of-living increase for SCC-contracted SOTPs could help retain current treatment providers and attract new providers. The cost of living in Washington has increased, not declined. We recommend that cost-of-living pay increases for SOTPs be enacted statewide. Insight from reviewing billing practices in similar states (Recommendation No. 3) or similar cost-of-living adjustments conducted by other in-state programs could also inform how to develop a cost-of-living pay increase.

No. 6

Recommendation

The SCC should incentivize providers who contract with them by paying for a portion of their continuing education units (CEUs) specific to their SOTP credential and/or trainings that may be necessary for treatment of LRA clients or the specialized population.

Background

SOTPs must already meet a series of requirements that are mandated by state law in order to maintain their license. Per WAC 246-930-410, SOTPs are required to complete 40 continuing education units (CEUs) every two years to maintain their license. The statute requires that 30 of the 40 CEUs must be earned through attending courses, workshops, institutes, or conferences that are relevant to the provider's field of work. By partially covering the costs of CEUs that providers are mandated to complete, the SCC could attract more SOTPs to contract with them to serve LRA clients. Contracted SOTPs could use the partial cost coverage to obtain CEUs on general topics or explore training in a specialty area to help them better serve LRA clients.

No. 7

Recommendation

Cover costs associated with traveling to McNeil Island while carrying out LRA treatment.

Background

A provider must travel to McNeil Island when working with LRA clients. Costs for travel and parking are not currently covered or reimbursed for SOTPs. For example, providers must currently pay $11.29 out of pocket each day to park at the ferry terminal and boat to the island. This is the only place available to park, yet these costs are not eligible for reimbursement. Other stakeholders who visit the SCC to attend client meetings are reimbursed for parking.

No. 8

Recommendation

The Legislature should create a temporary funding stream or grant to subsidize the cost of SOTP licensure fees for new and renewing providers who treat LRA clients. The high costs to obtain this certification is cumbersome and a barrier.

Background

Like all professions credentialed in Washington, SOTP licensure fees are structured based on the costs to keep the SOTP profession operational in the state. Many factors affect the fees associated with each profession. This includes the number of licensed providers who are credentialed in the profession, the costs for DOH to manage and operate the profession, assistant attorney general support, and disciplinary costs. There are currently only 97 state certified SOTPs in Washington. This shortage of providers not only struggles to meet the current demands for treatment services, but also

contributes to high licensure fees that are passed on to individual providers.[31] This fee process can be a disincentive to certification. Numerous stakeholders and SOTPs have noted that the costs associated with becoming a licensed SOTP in Washington cause major hesitation and act as a deterrent to joining the field.[32]

The SCC currently has a fee waiver option that it can offer to SOTPs who contract with them. However, due to the low amount of SOTPs in the profession the waiver process is currently flawed. If the SCC provides a licensure fee waiver to an individual provider, then the fees that are waived become costs that the other 96 SOTPs must pay. Essentially, the costs associated with the profession must be covered for the profession to continue, regardless of a fee waiver. When additional providers join the profession, the costs on the individual providers will naturally decrease since more providers can share the burden of costs. The SOPB recommends that a temporary fund or grant be created by the Legislature to subsize the licensure fees for new and renewing providers that work with LRA clients. Subsidizing this cost could help incentivize new providers to join the profession and encourage existing providers to continue practicing as SOTPs.

Support for increasing SOTPs

In March 2021, the Senate Human Services, Reentry, and Rehabilitation Committee convened the SOPB to review policies and practices related to youth who have committed sex offenses.[33] Though there are significant differences in these assignments (SB 5163 and March 2021) and the populations that each addresses, there is crossover about the SOTP shortage.

The SB 5163 workgroup unanimously supports the recommendations proposed by the SOPB in response to the SOPB's March 2021 assignment. This includes amending the SOTP licensure requirements (outlined in RCW 18.155.020) to allow associate-level treatment providers to be affiliates.[34,35] The proposed recommendation would modify the DOH SOTP requirement in RCW 18.155.020 to allow SOTPs to supervise up to four affiliates, regardless of their full-time or part-time status. This change has the potential to increase how many SOTPs qualify to contract and serve SCC clients.[36] Per the SCC's current contract, the contractor can permit affiliates to observe and participate in services directly supervised by the contractor, but the contractor must be physically present, except when an affiliate provides replacement coverage for the contractor. The affiliate can provide no more than 14 days of coverage during a contract term unless it is preapproved by the chief of resident treatment.

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[31] See Appendix A: Sex Offender Treatment Provider Fees and Renewal Cycle.
[32] See Appendix G.
[33] See Appendix K regarding the March 2021 assignment
[34] Note: The Department of Health was consulted on these recommendations but did not vote for or against this recommendation.
[35] See SOPB's report entitled *Recommendations and current practices for minors who have committed sex offenses*, recommendations numbers 4, 5 and 10
[36] See SOPB's report entitled *Recommendations and current practices for minors who have committed sex offenses*, recommendation number 5

Appendices

Appendix A

Sex Offender Treatment Provider Fees and Renewal Cycle (WAC 246-930-990)

Sex offender treatment provider fees and renewal cycle. (WAC 246-930-990)

(1) Certificates must be renewed every year on the practitioner's birthday as provided in chapter 246-12 WAC.

(2) The following nonrefundable fees will be charged for:

Title of Fee	Fee
Sex offender treatment provider:	
Application and examination	$600.00
Reexamination	250.00
Initial certification	200.00
Renewal	1,000.00
Inactive status	300.00
Late renewal penalty	300.00
Expired certificate reissuance	300.00
Expired inactive certificate reissuance	150.00
Duplicate certificate	15.00
Verification of certification	15.00

(3) The following nonrefundable fees will be charged for **affiliate treatment provider:**

Title of Fee	Fee
Application and examination	400.00
Reexamination	250.00
Renewal	500.00
Inactive status	250.00
Late renewal penalty	250.00
Expired affiliate certificate reissuance	250.00
Expired inactive affiliate certificate reissuance	100.00
Duplicate certificate	15.00

Appendix B

Sex Offense Treatment Providers Listed with the Washington Department of Health

Sex Offender Treatment Providers (SOTPs) Listed with WA Department of Health (DOH)

Summary Statistics | Dr. Megan Schoor, Interim SOPB Coordinator | SOTP Directory pdf | SOTP Website Link

A total of **42 SOTPs** in Washington are listed on DOH's SOTP Directory website, which is more current than the SOTP Directory that was published in January 2020.

Most of the 42 SOTPs on DOH's Directory website are **Licensed Mental Health Counselors** (45% or 19 SOTPs) or **Licensed Psychologists** (24% or 10 SOTPs).

Type of SOTP	Percent
Licensed Mental Health Counselor (n = 19)	**45%**
Licensed Psychologist (n = 10)	**24%**
Licensed Independent Clinical Social Worker (n = 6)	14%
Licensed Clinical Independent Social Worker (n = 3)	7%
Counselor Certified Certification (n = 1)	2%
Licensed Advanced Social Worker (n = 1)	2%
Certified Behavior Technician (n = 1)	2%
Licensed Mental Health Counselor Associate (n = 1)	2%

King, **Pierce**, **Snohomish**, and **Thurston Counties** are served by more SOTPs than other Washington counties, especially Licensed Clinical Independent Social Workers, Licensed Mental Health Counselors, and Licensed Psychologists, respectively. **SOTPs also frequently serve more than one county.**

WA County	***Certified Behavior Technician*** (n = 1)	***Licensed Mental Health Counselor Associate*** (n = 1)	***Licensed Advanced Social Worker*** (n = 1)	***Counselor Certified Certification*** (n = 1)	***Licensed Clinical Independent Social Worker*** (n = 3)	***Licensed Independent Clinical Social Worker*** (n = 6)	***Licensed Psychologist*** (n = 10)	***Licensed Mental Health Counselor*** (n = 19)
Benton	**1**					**1**		**1**
Chelan								**1**
Clallam								**1**
Clark							**2**	**1**
Cowlitz			**1**					**1**
Douglas								**1**
Franklin	**1**							**1**
Grant								**2**
Island						**1**		
Jefferson								**1**
King		**1**		**1**	**3**		**2**	**7**
Kitsap							**1**	**1**
Kittitas								**1**
Pierce		**1**				**1**	**4**	**3**
San Juan						**1**		
Skagit						**2**		**1**
Snohomish						**2**	**1**	**4**
Spokane	**1**							**1**
Thurston						**1**	**3**	**2**
Walla Walla								**1**
Whatcom						**2**		**1**
Yakima								**2**

Note: The following counties were **not** listed by the SOTPs as areas they serve: Adams, Asotin, Columbia, Ferry, Garfield, Grays Harbor, Klickitat, Lewis, Lincoln, Mason, Okanogan, Pacific, Pend Oreille, Skamania, Stevens, Wahkiakum, Whitman.

Adults, Females, and Juveniles are the main client groups who are served by SOTPs listed on the DOH's Directory website.

Client Group	% of SOTPs
Adults	**95%** (n = 40)
Individuals with Developmental Disabilities	**55%** (n = 23)
Juveniles	**64%** (n = 27)
Females	**74%** (n = 31)
LGBTQ+	**2%** (n = 1)
Veterans	**2%** (n = 1)

Licensed Mental Health Counselors (n = 19) **and Licensed Independent Clinical Social Workers** (n = 6) **serve a greater variety of client groups than other types of SOTPs in Washington.**

	Certified Behavior Technician (n = 1)	***Licensed Mental Health Counselor Associate*** (n = 1)	***Licensed Advanced Social Worker*** (n = 1)	***Counselor Certified Certification*** (n = 1)	***Licensed Clinical Independent Social Worker*** (n = 3)	***Licensed Independent Clinical Social Worker*** (n = 6)	***Licensed Psychologist*** (n = 10)	***Licensed Mental Health Counselor*** (n = 19)
Adults	**1**	**1**	**1**	**1**	**3**	**5**	**9**	**19**
Individuals with Developmental Disabilities		**1**	**1**	**1**	**3**	**1**	**7**	**9**
Juveniles	**1**	**1**		**1**	**2**	**3**	**5**	**14**
Females	**1**	**1**		**1**	**2**	**4**	**6**	**16**
LGBTQ+						**1**		
Veterans								**1**

Four of the 42 SOTPs in the DOH registry (10%) accept Apple Health as payment for services.

- Two of these four SOTPs are **Licensed Mental Health Counselors** who serve the following counties:
  - Benton, Franklin, Grant, Kittitas, Walla Walla, and Yakima Counties (SOTP #1)
  - King, Pierce, and Snohomish Counties (SOTP #2)
- SOTP #3 is a **Licensed Psychologist** who serves Pierce County
- SOTP #4 is a **Licensed Mental Health Counselor Associate** who serves King and Pierce Counties

Appendix C

SCC Provider Contract Terms and Conditions Template

1. **Definitions Specific to Special Terms**. The words and phrases listed below, as used in this Contract, shall each have the following definitions:

   a. “Authorized Designee” means an individual who is designated in writing by the person who is identified in this Contract to provide an approval or direction to act on such person’s behalf with regard to an approval or direction.

   b. "Certified Affiliate Sex Offender Treatment Provider" or "Affiliate" means a licensed, certified, or registered health professional who is certified by the state of Washington as an Affiliate Sex Offender Treatment Provider to provide SOTP Services under the supervision of a Certified SOTP.

   c. “Chief of Transition and Program Accountability” means the SCC-employed professional whose responsibilities include oversight of the transition of SCC Residents to LRA settings and certain programs conducted in those settings. For purposes of this Contract, the term “Chief of Transition and Program Accountability” shall include an Authorized Designee of the Chief of Transition and Program Accountability.

   d. “Chief of Resident Treatment” means the SCC-employed psychologist who oversees the delivery of SOTP services under this Contract. For purposes of this Contract, the term “Chief of Resident Treatment” shall include an Authorized Designee of the Chief of Resident Treatment.

   e. “Community Treatment Plan” or “CTP” or “Treatment Plan” means a written document the Contractor prepares for the court that detail how control, care and treatment services will be provided while protecting the community for a Resident who may be conditionally released to a Less Restrictive Alternative (LRA).

   f. “Contract Manager” shall mean the individual identified as the DSHS Contact on page one of this Contract. For purposes of this Contract, the term “Contract Manager” shall include an Authorized Designee of the Contract Manager. DSHS may notify Contractor in writing of changes to the Contract and/or their respective contact information without need for formal amendment of this Contract.

   g. “Contractor” shall refer to the person or entity identified as the Contractor on page 1 of this Contract. As used in this Contract, “Contractor” shall include “Contractor Personnel.”

   h. “Contractor Personnel” shall refer to all individuals who provide Services under this Contract including any Affiliates who observe or participate in the delivery of Services under this Contract. Contractor Personnel who deliver unsupervised Services must meet be certified SOTPs. Contractor Personnel must meet all requirements applicable to Contractor and be fully bound by the terms of this Contract in the same manner as Contractor.

   i. “Corrections Specialist” or “CS” means the Department of Corrections (DOC) employee who is responsible for community supervision of the Resident and who serves as a member of the Resident’s Community Transition Team.

   j. “Dynamic Risk Factors” or “DRFs” mean aspects of a person’s life that are known to

heighten the risk for sexual re-offense and are amenable to change. DRFs include both sexual self-management deficits and general self-management deficits. A Resident's DRFs may change throughout treatment.

k. "Functional Assessment" is a process of data collection and assessment of the Resident aimed at identifying problematic behavioral patterns, including the frequency of specific target behaviors, any identifiable antecedents to the behavior(s), and any reinforcing consequences to the behavior(s).

l. "Less Restrictive Alternative" or "LRA" means court-ordered setting that is less restrictive than total confinement that satisfies the conditions set forth in RCW 71.09.092.

m. "Positive Behavioral Support Plan" or "PBSP" means a plan created from Functional Assessment data to best support a Resident within their current environment. The PBSP guides the staff members who provide care and supervision to be aware of behavioral triggers and utilize interventions.

n. "Resident" as provided in 388-880-010 WAC, means a person who is court-detained or court-committed pursuant to chapter 71.09 RCW or who has been conditionally released to an LRA. For purposes of this Contract, "Resident" refers to an individual who has been identified by the Court to receive SOTP Services from the Contractor during placement in an LRA and who has been assigned by the Contract Manager to receive Services from Contractor pursuant to this Contract.

o. "Resident's Community Transition Team" or "Transition Team" or "RCTT" means the group of professionals that oversees a Resident's transition from SCC to an LRA in the community. The RCTT is comprised of the Contractor, a Corrections Specialist and a SCC-designated RCTT facilitator. If the Resident lives at an LRA contracted by DSHS, the RCTT includes the LRA Contractor.

p. "Secure Community Transition Facility" or "SCTF," as provided in 388-880-010 WAC, means a residential facility operated by DSHS for persons civilly committed and conditionally released to a LRA under RCW 71.09.020. A Secure Community Transition Facility has supervision and security, and ensures the provision of SOTP Services.

q. "Senior Clinical Team" means a group of senior staff members at the SCC that is chaired by the Chief of Resident Treatment.

r. "Services" means the SOTP Services provided by Contractor after being approved by the Court to provide those Services to the specific Resident and after receiving approval from the Contract Manager to provide those services pursuant to this Contract, as described more fully in these Special Terms and Conditions.

s. "Sex Offender Treatment Provider" or "SOTP" or "Certified SOTP" or "CSOTP" means an individual who is certified as a Sex Offender Treatment Provider by the State of Washington, in accordance with chapter 18.155 RCW.

t. "Sexually Violent Predator" or "SVP," as provided in 388-880-010 WAC, means any person who has been convicted of or charged with a crime of sexual violence and

who suffers from a mental abnormality or personality disorder which makes the person likely to engage in predatory acts of sexual violence if not confined in a Secure Facility.

u. "Special Commitment Center" or "SCC" means the total confinement facility operated by the Behavioral Health Administration of the Department of Social and Health Services for the care, control, and treatment of sexually violent predators, located on McNeil Island.

2. Purpose. The purpose of this Contract is for Contractor to provide Sex Offender Treatment Provider Services and related services, such as case consultation with respect to Residents who are court-ordered to a Less Restrictive Alternative (LRA) or who are temporarily returned to SCC or SCTF from an LRA, and for Contractor to provide reports and testify as requested by either SCC or the court, and as further described below in Section 4, Statement of Work.

3. Contractor Qualifications and Requirements. The individuals performing services under this Contract must meet these requirements:

a. **Licensing.** Prior to providing Services, the Contractor shall furnish evidence to the Contract Manager identified on Page 1 of this contract that:

(1) Each individual who will provide Services under this Contract is a Certified Sex Offender Treatment Provider (SOTP) or is a Certified Affiliate SOTP working under the supervision of Contractor and certified by the state of Washington in accordance with chapter 18.155 RCW, Sex Offender Treatment Providers. If Contractor will utilize an Affiliate, Contractor shall furnish evidence that the Affiliate has been issued a certificate to evaluate and treat sex offenders under the supervision of an SOTP and shall seek approval of the Chief of Resident Treatment prior to permitting the Affiliate to provide Services for which the Contractor is not present.

(2) The Contractor shall report to the DSHS Contract Manager any actions brought against the Contractor's professional certification within three (3) calendar days of the occurrence.

(3) Contractor will maintain SOTP certification and, if an Affiliate will participate in the Services under this Contract, will maintain Affiliate SOTP certification, throughout the term of this Contract. All Contractor Personnel shall complete all continuing education as mandated in WAC 246-930-410.

b. **Online Background Checks.** In accordance with RCW 74.34.070, 74.34.020, 72.05, 43.20A.710, 43.43.834, 43.43.837 and chapter 388-700 WAC, Contractors and Contractor Personnel who may or will have either regular or limited access to any SCC Residents must be cleared through a DSHS-approved criminal history and background check prior to providing services under this Contract.

(1) In addition to disclosures provided as part of the background check application, the Contractor shall report any arrests or violations of law that occur after making such application to the Chief of Resident Treatment and the Contract Manager within three (3) days of the occurrence.

(2) The Contractor may not perform or provide Services under this Contract if the Contractor has:

(a) Been convicted of a sex offense, as defined in RCW 9.94A.030;

(b) Been convicted in any other state of an offense that under the laws of this state would be classified as a sex offense as defined in RCW 9.94A.030;

(c) Been convicted of any other crime that is grounds for disqualification of a DSHS contractor; or

(d) Been suspended or otherwise restricted from practicing as a health care professional in any state, federal, or foreign jurisdiction.

c. Fingerprint Background Check. In accordance with RCW 43.43.837(5), Contractor is required to be fingerprinted for purposes of completing a background check prior to providing Services under this contract. Each Contractor shall complete and submit to the Contract Manager DSHS Form 27-089 which may be retrieved on line here: Fingerprint Notice

d. Previous SCC Employment. Contractor shall comply with RCW 42.52.080 and shall not employ or subcontract with an individual to provide Services under this Contract if that person previously worked at the SCC and was involved in the administration or negotiation of a contract with Contractor or had authority to make discretionary decisions regarding the negotiations or administration of Contractor's contract or contracted services. This limitation shall apply for a period of one year following termination of the individual's employment with the SCC. If the individual participated in legislative or executive action with respect to funding of a contract with Contractor, this limitation shall continue for two years following termination of the individual's employment with SCC.

e. Ethical and Dual role consideration. Contractor shall inform the SCC in writing regarding any potential conflict of interest regarding the role of Contractor in providing Services for any Resident under this Contract.

f. Tuberculosis (TB) Screening. The Contractor shall provide proof of TB screening obtained within the past year from a non DSHS provider, prior to providing services under this Contract. The Contractor shall also provide proof of all subsequent annual TB screenings occurring during the term of this Contract. In the event of a positive TB screening, Contractor shall provide proof to SCC of satisfactory status through documentation of appropriate follow-up screening.

g. Acknowledgment of Laws Regarding Sex Offenses and Sexual Misconduct. The Contractor shall be knowledgeable of the provisions of RCW 13.40.570, Sexual Misconduct by State Employees, contractors and of the crimes included in chapter 9A.44 RCW, Sex Offenses. Contractor shall sign and submit to the Contract Manager an Acknowledgment of its review of these provisions. Contractor shall be knowledgeable about the Resident's crimes included in chapter 9A.44 RCW, Sex Offenses.

h. Non-Disclosure of Confidential Information. The Contractor shall sign and submit

to the Contract Manager the DSHS Agreement on Nondisclosure of Confidential Information – Non Employee, DSHS Form 03-374B. (Rev 05/2012) prior to having any access to client data. This form may be retrieved on line here: DSHS NDA

i. **Training.** The Contractor shall complete training related to Sexually Violent Predators as determined necessary by the Contract Manager.

j. **Standards.** The Contractor shall comply with the SOTP professional standards and ethics set forth in WAC 246-930-301 through 246-930-340.

k. **Use of Affiliates.** As long as it does not violate a Resident's specific court ordered conditions and has been approved by the RCTT, the Contractor may permit Affiliates to observe and participate in Services directly supervised by Contractor. Contractor must be physically present during these Services, except for occasional periods of Affiliate replacement coverage that may be provided when the Contractor is on vacation or ill. The specific dates and hours of Services provided by an Affiliate providing replacement coverage for Contractor shall be stated on the Contractor's invoice and monthly reports. Affiliates must be qualified to provide any replacement coverage they are assigned to provide. The Contractor shall notify Contract Manager of any incidents of replacement coverage. Except as preapproved by the Chief of Resident Treatment, Affiliates shall provide no more than 14 days of replacement coverage during the term of this Contract.

4. **Statement of Work**. The Contractor shall provide the services and staff, and otherwise do all things necessary for or incidental to the performance of the Services, as set forth below:

a. **Sex Offender Treatment Provider Services.** The Contractor shall provide Sex Offender Treatment Provider Services for Residents as follows:

(1) **Court Orders and Assignments.** Before any Services shall be eligible to be compensated under this Contract, Contractor must have been approved in writing by the Court to provide SOTP services for the specific Resident, and must have been assigned in writing by the Contract Manager to provide Services to that Resident. Upon receipt of a court order approving Contractor to provide Services, Contractor shall immediately transmit the order to the Contract Manager with a request that the Resident be assigned to Contractor pursuant to this Contract.

(2) **Pre-Placement Review**. Prior to a Resident's transition to a Less Restrictive Alternative placement, the Contractor shall meet with the Resident, consult with the Resident's SCC therapist, and conduct a complete records review. If requested, by the RCTT, the Contractor shall participate in discussion of the Resident with the SCC Senior Clinical Team prior to the Resident's release to the LRA.

(3) **Preapproved Review of Additional Records**. Contractor shall conduct record reviews that are in addition to the records review included in the pre-placement review described in Subsection 4.a (1), as determined necessary and preapproved by the Chief of Resident Treatment or Contract Manager.

(4) **Community Treatment Plan Review.** Contractor shall submit a written, individualized Community Treatment Plan for each Resident referred to the Contractor within fourteen (14) calendar days following the pre-placement review described in Subsection 4.a (1) above. The CTP shall be submitted to the Chief of Resident Treatment for approval and shall meet the requirements of 388-880-040 WAC, Individual Treatment. The Contractor shall update the individualized CTP ninety (90) days from the date of the Resident's placement in the LRA and shall review and update the Resident's CTP, if requested by the Chief of Resident Treatment every six (6) months. Contractor shall update the individualized CTP whenever additional services are preapproved by the Chief of Resident Treatment. The minimum contents of the CTP are set forth on Exhibit C, Community Treatment Plan Requirements.

(5) **Evaluations**. Contractor shall perform Evaluations on a monthly basis that assess the Resident's treatment progress in relation to identified Dynamic Risk Factors and issues related to public safety. This assessment shall be submitted in writing as part of the Monthly Report described below in this Section 4, Statement of Work, Subsection c.(2), Monthly Report and on Exhibit B, SOTP Contractor Monthly Reports.

(6) **Best Practices – ATSA Practice Guidelines**. Contractor shall ensure that treatment for Residents is consistent with best practices as identified by the Association for Treatment of Sexual Abusers (ATSA). The Contractor shall obtain a copy of the ATSA Practice Guidelines for the Assessment, Treatment and Management of Male Adult Sexual Abusers (2014) ("ATSA Practice Guidelines"), to include the ATSA practice guidelines for treatment of individuals with Intellectual and Developmental Disabilities (IDD), at the Contractor's own expense. These can be obtained by contacting ATSA at www.atsa.com. Except as preapproved in writing by the Chief of Resident Treatment, no treatment approaches other than those set forth in the ATSA Practice Guidelines shall be reimbursed under this Contract.

(7) **Individual Counseling**. Contractor shall provide a minimum of one (1) individual counseling session per week, up to a maximum of two (2) sessions per week. Each counseling session shall be up to one (1) hour in length, or as otherwise preapproved in writing by the Chief of Resident Treatment.

(8) **Additional Contact**. Scheduled telephonic or other contact with the Resident between the individual counseling sessions described in Subsection 4.a.(6) above must be preapproved by the Chief of Resident Treatment.

(9) **Group Counseling**. Contractor shall provide a minimum of one (1) group counseling sessions specific to sex offender treatment per week, up to a maximum of two (2) group counseling sessions per week. Each group counseling session shall be a maximum of three (3) hours in duration, unless otherwise preapproved in writing by the Chief of Resident Treatment. In the event the Chief of Resident Treatment determines that group therapy sessions are contraindicated for a Resident, Contractor shall not provide these services and shall not invoice for them with respect to that Resident.

(10) **Participation in RCTT Meetings and Senior Clinical Team Progress**

Reviews. Contractor shall serve on and participate in meetings of the Resident's Community Transition Team in order to coordinate treatment goals, discuss progress, and ensure compliance with the court-ordered conditions of release. The location of RCTT meetings shall be determined as needed by the RCTT. Contractor shall also participate in SCC Senior Clinical Team progress reviews as requested by the Chief of Resident Treatment at a location designated by the Chief of Resident Treatment.

(11) **Functional Assessment Report.** A written Functional Assessment report is required when a Resident has a current Functional Assessment from the SCC and/or when it is recommended by the SCC Senior Clinical Team. When required, Contractor shall complete this Functional Assessment, in collaboration with the LRA for data collection, within ninety (90) days of the Resident arriving at the LRA. This report shall be submitted to the Chief of Resident Treatment and the Contract Manager upon completion.

(12) **Positive Behavioral Support Plan.** When indicated by the Functional Assessment report, the Contractor shall complete the PBSP in collaboration with the LRA. The PBSP shall be completed and implemented within thirty (30) days of the completion of the Functional Assessment report. The Functional Assessment report will be used when developing the PBSP, which shall adhere to literature and best practice of behavioral analysis. All tangible incentives included in the PBSP that require purchase or billing must be preapproved in writing by the Contract Manager before they can be offered.

b. **Other services.** The Contractor shall provide other Services as follows:

(1) **Ancillary Treatment.** Contractor shall provide ancillary treatment as determined appropriate and preapproved by the Chief of Resident Treatment. This may include transitional services identified by the Resident's Community Transition Team as necessary to facilitate treatment and integration of the Resident into the community. These services may consist of asking a family member or other individual to participate in the Resident's transition for educational purposes, chaperone training, assessment for a referral, etc.

(2) **Ancillary Therapy - Limitations**. The Contractor shall not provide family and relationship support as it pertains to current sex offender treatment issues to anyone other than the Resident, unless preapproved in writing by the Chief of Resident Treatment or required under a court order.

(3) **Limitation on Referrals**. Contractor shall inform SCC regarding all referrals of the Resident for treatment or additional services not provided through this Contract, which referrals shall also be presented RCTT for approval.

(4) **Testimony.** Contractor shall appear and testify in depositions and superior court proceedings as requested by the SCC or the court.

(5) **RCTT Consultations.** Contractor shall serve as a member of the Resident's Community Transition Team and will attend monthly RCTT meetings. In addition, Contractor may consult with RCTT members outside of monthly meetings via face-to-face meetings, phone calls, emails or in writing to discuss the services

performed under this Contract. These meetings shall not exceed one (1) hour per month unless authorized in writing by the Contract Manager.

(6) **Resident Violations**. Contractor shall immediately report violations of the Resident's court-ordered conditions to the Court, the prosecutor, the assigned CS, the Chief of Residential Treatment, the DSHS contract manager and the SCC Chief Executive Officer. If outside normal business hours, Contractor shall notify SCC Control at 253-589-6301, who will forward the information to the Chief of Resident Treatment and SCC Chief Executive Officer.

(7) **Violation Reviews by RCTT**. If a Resident's Community Transition Team needs to meet to review violations outside of the usual monthly RCTT meeting, such violation review meeting shall occur telephonically or in person and shall not exceed two (2) hours.

(8) **Residents Returned to SCC.** If a Resident is returned to the SCC, the Contractor shall assist in requesting Resident cooperation in providing a release of information to permit SCC to develop a continuity plan. Contractor may continue to provide individual and group counseling sessions as ordered by the Court or as directed by the Chief of Resident Treatment

(9) **Residents Returned to SCTF**. If a Resident is returned to an SCTF due to a violation of the court-ordered conditions, the Contractor shall continue to provide community-based treatment according to the terms currently specified within this Contract, as requested by the SCC.

c. **Records and Reports Generally.** The Contractor must maintain typed or legible handwritten records related to all Services provided including, but not limited to, the following:

(a) Progress notes for each individual and group session.

(b) Notes for all contact with Residents outside of treatment sessions (including face-to-face, telephonic, and written contacts).

(c) Notes for face-to-face, telephonic, and written communication with Resident's family, friends, or other appropriate parties.

(d) Consultation with other professionals (including face-to-face, telephonic, and written contacts).

(e) Reports as described on Exhibit B, SOTP Contractor Monthly Reports, shall be submitted to the SCC as provided therein.

(f) These records shall be made available to SCC for review as determined necessary by the Chief of Resident Treatment. These records must also be located and maintained in accordance with 388-880-043 WAC Resident records – location and custody.

d. **Time Frames, Volumes, Durations and Approvals of Services**. Services shall be provided within the time frames, within the frequencies, and for the durations set

forth in Exhibit E, Service Types, Volumes, Approvals and Rates. If a Service, or some aspect of a Service, requires preapproval, Contractor shall secure written preapproval prior to providing the Services as requested in these Special Terms and Conditions, and shall include documentation of this preapproval with the applicable invoice**.**

e. **Termination of Treatment.** In addition to any notifications required to be provided to the court, the Contractor shall provide advance written notification to the Contract Manager and the SCC Chief of Transition and Program Accountability, of the Contractor's decision to terminate treatment with a particular Resident. The Contractor may initially provide verbal notification to the Contract Manager but must follow-up with a written notification of termination within twenty-four (24) hours.

5. Use of Contractor Offices by SCC or SCC Contractors

Subject to availability and advance agreement by Contractor, Contractor will allow SCC or its designated SCC contractors to utilize office space in Contractor's current place of business for purposes of performing interviews as part of annual evaluations for SCC LRA Residents. Contractor shall be entitled to invoice SCC at the hourly space usage rate detailed in Section 8, Consideration.

6. SCC Responsibilities. The SCC shall provide the Contractor with the following:

a. **Written Materials**. SCC shall provide written materials detailing the operation and purpose of the Sexually Violent Predator Program and other relevant materials, as determined necessary by the Chief of Resident Treatment.

b. **Security Clearance**. SCC shall provide security clearance to McNeil Island, SCC, and SCTF(s) on an as-needed basis.

7. Performance Tracking; Performance and Outcome Measures. The Contract Manager shall track and evaluate Contractor's performance based upon some or all of the service requirements set forth in Section 4, Statement of Work. In addition, the Contractor's performance may be reviewed based upon the following outcome measures:

a. The timeliness of Contractor's Services;

b. The quality of the Contractor's Services based upon any feedback received from Clients and Facility personnel;

c. The quality of the Contractor's Services based upon the timeliness, thoroughness and responsiveness to Facility requirements as set forth in any reports required to be submitted under this Contract; and

d. If applicable to this Contract, the Contractor's efforts to assist Clients with behavioral health conditions to avoid involvement in the criminal justice system.

8. Consideration. The maximum total consideration payable to the Contractor for satisfactory performance of the Services under this Contract is up to the maximum amount set forth on page 1 of the Contract, as modified on page 1 of the most recent

amendment, if applicable. This maximum amount includes any and all fees and expenses incurred by Contractor in performing this Contract. Payment is contingent on the satisfactory performance of the Services, including all deliverables described in this Contract. Payment shall be based on the following:

a. **Schedule**. Subject to the Contract Manager's assignment of a Resident to Contractor for Services and the submission of documentation of all required preapprovals with its invoice, Contractor shall be entitled to bill for Services in accordance with the Service Types, Volumes, Approvals and Rates attached to this Contract as Exhibit E.

b. **Expenses Requiring Preapproval.** The following types of travel expense reimbursement shall be subject to preapproval and are subject to State of Washington Travel Reimbursement guidelines (www.ofm.wa.gov/resources/travel.asp) in effect at the time of service for the county in which Services are provided and shall be limited to the following:

   (1) Lodging at a commercial lodging facility.

   (2) Up to three (3) meals per day as actually purchased, during the period in which the Contractor is providing Services.

   (3) Air fare for travel between the Contractor's place of business and the location where Services are provided. (Note: Preapproved air travel shall be reimbursed at coach or economy rates, whichever is least expensive. The Contractor shall not be reimbursed for any insurance the Contractor purchases from the airline, ticket vendor, or any other provider of travel insurance.)

   (4) Parking of the Contractor's personal vehicle at a parking facility serving the airport of departure, at the most economical rates available.

   (5) Car rental while at the destination location, at either economy or mid-sized rates, for the days when services are provided. (Reimbursement shall not include any insurance the Contractor purchases from the car rental company/vendor.)

   (6) Up to $20 reimbursement for automobile fuel, or as otherwise approved by the DSHS Contract Manager.

c. **Receipts.** Receipts for all lodging, air fare, parking, car rental, and automobile fuel expenses to be considered for reimbursement must be attached to invoices submitted to SCC.

d. **Unanticipated or Extraordinary Expenses.** Expenses incurred by the Contractor outside of the expenses eligible for reimbursement as set forth above shall be considered on a case-by-case basis by the DSHS Contract Manager.

e. **Office Space Usage.** Payment for use of Contractor's office space as provided under Section 5 of these Special Terms and Conditions shall be at the rate of $60.00 per hour.

f. **Expenses Not Requiring Preapproval**. The Contractor shall be entitled to invoice

DSHS for Contractor's time in traveling from the Contractor office location that is closest to the destination to which Contractor must travel to provide Services required under this Contract. Contractor shall maintain a log identifying all travel for which reimbursement of travel time is requested, which shall be submitted with Contractor's invoice and shall identify the reason for travel, the point of departure, departure time, destination, and arrival time. Reimbursement of travel time shall not exceed two hours, each way, and shall be billed at the rate of $100 per hour of travel time. .

g. **Use of Personally Owned Vehicles.** Contractor shall not be entitled to charge DSHS for mileage involved in use of a personal vehicle, nor shall Contractor be entitled to reimbursement for travel hours spent commuting. "Commuting" shall refer to all travel between Contractor's home and any place of business operated by Contractor.

h. **Parking near Steilacoom Dock.** The Contractor shall be not be reimbursed for the cost of parking at the 'Self Pay' Lot at Steilacoom Dock. Contractors shall not park in the staff parking lots located on the east side of the Dupont-Steilacoom Road (Union Avenue). Violators may be ticketed by the Town of Steilacoom and will not be reimbursed for ticket costs. If the SCC previously provided the Contractor with an Employee parking pass, Contractor must return this pass to the Contract Manager.

9. Billing and Payment.

a. **Invoice System**. The Contractor shall submit invoices using State Form A-19 Invoice Voucher no later than fifteen (15) calendar days following the month in which the services were provided. Failure to submit invoices in a timely manner shall result in delay in consideration of subsequent invoices. Consideration for services rendered shall be payable upon receipt and acceptance by the DSHS contract manager of properly completed invoices submitted not more often than monthly to the following email address: CBS3Institution-Fiscal@dshs.wa.gov. The DSHS contract number should be identified in the Subject line of the email.

Although emailing the invoice is the preferred and faster method, should the Contractor not be able to use email, the invoice may be mailed to the following address:

Department of Social and Health Services
Consolidated Business Services (CBS3)
Attention: Accounting
1949 South State Street
MS: N27-35
Tacoma, WA 98405
CBS3Institution-Fiscal@dshs.wa.gov

b. **Invoice Contents and Receipts**. Contractor's invoices shall document, to DSHS' satisfaction, the types, volumes, required approvals and rates for the Services provided by Contractor, with specific reference to the numbering associate with each type of Services as set forth on Exhibit E, Service Types, Volumes, Approvals and Rates. The dates and hours of service, applicable rates or payment amounts, and expense reimbursement requested, must be set forth with specificity.

c. **Reimbursement.** To be eligible for reimbursement, expenses must be supported with legible itemized receipts. When preapprovals are required, the Contractor must submit documentation of preapprovals with its invoices. SCC shall not be responsible for delays in processing invoices caused by the need to request that Contractor provide the required detail to support its charges, as described in this paragraph.

d. **Payment**. Payment shall be considered timely if made by DSHS within thirty (30) days after receipt and acceptance by the Contract Manager of the properly completed invoices. Payment shall be sent to the address designated by the Contractor on page one (1) of this Contract. DSHS may, at its sole discretion, withhold payment claimed by the Contractor for services rendered if Contractor fails to satisfactorily comply with any term or condition of this Contract.

10. Insurance

The Contractor shall obtain and maintain for the duration of the Contract, at Contractor's expense, the following insurance coverages, and comply with the following insurance requirements.

a. General Liability Insurance

The Contractor shall maintain Commercial General Liability Insurance or Business Liability Insurance, no less comprehensive than coverage under Insurance Service Offices, Inc. (ISO) form CG 00-01, including coverage for bodily injury, property damage, and contractual liability. The amount of coverage shall be no less than $1,000,000 per occurrence and $2,000,000 General Aggregate. The policy shall include liability arising out of the parties' performance under this Contract, including but not limited to premises, operations, independent contractors, products-completed operations, personal injury, advertising injury, and liability assumed under an insured contract. The State of Washington, Department of Social & Health Services (DSHS), its elected and appointed officials, agents, and employees of the state, shall be named as additional insureds.

b. In lieu of general liability insurance mentioned in Subsection a. above, if the Contractor is a sole proprietor with less than three contracts, the contractor may choose one of the following three general liability policies, but only if attached to a professional liability policy. If selected the policy shall be maintained for the life of the contract:

Supplemental Liability Insurance, including coverage for bodily injury and property damage that will cover the contractor wherever the service is performed with minimum limits of $1,000,000 per occurrence; and $2,000,000 General Aggregate. The State of Washington, DSHS, its elected and appointed officials, agents, and employees shall be named as additional insureds;

or

Workplace Liability Insurance, including coverage for bodily injury and property damage that provides coverage wherever the service is performed with minimum limits of $1,000,000 per occurrence; and $2,000,000 General Aggregate. The State

of Washington, DSHS, its elected and appointed officials, agents, and employees shall be named as additional insureds:

or

Premises Liability Insurance if services are provided only at their recognized place of business, including coverage for bodily injury, property damage with minimum limits of $1,000,000 per occurrence; and $2,000,000 General Aggregate. The State of Washington, DSHS, its elected and appointed officials, agents, and employees shall be named as additional insureds.

c. Workers' Compensation

The Contractor shall comply with all applicable Workers' Compensation, occupational disease, and occupational health and safety laws and regulations. The State of Washington and DSHS shall not be held responsible for claims filed for Workers' Compensation under Title 51 RCW by the Contractor or its employees under such laws and regulations.

d. Employees and Volunteers

Insurance required of the Contractor under the Contract shall include coverage for the acts and omissions of the Contractor's employees and volunteers. In addition, the Contractor shall ensure that all employees and volunteers who use vehicles to transport clients or deliver services have personal automobile insurance and current driver's licenses.

e. Subcontractors

The Contractor shall ensure that all subcontractors have and maintain insurance with the same types and limits of coverage as required of the Contractor under the Contract. Failure of Subcontractors to comply with the insurance requirements in this Contract does not limit the Contractor's liability or responsibility.

f. Separation of Insureds

All insurance policies shall include coverage for cross liability and contain a "Separation of Insureds" provision.

g. Insurers

The Contractor shall obtain insurance from insurance companies identified as an admitted insurer/carrier in the State of Washington, with a current Best's Reports' rating of A-, Class VII, or better.

h. Evidence of Coverage

The Contractor shall, upon request by DSHS, submit a copy of the Certificate of Insurance, policy, and additional insured endorsement for each coverage required of the Contractor under this Contract. The Certificate of Insurance shall identify the Washington State Department of Social and Health Services as the Certificate

Holder. A duly authorized representative of each insurer, showing compliance with the insurance requirements specified in this Contract, shall execute each Certificate of Insurance.

The Contractor shall maintain copies of Certificates of Insurance, policies, and additional insured endorsements for each subcontractor as evidence that each subcontractor maintains insurance as required by the Contract.

i. Material Changes

The insurer shall give the DSHS point of contact listed on page one of this Contract 45 days advance written notice of cancellation or non-renewal of any insurance policy required under this Contract. If cancellation is due to non-payment of premium, the insurer shall give DSHS 10 days advance written notice of cancellation. Failure to provide notice as required may result in termination of the Contract.

j. Waiver of Subrogation

Contractor waives all rights of subrogation against DSHS for the recovery of damages to the extent such damages are or would be covered by insurance required under the Contract. Contractor agrees to obtain any endorsement that may be necessary to affect this waiver of subrogation, but this provision applies whether or not DSHS receives the waiver of subrogation endorsement from the insurer.

k. Coverage Limits

By requiring insurance, the State of Washington and DSHS do not represent that the coverage and limits required in this Contract will be adequate to protect the Contractor. Such coverage and limits shall not limit the Contractor's liability in excess of the required coverage and limits, and shall not limit the Contractor's liability under the indemnities and reimbursements granted to the State and DSHS in this Contract.

l. Primary Coverage

All Contractor's insurance provided in compliance with this Contract shall be primary and shall not seek contribution from insurance or self-insurance programs afforded to or maintained by the State. Insurance or self-insurance programs afforded to or maintained by the State shall be in excess of, and shall not contribute with, insurance required of the Contractor and Subcontractors under this Contract.

m. Waiver

The Contractor waives all rights, claims and causes of action against the State of Washington and DSHS for the recovery of damages to the extent said damages are covered by insurance maintained by Contractor.

n. Liability Cap

Any limitation of liability or liability cap set forth in this Contract shall not preclude DSHS from claiming under any insurance maintained by the Contractor pursuant to

this Contract, up to the policy limits.

o. Business Automobile Liability Insurance

The Contractor shall maintain a Business Automobile Policy on all vehicles used to transport clients, including vehicles hired by the Contractor or owned by the Contractor's employees, volunteers or others, with the following minimum limits: $1,000,000 per accident combined single limit. The Contractor's carrier shall provide DSHS with a waiver of subrogation or name DSHS as an additional insured.

p. Professional Liability (errors & omissions)

The Contractor shall maintain insurance of at least $1,000,000 per occurrence, $2,000,000 General Aggregate for malpractice or errors and omissions coverage against liability for damages because of personal injury, bodily injury, death, or damage to property, including loss of use, and damages because of negligent acts, errors, and omissions in any way related to this contract.

11. Disputes. The Contractor may request resolution of a dispute according to SCC's contract dispute resolution process as follows:

a. Contract disputes shall be resolved at the lowest organizational level possible in which the Contractor shall submit a written request for resolution directly to the Contract Manager. The request must include the following information:

(1) The Contractor's name, address, phone number.

(2) The Contract number.

(3) Identification and description of the issue(s) in dispute.

(4) A statement describing the Contractor's position on the issue in dispute, including any documentation that supports this position.

b. The Contractor's request for dispute resolution must be mailed to the address listed on the front of this contract within ten (10) days after the Contractor could reasonably be expected to have knowledge of the issue in dispute.

c. The Contract Manager shall review the dispute resolution request and issue a written response to the Contractor within 30 days of receiving the written request.

d. Items not eligible for dispute include the amount of any rates set by law, regulation, or DSHS policy.

e. Except for those items of dispute that fall under RCW 43.20.B.675, Revenue recovery for the Department of Health and Social Services, the dispute resolution process described above is the sole administrative remedy available under this Contract.

Appendix D

SCC Sex Offense Treatment Provider (SOTP) Rates for Psychologists

EXHIBIT E – SOTP SERVICE TYPES, VOLUMES, APPROVALS AND RATES					
Section Ref	**Description**	**Maximum Duration** **Longer Service by Written Preapproval Only**	**Volume (per Resident)**	**Hourly rate**	**SCC approver**
4. a. 1.	Pre-LRA Placement Review	Up to 3 hours unless a longer period is preapproved	One time/placement	$150	Chief of Resident Treatment
4. a. 2.	Pre-LRA Additional Record Review	Up to 8 additional hours if approved	One time/placement	$150	Contract Manager
4. a. 3.	Community Treatment Plans and Updates to Community Treatment Plan	Up to 4 hours per CTP or updated CTP	Upon Placement and every six months thereafter	$150	Contract Manager or Chief of Resident Treatment
4. a. 4.	Monthly Reports	Up to 3 hours per report	Monthly	$150	Contract Manager
4. a. 6.	Individual Counseling	1 or 2 hours per session	2 one-hour sessions/week, or 1 two-hour session/week	$150	Chief of Resident Treatment
4. a. 7.	Additional Contacts with Resident between counseling sessions	As preapproved	As preapproved	$150	Chief of Resident Treatment
4. a. 7.	Phone calls to family, friends and chaperones	Up to 2 hours	Monthly	$150	Contract Manager
4. a. 8.	Group Counseling Sessions	Up to 3 hours per session	1-2 sessions/week	$75 (per Resident)	Contract Manager
4. a. 9.	Participation in RCTT meetings. Participation in Senior Clinical Team Progress Reviews when requested by Chief of Resident Treatment	Up to 2 hours per Resident per month, unless additional hours are preapproved	Monthly	$150	Chief of Resident Treatment
4. a. 10.	Functional Assessment	Up to 10 hours	As required or referred by Senior Clinical	$150	Chief of Resident Treatment

4. a. 11.	Positive Behavioral Support Plan	Included in Maximum Hours for Functional Assessment	As required based on Functional Assessment or referred by Senior Clinical Team	$150	Chief of Resident Treatment and, for incentives in PBSP, Contract Manager
4. b. 1.	Ancillary Support	As preapproved	As preapproved	$150	Chief of Resident Treatment
4. b. 4.	Subpoena for Deposition or Testimony	Preparation Time must be preapproved	As Required	$150	Contract Manager
4. b. 5.	Interim RCTT Consultations	Up to One Hour Per Month	Monthly	$150	N/A
4.b.6 and 4.b.7	Violation Reports and RCTT Violation Reviews	Up to Two hours Per Violation	As required	$150	N/A
7. b. 2.	Preapproved Travel Expenses	As preapproved	As preapproved	State Guidelines	Contract Manager
7. f. 1.	Business Travel Hours (excluding commuting) recorded in travel log	Up to 2 hours each way for a maximum of 4 hours per trip	As Required and submitted with monthly billing	$100 per hour	Contract Manager

Appendix E

SCC Sex Offense Treatment Provider (SOTP) Rates for Non-Psychologists

EXHIBIT E – SOTP SERVICE TYPES, VOLUMES, APPROVALS AND RATES					
Section Ref	**Description**	**Maximum Duration** **Longer Service by Written Preapproval Only**	**Volume (per Resident)**	**Hourly rate**	**SCC approver**
4. a. 1.	Pre-LRA Placement Review	Up to hours unless a longer period is preapproved	One time/placement	$125	Chief of Resident Treatment
4. a. 2.	Pre-LRA Additional Record Review	Up to 8 additional hours if approved	One time/placement	$125	Contract Manager
4. a. 3.	Community Treatment Plans and Updates to Community Treatment Plan	Up to 4 hours per CTP or updated CTP	Upon Placement and every six months thereafter	$125	Contract Manager or Chief of Resident Treatment
4. a. 4.	Monthly Reports	Up to 3 hours per report	Monthly	$125	Contract Manager
4. a. 6.	Individual Counseling	1 or 2 hours per session	2 one-hour sessions/week, or 1 two-hour session/week	$125	Chief of Resident Treatment
4. a. 7.	Additional Contacts with Resident between counseling sessions	As preapproved	As preapproved	$125	Chief of Resident Treatment
4. a. 7.	Phone calls to family, friends and chaperones	Up to 2 hours	Monthly	$125	Contract Manager
4. a. 8.	Group Counseling Sessions	Up to 3 hours per session	1-2 sessions/week	$50 (per Resident)	Contract Manager
4. a. 9.	Participation in RCTT meetings. Participation in Senior Clinical Team Progress Reviews when requested by Chief of Resident Treatment	Up to 2 hours per Resident per month, unless additional hours are preapproved	Monthly	$125	Chief of Resident Treatment
4. a. 10.	Functional Assessment	Up to 10 hours	As required or referred by Senior Clinical	$125	Chief of Resident Treatment

4. a. 11.	Positive Behavioral Support Plan	Included in Maximum Hours for Functional Assessment	As required based on Functional Assessment or referred by Senior Clinical Team	$125	Chief of Resident Treatment and, for incentives, Contract Manager
4. b. 1.	Ancillary Support	As preapproved	As preapproved	$125	Contract Manager
4. b. 1.	Preauthorized Ancillary Treatment		As authorized	$125	Contract Manager
4. b. 4.	Subpoena for Deposition or Testimony	Preparation Time must be preapproved	As Required	$125	Contract Manager
4. b. 5.	Interim RCTT Consultations	Up to One Hour Per Month	Monthly	$125	N/A
4.b.6 and 4.b.7	Violation Reports and RCTT Violation Reviews	Up to Two hours Per Violation	As required	$125	N/A
7. b. 2.	Preapproved Travel Expenses	As preapproved	As preapproved	State Guidelines	Contract Manager
7. f. 1.	Business Travel Hours (excluding commuting) recorded in travel log	Up to 2 hours each way for a maximum of 4 hours per trip	As Required and submitted with monthly billing	$100	Contract Manager

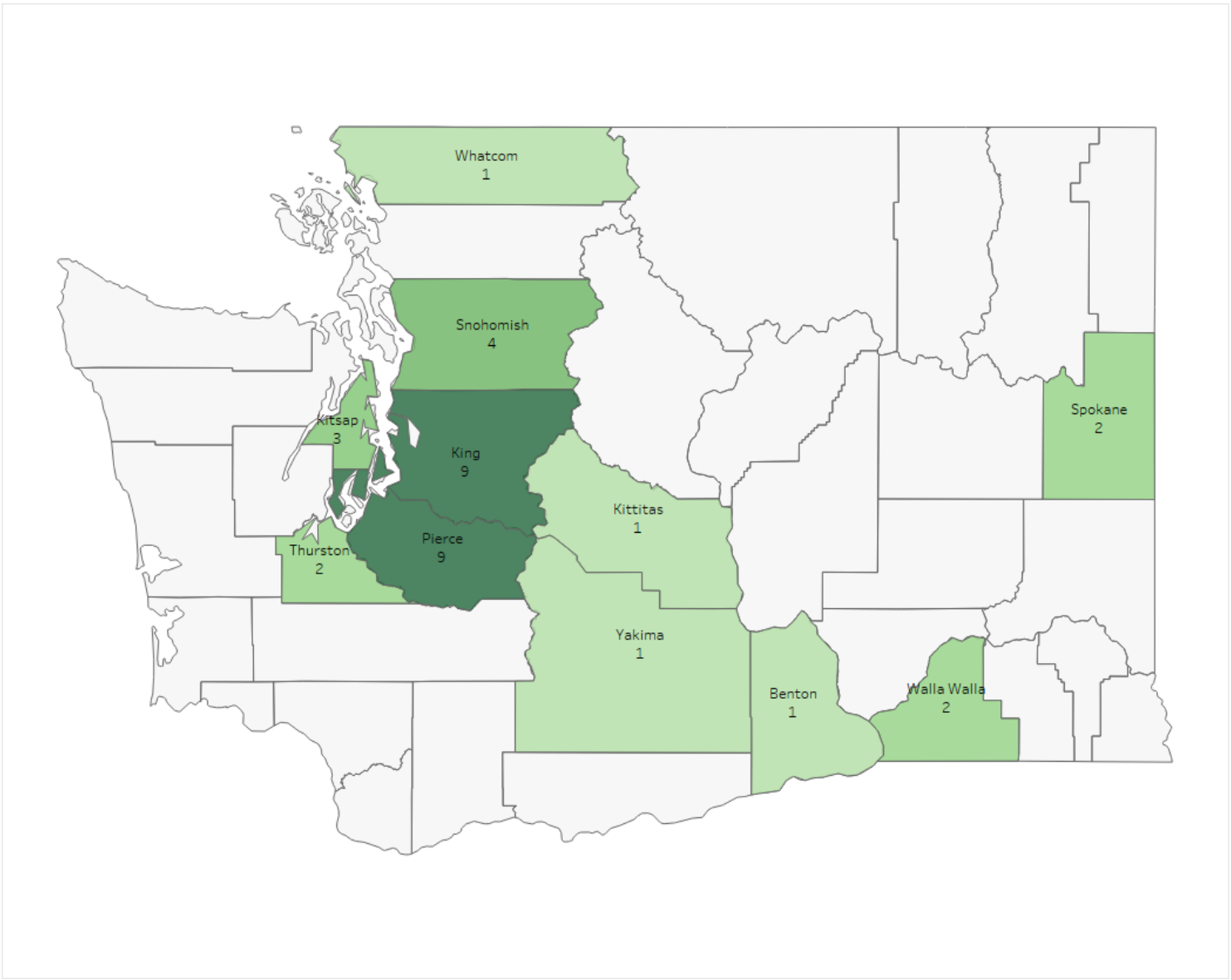
Appendix F

SCC Current and Predicted Caseload Handout

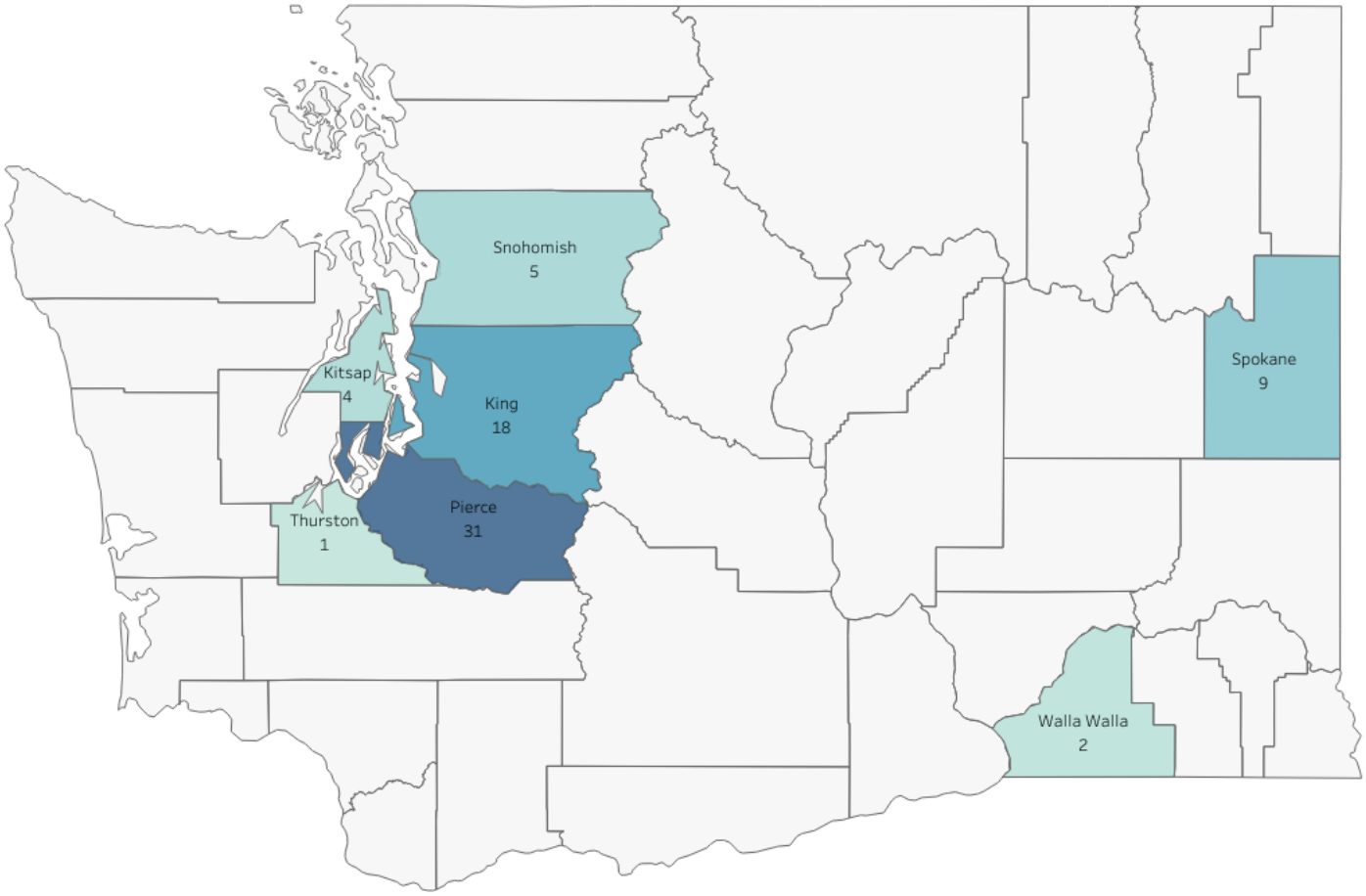
Current Caseloads of SOTPs who serve LRA Clients

Data tables compiled by Jonathan Sherry, SCC's Director of Discharge Services
Maps prepared by Tomas Mosquera, OFM Forecasting & Research Division

Current SCC-Contracted SOTP Providers by Service Area

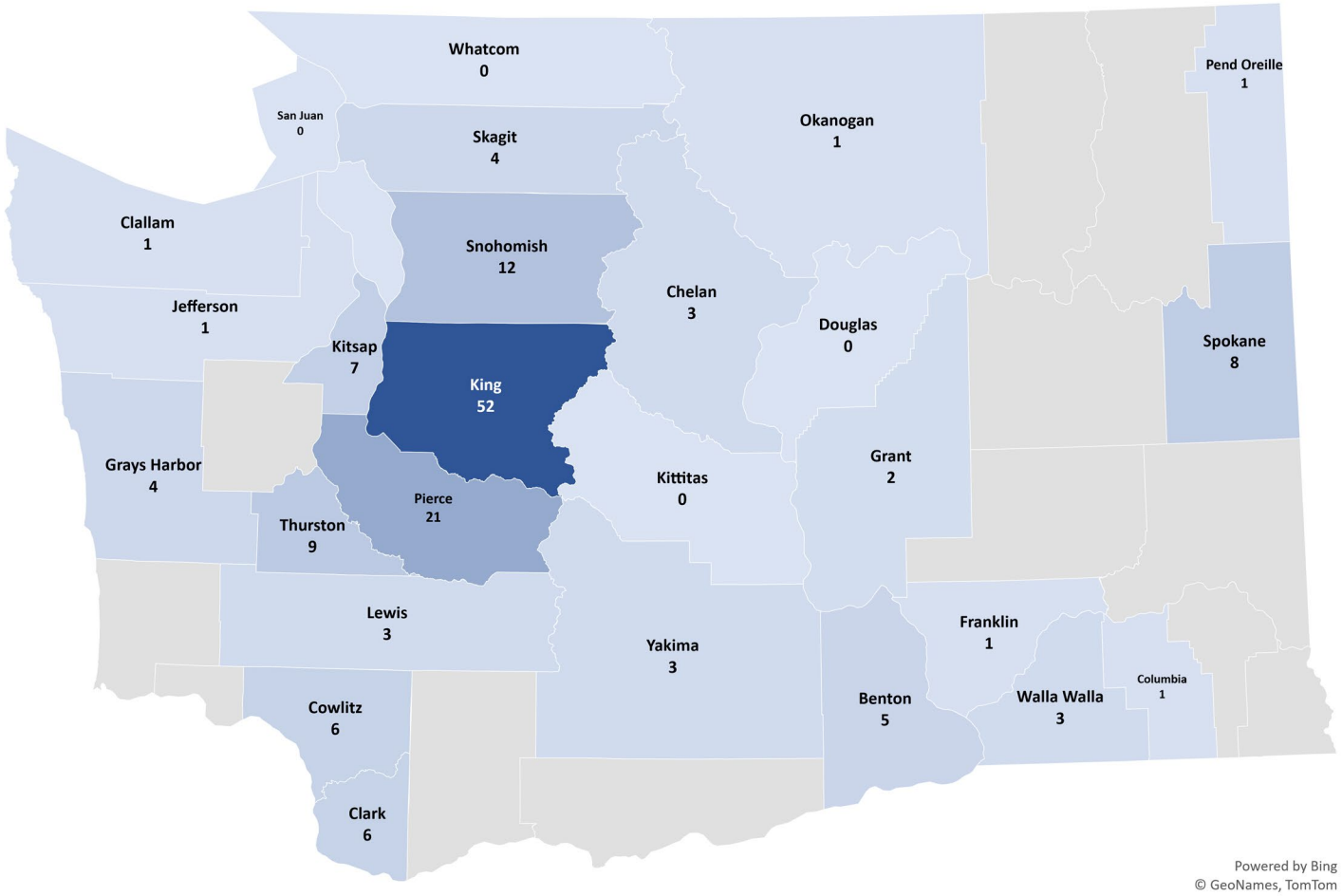


Map of Current LRA Residents by County (County Map Link | Zip Code Map Link | City Map Link)



SCC's Predicted LRA Caseload by County of Commitment

Data on Total Confinement (TCF) Residents who could qualify for an LRA, based on the resident's county of commitment. Only includes the current population of adult residents who have come into contact with SCC or WSH.



Based on these predictions, SCC expects the number of LRA-eligible residents to increase in counties that SOTPs currently don't serve. LRA capacity needs to be expanded in areas where SOTPs do not provide coverage to LRA clients.

Appendix G

Compiled Feedback from SOTPs with LRA Experience

Compiled Feedback from SOTPs: Working with LRA Clients in Washington
August 2021 | Prepared by Megan A. Schoor, MPA, PhD, LSSBB

In August 2021, the SB 5163 Workgroup and Interim SOPB Coordinator organized a virtual Listening Session and online survey to gather feedback from Sex Offense Treatment Providers (SOTPs) who have experience working with LRA clients in Washington. The questions below were asked via the Listening Session during the public workgroup meeting, online survey, and email message. The online survey was available until August 27th.

1. *Have you worked with or considered working with LRA clients?*
2. *What's it like to be an SOTP who works (or worked) with LRA clients? What knowledge, skills, and abilities are needed to be a high-quality SOTP? Please provide as much detail as possible.*
3. *How would you describe your experience as an SOTP contracting with DSHS? What went well? What could have gone better?*
4. *What barriers or challenges do/did you face as an SOTP working with LRA clients?*
5. *What incentives would help increase the availability and quality of SOTPs who serve LRA clients?*
6. *What other suggestions do you have to help increase the availability and quality of SOTPs who serve LRA clients in Washington?*

This handout compiles all feedback from the August 26th Listening Session, emails, and online survey. Feedback is organized based on each of the six questions and the emerging themes from the responses. Eleven major themes emerged from gathering feedback from SOTPs who have experience working with LRA clients:

Major Themes from SOTP Feedback	
1. Most participants who provided feedback have worked with LRA clients for ~10-20 years.	7. Collaboration within and outside of Transition Teams can be adversarial. Cultural competency may be lacking within multi-agency Transition Teams.
2. LRA clients are sometimes difficult to work with given the complexity of their cases. SOTPs find the work both rewarding and challenging.	8. SOTPs cannot anticipate potential changes to their caseload because they have no advance notice of when LRA clients are assigned to them.
3. SOTPs who work with LRA clients should regularly engage in helpful professional development trainings and resources, including with other treatment providers.	9. There is a need to increase camaraderie and collaboration among SOTPs and multi-disciplinary teams.
4. A successful contracting experience involves strong client-centered collaborations with agency partners and fellow SOTPs.	10. Dismantle the misperception that no “quality” SOTPs currently work in Washington.
5. The current licensing process and contracting system does not incentivize SOTPs to work in the field, much less with LRA clients.	11. The costs and requirements to become a licensed SOTP can be confusing and a barrier to entering the field.
6. Contracts, billing, and compensation rates are major challenges for SOTPs who work with LRA clients.	

1. Have you worked with or considered working with LRA clients?

Emerging Theme #1: Most participants who provided feedback have worked with LRA clients for ~10-20 years.

Listening Session:

- **Dr. Michael O'Connell** worked with a few LRA clients in the late 1990s. As President of WATSA in the 2000s, he testified with the idea of getting partial indemnification to make the profession less frightening, and that made a difference. His time felt like important work and was a rewarding experience.

Online Survey:

- "I have work[ed] with a number of LRA clients for the past 9 years" **– SOTP Survey Participant #1**
- "Only in my capacity as a member of the Clinical Dept. at SCC... I have assisted to prepare residents from all 3 tracks on their way towards an LRA, as well as working with those who have been returned due to violations. It is a long process, with a lot of miscommunication towards the residents coming from DAs, social workers, and Community Specialists. This creates frustrating confusion, especially for those who struggle with cognitive difficulties…" **– SOTP Survey Participant #2**
- "Yes, for the last 9 years." **– SOTP Survey Participant #3**
- "yes, have worked with LRA since 2005. When in California my last year worked with similar population but we didn't call them LRA, just "bid offenders." This [is] because of the complexity of the cases (mental health issues + substances + offending)." **– SOTP Survey Participant #4**
- "Yes, I work with LRA clients" **– SOTP Survey Participant #5**

2. What's it like to be an SOTP who works (or worked) with LRA clients? What knowledge, skills, and abilities are needed to be a high-quality SOTP? Please provide as much detail as possible.

Emerging Theme #2: LRA clients are sometimes difficult to work with given the complexity of their cases. SOTPs find the work both rewarding and challenging.

Listening Session:

- **Dr. O'Connell** had around 3 LRA cases at the same time, and it took about 20 percent of his clinical time. They are high-demand cases.
- **Jay Williamson** shared that there is a lot of time spent working with difficult cases. It is important to help them try to understand and stay connected with people. It is an ongoing process, and each person is different. He appreciates all of the feedback from other SOTPs, and the hard work that people put in to working with LRA clients.

Online Survey:

- "It can be frustrating at times. The liability with this population is exceedingly high and the contracted rates had not changed since this program was started until this year when I explained that I was not able to continue offering services at the below market rate. The SCC was unable to increase the rate as requested and it was a nominal increase instead." **– SOTP Survey Participant #1**
- "I find the cases interesting and challenging. They make me work harder and after so many years I appreciate the challenge" **– SOTP Survey Participant #4**
- "I very much enjoy working with this population of clients--my favorite." **– SOTP Survey Participant #5**

Emerging Theme #3: SOTPs who work with LRA clients should regularly engage in helpful professional development trainings and resources, including with other treatment providers. Continuing education trainings should be expanded for SOTPs.

Listening Session:

- **Dr. O'Connell** stated there is a higher percentage of clients with high psychopathy. Recommended attending conferences and training that offer help and information on working with these clients. Seek out additional reading resources. Having additional consultation experience working with psychopathic individuals is invaluable. ATSA conferences offer them regularly, and those trainings were very helpful.
- **Dr. Olson** agreed that seeking out training, books, conferences are profoundly important to being a great SOTP. It's also important to be a good clinician that can tailor services to the individual, not just focus on a one-size-fits-all approach.

Online Survey:

- "It has been a deep work. There have been such good experiences through the depth that is required to do this work. It is suggested that as an SOTP for LRA clients, that you have consistent contact with other treatment providers." **– SOTP Survey Participant #3**
- "I would like to see training on report writing, psychopathic and narcissistic personality training, training on criminal personality. Also training on therapy aside from criminogenic issues. What new modalities of therapy might be effective with the population" **– SOTP Survey Participant #4**
- "Keep the Ball Rolling." **– SOTP Survey Participant #3**

3. How would you describe your experience as an SOTP contracting with DSHS? What went well? What could have gone better?

Emerging Theme #4: A successful contracting experience involves strong client-centered collaborations with agency partners and fellow SOTPs.

Listening Session:

- **Dr. Olson** shared the importance of having a good partner within the organization and with partner agencies like DOC. You're working with them to help with the success of your work and the success of the client.

Online Survey:

- "The depth that it has had me work with. If I would have had other providers explain some of the difficulties that they faced." **– SOTP Survey Participant #2**

Emerging Theme #5: The current licensing process and contracting system does not incentivize SOTPs to work in the field, much less with LRA clients.

Listening Session:

- **Dr. O'Connell** shared that there has been a gradual decline in the number of SOTPs in the recent years. One bill that passed last year now requires that you be fully licensed in one of the underlying health care professions in order to become an Affiliate SOTP, which may discourage new providers from entering the field.

Online Survey:

- "In the past 15 years the contracted rate has not been adjusted in line with inflation and it does not justify the liability and time requirement associated with the contract." **– SOTP Survey Participant #1**

4. What barriers or challenges do/did you face as an SOTP working with LRA clients?

Emerging Theme #6: Contracts, billing, and compensation rates are major challenges for SOTPs who work with LRA clients.

Listening Session:

- Dr. O'Connell shared that the SCC cut to pay was a major reason for his decision to no longer take LRA clients.
- Dr. Olsen shared that a brand new SOTP immediately out of graduate school who cannot practice independently typically start at $155 per hour. Up to $225/hour and $275/hour for a forensic rate.
- Devon shared that King County have a cap of $200/hour for experts, which doesn't allow for increase in COLA or fair market demand.

Online Survey:

- "The contracted rate is too low to justify the liability and work involved." **– SOTP Survey Participant #1**
- "The billing process is awful. There are too many entities working on one case, and no one is talking…Pay us a lot more and pay us on time. Pay for our health insurance" **– SOTP Survey Participant #5**

Emailed Feedback:

- "I began working with the second-ever LRA client in 1996. For at least ten years there was no contract. The court ordered me to provide services, etc., and I sent in a bill once a month. Somewhere in the mid-aughts I got presented with a contract to sign. The fee structure lined up with what I had been charging. I had no problem signing that. I have long heard that there were people who worked at SCC who thought community-based treatment providers had a soft deal and a cushy life, charging for work they did on an hourly basis with no appreciation for the overhead that covered. I have also long heard that SCC wanted to have more control over the community-based treatment process. That hasn't happened, yet, but this 5163 process provides another opportunity to push that agenda. Irwin Dreiblatt, Ph.D. was my long-time mentor and someone I consulted with from 1984 until he retired in the mid- 2000s. He was the State's expert witness in many SVP civil commitment trials, including the very first SVP case – Andre Brigham Young. He commented on the SVP and LRA process as he neared retirement and said he thought the most useful element was how we used independent, community-based treatment provers who could offer experienced, professional judgment which was independent of institutional and political forces. **– Emailed SOTP #2**
    - ***Additional Feedback from Emailed SOTP #2:*** …[A] few years back I had three LRA cases when I was sent a renewal contract form to "review, sign and send back." Embedded in the contract – page 28 of 35, as I recall – was a reduction in fees from $150 per hour to $125. I said I wouldn't agree to that. SCC had their AAG set up court hearings to get a different SOTP assigned. The Courts wouldn't agree to that in two cases but stated it wouldn't get involved in contractual matters. One of the three LRA clients was a few months away from an Unconditional Discharge. The other two I saw through to their Unconditional Discharges, a couple years for one and then 4 or 5 years later for the second one. SCC didn't pay me ANYTHING for many months, then paid me at their reduced rate. Not a friendly environment I wanted any more to do with. How are you going to attract SOTPs like that? Many other SOTPs heard this story and, in spite of that, I've encouraged them to consider taking on LRAs.
- "I'm a licensed psychologist. with specific expertise in working with adults with autism. I received your note about the session on 8/26. Please be aware that it's difficult at best for most people to attend, because (a) that's short notice, and (b) the time you have requested cuts into not one, but two therapy hours for most of us, since sessions typically start at the beginning of the hour. The sex offender portion of my practice is currently limited to doing pre- and post-trial evaluations. I no longer provide treatment, particularly to people with LRAs. The reason is simple: money. I did my supervised hours with a team of people in Tacoma that worked with sex offenders, including transitioning people off McNeil Island. When it came time to get my own contract, I read the clauses. I discovered that I would be paid for therapy, but time to complete additional paperwork, work with CCOs, complete review paperwork, attend review board meetings, etc., was not compensated beyond two hours per quarter (if I remember correctly). I knew from experience working with members of the team that usually that type of overhead work took at least 10% of a provider's time, and that it could take up to 50% of a provider's time, depending upon where the offender is in his process. It meant that during some months, my hourly pay could be halved. That's not an option for me, financially. I actually question how this is legal, since it means that the work is not compensated. Even if the time doing administrative overhead was compensated, the reality is that the state's hourly pay rate for doing therapy is well below market value. For better or worse, everyone's mental health suddenly became more important due to the pandemic. I can currently make about 50% to 70% more treating

private patients that are not sex offenders. I have a six month wait list for both therapy and evaluation. The only financially positive things the state could theoretically give me are healthcare and a pension, and that's only if I work as a full-time employee, not as a contractor treating people on LRAs. In light of the personnel turnover I've seen in my peers, it's unclear to me that I'd want to work for the state as an FTE psychologist long enough to get a pension. Both full-time and contract mental healthcare practitioners other than psychiatrists are inadequately paid by the state. They have not had a raise in years. The main reason psychiatrists got a raise in the last ten years was because they essentially went on strike a few years ago at WSH; they were able to do so because they are not considered essential personnel by law. Psychologists are; going out on strike would break the law, so that kind of collective bargaining is not an option. Instead, to earn our market value, we simply don't work for the state in areas where we are not adequately compensated. That's one of the major reasons Western State is woefully understaffed right now. Taking care of sex offenders on LRAs is another undercompensated area. It's really offensive to me and most of my doctoral-level colleagues that the state pays us less than half of what psychiatrists earn. We do the repetitive work of monitoring and staying in contact with people with very difficult health care problems. A lot of the burden of helping them stay out of trouble is on our shoulders, not the shoulders of someone they see once a quarter for medication management. If something happens to the offenders, we're usually the ones that get the blame, not their psychiatrist. At the same time, most of us have the same number of years of training as physicians. The pay differential is, quite frankly, insulting. The sad part is that I found working with people on LRAs to be a very meaningful job. Every so often, I would see one of the offenders suddenly get insight into himself, and it made the effort we both put in worthwhile. But "meaningful" doesn't pay the bills; money does. Financially, it just doesn't make sense for me to continue doing therapy with sex offenders. The state pays me more closely to my open market value when I do evaluations; it doesn't do so for therapy. If the compensation became closer to the current market value for therapy, I would welcome working with people on LRAs." **– Emailed SOTP #3**

Emerging Theme #7: Collaboration within and outside of Transition Teams can be adversarial. Cultural competency may be lacking within multi-agency Transition Teams.

Listening Session:

- **Dr. O'Connell** stated he never felt pressured, and that the real problem was getting people to show up for the team meetings. It's hard to make critical decisions when all representatives are stretched too thin and not able to attend.
- **Priscilla Hannon** stated the challenge mostly lies with organizations and systems in place. There is often a feeling and experience of bullying.

Online Survey:

- "I have not worked at SCC or SCTF, so I am not familiar with the workings. This sometimes made for challenges in understanding their positions (if different from mine) but was able to accept their agenda might be somewhat different from mine, and I thought we mostly worked well together. When there were misunderstandings, I don't think we addressed and clarified them." **– SOTP Survey Participant #4**

- "It's a challenge. DSHS are generally aligned with DOC. SOTPs are on an island so to speak of our own. You will not get much constructive feedback from SOTPs on this question, as DSHS contracts and pays us (i.e., our boss). Remember we are private practitioners." **– SOTP Survey Participant #5**
- "The barriers is helping these LRA clients was often letting them believe you really wanted to help them in the long run." **– SOTP Survey Participant #3**
- "With minority clients, I was not always sure we were on the same page. Sometimes others seemed a little surprised when I directly addressed issues of race, age, gender. Maybe too blunt? However, no comments were made at racial specific reading assignments I might give or discussions." **– SOTP Survey Participant #4**
- "Stop leaving the social work tasks to the SOTPs. We do not have time. DOC is a challenge--it's absolutely ridiculous at times. I have been screamed at, talked about through email chains and treated as though I'm being supervised. It's exhausting. The attorneys in general are secretive, but expect you to be transparent. The adversarial approach is exhausting from both sides. The defense attorneys make more of an effort to get to know you as a therapist; prosecutors never. However, some of the defense attorneys instantly take an adversarial stance if the client is screwing up. Threaten litigation, try to corner you, threaten a deposition, etc. -When the clients screw up, we get a lot of "I defer to the SOTP" on what to do, even when it's a DOC technical violation. Zero comprehension on how this challenges the therapeutic alliance. **– SOTP Survey Participant #5**

<u>Emailed Feedback:</u>

- ***Additional feedback from Emailed SOTP #2:*** …Three SOTPs I work with or consult with have seriously looked at LRA cases presented to them by defense attorneys. All three said the clients did not look to them to be meaningful LRA candidates and the defense attorneys seemed to be throwing them a Hail Mary pass and they felt uncomfortable about being used in that way and glad they had me to consult with – helping them avoid taking on a terrible case they would have been responsible for. The defense attorneys were very pushy. In another case I am aware of, the SOTP was presented with a treatment contract they had purportedly written up. In fact it was written up, on the SOTP's letterhead, by the defense attorney. That person will never go near an LRA case, ever again. Some SOTPs just don't want to deal with high-risk cases. Who needs the hassle and throw in whatever stories they've heard about the difficulty of dealing with these cases. You've read Dr. Packard's letter to Jennifer Ritchie[1]. Another SOTP and I reviewed and commented on earlier drafts of that letter and the troubles it outlines are widely shared by many other SOTPs I've talked to who have had LRA clients. Some of them had LRA clients and are done, for good. Others have heard those stories and have stayed away. More than a couple of SOTPs have talked about how DOC CCOs have actively undermined their work. I know of a couple cases where a CCO lied about the SOTP in the pre-release report to the court in order to get the LRA plan ditched. I had a CCO actively work to undermine a community LRA and set the stage where the guy f***ed up in frustration and got sent back to total confinement. He did the deeds but the CCO laid the groundwork. That guy

[1] To review this letter, please see Appendix H: LRA Case Recommendations Letter from Dr. Richard Packard to Jennifer Ritchie (March 14, 2017).

eventually got back out via an SCTF, then to a community LRA and was the last of my LRA clients to get an unconditional discharge. But along the way it was pulling teeth to get conditions reduced to afford a glide path to where the last day of his LRA was anything like the first day of his unconditional discharge. Brandon Duncan had to intervene because the CCO was this far from arresting him and sending him back to the island for getting gas at a station his previous CCO had OK'ed but which was not evident in the file. The conditions never got changed because the Court and the AAG were waiting for the transition team to make a (unanimous) decision, which will never happen. I wrote about the need for a step-down process in every single monthly progress report for at least 6 months, but nothing happened. I think the defense attorney in that case just didn't feel like doing the work necessary to get a hearing scheduled. It is just so frustrating not having an SCC representative appear or participate in transition team meetings for community LRAs. They're there some of the time. Tabitha Yockey at the Seattle SCTF is a gem, but she has a limited caseload and has the bandwidth to be available and to stay informed about the client's progress. That makes a difference and is in stark contrast to SCC reps at RCTTs for community LRA cases. This could be done so much better and everyone knows this."

Emerging Theme #8: SOTPs cannot anticipate potential changes to their caseload because they have no advance notice of when LRA clients are assigned to them. The SCC should collaborate with contracted SOTPs to identify ways to improve this communication process.

Emailed Feedback:

- "Another important comment to note, none of the SOTPs know when the next LRA client is coming. Perhaps if we knew how many referrals/clients were coming in, we would make space for more in our private practice… I truly believe that investing in the resources you already have should be the first step. Thank you!" **– Emailed SOTP #1**

Online Survey:

- "All SOTPs are private practice, all we hear from this workgroup is we need more "quality" "availability" SOTPs, however we have no idea when the next referral is coming, SOOOOO, we take on other clients from other referral sources. If we had more of a predictable case load, we wouldn't need to take on other clients, making us more available for additional cases. It's simple and these work groups keep missing this. We take on a client and work so hard to get them through LRA, but all the sudden they are done with LRA and we get notice. Does any of our work matter? I am still unsure about this monthly SCC senior clinical meeting. How does this impact us as community SOTPs. No consistency on reports. I would prefer DSHS make up a quick monthly report format and let us know what they want. Who cares! Just give us one…We need to have a fair and predictable referral system. We have NO idea how many referrals we will get, so as private practitioners we take other cases!" **– SOTP Survey Participant #5**

5. What incentives would help increase the availability and quality of SOTPs who serve LRA clients?

Emerging Theme #9: There is a need to increase camaraderie and collaboration among SOTPs and multi-disciplinary teams

Online Survey:

- "We need to develop more SOTP's and the SCC needs to pay a fair market, livable contact rate." **– SOTP Survey Participant #1**
- "More SOTP sessions with others." **– SOTP Survey Participant #3**
- "The reports are endless. Love working with the challenging cases, hate the homework. But I understand it needs to be done and I slug through. Many therapists are terrified of going to court, even though I haven't gone that often, but when they learn they will be working with such a collection of professionals from different professions they are hesitant." **– SOTP Survey Participant #4**

6. What other suggestions do you have to help increase the availability and quality of SOTPs who serve LRA clients in Washington?

Emerging Theme #10: Dismantle the misperception that no "quality" SOTPs currently work in Washington

Online Survey:

- "Please stop presenting this workgroup issue as "improve the quality of the current SOTPs". We happen to work very, very hard, not to mention we worked very hard to get where we are at. We are quality, change the approach, please. This should serve as some insight into how we feel about engaging with this system…Please stop saying, "increase ... QUALITY of SOTPs who serve LRA clients. We ARE quality--start to ask how the systems can increase how they interact with us. Stop saying quality, its offensive and feeds directly into your barriers and challenges questions--this is the attitude we feel too. I would like the opportunity to take the client into the community to practice their safety plans, etc. " **– SOTP Survey Participant #5**

Emailed Feedback:

- "I would really like to pass on two quick points— 1. Bottom line for me is, it's truly professionally offensive to keep seeing, "Increase the quality of the current SOTPs". Similar comments were made during the last WATSA meeting on LRA's and I chose not to comment—now here it is again. I think your group needs to start being more respectful for those of us who currently work with the LRA clients. You have some quality SOTPs who are very good and work incredibly hard. This needs to be reflective in the way we are presented. For me, this is probably a good start in figuring out how we feel and what we experience as SOTPs in this system." **– Emailed SOTP #1**

Emerging Theme #11: The costs and requirements to become a licensed SOTP can be confusing and a barrier to entering the field.

Listening Session:

- **Dr. Lopez** stated the financial component was difficult to balance especially during the pandemic. Until there was a change in legislation, it was also a barrier that a lot of previous work and experience from prior states did not count because the supervisor was not an SOTP in Washington.
- **Gina Romero** agreed that cost can be a barrier to pursuing the SOTP license.

Online Survey:

- "I recognize, and identify with, the struggle around licensing requirements that exist in WA state (i.e., lack of reciprocity)." **– SOTP Survey Participant #2**

Emailed Feedback:

- "I am an LMHC who is a psychology associate at the Special Commitment Center. I am not an SOTP working with LRA clients. However, I would like to get my SOTP credential. This would allow to work with LRA clients after I finish employment with the SCC. At this time there is an unpleasant sense of uncertainty about how SCC employees can get the SOTP credential. It is unclear if we have to pay for outside supervision or if our SCC supervisors can and will sign off on our hours after we have an independent clinical license and have worked the 2000 hours that I believe is needed for the credential. If this uncertainty were resolved I believe that many SCC employees would obtain their SOTP credentials and begin working with LRA clients and the shortage of SOTPs for them would be resolved. I am working on the ATSA education and I am also working on obtaining a supervisor for my SOTP hours because I do not feel any certainty that my supervisors at the SCC will sign off on the hours that I work at the SCC. I hope that this information is helpful. Please reach out to me if I can help in any other way. Thank you for this opportunity to be heard." **– Emailed SOTP #4**
- "I attend WATSA events but I am a Canadian psychologist practicing in British Columbia… thanks. I [am] only licensed to practice in BC. There are important registration/licensing issues regarding practicing outside where you are registered. This is even the case with telehealth where serious legal consequences can result from working with clients who reside outside where a practitioner is licensed. I've always had plenty of work here in my province and this I have never pursued licensure in the US." **– Emailed SOTP #5**

Appendix H

LRA Case Recommendations Letter from Dr. Richard Packard to Jennifer Ritchie (March 14, 2017)

Brain Health Northwest, LLC
219 – 1st Ave S, Suite 310
Seattle, WA 98104
brainhealthnorthwest.com
info@brainhealthnorthwest.com
Voice: 206-456-5454 Fax: 206-654-3246

Richard L. Packard, Ph.D.
Clinical & Forensic Psychology

Rogene M. Eichler West, Ph.D.
Clinical Neuroscience & Neurotherapy

March 14, 2017

Jennifer Ritchie, Senior Deputy Prosecuting Attorney
King County Prosecuting Attorney, SVP Unit
516 – 3rd Ave. S.
Seattle,WA 98104

RE: LRA cases

Dear Ms. Ritchie:

Following our conversation several weeks ago, I have received phone calls or emails from several individuals asking if I would consider accepting future LRA cases. I have also heard the same question from Dr. Yanisch, Tony Bowie of DSHS, and a few other defense attorneys. My answer has been the same: "not under the current situation." With the natural follow up questions, I thought it might be helpful to explain my thinking and lay out the conditions under which I would be willing to consider future LRA cases. Since you were the first to raise the question with me, I am addressing this letter to you, but I'm also cc'ing it to the others.

I certainly appreciate that treatment resources are limited. I also appreciate that with my office less than two miles from the Seattle SCTF and traffic what it is, having a close, convenient resource would be helpful. However, I view my over-arching clinical responsibility in these matters is to prepare a person, who has likely been living in an institution for many years, to be able to live in the community with an acceptable degree of risk. For these purposes, I define "acceptable degree of risk" as less than "more likely than not" to be consistent with the statute.

While there is great variation among LRA clients, many are ill-prepared for community living in contemporary society. Each client needs to be able to:

- Find and manage a home;
- Eat and exercise in a healthy way;
- Earn an income;
- Move about the community with either, or both, private and public transportation;
- Develop prosocial friendships;
- Participate in appropriate recreational activities;

- Appropriately manage communications with others;
- Determine and manage situations that may present with potential risks for antisocial and/or sexually deviant behavior;
- Identify and manage maladaptive thoughts, feelings, and behavior;
- Manage and refrain from using drugs and alcohol;
- Develop and further interpersonal relationships with family, friends, and, when reasonable and available, sexually intimate relationships.

At the time when release is considered, most of the LRA respondents I have seen are poorly prepared to meet many of these goals. Therefore, acquiring and mastering the needed skills and experiences should be part of their LRA plan. Unfortunately, this is hampered when the state agencies strictly follow a limited containment model of supervision. While that may reduce the agency's short-term exposure to liability if something goes wrong while the person is on supervision, it also restricts opportunities for skill acquisition and learning that will help reduce their risk over the long term

You may recognize many of the above goals as risk factors, otherwise known as criminogenic needs, as described by Andrews and Bonta in their seminal work, *The Psychology of Criminal Conduct.* They later described them within the larger context of what has now become the "Risk-Need-Responsivity" model. They are also the basis for one of the best validated actuarial risk assessment instruments for general criminality, *The Level of Service Inventory – Revised.* In that text, Andrews and Bonta argue that a rehabilitation model in which services are directed toward mitigating a client's criminogenic needs will have the best likely outcome for reducing recidivism. There have now been many outcome studies spread across corrections and forensic mental health showing that they were right.

I view the task of the LRA as preparing the client to live independently, without supervision, and do so without engaging in sexually deviant and/or criminal behavior. In other words, to be prosocial and contributing members of the community. The transition treatment plan should be a rehabilitation plan developed to address and meet the above goals.

Currently, the LRA model is not designed to meet rehabilitation goals. While everyone agrees with the notion that there should be no difference between the last day on supervision and the first day being unconditionally discharged, it is impossible to reach such a state without there being a systematic reduction of limits, contingent upon successful learning, and a broadening of opportunities and responsibilities consistent with the skills that have been learned. Simply letting someone out without allowing them to learn the skills, safely make mistakes with a feedback loop, and then master the skills, is only kicking the can down the road. If and when the client is released from supervision, then their probability of future recidivism has not been reduced, at least not to the degree it could.

Regarding the LRA model in general, I suggest the following:

1. Make the initial plan for a set number of months, with the goal being readiness for unconditional discharge within that time frame. While some clients will not be able to meet that goal, putting a desired end date creates a set of expectations for both the client and the transition team. It allows a set of objectives to be developed that, given the usual deficits, will place high demands on everyone. The client typically comes out of SCC with a rather high number of restrictions. These are then systematically reduced in the selected areas at a pace determined by meeting contingencies for mastering skills and achieving objectives. Once the person can demonstrate competence at a step, then the next, and more difficult, step is implemented.[1] Such methods will require considerably more planning and documentation at the outset for determining which goals are relevant and to describe the specific objectives, action steps, and contingencies needed. For many of the goals described above, there are tools available to help in this endeavor.[2]
2. CCOs can be a valuable resource and take on many more responsibilities for training clients in the community. For example, after a CCO does a site survey, he/she knows the circumstances and risk features of the location or service. The CCO then goes with the client to the location and takes a hands-on role in training them about how to be at the location, giving suggestions, offering feedback, and helping them learn how to cope with the challenges that exist there. The CCO also gets a far better notion of how the client behaves in those situations.
3. Locations, services and activities should be assessed in light of the individual client's skills and risks. They should not be denied based on *a priori* notions that are not empirically connected with the client. In other words, if a client has no history of sexual or violent offenses against children and no indication of sexually deviant interests in children, then locations or services should not be denied merely because they might be close to services or activities that include children. Restrictions and denials of activities and services should be based on making a direct connection between an empirically validated risk factor and the client.[3] Furthermore, the transition team member(s) who deny an activity or service for such a reason should be able to offer evidence, including but not limited to, professional and scientific research, supporting their conclusion.
4. When a location, activity or service is denied, the transition team members doing so should propose alternatives that would serve to meet the same goal. Or, make suggestions about how to teach and train the client to cope with the difficulty.

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[1] I much prefer that the contingencies for reduction of limitations be based on meeting objectives rather than simply the passage of time. However, it is also possible to combine them; e.g., "When Objective A has been completed, and at least X days/weeks/months has elapsed, then Restriction 1 will be relaxed and replaced with Restriction 2."

[2] Examples being the Vineland Adaptive Behavior Scales, the Adaptive Behavior Assessment System, and the Achenbach System of Empirically Based Assessment modules for adults.

[3] It is important to note that empirical evidence may include scientific data and conclusions, but is not limited to it. Much scientific evidence is based on group data from which are derived conclusions regarding the features and behavior of the group. Many offenders have risk factors that may not be shared by others and would therefore not be included in scientific results, yet are nonetheless true for them. However, they can be considered so long as they have been verified by observation or experience for the specific client.

5. Many people working in corrections are trained to consider the client as a "prisoner" or "parolee" and develop both overt and subtle behaviors that are demeaning and dehumanizing. For example, CCOs will not shake the hand of their client. This is often reciprocated by the client, and the vicious cycle of "Cops" and "Cons" is continued.[4] The ample desistance literature tells us that one of the key elements in desistance is the shifting of self-concept and attitudes from "screw-up" and "con" to that of competence and being a valued member of society. The members of the transition team should model such an expectation in both their attitudes and behaviors.
6. There should be enough professional resources. CCOs, DSHS coordinators, and even residential and escort staff should have manageable caseloads that let them do the needed work. For example, it is a common practice for the DSHS coordinator to "phone in" for the transition team meetings. I have no doubt this is due to having a caseload too large to let them appear in person. However, this has major drawbacks for communications between the team members and in the meeting. I have heard from other providers stating that they have seen decisions be deferred for months due to "fill in" staff at the team meetings and staff who do not know the client and his history well enough to make a decision.[5] It also sends a message to the client that they are not worth the time and attention to meet with them, in person.
7. I have also many times heard clients complain that there are insufficient staff to conduct their escort responsibilities, such that they miss appointments and other activities. Not only is it a dehumanizing experience,[6] it leads to delayed skill acquisition, inefficient scheduling for the professional with whom they have the appointment, and unnecessary harsh feelings from all involved.
8. While I have not personally had an LRA client living at an SCTF, I can see that, properly done, the SCTF experience could be quite valuable. From talking with other providers, that seems to not be the case, currently. I have heard that they do not get important, consistent observational information and that progress reports are often only done when the SCTF staff are so frustrated or angry that they take the time to write a note. Of course, such notes are subject to bias and may not accurately reflect the client's typical behavior. The treatment providers often do not get input or consistent data for treatment objectives to be completed at the SCTF. One clinician simply stopped asking due to a complete lack of response by SCTF staff.
9. Related to #8 is an experience I have personally had on many occasions. When trying to understand or resolve something over which there had been disagreement, I have written emails asking questions of DOC and DSHS about their position and seeking to obtain

[4] Another example was offered by one of my clients who was having a GPS unit changed out. This was a routine matter and the CCO called him to set it up. He was not home at the time (which was approved), but told the CCO approximately when he would be home. When he arrived, he described having multiple DOC personnel at his home in multiple vehicles, wearing bullet-proof jackets, armed, with "DOC" in large block letters. He commented, "the neighbors probably thought it was a SWAT team."
[5] As a psychologist, if I were to do such a thing, it could be tantamount to unethical practice for which I could be disciplined by the Washington State Examining Board of Psychology.
[6] I had one person comment in an interview about this, saying, "They're like the phone company, they don't care, and they don't have to."

their evidence or understand their position. I almost never get a reply and, when I do, it does not answer the question or resolve the concern.

10. Along a similar vein, treatment providers are not informed about important changes at DSHS and/or DOC. When people leave important positions or their responsibilities change, it seems that the agency does not care to let us know, or how they expect to hand-off the responsibility to someone else. When policy or practice changes happen that effect our clients, we usually hear about it from the client and not from the agency. I think there needs to be some sort of consistent, regular pathway to give us "the news" so we are not left in the dark and wondering what to do.
11. In my opinion, the state needs to rely less upon polygraph methods to discover what a client is doing, and more on direct observation/surveillance of their activities. Polygraph methods vary greatly and have notoriously poor reliability and validity. Many polygraph techniques have never been subjected to scientific validation. It would be far better to have CCOs conduct direct observation, including covert surveillance, to verify a client's activities and movements. CCOs need to have a caseload size to allow them to conduct such time-intensive activities.
12. The role of education, training and meaningful work is crucial to long-term independence, self-worth, and establishing a prosocial, structured daily routine. Idle hands really are "the devil's workshop." While I realize that there are many complications involved in facilitating a client's education or employment, this is such an important role for an adult, I think much effort needs to be put into establishing a known, stream-lined, effective process for facilitating it.
13. Systematic internet training and monitoring of internet activity and devices is also crucial. The recent WATSA conference was dedicated to this topic and it quickly became clear to me that while there are many benefits to internet activity for clients, there are many risks, too. The entire topic has become far too complex and fast-moving for the average therapist or CCO to master. I think it would be quite wise to have broader training for therapists and CCOs, as well as to seriously consider having a consultant available to help set up a client's devices, monitor activity, and conduct training.
14. Like the role of education and work, recreational and social opportunities also need be better implemented, with a known, stream-lined, effective process for facilitating these important components of prosocial adult life.
15. There needs to be some other way to handle minor violations. As it is, all violations are "equal" and result in formal reports to the Court. Often, there are minor, "technical" violations that come about from accidents, mistakes, misunderstandings or inconsistent applications of the rules but are not due to non-compliant attitudes, willful behaviors, intentional manipulations, or efforts to circumvent the rules. Yet, the agencies' responses are the same and can have serious potential results. I am even more concerned that such responses make things worse by leading the client to be reluctant to disclose and fearful of making even small mistakes. Yet, we know from decades of research on learning that making mistakes and correcting them is an essential component of the learning process. Surely, there can be a better way of helping clients learn from mistakes and accidents without treating them the same as if they are willfully malevolent. Even prisons

distinguish between minor (or "general") infractions and major ones. Surely we can do better.

While the above are general observations and suggestions for the LRA process, I have my own requirements to address before I will consider further involvement with LRA clients. I take an approach to my clinical work with sex offenders that incorporates current clinical neuroscience, in addition to conventional, cognitive-behavioral sex offender treatment. I realize that some of the professionals in DSHS and DOC may be ignorant of that science, and, hence, less likely to approve. However, we base our work at Brain Health Northwest on established empirical science and my primary colleague, Dr. West, is a former professor of neuroscience with an impressive publication history. I cannot allow someone else's ignorance to substitute for our professional and scientific judgement. We are always open to explaining the rationale for our recommendations as well as providing the scientific literature supporting them. In addition, we have made presentations at professional and scientific meetings and will continue to do so. My requirements for future LRA cases:

1. Reimbursement rates for services must be raised to our current fee schedule. This can be obtained by downloading it from our website or by asking for it.
2. Allow and reimburse for the use of clinical neuroscience intervention methods included QEEG assessment, neurofeedback/biofeedback, 3D Multiple Object Tracking, and neurostimulation methods like CES, tDCS, AVE, and others.
3. Some of these methods do not involve psychotherapy or specialized training in working with sex offenders, but do require specialized technical knowledge in the method being used. It would be necessary that such services be allowed for and reimbursed when administered by professional who are not certified sex offender treatment providers, but who work at Brain Health Northwest. All services would be directed, supervised and managed by myself, a fully certified sex offender treatment provider.
4. When appropriate for a specific client, allow and reimburse for the use of specialized consultants such as nutritionists, naturopaths, expressive/body methods (e.g., yoga, art therapy), marital and/or family therapy, EMDR, and other trauma-centric interventions.

I also want to see that the state agencies are serious about revising and altering the LRA process and practices, along the lines in my general recommendations. I think that it's very important for everyone involved in this system to keep in mind that almost all SVP clients are severely damaged individuals.[7] Almost all of them have multiple developmental problems, many incidents of seriously harmful behavior, often a history of severe trauma themselves, and, quite often, serious cognitive deficits, too.[8] In Andrews and Bonta's model, these are called

[7] As far back as 1997, in a study we did at the Twin Rivers Sex Offender Treatment Program, a population at considerably less risk than those at SCC, 31% of the inmates coming into the program met the diagnostic criteria for *acute* Posttraumatic Stress Disorder, at the time of admission.

[8] In a recent study (Levenson, J.S., & Socia, K.M. (2016). Adverse childhood experiences and arrest patterns in a sample of sexual offenders. *J of Interpersonal Violence, 31,* 1883-1911.) of 740 sexual offenders, "…CSA (childhood sexual abuse), emotional neglect, and domestic violence in the childhood home were

"responsivity problems." They are all too often the most overlooked component in a program and the ones that prevent a client from taking the best advantage of treatment and community supervision in order to resolve their core criminogenic needs. We know from decades of research that addressing the criminogenic needs is essential to reducing long-term risk. With such high-risk people, I want to be able to use everything at my disposal that has even a modicum of likelihood for addressing a client's responsivity issues and reducing those core criminogenic needs. Frankly, I think to do less is an abrogation of our responsibilities.

If the goal is to see our clients be able to live safely and at least somewhat productively in the community, that goal will not be achieved only by marking time. Keeping them in a highly structured and strictly limited containment model will not result in significant improvement of these multiple problems. It is necessary to take proactive effort using methods designed for the job. I cannot emphasis too much that even more relevant services must still be rendered with enough intensity to make a difference. That translates to having enough staff, who are properly trained in the relevant tasks, and sufficiently supervised to do their job. It also means having productive attitudes and enough resources available to do the job. To do otherwise is to create a Potemkin Village; it might look good on the surface, but it won't do anything beyond satisfying the idly curious.

If others are seriously interested in doing the same, then I, personally, and the other professionals at Brain Health Northwest are interested in helping that come about. We are certainly open to the idea of collaborating with DSHS and DOC, so long as we can share congruent goals and have the resources to meet them. I have an idea that some of my currently ambivalent colleagues in the broader WATSA community might feel the same.

Very truly yours,

Richard Wollard, PhD

WA. Licensed Psychologist #1613
WA. Certified Sex Offender Treatment Provider #44

cc: Martin Mooney, Snohomish County Public Defender
Dan Yanisch, Psy.D., Special Commitment Center
Pete MacDonald, Esq.
R. Ival Gaer, Esq.
Tony Bowie, Special Commitment Center
Christine Sanders, Esq.
Jacklynn Zorich, The Defender Association
Ken Chang, Esq.

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all significant predictors of the total number of sex crime arrests but not for nonsex arrests, total arrests, or criminal versatility."

Appendix I

Sex Offense Treatment Provider Fee Schedule – Minnesota

Provider Fee Schedule received from Minnesota

	Contract #1	Contract #2	Contract #3	Contract #4	Contract #5	Contract #6	Contract #7	Contract #8	Average
Intake	$320.00	$1,300.00	$182.50	$185.00	$300.00	$350.00	$330.00	$200.00	$266.00
Individual	$160.00	$170.00	$120.00	$150.00	$150.00	$175.00	$165.00	$150.00	$155.00
Group	$50.00	$85.00	$89.50	$50.00	$150.00	$100.00	$80.00		$86.36
Family	$150.00	$170.00	$160.00	$200.00	$150.00	$175.00	$165.00	$200.00	$171.00

Appendix J

Summary of Other States' Laws on Less Restrictive Alternatives

State	LRA at time of commitment	LRA for those already committed to a secure facility	Link to statutes
Arizona	When an individual is determined to meet the commitment standard, the district court may commit the person to a facility or release him to a less restrictive alternative. 90-day inpatient evaluation prior to actual release to an LRA during which LRA is investigated by state hospital and additional conditions may be proposed. The release to an LRA may be revoked by court order.	If commited to a facility, annual review reports required to state if LRA is in best interst of the person and will adequately protect the community. Individual may petition annually for release to LRA or full discharge regardless of endorsement by state hospital.	Ariz. Rev. Stat. §§ 36-3701 to -3717
California	No LRA option specified at time of commitment. When an individual is determined to meet the commitment standard, the person is committed to a secure facility. (§ 6604)	Annual report to the court is required to include consideration of whether release to a LRA or an unconditional release is in the best interest of the person and conditions can be imposed that would adequately protect the community (§ 6605). Individual may petition for conditional release or unconditional discharge without endorsement by state hospital (§ 6608).	Cal. Welfare & Institutions Code §§ 6600-6609.3
Florida	No LRA option specified at time of commitment. When an individual is determined to meet the commitment standard, the person is committed to a secure facility. (§ 394.917 (2))	Annual reviews and right to petition for release but no specific direction to consider LRA. (§ 394.918)	Fla. Stat. §§ 394.910-.932
Illinois	When an individual is determined to meet the commitment standard, the district court's commitment order specifies either care in a secure facility or conditional release. (§40(b)(2))	Annual report to the court is required for the purpose of determining whether the person has made sufficient progress to be conditionally released or discharged. (§55) Person may petition for conditional release six months after commitment or denial of previous petition. (§60)	725 Ill. Comp. Stat. 207/1-99

Iowa	No LRA option specified at time of commitment. When an individual is determined to meet the commitment standard, commitment is to a secure facility. (§229A.7, ¶¶ 5.b. and 7)	Annual review examination and report includes consideration of whether the person is suitable for placement in a transitional release program. (§229A.8. ¶ 5.e.(1)(b)). Establishes transitional release program. (§229A.8A) Allows for release with supervision and without supervision, which is still not full discharge. (§229A.9A)	Iowa Code §§ 229A.1-.16
Kansas	No LRA option specified at time of commitment. (§59-29a07(a),(b))	Annual examination of person's mental condition with right to petition for release. Burden is on state to prove beyond a reasonable doubt that the person remains not safe to be placed in transitional release and if transitionally released is likely to engage in acts of sexual violence. (§59-29a08(c)(3)) During transitional release, person is annually examined to determine if appropriate for conditional release. (§§59-29a18, 59-29a19)	Kan. Stat. §§ 59-29a01 to -29a23
Massachusetts	No LRA option specified at time of commitment.	Individuals may apply to participate in a "community access program" annually. Community access program participants continue to reside within secure facility. (§6A) Allows for annual petitions for discharge. (§9)	Mass. Gen. Laws. ch. 123A, §§ 1-16
Minnesota	Presumptive commitment to a secure treatment facility unless individual establishes by clear and convincing evidence that a less restrictive treatment program is available consistent with treatment needs and public safety. (§253B.185, subd. 1(d)) Alernatively, stay of commitment with custody assumed by individual or agency with conditions. (§253B.095)	Individuals may petition for reduction in custody (transfer out of secure facility, provisional discharge, or full discharge) six months after commitment or final disposition of last petition. (§253B.185, subd. 9)	Minn. Stat. ch. 253B

Missouri	No LRA option specified at time of commitment. When an individual is determined to meet the commitment standard, commitment is to a secure facility. (§632.495, ¶¶2,3)	Annual examination of person's mental condition with right to petition for release. Burden is on state to prove by clear and convincing evidence that the person remains not safe to be at large and if released is likely to engage in acts of sexual violence. (§632.498,¶5) Conditional release graned when person's mental abnormality has so changed that the person is not likely to commit acts of sexual violence if released. (§632.505)	Mo. Rev. Stat. §§ 632.480-.513
Nebraska	If, when an individual is determined to meet the commitment standard, voluntary hospitalization or other LRA is available and would suffice to prevent repeat of sexual offending, then commitment petition is either dismissed or proceedings are stayed for up to 90 days for the individual to obtain voluntary treatment. (§71-1209 (3))	No LRA option specified as intermediate to full release or full confinement. (§71-1220)	Neb. Rev. Stat. §§ 71-1201- to 1226
New Hamphire	No LRA option specified at time of commitment. When an individual is determined to meet the commitment standard, commitment is to a secure facility for up to 5 years (with ability to recommit for unlimited number of 5-year periods). (§§135-E:11,12)	Individual may petition for release. (§135-E:14)	N.H. Rev. Stat. ch. 135-E

New Jersey	No LRA option specified at time of commitment. When an individual is determined to meet the commitment standard, commitment is to a facility designated for the custody, care, and treatment of sexually violent predators. (§§30:4-27.32, 30:4-27.34)	Annual review hearings (but no requirement that LRA be considered annually) and right to petition for discharge. (§30:4-27.35) After initial commitment to a secure facility, the Department of Human Services may recommend conditional discharge to be granted if the committing court finds that the person will not be likely to engage in acts of sexual violence because the person is amenable to and highly likely to comply with a plan to facilitate the person's adjustment and reintegration into the community so as to render involuntary commitment unnecessary for that person. (§30:4-27.32)	N.J. Stat. §§ 30:4-27.24 to .38
New York	If an individual is determined to be a detained sex offender who suffers from a mental abnormality, then the court determines whether the individual requires confinement or requires strict and intensive supervision. (§10.07 (f)) Conditions for strict and intensive supervision are detailed. (§10.11)	Annual examinations to determine if individual is dangerous sex offender in need of confinement; allowance for petitions seeking discharge or change to strict and intensive supervision. (§10.09)	N.Y. Mental Hyg. Law §10
North Dakota	If the individual is determined meet the commitment standard, commitment is to the least restrictive available treatment facility or program necessary to achieve the purposes of this chapter; however, there is no requirement to create a LRA specifically for an individual. (§25-03.3-13)	Annual evaluation to determine whether individual is to be discharged. (§25-03.3-17). Facility director may petition court for placement of the individual in the community for treatment on an outpatient basis. (§25-03.3-24)	N.D. Cent. Code § 25-03
Pennsylvania	[Sexually violent person commitment in Pennsylvania is limited those adjudicated delinquent as juveniles for specified acts of sexual violence and are still institutionalized and in need of treatment at age 20. (§6401)]	Annual review by court; if individual no longer meets critera for commitment, an outpatient treatment plan is ordered to be developed. (§6404)	42 Pa. Consol. Title 42 ch. 64

South Carolina	No LRA option specified at time of commitment. When an individual is determined to meet the commitment standard, commitment is to a secure facility. (§44-48-100(A))	No LRA option specified as intermediate to full release or full confinement. Annual examination and report to committing court. Court orders a hearing if there is probable cause to believe the individual's condition has so changed that the person is safe to be at large, and if released, is not likely to commit acts of sexual violence. (§44-48-110)	S.C. Code §§ 44-48-10 to -170
Texas	All commitments are to outpatient treatment and supervision, continuing until the person's behavioral abnormaility has changed to the extent that the person is no longer likely to engage in a predatory act of sexual violence. (§841.081(a)) Required conditions on outpatient civil commitment are provided by statute. (§841.082) Violation of any conditions is a 3rd degree felony. (§841.085)	Biennial examination and report to court must consider whether to modify conditions and whether to release from all conditions. (§§841.101-102) Individual may separately petition for release. (§§841.121-122)	Tex. Health & Safety Code § 841
Virginia	When the individual is determined to meet the commitment standard, the district court decides whether to commit to a secure facility (§§37.2-909, ¶A) or to continue the trial for up to 60 days while the suitability of a less restrictive alternative is investigated by their department of human services. (§§37.2-908, ¶¶ D-F)	Annual review hearing and report reevaluating the individual's condition and recommending treatment. Court may determine if individual is to be conditionally released. Department is responsible for developing a conditional release plan if court orders conditional release. (§37.2-910) Conditional release standards and requirements specified in statute. (§37.2-912-914)	Va. Code. §§ 37.2-900 to - 921

Washington	No LRA option specified at time of commitment. When an individual is determined to meet the commitment standard, commitment is to a secure facility. (§71.09.060 (1))	Annual examination and report to committing court must consider whether the individual currently meets commitment standard and whether conditional release to an LRA is in the best interest of the person and conditions can be imposed that would adequately protect the community. (§71.09.070 (1)) Statutory authorization for establishment of transitional facilities, including considerations for siting of those facilities in counties and incentive grants and payments. (§§71.09.250-344)	Wash. Rev. Code §§ 71.09.010 to - .903
Wisconsin	No LRA option specified at time of commitment. When an individual is determined to meet the commitment standard, commitment is to a secure facility. (§§980.06, 980.065)	Annual reexamination of mental condition with express consideration of whether sufficient progress made for supervised release or discharge. (§980.07 (1))	Wis. Stat. ch. 980
United States	No LRA option specified at time of commitment.	Individual may be conditionally discharged "under a prescribed regimen of medial, psychiatric, or psychological care or treatment" if he will not be sexually dangerous to others while under those conditions. (¶(e))	18 U.S.C. §4248

Appendix K

Senate Human Services, Reentry, and Rehabilitation Project Request Letter (March 1, 2021)

Washington State Senate

Senator Jeannie Darneille
27th Legislative District

Olympia Address:
237 John A. Cherberg Building
PO Box 40427
Olympia, WA 98504-0427

Phone: (360) 786-7652
FAX: (360) 786-1999
Toll-Free: 1-800-833-6388
Jeannie.Darneille@leg.wa.gov

March 1, 2021

David Schumacher
Director, Office of Financial Management
State of Washington
P.O. Box 43113
Olympia, WA 98504-3113

Dear Mr. Schumacher,

As Chair of the Senate Human Services, Re-entry, and Rehabilitation Committee, I request that the Sex Offender Policy Board (SOPB) convene pursuant to RCW 9.94A.8673 to undertake projects related to research and recommendations regarding youth who have committed sex offenses.

Over the course of the past year, the legislature has been deeply engaged on this topic. The Human Services, Re-entry, and Rehabilitation Committee held a work session on the issue of youth sex offender registration on December 2nd and has also considered and approved for further consideration SSB 5123. This bill was the culmination of a series of informal workgroup meetings over this past interim.

> As SSB 5123 continues to move through the legislative process, it has generated conversations on several other matters pertaining to this population but not addressed by this legislation. In particular, we have received feedback that the system for treatment of youth who have committed sex offense requires examination and redress. While that is outside the scope of SSB 5123, I agree that to be successful in our goal of preventing these offenses from occurring, we need to ensure that our treatment system includes a coordinated community response to offending comprised of all stakeholders in order to be robust and effective. The community response should focus on reducing risk factors and increasing protective factors, promoting family stability and increasing ties to the community Such a coordinated response is needed to recognize the harm experienced by victims of youth who have committed sex offenses.

In addition, SSB 5123 will only cover a portion of youth who have committed sex offenses. The legislature could not find consensus this year on a response to youth age 16 and 17 that are adjudicated of Class A or Class B offenses or those that are declined into adult court. These are several areas where we hope to rely on the expertise of the SOPB for policy recommendations.

The Sex Offender Policy Board (SOPB) serves to advise the governor and the Legislature on issues relating to sex offender management. The Legislature may request that the SOPB convene to undertake projects to assist policymakers in addressing issues relating to sex offender policy. Age appropriate response to youth who

commit sex offenses remains a critically important issue to not just my district, but the entire state. To that end, the Senate Human Services, Re-Entry, and Rehabilitation Committee formally requests that the SOPB undertake the following projects:

1. Conduct a review of current juvenile sex offender treatment programs in Washington including the availability, affordability, accessibility and efficacy of treatment resources available across the state and in institutional settings and an analysis of geographic disparity and recommendations for improvement to the current treatment infrastructure and availability of resources;
2. Conduct a review of the current juvenile sex offender policies in Washington State including:

    a. Registration requirements for 16 and 17 year olds as well as minors being prosecuted in adult court and a comparison with other states;

    b. Best practices and make recommendations for how describe these sexualized behaviors, how to name offenses relating to youth sex offenses; and how to differentiate between problem sexual behavior in children under 12 and youth who have engaged in harmful or illegal sexual behavior youth and are 12 or older;

    c. Statutory requirements for declining youth who commit certain sex offenses into adult court. In addition, if an individual is prosecuted in adult court for an offense that occurred as a youth, how should that offense be classified.

3. To the extent that data is available, conduct an analysis of racial disproportionality of youth adjudicated or convicted of sex offenses or related offenses as well as an analysis of short- and long-term effects resulting from registration requirements and charging patterns across the state.

4. Review research regarding best practices for juveniles who commit sex offenses including evidenced based assessments and treatment, coordinated community response through MDTS that include victim service providers, with the goal of increasing community safety reducing recidivism and prevent sexual abuse

5. Make recommendations regarding juvenile sex offender policies and practices including improvements to treatment resources, registration policies for minors adjudicated or convicted of sex offenses, revisions to statute for names of offenses, statutory requirements for declining youth who commit certain sex offenses into adult court, and other relevant policies.

Over the past year, I have worked closely with a group of stakeholders that have been key to the progress we have made thus far. In your deliberations, I would strongly encourage that you consult with and involve the following organizations and individuals:

- Dr. Elizabeth Letourneau, Director of the Moore Center for the Prevention of Child Sexual Abuse at Johns Hopkins Bloomberg School of Public Health
- The Office of Public Defense (George Yeannakis)
- King County Department of Public Defense (Katherine Hurley)
- King County Sexual Assault Resources Center (Mary Ellen Stone)
- Harborview Abuse and Trauma Center (Laura Merchant)
- Children's Advocacy Centers of Washington (Paula Reed)

Two other valuable resources are WATSA (Washington Association for the Treatment of Sexual Abusers) and the Department of Health Sex Offender Treatment Provider Advisory Committee.

I would like to invite you and representatives of the board to present and report on these projects to the Senate Human Services, Re-entry, and Rehabilitation Committee during Assembly Days later this year and request that a final work product be transmitted by December 1, 2021. My constituents and I appreciate the efforts of the board members to accomplish this task. We hope that the information and recommendations can help inform the Legislature in advance of the 2022 legislative session.

Sincerely,

Jeannie Darneille
State Senator, 27th Legislative District
Chair, Senate Human Services, Reentry, and Rehabilitation

Sex Offender Policy Board
Office of Financial Management
P.O. Box 43113
Olympia, Washington
98504-3113
360-995-3847