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Jennifer Ritchie, Senior Deputy Prosecuting Attorney
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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

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[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

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[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,

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
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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."