STATE OF WASHINGTON

SEX OFFENDER POLICY BOARD

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SEX OFFENDER POLICY BOARD
Juvenile Sex Offender Treatment Subcommittee
August 18, 2021 3:30pm-5:00pm
Zoom Meeting

Attendees: Jedd Pelander, DCYF; Whitney Hellyer, Harborview Abuse and Trauma Center; Larraine Lynch, KCSARC; Paula Reed, Children's Advocacy Centers of Washington; Karen Feller, treatment provider; Katie Hurley, King County Public Defense; Tim Kahn, treatment provider; Thea Mounts, OFM; Megan Schoor, OFM

Meeting Notes

Welcome & Call to Order

- **Megan** and **Jedd** welcomed everyone to the meeting. Meeting participants were asked mute their microphones when not speaking and asked to use the chat function and "Raise your hand" function through Zoom whenever they would like.
- **Megan** reminded people that the meeting was being recorded and the recording is available upon request.
- **Jedd** invited people to introduce themselves.

MOTION #21-2-4: MOTION TO APPROVE THE July 21, 2021 TREATMENT SUBCOMMITTEE MEETING MINUTES.

- **MOVED**: Katie Hurley
- **SECONDED**: Paula Reed
- **ABSTAINED**: None
- **PASSED**: Unanimously

Objective #1 – Review and Discuss Juvenile SOTP Survey Results

- **Jedd** shared that it seems like there is not enough potential SOTPs, or there are more SOTPs who may be on the verge of retiring as opposed to a growing number of SOTPs who are newer to the field. Why is that? There may be many reasons for those results, but pay and the fees that providers receive seem like a major factor. It is very common for other states to pay providers at higher rates than the rates for SOTPs in Washington. Washington could pay $75 for a one-hour session, whereas a provider in another state

like Oregon and Idaho are higher where they charge between $140-$150 per session. Realizing how different the pay is compared to other states may be a contributing factor.

- **Karen** shared that, as an SOTP with over 20 years of experience, the work is difficult, the reimbursement is much lower, and it comes with higher liabilities. It can be very hard to get people interested in the field. Certified SOTPs can have no more than two affiliates. Recruitment can be difficult sometimes because the position takes a certain set of skills and who is interested in doing hard work for less pay. Those who respond to recruitment tend to be newer to the field with good skills, but at some point, they realize that they could get the $75 hourly rate or $117 from insurance. There are also some attractive things about it, including partnerships with various agencies, the protocol and ATSA body that supports the field, etc. SOTPs who have affiliates tend to have affiliates because they have the capacity to do so. Pay is a huge problem, along with the availability of providers. Her impression is that there may be a false sense of accessibility among the surveyed SOTPs, because there don't seem to be many SOTPs who serve juvenile clients. There also may be a problem with availability of providers and accessibility by people to get to the providers based on funding. Another accessibility issue is the limited number of surveyed SOTPs who take insurance including Apple Health. Insurance can be confusing. There could be more education provided to SOTPs around when providers can bill insurance appropriately and trainings. Perhaps one way to do so is to partner with mental health centers to connect clients with services.
- **Larraine** asked, why might some SOTPs perceive some billing of insurance as unethical? **Karen** thinks it could be in how an SOTP conceptualizes the case. From a mental health lens, there could be qualifying diagnoses that have prominent features throughout the client's life. If the root of the sexual behavior comes from something that has a diagnosable condition, then providers could treat that diagnosable condition. Other outlying issues could not be billed to insurance. There could also be financial barriers for the client and families.
- **Jedd** wonders if we could encourage WATSA to provide trainings or other materials to SOTPs about the lens from which they see treatment.
- **Karen** shared that some SOTPs transition to serving adults because of better pay, and possibly also because of the perception that working with adults is less risky and more accountable to themselves, compared to working with children. That mindset may also be dictated by funding source: if an SOTP solely works with adults who have problematic sexual behaviors, the adult is a "silo of one" and can typically seek out other services if they have mental health issues or other issues to address.
- **Jedd** also highlighted that most referral sources are coming from state agencies for SOTPs, which is concerning because it suggests that clients are adjudicated or involved with the courts to receive services. **Karen** agreed and hears it often from families because many parents have mentioned not being able to find help or affording the help. The rate of pay may also play into the affordability of services. Karen's hourly contract rate has increased by $10 in thirty years of being an SOTP who contracts with DCYF.
- **Karen** wondered if it would be possible to recommend additional avenues of funding. Could we recommend greater advocacy around contacting insurance companies and

suggesting that sexual behavior should be non-exclusionary? **Jedd** also mentioned that behavioral health organizations (BHOs) have asked him questions about how to best serve that population and potential barriers they may face. Could the Dept of Health or BHOs merge these services so that insurance may be able to cover them?

- **Megan asked**, would the subcommittee's potential recommendations involve changes to RCWs, additional funds from Legislature, and/or internal agency changes?
- **Larraine** recalled from another meeting that SOTP Affiliates must be licensed (at least Master's level training) to become an Affiliate. Legislative changes may be needed in order for that wording to change from Affiliate to Associate. If we're thinking of growing the profession and want to train people post-grad in the three years before they are qualified to be licensed, then perhaps that would require an RCW change.
    - **Paula** wondered if there is a requirement or opportunity expand accessibility outside of the current SOTP network? Some clinicians with PSB or CBT training who are not current treatment providers wonder how to cultivate and find ways to get training to provide these services.
    - **Tim** was on the SOTP Licensing Board for the first eight years of its existence, and he recalls that the requirement to be an SOTP only exists when you are treating SOSA or SODDA clients. Technically, the licensing requirement only applies to those client groups. DSHS requires contracted providers to be licensed SOTPs for the SAY Program. Other agencies have done something similar, but not all. Those clinicians can provide sex offender services to clients as long as they are not SOSA or SODDA clients. However, some clinicians are liability-driven and may be concerned about the potential risk associated with providing sex offender services and not being a licensed SOTP.
    - **Jedd** mentioned that DCYF contracts state the need to be a certified provider, but non-certified providers may provide services when there are no certified providers available within four hours of the youth's home.
- **Megan** invited the Treatment Subcommittee members to an SOTP Listening Session that is hosted by the SB 5163 Workgroup on August 26th from 1:45 – 2:15 pm.
- **Tim** suggested that one recommendation to consider is to inform the Legislature about the SAY Program. In the 1990s, the Legislature allocated money to help children with sexual behavior problems. Now the funding is no longer available to serve those populations. There were many problems with implementation. It could be advantageous to revisit SAY funding, emphasize the preventive aspect, and explore any barriers at play when it comes to the requirements for families and clients to meet with providers.
- **Paula** asked, are SAY funds only limited to certified SOTPs? There may be restrictions, but **Jedd** and **Tim** are not sure. Larraine mentioned that she recently asked a contact whether a provider that she supervises could do an SAY evaluations and train them without getting their affiliate, and her contact said no. The provider would need to be an affiliate in order to conduct an SAY evaluation.
- **Katie** also wondered if there was an opportunity to think about the labeling aspect of the SAY program. Perhaps instead of saying Sexually Aggressive Youth, the subcommittee could consider recommending terms like Children with Problematic Sexual Behavior.

Another subcommittee is looking at language generally for renaming offenses, but the SAY component is not a topic in that subcommittee. Another opportunity with SAY is the ability to share information with law enforcement through SAY. People who are privately engaged with treatment may not have the same information-sharing provisions. Reducing disincentives to participate in SAY (especially if renamed) could help increase the willingness of people to go through the program. **Tim** agrees and thinks that we may have a much better chance of implementing that within the context of the SAY program. Changing the def from SAY to a program that addresses PSB could be a worthwhile recommendation. **Whitney** agrees, especially given the survey results that client motivation, fear of consequences, and stigma was the top barrier that surveyed SOTPs identified for juveniles seeking sex offense treatment services. The preventive emphasis could help start the conversation about lowering stigmas to empower families and clients to get the services they need and hopefully not reoffend.

- **Larraine** recently saw a presentation from SAY leadership that SAY is a funding stream and not technically a program. The presenter shared that there are only 24 SAY providers across the state. Perhaps one recommendation is to look at SAY beyond a funding stream. How is it implemented and rolled out? How are people referred in to SAY? Of those referred in, how many people actually receive services? If we look from a prevention standpoint, it's important to look at the errors from prior years and how it could move forward as a program. **Jedd** agrees that there could be ways to potentially make SAY a program. **Larraine** also mentioned that when SAY cases are sent to law enforcement, there tends to be time lost where families could be connected to services for their children. There could also be a recommendation about timely response – is there a centralized place that could take calls from families and provide a nonjudgmental, coordinated response on where victimized children can receive services, where children who have harmed others can receive services, along with family supports available to minimize shame and guilt.
- **Karen** asked, is it possible to also recommend that the renamed "SAY" program be accessible to children of any age, not just those under 12 years old who are in care? Perhaps opening the program up to children who may have harmed a sibling and potentially a risk to placement. Let's make the program preventive, not reactionary, to all ages, so that the program is accessible to more people. Some kids in care experience delays in accessing care because SAY requires an evaluation before they can determine whether they need placement or treatment. **Karen** has seen the process take nine months or a year for some youth to get any kind of care. Perhaps the SAY requirement is not based on age or prosecution, but by at-home placement, which is more costly than providing services to a child and keeping them out of care. **Jedd** also mentioned that social workers are required to connect with families twice per month, so it may require (depending on expansion) additional staff to connect with families.

Objective #2 – Brainstorm Proposals and Resource Needs

- **Jedd** will reach out to Michael Campbell and gather some additional DCYF policies to review regarding SAY, along with the requirements outlined in the RCW.

- **Paula** shared that the state of Missouri recently completed some work on this topic and will share the legislation around problematic sexual behaviors and program information to connect families with services. She will share those resources with the subcommittee.
    - https://www.missourikidsfirst.org/our-work/task-force/
    - http://www.senate.mo.gov/15info/pdf-bill/tat/SB341.pdf
- **Jedd** asked, does this group agree that Children with Problematic Sexual Behavior should be the language to use to rename the SAY "program"? Many members said Yes. **Paula** will also extend the invitation to the Person-first Language webinar that she is hosting on September 8th.
- **Jedd** also recognized that the SOTP pay rate in Washington State also seems to be a topic of interest for this subcommittee. **Tim** clarified that the Department of Health does not have any bearing on the pay scale; they oversee the licensing requirements for SOTPs. Comparing differences in rate of pay across states is difficult because Washington has a different system for licensing requirements, because it costs $1,000 per year for the SOTP license alone. Most states do not have that same requirement. **Jedd** wondered, perhaps the subcommittee could recommend that the SOTP Advisory Committee reduce some of the extra costs associated with the licensure for SOTPs? **Tim** shared that such a change may require legislative action. Since each program has to be self-sufficient and with relatively few SOTPs, it could be very expensive. The Legislature would have to be willing to subsidize the program to decrease the licensure costs.
- **Paula** also suggested that the subcommittee explore insurance eligibility for children with PSB and other diagnoses. **Tim** is under the impression that eligibility may be determined by insurance companies rather than any state or national policies. **Karen** agrees that it may be driven by insurance companies. You must have a legitimate diagnostic code to bill insurance, and there is no existing diagnostic code for PSB. There must be some other mental health disorder in other to bill insurance, but you can't bill independently without a disorder. Eligibility for Medicaid, however, does vary by state. **Jedd** shared that children under Oregon's Medicaid program can receive PSB services from providers in Oregon. If that family and child moves from Oregon to Washington, then they must find a new provider and that can be challenging.
- **Larraine** wonders if one recommendation could be to look at all the language in the RCW for the SAY Program. The wording is confusing, especially around funding, referrals from prosecutors, and eligibility requirements. Not sure if PSB is the answer, but perhaps a task force could determine whether Children with Problematic Sexual Behaviors is the appropriate change to the program name, especially if this subcommittee wants to recommend expanding eligibility to children up to age 18. **Tim** shared that revitalizing the SAY Program may be difficult and not easy to fix. **Larraine** shared, if the SAY Program is not a viable option, then perhaps the subcommittee should think more broadly and determine a more appropriate intervention. If SAY is not the appropriate intervention, then what is it through? If we could recreate things and have them in an ideal way?

Next Steps

- The September 15th subcommittee meeting will be extended by 30 minutes.
- The October 20th subcommittee meeting will be rescheduled to the week of September 22nd and extended by 30 minutes.

For the Good of the Order

- No questions or comments raised.

Meeting Adjourned at 5:06 pm

APPROVED AND ADOPTED BY THE JUVENILE TREATMENT SUBCOMMITTEE

_____/s/_____ __9/1/2021_____

Co-Chair Jedd Pelander Date

_____/s/_____ __9/1/2021_____

Co-Chair Rick Torrance Date