REPORT OF THE VIRGINIA STATE CRIME COMMISSION ON

SEX OFFENDER TREATMENT SERVICES IN VIRGINIA

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

SENATE DOCUMENT NO. 20

COMMONWEALTH OF VIRGINIA
RICHMOND
1996

COMMONWEALTH of VIRGINIA

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November 14, 1995

TO: The Honorable George Allen, Governor of Virginia
and Members of the General Assembly:

Senate Joint Resolution 284, agreed to by the 1995 General Assembly, directed the Virginia State Crime Commission to study alternatives for the treatment and supervision of sex offenders, and to submit its findings and recommendations to the Governor and the 1996 session of the General Assembly.

In fulfilling this directive, a study was conducted by the Virginia State Crime Commission in 1995. I have the honor of submitting herewith the study report.

Respectfully submitted,

Elmo G. Cross, Jr.
Chairman

EGC/dgs

MEMBERS OF THE VIRGINIA STATE CRIME COMMISSION 1995

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Edgar S. Robb

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Corrections Subcommittee

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This project was supported by Grant #96-A7885AD95, awarded by the Bureau of Justice Assistance, Office of Justice Programs, U.S. Department of Justice. The Assistant Attorney General, Office of Justice Programs, coordinates the activities of the following program offices and bureaus: Bureau of Justice Assistance, Bureau of Justice Statistics, National Institute of Justice, Office of Juvenile Justice and Delinquency Prevention, and the Office for Victims of Crime. Points of view or opinions contained within this document are those of the author and do not necessarily represent the official position or policies of the U.S. Department of Justice.

SEX OFFENDER TREATMENT SERVICES IN VIRGINIA

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Sex Offender Treatment Services in Virginia

I. Authority for Study

During the 1995 General Assembly session, Senator Edgar S. Robb of Charlottesville successfully patroned Senate Joint Resolution 284, directing the Virginia State Crime Commission to study sex offender treatment services in Virginia. SJR 284 specifically requested that the Commission "study potential, alternative sex offender treatments." (See Appendix A.)

Code of Virginia § 9-125 establishes and directs the Virginia State Crime Commission "to study, report, and make recommendations on all areas of public safety and protection." Code of Virginia § 9-127 provides that "the Commission shall have the duty and power to make such studies and gather information in order to accomplish its purpose, as set forth in Code § 9-125, and to formulate its recommendations to the Governor and the General Assembly." Code of Virginia § 9-134 authorizes the Commission to "conduct private and public hearings, and to designate a member of the Commission to preside over such hearings." The Virginia State Crime Commission, in fulfilling its legislative mandate, undertook the study of sex offender treatment services in Virginia.

II. Members Appointed to Serve

At the April 27, 1995 meeting of the Crime Commission, Chairman Elmo G. Cross, Jr., selected Rev. George F. Ricketts, Sr., to serve as Chairman of the Corrections Subcommittee, which was directed to conduct the study of sex offender treatment services in Virginia. The following members of the Crime Commission were selected to serve on the subcommittee:

Rev. George F. Ricketts, Sr., Hallieford, Chairman
Delegate Robert B. Ball, Sr., Richmond
Robert C. Bobb, Richmond
Delegate Howard E. Copeland, Norfolk
Attorney General James S. Gilmore, III, Richmond
Senator Janet D. Howell, Reston
Senator Edgar S. Robb, Charlottesville
Delegate Clifton A. Woodrum, Roanoke
Senator Elmo G. Cross, Jr., Mechanicsville, ex officio

III. Executive Summary

During the 1995 session of the Virginia General Assembly, Senator Ed Robb of Charlottesville successfully patroned Senate Joint Resolution 284, which directed the Virginia State Crime Commission to study sex offender treatment services. At the April 27, 1995 meeting of the Crime Commission, Chairman Elmo G. Cross, Jr., selected Rev. George F. Ricketts, Sr., to serve as Chairman of the Corrections Subcommittee, which was directed to conduct the study.

At the May 23, 1995 meeting of the subcommittee, Staff Attorney Dana Schrad presented an overview of five key study issues to be addressed in the study. Dr. Isaac Van Patten, Director of Community Corrections of Virginia, based in Roanoke, spoke on how sex offender treatment can work to reduce criminal recidivism. Dr. Van Patten suggested several ways to improve the way sex offenders are supervised and rehabilitated: 1.) Law enforcement and child protective service workers need better training; 2.) Juvenile and circuit court judges should receive educational information about sex offenders; 3.) Sex offenders should receive longer periods of probationary supervision; 4.) The Department of Corrections should use community corrections officers who are specially trained to supervise sex offenders, and 5.) More community treatment resources must be developed. Department of Corrections Director Ron Angelone also fielded questions from the subcommittee about the effectiveness of sex offender treatment.

On July 11, staff presented a research update, and proposed a study framework for the subcommittee's consideration. On August 29, Ms. Carolyn Cadasco, a treatment provider from Raleigh, North Carolina, described how community-based treatment programs and self-help support groups help recovering sex offenders to keep from re-offending. Dr. Dennis Waite, chief psychologist for the Department of Youth and Family Services, described how juvenile sex offender treatment programs operate in Virginia. Staff presented a status report on adult sex offender treatment programs that the Department of Corrections had provided to the subcommittee. At the October 3rd meeting, staff reviewed the draft report and recommendations prepared for the subcommittee. The subcommittee approved the recommendations and adopted the report to be forwarded to the full Commission for final approval. On November 14, 1995, the Commission adopted the study recommendations and approved the final report for publication as a Senate document.

IV. Background

The Corrections Subcommittee requested the that staff review studies done in Virginia that addressed sex offenders and options for treatment, supervision and punishment. The following studies were chosen by staff as indicative of the

development of criminal justice policy in Virginia as regards sex offenders. The summaries that follow are representative, but not exhaustive, of administrative and legislative sex offender studies conducted in recent years in Virginia.

• 1975 report of the Virginia State Crime Commission

In 1975, the Virginia State Crime Commission, under the direction of Chairman Stanley Walker of Norfolk, initiated a study of defective delinquents and sex offenders. The specially-appointed study group was chaired by Fairfax Commonwealth's Attorney Robert Horan. The purpose of the study was to review alternative approaches for the treatment of sex crime offenders. The subcommittee identified 24 different states, including Virginia, with statutes addressing sex offenders, and discovered that few states specified any special treatment for sex offenders. In most cases, Virginia included, sex offenders were housed with the general inmate population. In 1972-73, 371 felons were serving time for serious sex offenses in Virginia prisons, where no specially designed treatment programs or psychiatric evaluations were available at the time.

The study group, termed the Sex Offender Subcommittee, reviewed the sex offender statutes from Maryland, New Jersey, Washington and Wisconsin, which had codified treatment and, in some cases, mental health commitment protocols for sex offenders. In its interim report issued in 1975, the Sex Offender Subcommittee recommended amendments to the Code of Virginia to allow for indeterminate sentencing of sex offenders to provide for extended mental health treatment. The Subcommittee recommended the establishment of a 200-single cell diagnostic treatment center for court-referred sex offender cases to be established at an existing state mental health institution. House Bills 1280, 1410, 1489 and Senate Bill 711 were passed by the 1975 Virginia General Assembly to provide for psychiatric examinations and indeterminate sentencing of certain offenders. The laws empowered judges to review the treatment histories of sex offenders and determine when they could be safely released from custody.

The Commission continued the study from 1976 through 1978 with a 42-member task force to look at all aspects of criminal sexual assault. One of the five subcommittees conducted a review of other states' programs in hopes of developing a sex offender treatment program in Virginia. The subcommittee acknowledged the special treatment needs of sex offenders and in 1977 once again endorsed the establishment of a special treatment center for sex offenders. The subcommittee recommended that such a center be established under the supervision of the Department of Corrections. The 1978 report of the task force subcommittee detailed its review of other states' treatment programs, and the information collected from numerous interviews with offenders, psychiatrists and corrections officials. The subcommittee cautioned that treatment of sex offenders was a difficult process, often showing little in the way of rehabilitative results. However, the task force adopted the 1977 subcommittee recommendation that a sex offender treatment program be

established within the Department of Corrections with the assistance of the Department of Mental Health and Mental Retardation.

• 1992 report on Substance Abuse and Sex Offender Treatment Services for Parole Eligible Inmates, Joint Legislative Audit and Review Commission (JLARC)

In response to a JLARC study of Virginia's parole process, JLARC staff were directed to study treatment programs in Virginia's prisons for sex offenders and substance abusers. JLARC reported that a high percentage of the 14,841 Virginia inmates in 1990 had either substance abuse problems or were serving time for sex offenses. The Department of Corrections was credited with developing a "loose network of institutionally-focused services" that was far below identified treatment needs. Additionally, JLARC's study concluded that the Department of Corrections lacked adequate assessment tools, program policies and standards, and did not have adequately trained counselors with sufficient time to deliver services to sex offenders and substance abusers. JLARC recommended that the department develop comprehensive treatment policies and programs, adopt uniform treatment needs assessment instruments, have at least one case manager per 50 inmates and distinguish professionally between case managers and counselors. Also recommended were reductions in good time accrual for inmates who refuse treatment, and development of an interagency agreement between DOC and the Parole Board to approve conditional release for inmates who participate successfully in treatment programs.

• 1994 report on Inmate Work Initiative Implementation Guide prepared by Correctional Services Group, Inc. for Virginia DOC

According to DOC staff, about 16 percent of all Virginia inmates are sex offenders, 80 percent are substance abusers, and nearly all need general therapeutic counseling on life skills, anger control, family relationships, identity development, values and goals. The report indicates that it is DOC's goal to provide treatment services to about 40 percent of the entire prison population. It estimates that DOC would have to have $2,722,959 in funds over a five year period to provide treatment to offenders at the levels mandated by House Bill 1994.

In its section specific to sex offenders, the report stated that "all sex offenders need some form of treatment," although it varies in type and intensity with the offender's particular needs. The report recommended that "each (sex) offender must be evaluated for particular risk factors such as low self esteem, poor communication and social skills, or unhealthy attitudes toward sexuality." The report is focused primarily on the incarcerated population, and does not make recommendations specific to community corrections supervision and treatment programs.

• 1995 report of the Habitual Sex Offender Subcommittee (Lt. Gov. Commission on Reduction of Sexual Assault Victimization)

Virginia Lieutenant Governor Don Beyer began a comprehensive study of sexual assault in 1992 that resulted in the creation of the Commission on the Reduction of Sexual Assault Victimization. This study took an approach similar to that of the Crime Commission in the 1970's, and appointed several subcommittees to examine issues such as sexual assault statutes, victimization, prevention and offender treatment services. The Lieutenant Governor's Commission also recommended expanding the present array of treatment services in Virginia for sex offenders. Two additional studies were initiated under the auspices of the Commission that reported recommendations back to the Lieutenant Governor. One was a report on the biomedical treatment of sex offenders, which is reviewed later in this text. The second, which was requested by Delegate Morgan Griffith in House Joint Resolution 193 (1994), called for a study of the "confinement of sex offenders, with a concentration on Washington's existing statute," for possible adaptation and implementation in Virginia.

The Washington statute in question is one similar to that reviewed by the original Crime Commission study. It makes possible the indefinite confinement of "sexually violent predators" in mental health facilities until such time as they are determined by a mental health professional to no longer be a risk to public safety. The Habitual Sex Offender Committee, based on recent case decisions, questioned the constitutionality of the Washington statute, and determined that it would recommend an alternative approach to managing habitual sex offenders in Virginia. The committee reviewed the 1994 report from the Institute of Law, Psychiatry and Public Policy at the University of Virginia on biomedical treatment of sex offenders to determine if chemical castration offered a viable option. Also rejected for its potential illegality, the committee devised a third option to address habitual sex offenders in Virginia.

The legislation proposed by the committee, Senate Bill 940, was patroned by Senator Edd Houck of Spotsylvania, and was passed by the 1995 Virginia General Assembly. The bill amended Code of Virginia §§ 19.2-297.1 and 18.2-67 to create a two-time loser provision for habitual sex offenders. The statute requires mandatory life without parole for second time serious sex offenses, and requires mandatory punishment to the fullest extent of the law for second time less serious sex offenses. This legislation was proposed by the Habitual Sex Offender Committee based on the recognition that, first and foremost, sex offenses are serious crimes, and that rehabilitation efforts must be coupled with stringent penalties in order to ensure public safety.

These studies and others conducted both in Virginia and in other states share several common themes. First, it is generally agreed that some sex offenders are among the most difficult to rehabilitate, and devising appropriate and effective treatment for some sex offenders continues to be an elusive task. However, for certain types of sex offenders, studies have reported treatment successes when

offenders are properly evaluated and assessed, and sufficient and professional treatment and aftercare are provided. Finally, most studies conclude that there are populations of violent or habitual sex offenders that typically do not respond to treatment, and concern for public safety has dictated policies that call for long-term incarceration of these types of sex offenders.

A. Sex Offender Treatment Programs in Virginia

A report on the status of sex offender treatment programs in the Virginia Department of Corrections was requested by the subcommittee in order to assist the subcommittee in its deliberations. (See Appendix B.) According to the Department, its first formal treatment program for sex offenders was a 50 bed intensive program located in the late 1970's at the Powhatan Correctional Center. This early therapeutic community program, known as the House of Thought, closed in 1982 due to statewide agency budget cuts.

In the early 1980's, a committee was formed to assist the Department in developing sex offender treatment policies and training programs for staff. The Sex Offender Program Action Committee (SOPAC) today continues to provide staff training, despite the absence of a specific budget for such purposes. By 1990, weekly counseling groups and psycho-educational programs were operating in ten prisons which could accommodate up to 336 inmates. In 1992, the Board of Corrections adopted the current standard making sex offender treatment one of the five core programs to be offered in the major institutions.

Funding was received in 1993 for two therapeutic community programs to be operated at the Bland and Haynesville correctional facilities. During fiscal year 1995, the Department opted to eliminate the two 50-bed programs as part of a ten million dollar reduction in its annual operating budget. The Department states that it chose instead to prioritize its substance abuse treatment programs over the sex offender treatment programs because, according to the Department:

1. there are a greater number of inmates (80%) in need of substance abuse treatment than there are in need of sex offender treatment (16%);
2. substance abuse treatment is less expensive than sex offender treatment ($1,500 per year vs. $4,500 per year);
3. the consequence of treatment failure with substance abusers is less of a public risk than with sex offenders; and
4. substance abuse treatment has a longer record of success in lowering recidivism rates.

Currently, the Department reports that psycho-educational programs and weekly counseling groups are available for up to 350 inmates across most of the prisons. Services are provided by employees who serve both as case managers and as counselors. Probation and Parole Districts contract with private vendors for

assessment and treatment of sex offenders. Two community corrections programs that the Department promotes as models are the Newport News program, which utilizes regular polygraph testing, and a pilot intensive supervision program for sex offenders in Manassas.

B. Biomedical Treatment of Sex Offenders

In 1994, the Institute of Law, Psychiatry and Public Policy at the University of Virginia issued a report on the biomedical treatment of sex offenders at the request of the Commission on the Reduction of Sexual Assault Victimization. The report presented both a medical and legal history of the use of anti-androgens on sex offenders as a way to decrease uncontrollable sexual urges believed to trigger acts of sexual assault. The report, which was not widely distributed, was re-printed in the 1995 report of the Habitual Sex Offender Committee. It is borrowed from heavily here to document and summarize the research on biomedical treatment of sex offenders.

During the 1800's and early 1900's, surgical castration of sex offenders was considered to be a viable and appropriate punishment for rapists until such laws were ruled unconstitutional. Bio-medical treatment, often termed chemical castration, came into vogue in 1944 when female hormone therapy first was used as a way to diminish testosterone levels in men. It was, and still is, believed by some that reducing testosterone levels will reduce sexual urges in men that lead to acts of sexual assault. By 1966, a drug developed by Upjohn Pharmaceuticals, depo medroxyprogesterone acetate (MPA), which is distributed under the trade name Depo Provera, was being used by some sex offender therapists. Depo Provera was approved for use in the United States by the Food and Drug Administration in 1988.

Research and support of Depo Provera to chemically reduce testosterone levels in sex offenders as a viable rehabilitative therapy continues to flourish. A number of researchers report reductions in sexual offense criminal recidivism among subjects who take Depo Provera, although such results usually are coupled with caveats about the limits of the drug's success. For example, one researcher reported greater success in reducing recidivism among habitual sex offenders than with rapists. Many factors have been identified as influencing the success rates of some rehabilitative efforts, including the marital status of the offender and the presence of a substance abuse problem. Additionally, researchers warn against the use of anti-androgen (testosterone-reducing) drugs with juveniles who have not matured physically because of the abnormal development of secondary sex characteristics (such as body hair and overall growth.) Regular use of anti-androgens reportedly has produced side effects in male subjects such as fatigue, weight gain, cold sweats, hypertension, hypogonadism, insomnia, and hot and cold flashes. Additionally, the ability of such drugs to reduce the male sex drive is temporary, and sexual responsiveness reportedly returns to normal levels within

two to three weeks of the final treatments.

The controversy surrounding the use of anti-androgens on sex offenders focuses primarily on legal issues, such as informed consent and cruel and unusual punishment. Physical castration as part of a criminal sentence has been barred by the courts since as early as 1918 as cruel and unusual punishment in violation of the offender's Eighth Amendment constitutional rights. The legality of chemical castration, however, remains an unresolved legal issue.

The Institute of Law, Psychiatry and Public Policy questioned in its report whether an offender who volunteers to be treated with Depo-Provera truly can give informed consent. First, he must understand the potentially damaging and painful side effects that often accompany the use of Depo-Provera. An offender with mental health problems or without sufficient education may not fully understand the implications of the medical side effects, which also can include gastrointestinal difficulties, gallstones, diabetes mellitus and possible infertility. Secondly, the Institute points out that informed consent to biomedical treatment must be voluntary. Given the fact that an offender's choices are limited to length of incarceration vs. submission to biomedical treatment, it is arguable that a choice between the two is less than completely voluntary.

For punishment to be cruel and unusual in violation of the Eighth Amendment to the U. S. Constitution, the courts have ruled that it must be either inherently cruel, disproportionate to the crime for which it is imposed, or more severe than necessary to accomplish the state's penal purpose. The Institute's report points out that the courts are divided on the issue of when certain treatment amounts to punishment. In one federal court case, Rennie v. Klein, a four-prong test was used:

1. Does the drug have therapeutic value?
2. Is the administration of the drug recognized as accepted medical practice?
3. Is the drug to be administered as part of an on-going therapeutic program?
4. Are the drug's adverse effects unreasonably harsh?

In the final phase of its legal analysis, the Institute raised concerns about protecting the due process rights of sex offenders. The Fourteenth Amendment to the U. S. Constitution prohibits the state from taking a person's life, liberty or property without due process of law. The Institute points out that the courts have recognized a fundamental, though qualified, right to procreate which may be implicated by the potential for anti-androgens to cause infertility.

The Institute concludes its research report by stating that the effects of anti-androgens are reversible when treatment is terminated, which distinguishes chemical castration from physical castration. However, it warns against use of anti-

androgens with sex offenders on anything other than a voluntary basis to avoid attacks on constitutionality. The Institute stops short of recommending chemical castration as a viable dispositional option.

The manufacturer of Depo-Provera, Upjohn Pharmaceuticals, distributes Depo-Provera for use as a female contraceptive, and considers any other use of the drug to be an off-label usage. Upjohn released the following statement to the Crime Commission on May 16, 1995:

> "Depo-Provera is not indicated for chemical castration anywhere in the world. Upjohn has never sought this indication and has not sponsored research in this area. Therefore, we have no data, no comment and no opinions on this use."

C. Model Sex Offender Treatment Programs

A number of treatment approaches are used with sex offenders, including intensive therapy, medical treatment and support groups. New offenses committed by released sex offenders correlate directly with how much treatment they receive -- both in the correctional institution and while under community supervision, either post-release or as probationers. According to a 1993 study conducted by three Canadian psychologists, about 20 to 60 percent of untreated sex offenders re-offend over the five years following release, while 15 percent or less of treated offenders repeat their crimes. A lot depends on the type of offense, the history and frequency of offenses, and the overall effectiveness of the treatment program. Research indicates that the most successful treatment programs stress comprehensive cognitive and behavioral modification programs. Counseling, medical treatment, and group therapy may be part of such comprehensive programs.

Adequate needs and risks assessments of sex offenders must be done when the offenders enter the Department of Corrections. The assessments provide DOC personnel with the information needed to determine the type of treatment and level of supervision required for each sex offender.

Most community-based treatment is outpatient -- there are not many residential sex offender treatment programs operating in communities in Virginia. Additionally, residential treatment beds for sex offenders are much more expensive than outpatient therapy. However, those offenders who receive treatment while in prison have a greater chance of not re-offending if they receive some form of aftercare while under graduated release supervision in the community.

The following programs are examples of innovative approaches to sex offender treatment and supervision, both in correctional institutions and in community corrections. These examples are not exhaustive of the types of sex

offender treatment programs in operation in the United States, but they do represent the various components found in most successful programs.

The Shenandoah Valley Sex Offender Treatment Program

The Shenandoah Valley program was founded in 1985 in Harrisonburg, Virginia, in response to requests from the local courts for a program to treat adult male sex offenders. Since then the regional outpatient program has grown to include male and female adult and adolescent sex offenders. The program regularly receives referrals from state and federal agencies, courts and attorneys, and accepts referrals from a number of states. The Virginia Department of Corrections has approved the Shenandoah Valley program, a private agency, to provide treatment and evaluation services for its population. The program is comprehensive in its array of outpatient counseling and medical treatment services, including anti-androgen treatment, and is qualified to evaluate a broad range of sex offender clients. The staff is composed of licensed clinical social workers and treatment professionals with related masters and doctorate degrees.

Behavioral Medicine Institute of Atlanta

This hospital-based program in Atlanta, Georgia offers both inpatient and outpatient services, and evaluation services. The Institute operates one of the few inpatient hospital programs in the country, offering adolescent and adult treatment. The program excludes patients who are psychotic, but will accept learning disabled and patients with multiple medical problems. Standard outpatient treatment programs last one year, followed by a minimum of three years dedicated to relapse prevention. The outpatient program offers weekly small group counseling targeted at behavior modification and relapse prevention. The Institute also offers a four-week intensive outpatient treatment program for patients from other states who need intensive short-term care. The two outpatient treatment programs average $5,000 in cost, and the six to eight hour initial assessment costs $900. Court-ordered patients must pay for services before treatment begins. The program is run by a board-certified psychiatrist who specializes in sex offender treatment.

Oregon State Hospital Inpatient Treatment Program for Sex Offenders

As part of the inpatient treatment program for sex offenders at the state hospital in Salem, offenders are required to write about their sexual deviancies, and to document the feelings and behaviors that lead them to commit sex crimes. A primary component of the program is relapse prevention, which is an intensive process that prepares the offender to return to the community. The Oregon State Hospital program generally keeps offenders in the inpatient stage for two to 2-1/2 years, and then switches them to "pre-release" status. For six months, the offenders work or go to school during the day and return to the hospital at night. After they return to the community to live full-time, the offenders participate in an 18 month aftercare program in which they receive a decreasing amount of group counseling. The program reports that offenders who voluntarily enter the program are aware

that participation will not hasten their release dates, and that the aftercare program has provisions that are more restrictive than normal parole supervision. More than half of the offenders drop out and return to prison at some point in the program. According to the program, up to 80 percent of untreated offenders released from prison will reoffend. However, the Oregon State Hospital program reports that, of those offenders who complete all three phases of the program, fewer than 10 percent have reoffended sexually.

Pines Treatment Center Behavioral Studies Program

This program, located in Portsmouth, Virginia, is operated by Dr. John Hunter, and specializes in treating adolescent sex offenders, one of only a few programs for placing juveniles in the community. Dr. Hunter reports that 80 percent of the boys and all of the girls who come through his program have been sexual assault victims themselves, not an uncommon trend in sex offenders. Early intervention programs can help sexually abused youth who have begun to sexually abuse others. Many of the adolescent sex offenders who themselves were not abused were at least exposed to a highly sexualized environment in which explicit publications or videos were easily accessible. They also may have observed deviant sexual behaviors in their homes by other family members. The goal of most adolescent sex offender therapy is to help the offender unlearn the disordered thought processes that allow the abuse and to learn socially appropriate ways to interact with people. Individual, group and family therapy are standard components of such programs. As a residential program, the Pines Treatment Center takes security precautions to ensure that children in the program are safe from each other, using intensive supervision and separating the children by gender and by age. Dr. Hunter stresses the importance of aftercare when a child is released from a residential treatment program, particularly if there is little or no family support for the child's rehabilitation.

The Newport News Sex Offender Community Protection Program

The Newport News program was developed by local officials in Probation and Parole District 19 to respond to the need for a comprehensive supervision and treatment program for sex offenders under community correctional supervision. The program uses a team approach that incorporates the participation of a polygraph examiner, therapist, and a sex offender specialist from the Probation and Parole Office. The team relies on the involvement and support of the local courts, the local Commonwealth's Attorney, the Virginia Parole Board and victim services providers. A distinctive feature of the Newport News program is the use of polygraph examinations to assess and monitor the progress of sex offenders who participate in the sex offender treatment program.

Since polygraph examination results are not admissible in court in Virginia, the exams are used to encourage sex offenders under probation or parole

supervision to admit guilt for their offenses, and to encourage truthfulness and accountability in the treatment program. The program's sex offender specialist, Mr. Pryor Green, says the polygraph has been an invaluable tool in getting the offender to accept responsibility for his actions and participate honestly in treatment. The program, however, is facing some funding shortfalls, and is finding it difficult to pay for the four polygraph examinations it tries to schedule for each offender during the course of the program.

Self-Help/Twelve Step Programs for Sex Offenders

Sex Addicts Anonymous and other self-help programs rely on a variation of the twelve step programs developed for alcohol and other drug addictions. Members regularly attend group meetings, either in a correctional institution or in the community, and learn about the twelve step program to recovery that teaches its members how to abstain from compulsive behaviors. The common goal of the program is for participants to become sexually healthy, to control their compulsions and to help other so-called "sex addicts" to heal themselves. The programs are spiritual in nature and, while adopting the principles and traditions followed by Alcoholics Anonymous, programs for sex offenders do not affiliate themselves with other self-help programs. Members remain anonymous in the program, and the confidentiality of shared information is respected.

Such self-help programs can play a critical role in both therapy and aftercare, but cannot replace a comprehensive therapy program. They complement other therapeutic efforts by providing sex offenders with an opportunity to learn more about controlling compulsions and to receive support from others like themselves. The group members treat each other as equals who keep confidences, do not judge each other, and provide mutual support through sharing about their experiences. S.A.A. groups are supported through voluntary contributions from their members.

Sex Offender Therapeutic Community Treatment Programs

Therapeutic community programs have been used successfully in both prisons and community corrections programs to provide rehabilitation opportunities for drug offenders. The same program model was used to develop the sex offender therapeutic community programs at the Bland and Haynesville Correctional Centers. These two programs were treating 35 to 40 inmates at a time using group and individual counseling, behavior modification and general educational components. The unique aspect of therapeutic communities in prisons is that the participants, who volunteer for the program, are separated from the general inmate population and housed in a unit staffed with counselors trained to provide sex offender treatment. In an effort to expand work and other education opportunities, the Department of Corrections eliminated the funding for the sex offender therapeutic community programs as a cost-cutting measure.

D. Community Supervision of Sex Offenders

Intensive supervision of sex offenders released into the community is necessary to reduce recidivism. Treatment and intensive supervision together further reduce the chances that the sex offender will commit another crime, and will increase the offender's chances of successfully modifying his behavior.

The Department of Corrections has developed a set of standards for supervising sex offenders in the community, and training programs have been developed specifically for community corrections officers who supervise sex offenders. The standards provide direction for probation and parole officers in developing pre- and post-sentence investigations, and in the use of victim impact statements. Detailed instruction is provided on the intake process, supervision issues, special surveillance techniques, and compliance with the state sex offender registry requirements. The standards report contains examples of investigation and case management forms that have been annotated to address issues specific to sex offenders. Suggested special conditions for treatment, supervision, education, employment and special monitoring are included to assist the probation and parole officer in setting up supervision plans. A risk assessment outline has been developed especially for probation and parole officers to use with sex offenders.

Probation and parole officers should receive special training to supervise sex offenders, and efforts should be made to ensure that caseloads are sufficiently low to allow for effective monitoring of offenders. The Committee on the Supervision of Sex Offenders on Mandatory Parole, which developed the proposed standards in 1992, recommended setting up sex offender units consisting of a probation and parole officer and surveillance officer with a ratio of 35 clients to the two officers. A list of identified problem areas and recommendations for supervision of sex offenders were developed by the Committee. The Committee was comprised of personnel from the Department of Corrections, the Attorney General's Office, the State Crime Commission, and members of the Virginia Parole Board.

Probation and Parole District 35 in Manassas is piloting the proposed supervision standards under the direction of District Chief William Redmiles. Data collected from this program will be helpful in determining the success of special supervision standards for sex offenders. Information on the use of polygraph testing in Probation and Parole District 19 in Newport News also will be helpful in further developing methods for supervising sex offenders in the community.

E. Certification for Sex Offender Treatment Providers

In 1994, Senator Janet Howell successfully patroned Senate Bill 512, which mandates the state certification of unlicensed sex offender treatment providers and allows for the voluntary certification of certain licensed professionals. The bill amended Code of Virginia § 54.1-3600 to include a definition of "certified sex

offender treatment provider." The bill also added Code of Virginia §§ 54.1-2924.1 and 54.1-3609 through -3611 to create a Department of Health Professions Advisory Committee on Certified Practices to develop standards for the certification of sex offender treatment providers. Persons licensed by the Boards of Medicine, Nursing, Professional Counselors, Psychology and Social Work may apply voluntarily for sex offender treatment provider certification if they have met the prerequisite education, supervision and clinical requirements of the certification regulations. By doing so, such professionals will be allowed to represent themselves professionally as certified sex offender treatment providers. (See Appendix C.)

Some treatment providers who work or volunteer for government agencies are exempt from licensure requirements by the Boards of Professional Counselors, Psychology and Social Work. However, Senate Bill 512 requires those public sector employees who are exempt from licensure to be certified as sex offender treatment providers by the Board of Psychology. Such certification will ensure that sex offender treatment providers who are employed by, contract with or volunteer services to the Department of Corrections are minimally qualified by the state to render such services.

Proposed regulations have been developed and reviewed by the Board of Psychology. Final approval is pending outcome of hearings on November 14, 1995. The proposed certification regulations would require the applicant to have a post-baccalaureate degree from an accredited institution in medicine, psychology, counseling, nursing or social work, and at least 50 additional post-degree training hours in sex offense behavior, offender assessment and treatment, related criminal justice and legal issues, recidivism, treatment efficacy and program evaluation. The applicant also would have to provide documentation of 2,000 hours of post-degree clinical experience in related service delivery, including face-to-face treatment and assessment hours and 100 hours of clinical supervision. The certification is renewable annually.

The certification program also proposes standards of practice that ensure community protection and safety, disclosure to clients concerning experimental treatments, informed consent regarding exceptions to confidentiality and professional records maintenance. The standards also address the collaborative working relationship between the treatment provider and corrections officers and agencies, and the use of special equipment, such as the plethysmograph and the polygraph, in the course of treatment. A practitioner who fails to meet the regulatory requirements could be disciplined by the Board of Psychology, and may face certification revocation, suspension or failure to renew, a reprimand or a fine. Additional regulations are proposed for application for reinstatement two years following board action.

The certification program will ensure that treatment providers who work for

or contract with the Department of Corrections, the Department of Youth and Family Services or a local or regional jail have been professionally approved to provide such services. Certified sex offender treatment providers must be trained not only in the latest technologies and treatment protocols, they must have training in criminal justice system issues. They also must know how to work in collaboration with corrections officials, and be willing to comply with information-sharing requirements of the courts, corrections agencies and Parole Board. When the quality of sex offender treatment services is assured through professional certification, then the probability is greatly enhanced that sex offenders will be rehabilitated more successfully.

V. Findings and Recommendations

Finding: It is generally agreed that some sex offenders are among the most difficult to rehabilitate, and devising appropriate and effective treatment for some sex offenders continues to be an elusive task. However, for certain types of sex offenders, studies have reported treatment successes when offenders are properly evaluated and assessed, and sufficient and professional treatment and aftercare are provided.

Recommendation 1: The Department of Corrections and the Department of Youth and Family Services should continue to provide sex offender treatment services for incarcerated offenders, and for offenders under community supervision. Graduated release plans should include treatment and aftercare requirements and an appropriate level of supervision for sex offenders.

Finding: Most studies conclude that there are populations of violent or habitual sex offenders that typically do not respond to treatment, and concern for public safety has dictated policies that call for long-term incarceration of these types of sex offenders.

Recommendation 2: For those adult sex offenders convicted prior to the abolition of parole in Virginia, the Virginia Parole Board should consider whether those who otherwise qualify for discretionary parole release have participated successfully in sex offender treatment programs while in prison.

Finding: The use of anti-androgens to chemically treat sex offenders remains a controversial methodology. Current research does not promote chemical castration as a cure for sexual deviancy, but there are indications that biomedical treatment coupled with counseling and other therapy can help some offenders learn to control their sexual behaviors. Anti-androgen treatment, because of its serious side effects, should be voluntary and with informed consent, and should used only on adult offenders.

Recommendation 3: The Department of Corrections should consider the appropriate and voluntary use of anti-androgen treatments on some sex offenders, provided the offender gives voluntary, informed consent to the treatments. Such treatment should be provided only by qualified professionals, and the medical health of the recipients should be closely monitored.

Finding: There are a variety of treatment programs that have been designed for sex offenders, including intensive therapy, medical treatment and support groups. Needs and risk assessments play a critical role in determining appropriate treatment and supervision needs for sex offenders. Among the more successful institutionally-based programs are therapeutic communities, which separate sex

offenders from the general population and provide intensive therapy and behavioral modification services. However, support groups, self help programs, individual and group counseling, psycho-educational counseling and some forms of medical treatment also can be effective in the treatment and rehabilitation of sex offenders.

Recommendation 4: The Corrections Subcommittee concurs with the recommendation of the Crime Commission's HJR 518 Inmate Services Subcommittee that "the General Assembly should reinstate the two therapeutic communities for sex offender treatment providing 100 beds for treatment for three years and a two year aftercare component. Within the context of these programs, research and evaluation should be emphasized to measure the effectiveness of treatment on reducing recidivism. The Department of Corrections also should maintain the current psycho-educational groups for sex offender treatment to serve as both an adjunct to intensive treatment and as a screening tool for identifying those inmates most appropriate for treatment." Estimated cost to the Department of Corrections: $970,432 and 28 FTE positions.

Finding: Intensive supervision of sex offenders released into the community is necessary to reduce recidivism. Treatment and intensive supervision together further reduce the chances that the sex offender will commit another crime, and will increase the offender's chances of successfully modifying his behavior.

Recommendation 5: The Department of Corrections should monitor the pilot sex offender supervision projects in Manassas and Newport News, and provide a progress report to the Crime Commission by August, 1996.

Finding: When the quality of sex offender treatment services is assured through professional certification, then the probability is greatly enhanced that sex offenders will be rehabilitated more successfully. The certification program will ensure that sex offender treatment providers who work for or contract with the Department of Corrections, the Department of Youth and Family Services or a local or regional jail have been professionally approved to provide such services.

Recommendation 6: The Department of Corrections, the Department of Youth and Family Services and local and regional jail supervisors must employ, contract with, or accept volunteer services from state certified sex offender treatment providers to work with adult and juvenile sex offenders under state supervision in compliance with Code of Virginia § 54.1-3601.

VI. Resources

"Defective Delinquent and Sex Offender Study," Interim Report of the Virginia State Crime Commission, Senate Document No. 36, Commonwealth of Virginia, 1975.

Virginia Acts of Assembly, 1975.

"Substance Abuse and Sex Offender Treatment Services for Parole Eligible Inmates," Report of the Joint Legislative Audit and Review Commission, Senate Document No. 8, Commonwealth of Virginia, 1992.

"Habitual Sex Offender Subcommittee," Report of the Office of the Lieutenant Governor, Senate Document No. 41, Commonwealth of Virginia, 1995.

"Inmate Work Initiative Implementation Guide," House Bill 1994, Prepared by Correctional Services Group, Inc., for the Virginia Department of Corrections, February 2, 1994.

Rennie v. Klein,720 F2d. 266 (1983). (New Jersey federal court decision addressing treatment as punishment.)

Draft report of the Inmate Services Subcommittee, HJR 518 of Correctional Program Standards, Virginia State Crime Commission, September, 1995.

VII. Acknowledgements

The members extend special thanks to the following agencies and individuals for their cooperation and valuable assistance to this study effort:

Senator Edgar S. Robb, Charlottesville

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Virginia Board of Psychology

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U. S. Department of Health and Human Services

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Statewide Program Coordinator
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Dr. Isaac Van Patten, Director
Community Corrections of Virginia

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Virginia Department of Youth and Family Services

Appendix A

1995 SESSION
ENGROSSED

LD6263728

SENATE JOINT RESOLUTION NO. 284

Senate Amendments in [ ] — February 7, 1995

Requesting the Virginia State Crime Commission to study alternative treatments for sex offenders in Virginia's adult correctional institutions.

Patrons—Robb, Bell, Houck, Norment and Woods; Delegates: Callahan, Dudley, Fisher, Hamilton, Katzen, Kidd, Newman, Nixon, Orrock, Purkey, Reynolds, Rhodes, Tata, Wagner, Wardrup and Way

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Referred to the Committee on Rules

WHEREAS, because most of Virginia's prison inmates will eventually be released, they should be given the best treatment opportunity, if any is available, to avoid re-commitment to the prison system; and

WHEREAS, treatment for sex offenders has been historically shown to be ineffective to minimally effective, at best; and

WHEREAS, it is extremely important that treatment for sex offenders be implemented which has a greater chance for success; and

WHEREAS, some medical treatment regimes have been shown to reduce the recidivism rates of sex offenders; and

WHEREAS, an offender who is wishes to reduce his proclivity to commit sex offenses should be given the opportunity; and

WHEREAS, a reduction in an offender's criminal provclivity benefits both him and the citzens of the Commonwealth by reduction in prison costs and increased safety of the public; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Virginia State Crime Commission be requested to study potential, alternative sex offender treatments, including but not limited to drug treatment designed to reduce an offender's urge to commit sex crimes, and to make appropriate recommendations to the General Assembly. Technical assistance shall be provided to the [~~task force~~ Commission] by the Department of Corrections.

The State Crime Commission shall complete its work in time to submit its findings and recommendations to the Governor and the 1996 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

Official Use By Clerks

Passed By The Senate		**Passed By The House of Delegates**	
without amendment	☐	without amendment	☐
with amendment	☐	with amendment	☐
substitute	☐	substitute	☐
substitute w/amdt	☐	substitute w/amdt	☐

Date: _____ Date: _____

_____ _____

Clerk of the Senate Clerk of the House of Delegates

Appendix B

COMMONWEALTH of VIRGINIA

Department of Corrections

P. O. BOX 26963
RICHMOND, VIRGINIA 23261
(804) 674-3000

RON ANGELONE
DIRECTOR

August 1, 1995

Dana Schrad, Staff Attorney
Virginia State Crime Commission
General Assembly Building
910 Capitol Street, Suite 915
Richmond, Virginia 23219

RE: SJR 284, Sex Offender Treatment

Dear Ms. Schrad:

Per your request to Scott Richeson, the following is a summary of the history and current status of sex offender treatment in the Department.

The first formal treatment program for sex offenders began in the late 1970s with the House of Thought Therapeutic Community, a 50 bed intensive program located at the Powhatan Correctional Center complex. At that time the Department also operated less intensive weekly treatment groups at three prisons.

In the early 1980s the Sex Offender Program Action Committee (SOPAC) was formed to develop training and recommend policy to the Department. The Committee was designed to include members from the private sector, other public safety agencies as well as Department staff. SOPAC quickly assumed a leadership role and became successful in developing training curricula for staff working with sex offenders.

In 1982 the House of Thought Therapeutic Community for sex offenders, and it's companion substance abuse program, were closed due to statewide agency budget cuts. In spite of budget reductions, SOPAC's training continued and combined with the Department's administrative support, weekly sex offender treatment groups continued to develop in prisons throughout the system. These groups were operated by case-management counselors in

addition to their regular duties, so the quality of service varied among facilities based on staff time and expertise. By 1990, the Department was operating weekly counseling groups and psycho-educational programs in 10 prisons with treatment slots for 336 inmates.

Effective January, 1992, The Board of Corrections adopted a standard making sex offender treatment one of the five "core" programs to be offered in all major institutions.

In 1993 the Department received funding to implement two sex offender Therapeutic Community programs. Similar in design to the former House of Thought program, these programs were located at Bland and Haynesville Correctional Centers with each containing 50 beds. Unfortunately, during FY 1995, the Department was required to eliminate over $10 million dollars from its annual operating budget, forcing the closing of the Therapeutic Community programs. Other budget reductions were made in security staff, administrative positions, general counseling and recreation.

The Department decided to eliminate the sex offender programs in favor of salvaging substance abuse programs. Since funding is limited and not all types of services can be provided, we believe substance abuse programs offer a better investment of taxpayer dollars. This is because a larger number of inmates need substance abuse treatment (80% of inmates are substance abusers whereas 16% of inmates are sex offenders). Also, substance abuse treatment is less expensive per inmate ($1,500/year/inmate as compared with $4,500/year/inmate for sex offenders); the consequence of treatment failure is less of a public risk (relapse with a substance vs. a new sex crime); and, substance abuse treatment has a longer record of success in lowering recidivism rates.

Currently, sex offender treatment remains a core program requirement for major institutions. Most prisons do operate sex offender psycho-educational programs and many operate weekly counseling groups. There are approximately 350 treatment slots at any one time. These services are provided by case-mangement counselors in addition to their other duties. SOPAC continues to be an active Committee which conducts training and keeps the Department's sex offender approaches consistent with the state of the art nationally. Our current services are based on cognitive-behavioral approaches which emphasize relapse-prevention models and victim empathy.

In the Community Services area, Probation and Parole Districts contract with private vendors in each locality for assessment and treatment of sex offenders. A model community-based sex offender program is operating in Probation and Parole District 19 (Newport News), which provides offenders with therapy while using a polygraph to enforce community safety. Also, in Manassas, a pilot intensive supervision program for sex offenders is being implemented.

I hope this letter provides you with a sufficient status report on sex offender services in the Department. Please contact Scott Richeson at (804) 674-3296 if you have any questions.

Sincerely,

Ron Angelone

RA:HSR

cc: Mike Leininger
Scott Richeson

Appendix C

§ 54.1-2924.1. (Effective until July 1, 1999) Sex offender treatment providers. — The Board shall promulgate regulations for the voluntary certification of licensees as sex offender treatment providers. In promulgating such regulations, the Board shall consider the standards recommended by the Advisory Committee on Certified Practices pursuant to § 54.1-3610. The provisions of this section shall expire on July 1, 1999. (1994, c. 778.)

Editor's note. — This section was enacted by Acts 1994, c. 778, and will expire by its own terms July 1, 1999.

§ 54.1-3609. (Effective until July 1, 1999) Advisory Committee on Certified Practices. — The Advisory Committee on Certified Practices is hereby established and shall consist of ten members. One member each shall be appointed by the Boards of Medicine, Nursing, Professional Counselors, Psychology, and Social Work from their respective boards. The Board of Health Professions shall appoint the remaining five members, two of whom shall be citizen members of the Board of Health Professions or members of boards listed in § 54.1-2503 not required to appoint a member, and three of whom shall be sex offender treatment providers. Members shall serve five-year terms or until the expiration of this section, whichever first occurs. The term of any member who is a member of a board referred to in § 54.1-2503 shall expire contemporaneously with the expiration of his term on such board. Vacancies shall be filled in the same manner as original appointments. The provisions of this section shall expire on July 1, 1999. (1994, c. 778.)

Editor's note. — This section shall expire July 1, 1999 by its own terms.

§ 54.1-3610. (Effective until July 1, 1999) Powers and duties of Advisory Committee on Certified Practices. — A. The Advisory Committee shall:

1. Recommend to the Boards of Medicine, Nursing, Professional Counselors, Psychology, and Social Work standards for the voluntary certification of their licensees as sex offender treatment providers.

2. Recommend to the Board of Psychology standards for the mandatory certification of sex offender treatment providers for those professionals who are otherwise exempt from licensure under subdivision 4 of §§ 54.1-3501, 54.1-3601 or § 54.1-3701.

B. The provisions of this section shall expire on July 1, 1999. (1994, c. 778.)

Editor's note. — This section shall expire July 1, 1999 by its own terms.

§ 54.1-3611. (Effective until July 1, 1999) Restriction of practice; use of titles. — No person, including licensees of the Boards of Medicine, Nursing, Professional Counselors, Psychology, or Social Work, shall claim to be a certified sex offender treatment provider unless he has been so certified. No person who is exempt from licensure under subdivision 4 of §§ 54.1-3501, 54.1-3601 or § 54.1-3701 shall hold himself out as a provider of sex offender treatment services unless he is certified as a sex offender treatment provider by the Board of Psychology. The provisions of this section shall expire on July 1, 1999. (1994, c. 778.)