COMMONWEALTH of VIRGINIA

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November 7, 2016

The Honorable Thomas K. Norment, Jr.,
The Honorable Emmett W. Hanger, Jr.
Senate Finance Committee
10th Floor, General Assembly Building
910 Capitol Street
Richmond, VA 23219

Dear Senator Norment and Senator Hanger:

Item 331.D. of the 2016 *Appropriation Act*, required the Department of Behavioral Health and Developmental Services (DBHDS) to review and develop options to reduce the census growth and potential need for additional bed capacity at the Virginia Center for Behavioral Rehabilitation and report its findings to the Chairmen of the House Appropriations and Senate Finance Committees by November 1, 2016.

Please find enclosed the report in accordance with Item 331.D. Staff at the department are available should you wish to discuss this request.

Sincerely,

Jack Barber, M.D.

Cc: William A. Hazel, Jr., M.D.
Joe Flores
Susan Massart
Michael Tweedy

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The Honorable S. Chris Jones, Chair
House Appropriations Committee
General Assembly Building
P.O. Box 406
Richmond, VA 23218

Dear Delegate Jones:

Item 331.D. of the 2016 *Appropriation Act*, required the Department of Behavioral Health and Developmental Services (DBHDS) to review and develop options to reduce the census growth and potential need for additional bed capacity at the Virginia Center for Behavioral Rehabilitation and report its findings to the Chairmen of the House Appropriations and Senate Finance Committees by November 1, 2016.

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Study of Alternatives to Secure Confinement for Sexually Violent Predator:

An Analysis of Cost-Effective Alternative Methods of Treatment & Monitoring

To the Governor and

Chairs of the House Appropriations and Senate Finance

Committees of the General Assembly

Prepared by the

Department of Behavioral Health & Developmental Services (DBHDS)

November 1, 2016

TABLE OF CONTENTS

I. Executive Summary

Mandate: This report is submitted in accordance with Item 331 D of the 2016 *Appropriation Act*, which directs that the Department of Behavioral Health and Developmental Services shall review and develop options to reduce the census growth and potential need for additional bed capacity at the Virginia Center for Behavioral Rehabilitation. As part of this review the department shall evaluate alternative options such as greater use of conditional release for individuals in order to reduce the future need to increase the physical capacity of the facility. The department shall report its findings to the Chairmen of the House Appropriations and Senate Finance Committees by November 1, 2016.

Executive summary: The Department of Behavioral Health & Developmental Services (DBHDS) created a multi-disciplinary workgroup which was tasked with developing options to reduce census growth at the Virginia Center for Behavioral Rehabilitation (VCBR). As part of the review process the team conducted a thorough review of the existing program in the Commonwealth looking at its strengths and weaknesses. Opportunities to improve the efficiency and effectiveness of the existing program were reviewed. In addition, the workgroup sought information about programs in other states/jurisdictions and used that information to guide the formation of options which could be implemented in the Commonwealth. In total, seven options are offered for consideration. Each option can be implemented alone or in combination with other options. Each option has a relative financial cost, but also come with relative risk to community safety. Finally, each option comes with community perception about the manner in which Sexually Violent Predators are treated in the Commonwealth. Community perception has the potential to be a major barrier to several of the options. Finally, the workgroup attempted to assess the potential impact of each option on the overall census growth at VCBR. The opinion of the group is that while implementing options would have a net decrease on the census growth, overall it is anticipated that VCBR will continue to experience census growth (even if a majority of the options were implemented). The workgroup is of the opinion that it is in the best interest of the Commonwealth to proceed with expansion at VCBR as ultimately the secure treatment space will be needed.

Brief History of SVP Laws in the United States

As early as the 1930s, states began attempting to identify sexual offenders who suffered from mental disorders and required specialized treatment in order to mitigate risk of future sexual offending. Civil commitment statutes, often referred to as Mentally Disordered Sex Offender Statutes, or Sexual Psychopath Laws, were developed and called for identified offenders to receive specialized treatment. These statutes were intended to identify the most mentally disturbed sexual offenders and offer them hospitalization in lieu of imprisonment. Additionally, these statutes protected society by providing for ongoing commitment until the offender no longer presented a risk of committing future offenses. The statutes were quite popular for a period of time and by the 1960s, most state legislatures had passed some form of a civil commitment statute. Despite their popularity, many civil commitment statutes were subjected to extensive constitutional challenges. For example, opponents of civil commitment statutes questioned the appropriateness of detaining individuals for treatment when they had often been deemed unamenable to such treatment. In addition, sex offenders were often considered dangerous even after they had completed their prison term, so they were confined indeterminately to state hospitals where sex offender-specific treatment was not necessarily available. In other cases, offenders seeking to avoid prison presented themselves as mentally disordered in the hopes of securing more humane treatment. This caused the accuracy of all sex offender assessments to be called into question. Moreover, in some states, offenders who were diverted to mental health facilities were released outright, often sooner than they would have been released from prison if they had been ordered to serve their sentences. Eventually, given both the concerns about treatment and unease over the possible infringement of civil liberties, states began repealing their civil commitment statutes. By the late 1980s, most states had done away with these laws. In the few states that retained their civil commitment statutes, they were infrequently used. Following the demise of the first generation of civil commitment statutes, the focus of sex offender treatment shifted to the development of prison-based programs and community outpatient programs. Unfortunately, few residential community programs were available; therefore, many relatively dangerous sexual offenders were treated on an outpatient basis thus exposing the community to potential risk.

Beginning in the 1990s, after a spate of highly publicized crimes committed by recently released sex offenders, many states began to reconsider the possibility of civilly committing offenders who posed the highest risk of reoffending. It did not take long before states developed a second generation of statutes, attempting once again to address the distinct social problems posed by sexual offenders. These statutes took effect at the end of offender's prison sentence, instead of diverting the offender to treatment in lieu of incarceration. The statutes have been upheld as constitutional after challenges claiming double jeopardy and questioning whether they could be considered ex post facto laws. Other failed challenges have focused on the accuracy of the evaluations, specifically regarding the presence of a mental disorder and the offender's ability to control his behavior. Currently, twenty states and the Federal system have civil commitment

laws, and hundreds of sex offenders have been civilly committed in recent years. The only successful legal challenges to the validity of the programs have occurred in those states which have failed to release residents from civil commitment, as there must be a reasonable hope for discharge back to the community.

Virginia's Sexually Violent Predator Laws and the Census Growth at VCBR

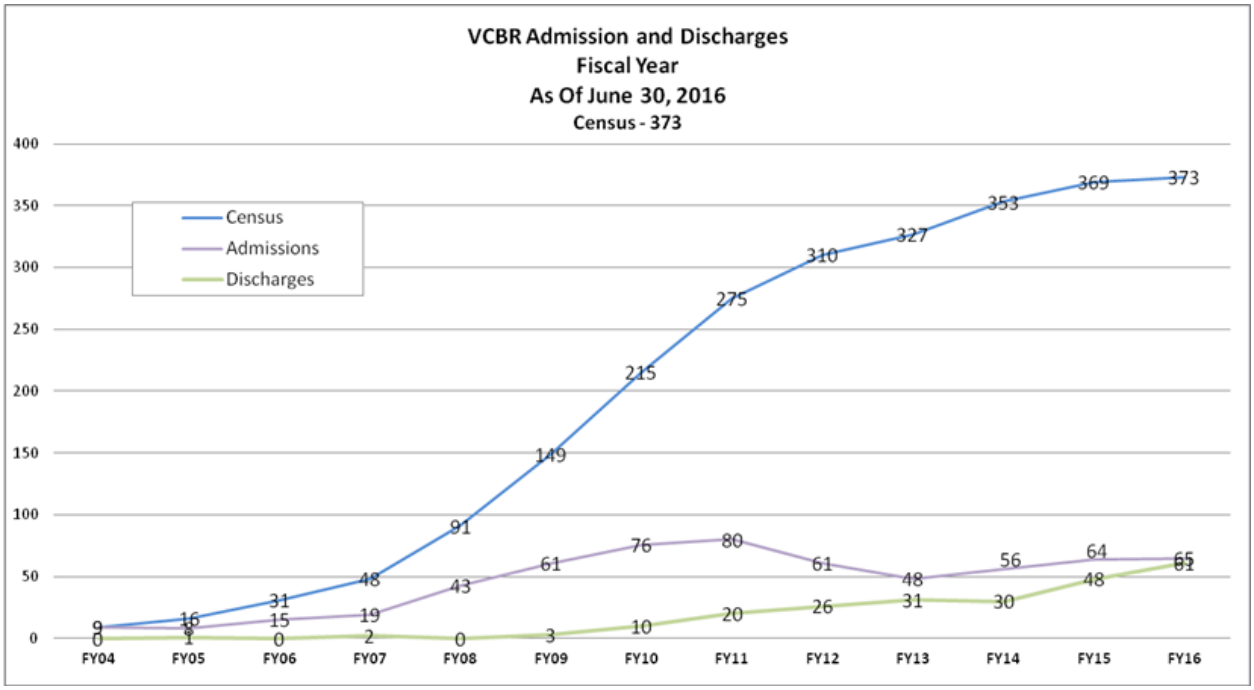
Virginia, like many other states, has created a system of post-sentence civil commitment for persons whom the state finds to meet criteria for Sexually Violent Predators (SVP) (§37.2-900), and who it feels present too great a risk for sexual recidivism to be released into the community. The Codes controlling this process are found under §37.2-900 et seq. of the Code of Virginia. These are civil codes and describe the conditions under which individuals are held under civil commitment. While civil commitment of violent sex offenders was written into the Code of Virginia back in 1999, the actual commitment system was not enacted until April 2003 after Virginia constructed its facility for the secure confinement and treatment of violent sexual offenders. Initially while a state of the art facility capable of housing/treating 300 SVPS was being constructed, existing buildings on the campus of a downsized training center were used to house/treat SVPS. In 2008 the program moved to its current location the Virginia Center for Behavioral Rehabilitation (VCBR) in Burkeville, Virginia.

The current VCBR facility was designed reflecting the 1999 SVP commitment laws to have a maximum capacity of 300 beds. Under the then prevailing SVP laws, admissions ran about one per month. At that rate a 300-bed capacity would have sufficed for about 20 years. This changed in 2006 when the Virginia Legislature expanded the number of qualifying crimes from four offenses to twenty-eight offenses and shifted the screening tool from the RRASOR (Rapid Risk Assessment of Sex offender Recidivism) to the Static-99 actuarial instrument. Combined, these changes increased the admission rate at VCBR by more than 300%. Most of this increase is as a result of the greater "capture" rate of the Static-99 actuarial instrument. The older instrument, the RRASOR was efficient at identifying high risk child molesters, but missed the more aggressive and antisocial sex offenders. The Static-99, developed by the same authors, corrected this shortcoming. As a result, changing to the Static-99 identified more SVP-eligible inmates. Review of data suggests that switching to the Static-99 captured more individuals, many of whom were indeed in need of secure confinement and treatment. This increased pressure on the SVP system for services at all levels.

In 2011, as census at this facility approached 300, the General Assembly mandated that the Department reconfigure 150 individual residential rooms for double-occupancy. The Department accomplished this mandate, bringing maximum capacity at VCBR up to 450 beds.

Chart 1 below shows the census grown at VCBR since its inception. In addition to showing the growth in census the chart shows the patterns of change in admissions and conditional releases.

Chart 1: VCBR Census, Admissions, & Discharges by Fiscal Year



The 2013 General Assembly approved and funded planning to expand the present VCBR to accommodate the growing census and the projection that the census would exceed the available bed capacity. Workgroups of experts were formed to study the needs of the Commonwealth. The workgroups studied the SVP commitment programs in other states and also reviewed historical data regarding the growth of the SVP population in the Commonwealth. Analyses were made of the various construction designs balancing treatment/security needs while containing construction costs. Analyses were conducted regarding the use of the current physical space within VCBR looking for opportunities to improve the efficiency of space utilization. Ultimately a design which included the addition of much needed treatment space (the current treatment space was built with a census cap of 300 residents and was built with the presumption of what was then the average participation rate in other SVP programs which VCBR exceeded with its 98% participation rate) along with the addition of sleeping space to accommodate an additional 258 residents was the recommendation of the workgroup. Once completed, this expansion will increase maximum capacity at VCBR to 708 residents. The design also maximizes future savings (should the demand for space exceed 708) by creating shelved space which could be completed if/when the demand requires expansion. The shelved space does not appreciably increase the overall construction costs but provides the Commonwealth with alternatives in the future (should they be needed) and capitalizes on savings associated with lower construction costs now that will be likely in the distant future.

Comparison of Virginia's SVP Program with Those Located in Other States

As mentioned above, twenty states and the Federal system have SVP statutes. Most are very similar, with the only difference being whether they allow those offenders who had been found to be "unrestorably incompetent to stand trial" to be committed as an SVP. A few states have

some significant differences. For example, Pennsylvania only commits juveniles who have "aged out" of the juvenile system. Historically, Texas operated a rather unique SVP program in that it had no secure confinement alternative but rather committed all SVPS to outpatient treatment. The program showed initial promise and was initially viewed as a less restrictive alternative to secure confinement. However, at that time in the Texas program any/all incidents of non-adherence often resulted in individuals being charged with felony offenses and for many this resulted in lengthy prison sentences. Over time the program fell under intense scrutiny due to constitutional challenges to the program and Texas eventually amended their code to be more consistent with other jurisdictions. Texas now operates a secure inpatient facility like the other states.

Arizona has the capability to commit a person directly to their Less Restrictive Alternative, a transitional housing unit on the grounds, but outside the secure perimeter. Minnesota has a site of their civil commitment program in the prison, and sex offenders incarcerated in prison are screened early, with those assessed to be the highest risk referred to the sex offender treatment program run by their mental health department. Since it is supervised by the same administration as the civil commitment program and run by the same staff, it is expected that those completing the prison site of the program will not need civil commitment. If they do not complete the program, their transfer to the civil commitment program should be seamless, with them at least being in a higher phase. States which do not have SVP statutes offer sex offender treatment in prison and sometimes use enhanced sentencing and/or lifetime parole as part of their sex offender management system.

SVP Treatment at VCBR

Since its inception, many changes were made in the treatment program at VCBR. Changes have included making the criteria for progression through the program clearer to both residents and staff, adding more structure and clear objectives for every group offered, implementing an integrated model for treatment (combining the models found to be the most effective for this population), being more responsive to learning styles by providing a separate track for intellectually disabled or severely psychiatrically impaired residents and special accommodations for those with learning disabilities, adding privileges both for positive behavior and progression in treatment, providing more vocational training and work opportunities, and providing transitional opportunities to improve adjustment in the community. In addition, all staff, regardless of their position are trained on the treatment phases and on how to respond therapeutically to residents. Also, a family outreach component was added, which attempts to bring support people "on board" with treatment concepts as early as possible in the resident's treatment.

On admission, each new resident participates in comprehensive multidisciplinary assessments to identify his treatment needs and risk factors for future sexual aggression. The results of the assessments are shared with the resident and then a comprehensive treatment plan is designed to meet their particular treatment/risk needs. The resident in then enrolled in various therapeutic activities to address their risk/treatment needs. The current treatment program is a comprehensive program that uses an integrated model, combining the best of cognitive-

behavioral interventions, the relapse prevention model, the pathways model, the Good Lives model, Dialectical Behavioral Therapy (DBT), trauma work and relational therapy. It also follows the Risk-Needs-Responsivity principles, with treatment targets mainly focusing on criminogenic needs, a special track for intellectually disabled offenders, and special accommodations for those with significant learning disabilities. It is a three-phase program with clearly identified goals for progressing through the phases and clearly identified requirements regarding the length of time an offender must demonstrate identified behavioral goals before he will be promoted to the next phase. This makes progression through the phases clear to both residents and staff, and protects against bias or over-investment on the part of treatment providers. The phase goals are based around dynamic risk factors, so progression through the phases correlates with the changes desired by forensic evaluators and judges before recommendations for release will be given. Groups are divided into core (process) groups and numerous topic-focused module groups addressing specific topics related to criminogenic needs. These module groups have clear objectives and are more didactic in nature than the core groups. Each resident receives a clear report at the end of each quarter specifying how he was observed either to meet or not meet each phase goal. Residents obtain one level of privileges just for following the rules of the facility, and can earn extra privileges if they happen to also be in an advanced phase of treatment.

Outcomes of Treatment at VCBR

The intended outcome of commitment to VCBR is for those individuals who demonstrate progress in treatment and who demonstrate the skills necessary to live successfully and safely in the community to be released and to retain at VCBR those individuals who remain at high risk for sexual offending. To measure the success of a program one would look at the proportion of individuals in each phase of treatment, expecting to see that at least a portion of individuals are moving from one phases of treatment to the next. Additionally, "success" can be measured by looking to see how many individuals are conditionally released from the program. Additionally, to measure the relative success of the program one could compare the Virginia program to that of other states to determine if Virginia is conditionally releasing proportionately (compared to the overall number committed) more or fewer residents. Finally, the success of the program can also be measured by the rate of violent sexual reoffending and making a comparison between the observed re-offending rater and the nationally publicized re-offense rates.

Phase of Treatment

As of June 30, 2016 the following represents the breakdown in the percentage of VCBR residents in each phase of treatment:

Phase of Treatment	Percentage of Residents
Phase I	40%
Phase II	47%
Phase III	13%

With regard to phases, in order to be promoted to one phase to the next, the resident must demonstrate achievement of his/her treatment goals for two consecutive quarters (i.e. 6 months). While ideally there would be a linear progression from one phase to the other, practically speaking there are times when residents have set backs in their treatment and must move back to an earlier phase in order to focus their treatment on issues/areas needing further work. While in theory discharge planning begins on the date of admission, it is when an individual moves to Phase III that there is increased emphasis on securing the requisite services to support individuals who are granted conditional release. As there tends to be a fairly high concordance rate between evaluators' recommendations for release and that of the court, relatively few individuals remain in Phase III for an extended time. That being said, historically there were a relatively large number of individuals "stuck" in Phase III due to a lack of community resources. To remediate this issue, DBHDS/VCBR reallocated existing funds to help create supports in the community to facility safe release. The funding is used for such activities as securing a residence by paying the first month's rent, purchasing needed resources, etc. With the advent of such funding VCBR was able to clear the backlog of individuals stuck in Phase III. The backlog is nearly clear and the number of discharges likely will decrease slightly (as there are fewer residents in Phase III).

Conditional Releases

Chart 2 below shows the number of new Conditional Releases from VCBR by fiscal year. As can be seen early on in the programs history relatively few individuals were released from the program. However, starting in FY '13, the number of Conditional Releases began to increase and have continued to increase each fiscal year. While a portion of these more recent releases can be attributed to clearing a backlog of individuals ready for release, overall the statistics demonstrate that in fact the treatment program at VCBR has been effective in preparing individuals for release. This increased rate of release has helped push back the date when additional beds will be needed at the facility. Unfortunately, without additional resources it is unlikely this elevated rate of release can be maintained, thus necessitating the creation of more secure, inpatient treatment space.

Comparison of Virginia to Other Jurisdictions with SVP Commitment

Data was obtained from other states that have similar SVP commitment laws in order to compare Virginia's program with these other programs with regard to both the overall number of individuals granted conditional release from the secure treatment program but also to compare the ratio of the number of conditional releases to the overall number of individuals civilly committed. Chart 3 shows how Virginia compares to the other jurisdictions in terms of the overall number of conditional releases from the secure treatment program. As is evident, Virginia has had more conditional releases than any of the other programs for which data was available. Chart 4 provides statistics on the relative proportion of conditional releases to commitments. Again Virginia has the highest proportionate number of conditional releases from secure confinement. While Virginia ranks fourth in terms of the overall committed SVP population, it leads the way in terms of the number of individuals granted release, thus clearly demonstrating that Virginia is maximizing the use of Conditional Release (at least as compared to other SVP commitment programs).

Chart 2: Conditional Releases from VCBR by Fiscal Year

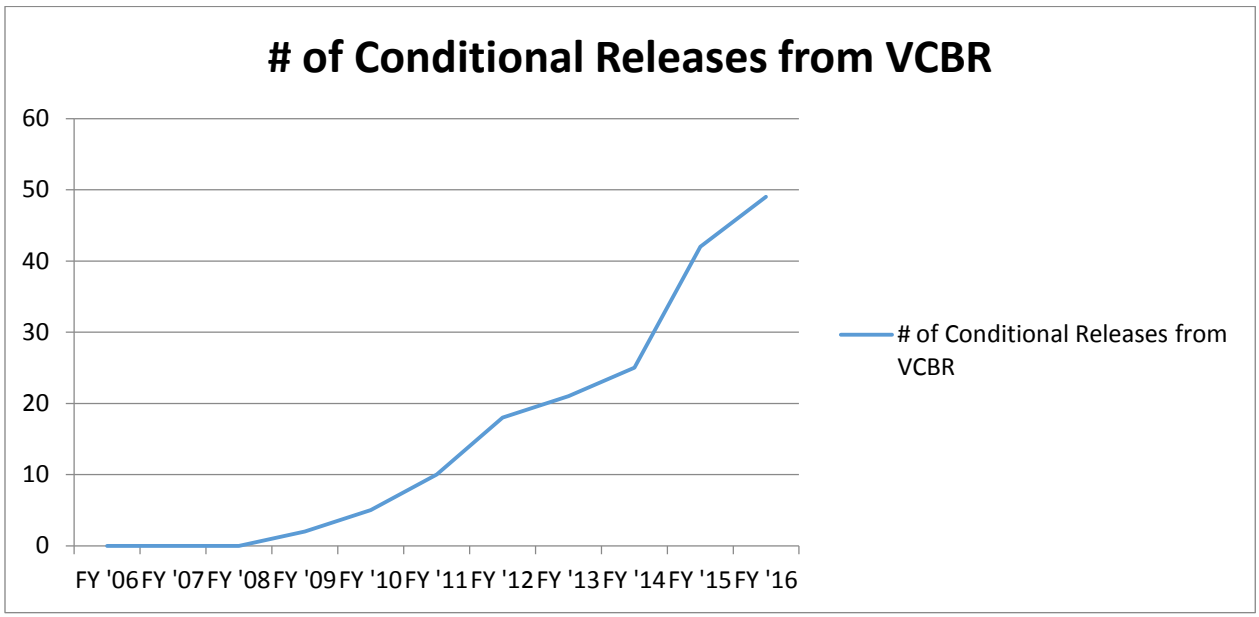


Chart 3: Census & Conditional Releases of Other State SVP Commitment Programs

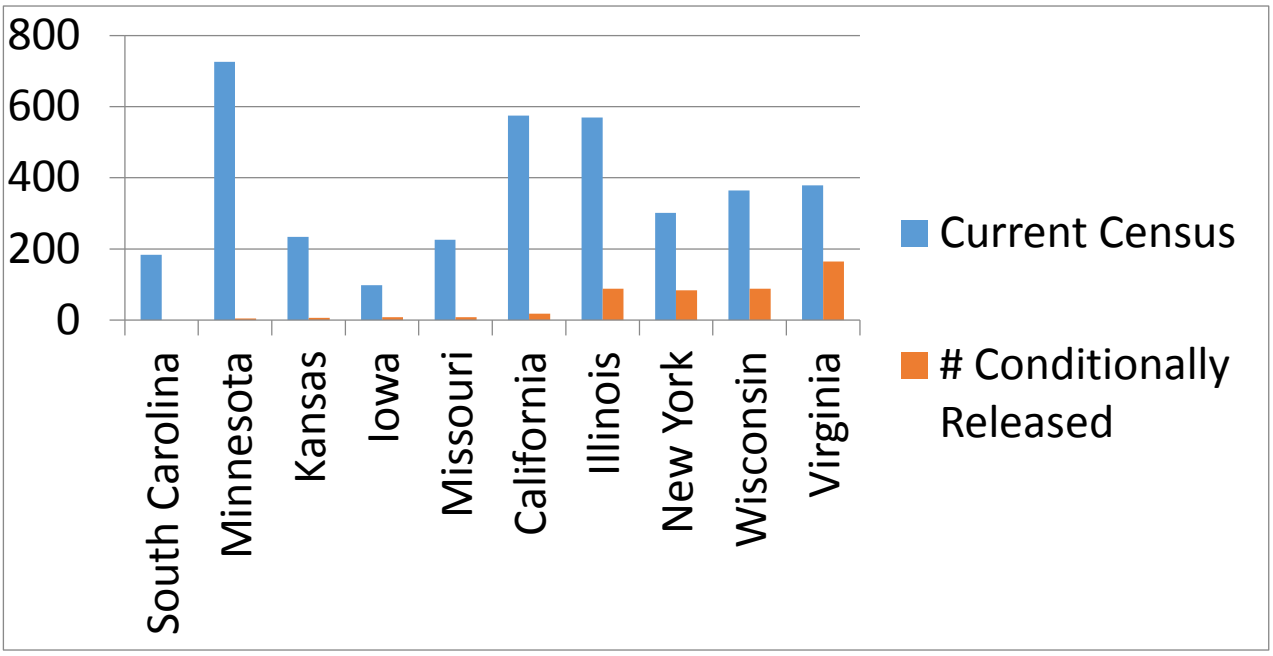
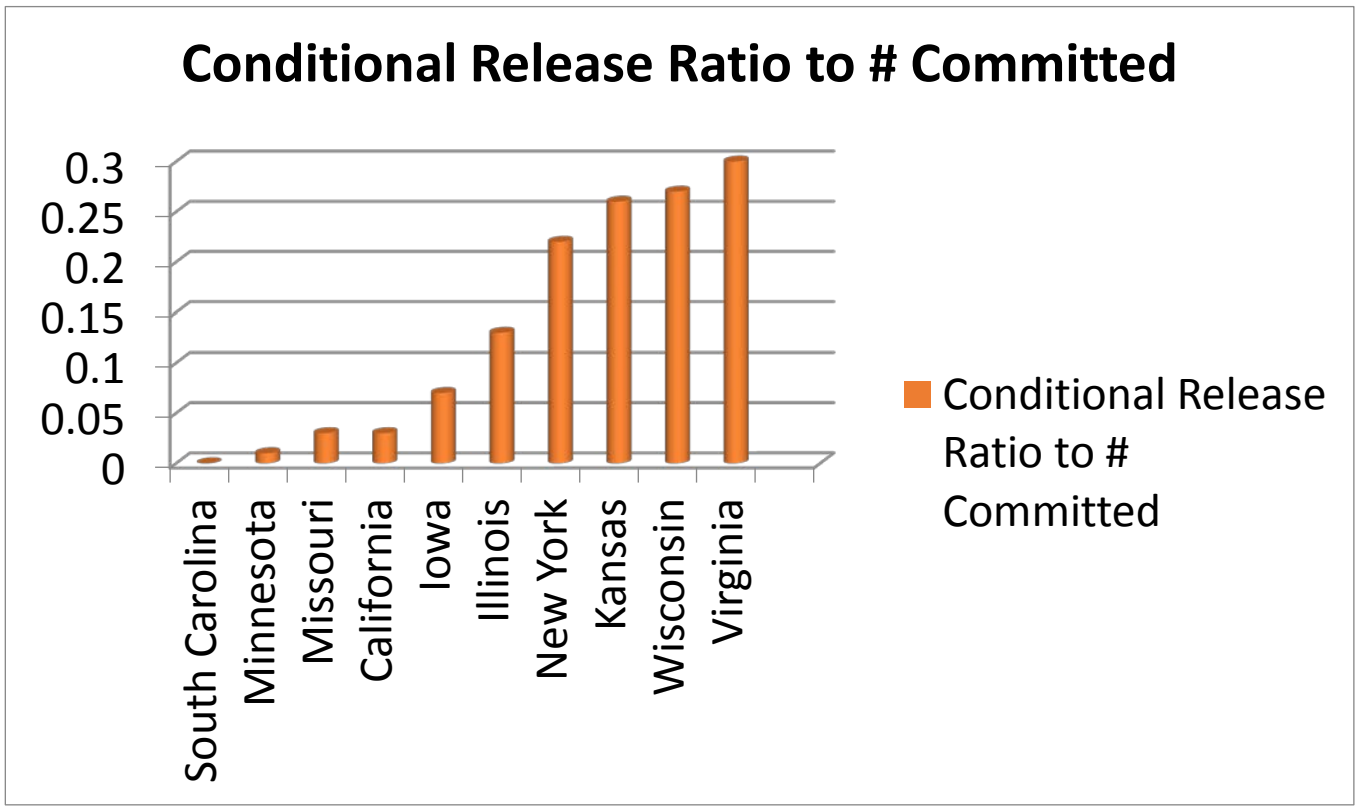


Chart 4: Ratio of Conditional Releast to Number Committed



Sexual Re-Offending Rate of Individuals Released from VCBR

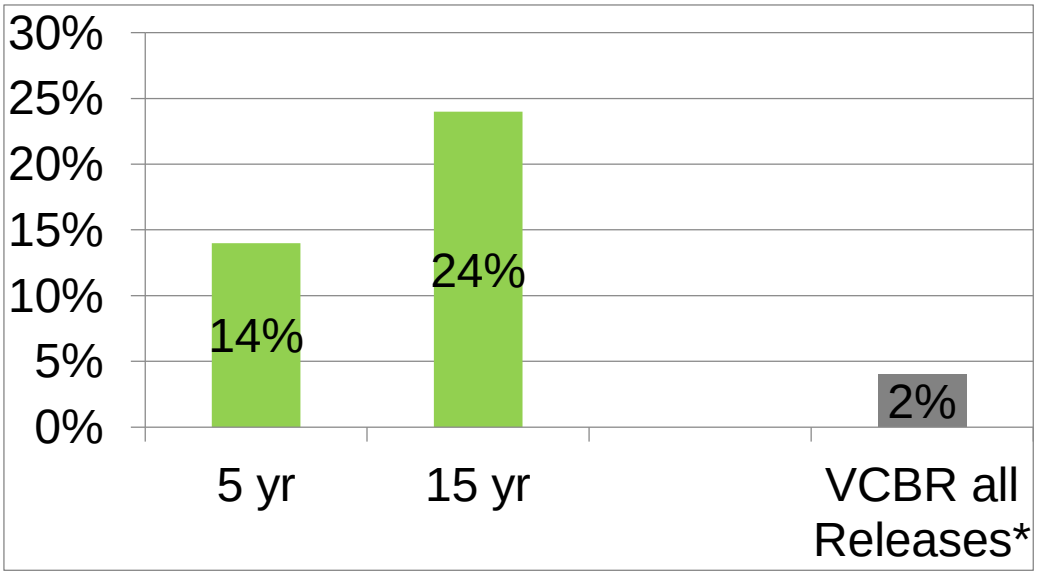
Clearly, one of the primary goals of treatment at VCBR is to address the individual's risk factors for sexual re-offending and mitigate those factors to the degree possible. Additionally, the goal of Conditional Release is to provide the individual granted release with sufficient supports, oversight, and monitoring so as to detect when/if the individual is exhibiting thoughts/behaviors which historically precede incidents of sexual offending and intervene prior to re-offense. While ideally no individuals would sexually re-offend, unfortunately there are rare incidents where sexual re-offending occurs. Looking at the studies which are conducted on higher risk sex offenders, (which is more reflective of the population at VCBR), we offer the following statistics:

Oliver, Wong & Nicholaichuk (2008) found treated sex offenders recidivated at a rate of 16.9% as compared to the untreated sex offenders who recidivated at a rate of 24.5%, (during a five-year follow-up period). Some other studies include Lowden et al (2003) who found that treated sex offenders had three times lower recidivism rates than untreated sex offenders. McGrath et al (2003) found that treated sex offenders reoffended at a rate of 5% as compared to 30% for untreated sex offenders. MacKenzie (2006) found that treated sex offenders reoffended at a rate

of 9% as compared to 21% for untreated. Kriegman (2006) found a recidivism rate of 19% for treated sex offenders as compared to 38% for untreated sex offenders.

Chart 5 compares the sexual re-offense rate for individuals treated at and released from VCBR with national re-offense rates (averaging know re-offense rates for high risk offenders). As can be seen, the sexual re-offense rate for treated sex offenders is lower than the national average and reflects indeed treatment and close monitoring during conditional release are effective in mitigating some of the risk (although all the risk can never be fully mitigated). The data suggests that while Virginia is releasing more SVPs than other jurisdictions, this practice has not resulted in higher sexual re-offense rates.

Chart 5: Sexual Re-Offense Rate for Individuals Released from VCBR



*Note that many of VCBR release have been within the last three years thus have not been in the community for the 5/15 years noted in these national samples.

Strategies for Census Management: Potential Alternatives to Secure Confinement

For any behavioral healthcare agency, census demand is affected by the following variables:

- Demand for new admissions
- Length of stay within the treatment program
- Number of discharges
- Re-admissions

In order to decrease the census demand, organizations can attempt to make changes in any/all of the above areas. Most often changes are needed in each factor if an organization is to achieve sustained census management. The factors are also interconnected and changes in one factor can have either positive or negative effects on other factors. For example, if admissions increase

often times organizations will see an increase in length of stay (as resources become thinner and must be shared amongst more individuals) and increases in re-admission rates (as individuals are discharged without having fully addressed the issues which warranted their initial commitment. Additionally, at times agencies can impact some aspects of the factors, although often other aspects are out of the control of the agency.

Admissions

In the Commonwealth the admission rate is predominantly controlled by external forces. Whether an individual should be evaluated for possible SVP commitment is dictated by the Code of Virginia and the list of eligible predicate offenses. As was referenced earlier in this report, when the General Assembly increased the number of predicate crimes which make individuals eligible for consideration for civil commitment the Commonwealth experienced a sharp increase in the admission rate at VCBR. Similarly, when the Code mandated screening tool was changed to a tool which identified a wider range of sexual offenders, the Commonwealth experienced an increase in VCBR admissions because the new tool identified individuals who previously would have not been screened for possible civil commitment. This is not to suggest that the inclusion of the additional predicate crimes and/or the change in screening tool was a wrong decision, rather these instances provide examples of how changes can affect admission rates. In fact, the experts in the field have opined that indeed adding additional predicate crimes and changing the tool captured individuals who in their professional opinions were high risk for sexual re-offending and who indeed were in need of secure confinement & treatment.

Option 1:

The General Assembly could repeal the changes made to the Code of Virginia in 2006 and/or eliminate some of the included predicate offenses thus decreasing the pool of SVP eligible individuals. This would result in a decrease in the number of individuals committed for treatment at VCBR. However, this strategy would cause the release of individuals who could be at high risk for sexual reoffending with no guarantee they had received sufficient treatment to remediate their risk factors. As referenced above, observations from experts in Virginia suggest that while the expansion of predicate offenses did lead to census expansion at VCBR the impression is that those additional individuals who were committed truly were in need of secure treatment. While DBHDS does not recommend this strategy, in the spirit of full disclosure we felt compelled to offer this as a potential option.

There are some additional strategies which have some potential to decrease the need for secure confinement/treatment. First, it is possible the demand could be decreased if individuals were provided more intensive treatment while serving their sentences in the Department of Corrections (DOC). DOC currently operates three different types of sexual offender treatment programs with SORT (Sexual Offender Residential Treatment) being the most robust and targeted at the highest risk sex offenders. Due to financial and resource constraints the DOC is only able to operate one SORT program which has a limited capacity. While unfortunately the Commonwealth does not have definitive data on the effectiveness of the SORT program (in

terms of effect on diversion from VCBR commitment and/or decreasing the length of stay for those who eventually end up being committed to VCBR), it stands to reason that it is possible to provide some select, motivated individuals with sufficient treatment while in DOC custody to sufficiently mitigate their risk for future sexual re-offending so as to make them either not eligible for SVP commitment or conversely while eligible for SVP commitment deemed a suitable candidate for Conditional Release rather than requiring placement at VCBR.

It is notable that Minnesota has implemented a variant of this strategy and anecdotally there are reports of some success (although there are no published reports). In Minnesota the state behavioral healthcare authority rather than the Department of Corrections actually operates the clinical aspects of the SVP treatment program while the DOC operates the larger facility and is responsible for the safety/security of the facility. By creating this design, those individuals receiving SVP treatment in DOC receive the same type of treatment as is provided in the civilly committed SVP program (operated in a behavioral health facility) thus if an individual, despite treatment, ends up being civilly committed the fact they have received the same types of treatment while in DOC can decrease their length of stay because they can enter the civilly committed SVP program in a higher phase of treatment. The cost to operate a pre-commitment treatment program housed in the DOC is less than the cost to operate a post-commitment treatment program within DBHDS, however, it must be noted that the cost per resident will be higher than the current operating cost of DOC beds/units.

Option 2:

The General Assembly could fund the creation of a pilot, specialized sex offender treatment program housed in the Department of Corrections but with the clinical treatment program operated by DBHDS. The program will target individuals at high risk of being civilly committed at the end of their sentence but who are identified as benefitting from pre-committed SVP treatment with the goal of either avoiding civil commitment (when safe to do so) or shortening their eventual length of stay should they be civilly committed by the Court. The length of the program will be approximately 18 months. Ideally the program should be housed in a facility in relative close proximity to VCBR so as to allow for better support and collaboration from DBHDS staff. DBHDS estimates the following costs to operate a 25 bed unit:

Resource	**Cost (Includes salary + benefits)**	**Resource**	**Cost (Includes salary + benefits)**
Two Therapists	**$120,000**	Ten Treatment Techs	**$400,000**
One Therapy Assist	**$50,000**	One Supervisor	**$140,000**
Contractual Services (i.e. polygraph, PPG, etc.)	**$20,000**	Indirect Costs (IT, HR, fiscal, etc.)	**$25,000**
		Total	**$780,000**

DOC would likely incur some indirect costs as they would likely lose operational space (because most DOC units contain more than 25 individuals) which could result in increased crowding in

the larger DOC system. There would also be more individuals entering the prison daily thus increasing the demand on security. The food/medical costs should not change as these would be individuals already in DOC custody and for whom DOC is providing such services.

Like any new collaborative relationship there are numerous details which would need to be worked out before implementing such a program in order to make it successful. DBHDS and DOC have a long history of positive collaboration which will be assets in creating this program.

Length of Stay

Length of stay is affected by a variety of factors to include the severity of the problem which necessitated admission (in the case of SVP commitment the risk of sexual re-offending), the availability of and intensity of treatment resources (which includes the staff to client ratio), client motivation, and the availability of resources to support discharge (which will be addressed separately in a later section). Despite the successes seen at VCBR, when compared to other secure SVP programs in other states, VCBR is significantly understaffed (for our current population). It is our opinion that with increases staffing VCBR would be able to provide more intensive services thus likely decreasing the length of stay for some residents. Increased staffing would not only increase the availability of services to those fully participating in the treatment program but would also allow for additional staff to provide one to one intervention to those less motivated to participate and/or to those who become "stuck" in a phase of treatment.

Option 3:

The General Assembly could fund the following positions at VCBR in order to provide more intensive treatment to existing residents so as to attempt to decrease the length of stay.

Position	Cost (salary + ben)	Position	Cost (salary + ben)
Therapist (X4)	$324,105	Vocational Aid (X2)	$109,823
Treatment Tech (X15)	$823,669	Discharge Assist	$63,659
Psychiatry Manager	$289,431	RN II (X2)	$225,000
Program Admin Mngr	$150,000	Security Officer (X8)	$439,290
		Total	$2,424,977

Number of Discharges

The development of SVP conditional release plans and home plans is an essential part of the Commonwealth's civil commitment program. As referenced earlier, the risk of re-offense is contextual and is dependent on the level of supports, oversight, and supervision available to the individual in the community. As risk is contextual (dependent on the environment in which the individual resides), even if an individual has completed the treatment program at VCBR and has mastered some new skills to manage their sexual reoffending risk factors, without sufficient supports/oversight/ and monitoring being available in the community they likely are not an appropriate candidate for release. What makes a residence suitable and appropriate is based on

the individual's history of criminal and sexual aggression. For example, individuals whose sexual offending history is focused on children would not be permitted to live with children, in a building that contained a child care center, or next to an elementary school, etc. Further, an individual with a drug or alcohol abuse history would not be recommended to live in a neighborhood with a high drug crime profile (although given the negative community feelings about sex offenders coupled with limited resources often individuals have no other option than to live in areas with higher crime rates and more prevalent rates of substance misuse). Residences are approved based on their lack of proximity to high risk stimuli.

Once a potential domicile has been identified, its address is provided to the Department of Corrections (Probation & Parole) for investigation. A probation officer is assigned to investigate the home. This investigation always includes an on-site visit to the home/residence, interviews with the landlord, and/or persons residing in the home. This investigation is guided by a Sex Offender Home Plan Checklist. The officer summarizes his or her observations, impressions, or concerns on the checklist and returns it to the DOC coordinating officer. The completed plan is returned to the DBHDS for inclusion with the CRP and is submitted to the Court of jurisdiction for review (as ultimately it is the Court who determines whether or not an individual meets the criteria for Conditional Release).

In those cases where a proposed home plan is rejected – for example for the presence of high risk elements – the legal parties are notified and a search for a viable alternative plan begins. This process is repeated as necessary until a suitable and appropriate home plan is approved.

Finding suitable and appropriate domiciles is a routine and significant barrier to SVP conditional release. In many cases, individuals found SVP have neither local family nor other social support networks available to them. As a result, individuals found eligible for discharge to conditional release directly from DOC cannot find an approved domicile and are instead admitted to VCBR.

Because of a persistent lack of suitable and appropriate housing in the community, more individuals have been found eligible for SVP conditional release than the system has been able to discharge. Suitable and appropriate housing was and remains the single most significant barrier to discharge. Since the inception of the SVP civil commitment program, individuals with family or other support networks in the community were the most likely to be discharged to SVP conditional release. Conversely, those without available family or a community support network were least likely to be conditionally released. In some cases it has taken two years to find suitable and appropriate housing so that a discharge to SVP conditional release can be accomplished.

Option 4:

It is possible for the Commonwealth to invest in creating greater community capacity to manage SVPs on Conditional Release. Specifically, the Commonwealth could fund transitional residential placements for those SVPs who otherwise have been deemed ready for release but who lack safe, appropriate, housing. The transitional residence would be the residence of the individual's conditional release and the court would order them to live at the residence (and failure to do so could be viewed as a violation and result in revocation of

release). A transitional housing program would include a residence (where multiple (4-8) individuals could live) with 24/7 awake supervision. It is estimated that the Commonwealth could keep filled 40-45 beds at any given time. Ideally the transitional residents would be located throughout the Commonwealth thereby allowing individuals to return to their community of origin (should they desire and should this be in their/ the community's best interest) where they might have access to better community supports. However, there would be a fiscal advantage of grouping the residents closer together so as to share staffing/resources. Obviously one of the biggest obstacles would be finding localities who would not be openly hostile to having such a program in their community.

During daytime hours residence would work with staff on job seeking skills, learning to take public transportation, budgeting, independent living skills, establishing resources/supports in the community (such as AA/NA, etc.) and on developing a long range transition plan. Initially residents would stay in the program rent free and would be required to save any income received from employment (for the purpose of saving enough funds to allow them to transition to more independent living when deemed ready). Over time they would be required to contribute to the costs, thus teaching them to manage their finances. In the evenings and on weekends the residents would participate in treatment activities. There would be meeting space available to facilitate meetings with probation officers, counselors, and representatives from social services agencies from whom residents might receive assistance. It is anticipated individuals would remain in the program for 9-12 months (the critical time period when individuals are at increased risk for non-compliance with conditions of release) to help them establish a healthy lifestyle. Once they are deemed ready, the staff would aid the individual in finding more independent living and then seek the Court's approval for a change in residence.

The benefit of this model would be that some individuals who currently spend extended periods of time in the secure confines of VCBR due to lack of housing options could be treated/managed in the community thus freeing up bed space at VCBR for those most in need of secure treatment/housing. The Commonwealth could either contract with private industry/individuals to secure housing and/or use surplus government buildings to serve this purpose. The advantage of contracting with private industry is that the Commonwealth would not need to invest in capital projects. The advantage of using surplus property is that it is readily available, would require some limited renovation, and often times is located in isolated locations away from other families, schools, churches, etc. who often object to have sexually violent predators living in their neighborhoods. The isolated location, however, can become a barrier in that the purpose of transitional housing would be to aid individuals in adjusting to life in the community and on developing natural supports (i.e. employment, transportation, treatment services, etc.) and often these resources/supports are in short supply in isolated locations.

Estimating the cost of such a program is challenging and there are many unknown variables the least of which is whether the program would be operated by the Commonwealth or by private industry. Be that as it may, staffing composition roughly would include: Two residential techs (estimated salary + benefits = $40,000) on day and evening shifts and one

residential tech on overnight shift. Additionally, each residence would need access to a case manager/job coach for 10 hours per week (Salary + benefits = $55,000). Access to therapists (to provide individual and group therapy) for 20 hours per week (Salary + benefits = $60,000) and a program supervisor (10 hours per week at approximately $140,000 for salary + benefits) is essential. Finally, all residents would be required (per Code) to have GPS monitoring which has an approximate cost of $1,200 per year. Access to polygraph services will be essential to monitor compliance (rate dependent on frequency of polygraphs). For individuals who do not have a probation/parole supervision requirement of their original sentences, funding would need to be made available to assign a probation officer to each individual (current contract between DBHDS & DOC is $24,000 per individual per year). Finally, the program would need to feed and clothe the residence and provide for their basic human needs.

Option 5:

At any given time there are 6-8 individuals committed to VCBR whose primary issues are psychiatric instability or intellectual deficits. While these individuals have been committed to VCBR for sex offender treatment those with the most severe disorders often are unable to fully benefit from the treatment due to psychiatric instability or intellectual deficits. These individuals' greatest risk to the community is not necessarily related to predatory sexual offending but rather related to them becoming non-complaint with treatment, become symptomatic (which can include engaging in sexualized behavior), and become unstable in the community. The needs of these individuals can be met by having them live in 24/7 supervised living environments where they are provided with comprehensive behavioral health/ developmental disability services (such as day treatment, case management, psychiatric care, medical monitoring, etc.). It is likely these individuals will require this level of service indefinitely, thus this is not seen as a transitional program, but rather a permanent residence (as long as the individuals therapeutic and risk needs can be met by the program). There are many such programs for individuals with chronic mental illnesses and it is feasible that an existing program could absorb these individuals and/or create a specialized program for these individuals (given their unique needs). It is estimated that the cost to house/treat each individual would be approximately $75,000 per individual per year. While it is possible that some of these individuals might be eligible for Medicaid or other entitlements, it would be prudent to budget the $75,000 per year as many of the needed service may not be covered by Medicaid or the other entitlements. Funding would also need to be made available for assignment of a probation officer (for those individuals who do not have a probation/parole obligation associated with their original sentence. Over time it is likely VCBR will again have individuals with a similar diagnostic picture/treatment needs and additional programs could be created in the future.

Option 6:

At any given time VCBR has 8-10 residents who have severe, debilitating medical conditions which require nursing home level of care. For many of the individuals the medical conditions are chronic and at times terminal. Often times the medical conditions are so debilitating as to render the risk of sexual re-offending minimal. While such individuals might be eligible for

Unconditional Release (if the court finds they no longer meet the criteria for being a Sexually Violent Predator predominantly because they physically are incapable of re-offending) their criminal histories coupled with their histories of having been determined to be a sexually violent predator coupled with their lack of health care insurance makes nursing home placement nearly impossible. It is possible that the Commonwealth could seek to contract with an existing nursing home to use a wing of the home specifically for this population. It is possible that if the Commonwealth agreed to be the payer for the beds (regardless of whether they are utilized or not) that we could secure 8-10 beds for this target population. It is likely that a small amount of funding would need to be made available for capital improvements to ensure the other residents are safe from these historically violent individuals. Currently the average cost for a nursing home bed in Virginia is approximately $81,000 per year thus the cost of purchasing 10 beds would be $810,000 per year. It is estimated that this would become a permanent residence for these individuals although several have terminal illnesses which would create some vacancy in the program.

Readmissions

With the growing number of Conditional Releases over the last four fiscal years, the Commonwealth has also begun to experience an increase in the number of individuals who struggle on Conditional Release and eventually have their Conditional Release revoked and are re-admitted to VCBR. These readmissions contribute to the census demand at VCBR. As of June 30, 2016 there had been 176 failure episodes, meaning that the individual violation(s) of their court ordered conditional release plan were serious enough, or represented multiple violations, that the individual was jailed and completed an emergency custody order (ECO) SVP evaluation. As of June 30, 2016, 68 individuals have had their conditional release revoked with 54 being readmitted to VCBR and the remaining 14 either incurring new sentences for new offenses and/or having previously suspended time reapplied and being sent back to DOC custody. Chart 6 shows the revocation rate by year and by release type (i.e. whether released from VCBR or released directly from DOC):

Chart 6: SVP conditional release revocations requiring admissions to VCBR (FY08 to FY15)

Type of Revocation	FY08	FY09	FY10	FY11	FY12	FY13	FY14	FY15	FY16
Individual released from VCBR	0	0	0	0	3	0	2	9	15
Individual released directly from DOC	0	3	2	3	2	2	4	6	4
Total	0	3	2	3	5	2	6	15	19

The number one cause for revocation appears to be returning to the abuse of substances. Revisions have been made to the substance abuse groups offered at VCBR; however, residents who have relapsed into substance abuse indicate that without a transitional unit, no groups can prepare them for the experience of being “bombarded” by substance abuse upon their release.

Since they usually can only afford housing in high crime areas, they reported being approached on a daily basis to buy drugs, and also report observing and smelling the use of substances in the boarding houses in which they reside.

The second most common cause for revocation is use of pornography/use of dating sites/"sexting"/prostitution. Many residents report feeling rejected socially upon release and turn to these to cope with the loneliness.

Sexual recidivism has been quite low (approximately 2%), and recidivism into other criminal behavior besides illegal use of substances is also quite low.

Option 7:

The Commonwealth could invest in creating the transitional facilities described in Option 4 (above) as a means of decreasing the readmission rate. Not only could individuals be initially conditionally released to a transitional facility, but additionally individuals who are conditionally released to independent living, living with family, or boarding homes that begin to struggle while on Conditional Release could be moved to a transitional facility to provide more structure, support, and oversight thus potentially minimizing the need for revocation and readmission.

Impact of Options on VCBR Census

Obviously each option outlined above would have a different impact on the VCBR census. If multiple options are selected/funded then the impact could be compounded and thus create even a larger impact. However, in analyzing admission trends and forecast reports on the number of SVP eligible DOC inmates who will be eligible for release (and therefore eligible for commitment) in the coming six fiscal years it is anticipated that while implementing the options may decrease census growth, even if all options were implemented the Commonwealth is unlikely to experience a reversal in growth. Rather implementation of the options will simply slow the growth although it is anticipated that each year there will be a net increase in the census (albeit a lower net increase than is currently being experienced). DBHDS recommends that the expansion of VCBR proceed as ultimately the Commonwealth will ultimately need the secure treatment space.

As for which options should be implemented, this is a question best answered by the leaders in the Commonwealth. Obviously the options come with associated costs and associated community risks. Some options do not substantially increase risk and do provide some hope for decreasing admission. Other options come with some modest risk, but have the potential to have a greater impact on census growth. Finally, one option would significantly decrease census growth but at the expense of moderate to high risk to the community. While DBHDS has information about each option it is beyond the scope of the role of the agency to decide which option(s) best meet the needs of the Commonwealth. The General Assembly and the Governor are best situated to reflect the Commonwealth's priorities and values and decide a course of action.