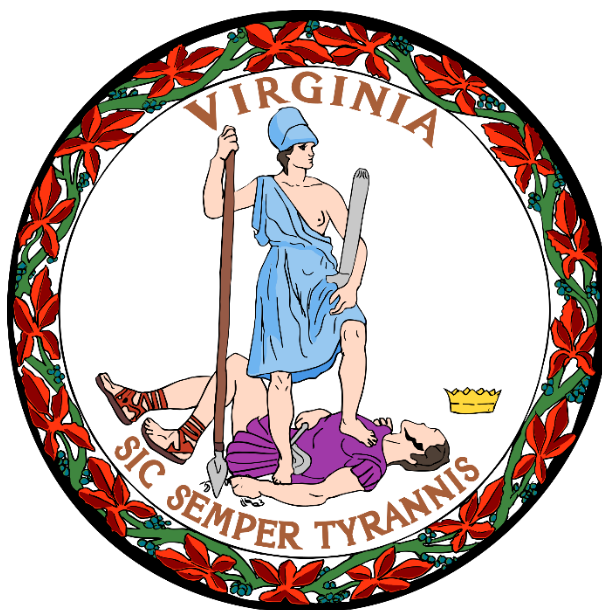
Report to the Governor and Chairman of the House of Appropriations and Senate Finance Committees

Access to Sex Offender Treatment in Virginia Prisons



Brian J. Moran
Secretary of Public Safety and Homeland Security
November 15, 2020

Preface

This report was written in response to Item 381, Paragraph H, from Chapter 854 of the 2019 Acts of Assembly.

"The Secretary of Public Safety, in consultation with the Secretary of Health and Human Resources, shall convene a workgroup to report on the feasibility of increasing access to sex offender treatment for inmates held in the Commonwealth's adult correctional centers. The workgroup shall identify the different types of sex offender treatment currently available at the Department of Corrections and the numbers of offenders treated annually in each program. The workgroup shall consider the most effective time during an inmate's confinement to screen for treatment, and whether the existing Departmental policy should be modified. The report shall also recommend specific short- and long-term strategies for the Commonwealth to employ, and identify staffing and other costs required for implementation. The report shall be submitted to the Governor and Chairmen of the House Appropriations and Senate Finance Committees by November 15, 2020."

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Executive Summary

Pursuant to the budget language, the Secretary of Public Safety and Homeland Security convened a workgroup with staff from the Secretariat of Public Safety and Homeland Security, the Secretariat of Health and Human Resources, Department of Behavioral Health and Developmental Services (DBHDS) and the Department of Corrections (DOC), which met quarterly (see Appendix A for workgroup membership). In between workgroup meetings, subcommittees met to discuss more specific topics, such as the sex offender treatment continuum across DOC and DBHDS, internal DOC processes affecting the provision of treatment and analysis of DOC and DBHDS datasets (see Appendix B for subcommittee membership).

The DOC has multiple levels of sex offender treatment available within the institutions with varying intensity according to risk for recidivism. Currently, 16 facilities of differing security levels and throughout every region are designated to provide sex offender treatment. This treatment can include the foundational psychoeducational program and therapeutic treatment, if needed for offenders of higher risk. The Sex Offender Residential Treatment (SORT) Program is the Department's highest level of treatment. Located at Greensville Correctional Center, this program provides intensive sex offender-specific assessment and treatment for offenders at a medium to high-risk for sexual re-offense. Overall, the types of treatment offered by the DOC are similar to those provided in other states.

Sex offenders may be reviewed under the Sexually Violent Predator (SVP) Act, §37.2-900. The DOC conducts the screening toward the end of an offender's sentence. If adjudicated as SVP by a court, an offender may be committed to the Virginia Center for Behavioral Rehabilitation (VCBR), a DBHDS inpatient facility.

The DOC hired a mental health services analyst to examine multiple DOC and DBHDS datasets. Offenders adjudicated as SVP between 2012 and 2018 were studied. While the numbers were too small to derive conclusive results, the available data indicated that participation in the SORT Program may mitigate an offender's likelihood of being committed upon release. The workgroup also found that it would be beneficial to hire more specialized staff to screen offenders at the beginning of their incarceration and provide the appropriate level of treatment to all releasing offenders.

Recommendations:

Short-term Strategies:

1. Screen sex offender risk at the beginning of their sentences in order to triage them to the appropriate level of treatment in a timely manner. This strategy would require funding and two FTEs.
2. Increase the number of certified sex offender treatment providers dedicated to the provision of sex offender services. This strategy would require funding and three FTEs for three regional mental health staff.
3. Support cognitive counseling and treatment programs for sex offenders. This strategy would require funding and 20 FTEs to include 10 cognitive counselors and 10 treatment officers dedicated to sex offender services.
4. Improve release planning for sex offenders. This strategy would require funding and one FTE to assist with release planning.
5. Continue needs assessment for specialized programming for lower functioning sex offenders incarcerated with the DOC.

Continuous and Longer-term Strategies:

1. Reduce mental health staff caseload ratios from 1:15 to 1:12, increase the ability to offer additional sex offender-specific and ancillary programming, and provide additional re-entry programming to SORT program participants to strengthen the efficacy of the SORT program. This strategy would require funding and six FTEs to include two mental health positions, two cognitive counselors, and two treatment officers.
2. Continue collaboration between DOC and DBHDS regarding sex offender treatment continuity as well as data sharing and analysis.

3. Perform staffing analysis for whether additional specialized probation and parole officers are needed to provide effective supervision of sex offenders released from custody.

Background
This section outlines current DOC treatment practices and the number of offenders participating in the treatment programs. Brief descriptions about Virginia's Sexually Violent Predator Act and sex offender treatment information from other states are also provided for context.

Summary of Current DOC Sex Offender Treatment
Typically, an offender enters the DOC through an intake facility where information is gathered and reviewed (e.g., medical history, mental health history, needs assessment, reading assessment) to determine the most appropriate institutional placement. Placement is decided by weighing many factors, including security, educational, vocational, medical, mental health, and reentry needs. Screening for and participation in DOC sex offender treatment usually occurs in the last two to five years of an offender's incarceration. Sex offender treatment is compulsory for offenders serving time for a sexual offense and may be recommended for offenders exhibiting problematic sexual behavior. If an offender is eligible for review under the SVP Act, that review process begins in the last two years of incarceration. Upon release from prison, sex offenders usually have a probation or parole period during which sex offender treatment is required.

Sixteen DOC institutions (including one female facility), of varying security levels located throughout the Commonwealth are designated to provide sex offender treatment services (see Appendix C for a complete listing of designated treatment sites). Each of these facilities maintains a centralized list of sex offenders to facilitate accurate tracking and prioritization of offenders for treatment and also identifies at least one case management counselor (CMC) and one mental health services staff member to provide this programming. In addition, Departmental policy requires specific levels of training for staff providing sex offender services. Depending on the type of services provided, staff may need to attend specific training at the DOC's academy for staff development, be supervised by or certified as a sex offender treatment provider (CSOTP), or licensed in their respective field. While DOC sex offender treatment is compulsory, offenders may incur consequences, such as transfer to another facility or the inability to earn good time, for noncompliance. The risks and benefits of treatment are clearly outlined to each offender prior to entering therapeutic group so he or she can make an informed decision on whether or not to participate.

Designated sex offender treatment sites provide a variety of services including assessment, psychoeducational groups, and therapeutic groups. Assessment is comprised of specialized evaluation tools used to identify an offender's specific sex offender treatment needs or risk of re-offense. Depending on available resources, some facilities are able to provide additional sex offender-specific testing as well. Psychoeducation is the first and most basic level of intervention. It involves education-based groups covering both sex offender-specific, and ancillary topics, which require an offender to demonstrate a particular level of content knowledge. Although psychoeducation alone does not necessarily reduce recidivism, research has shown that sex offenders can benefit from preparation for treatment (e.g., education). Psychoeducation can increase motivation to change and lead to higher treatment effectiveness.[1,2] These groups also introduce offenders to what they may expect while on supervised probation, which can help with their reentry process. Institutional counseling staff initially refers offenders to psychoeducational treatment, and offenders are prioritized for group according to their release date. Currently 11 of the 16 designated sites are providing this level of service. For calendar year 2019, 50 group sessions were held and 328 offenders completed the DOC's psychoeducational group.

[1] Jumper, S. (2018). "I'll change if you guys change:" Adapting systems to maximize treatment readiness among men who sexually offend. *The Forum Newsletter, XXX*(2).
[2] Sowden, J. N., & Olver, M. E. (2017). Sexual offender treatment readiness, responsivity and change: Linkages to treatment completion and recidivism. *Journal of Forensic Nursing, 13*(3), 97-108.

Following completion of required psychoeducational groups, offenders are screened for therapeutic treatment needs. Therapeutic individual or group treatment identifies and addresses the dynamics and occurrence of sexual behavior, and uses therapeutic strategies to promote behavioral change. This level of treatment targets offenders who have been determined to be at medium to high risk of sexual reoffending and requires offenders to apply treatment material to their own thoughts, behavior and offenses. Staff providing this level of treatment are required to already have, or be pursuing, a CSOTP, which requires specialized training and supervised experience. Unfortunately, due to referral issues and lack of qualified staff (see Appendix D for more information), only one designated site was able to run this mid-level treatment in 2019. Mitigation has been ongoing, including consistent recruitment of trained staff, training current staff and refining treatment needs reports available in the DOC's offender database.

Residential treatment utilizes psychoeducational and therapeutic interventions as well as specialized assessment. By policy, counseling staff must refer all offenders who meet the admission criteria for residential treatment (e.g., within several years of release from incarceration). Residential program staff review referrals and accept those most appropriate for intensive treatment. Offenders participating in this level of treatment live in a designated housing unit in order to best facilitate a therapeutic milieu. Departmental policy also requires residential treatment programs to be licensed as mental health units by DBHDS and for all clinical staff to have a CSOTP. Currently, the DOC's most intensive treatment, the Sex Offender Residential Treatment (SORT) Program, is located at Greensville Correctional Center and has an 86-bed capacity.

The SORT Program is dedicated to providing comprehensive assessment and treatment services to offenders who are within 18 months to 3 years of their release date and have been identified as being at moderate to high risk for sexual reoffending. Although the program recognizes that there is no "cure" for sex offending behavior, the goal is to enhance the safety of the citizens of the Commonwealth by teaching skills (e.g., how to manage deviant sexual arousal, alter problematic thinking patterns, reduce criminal thinking, improve self-regulation abilities) to identified sex offenders in an effort to reduce risk for recidivism.[3] To that end, the SORT Program utilizes evidence based techniques which have been shown to have the greatest likelihood of reducing sexual reoffending behavior and target risk factors. The treatment methods and theoretical underpinnings of the SORT Program are based on the merging of the risk-needs-responsivity model, transtheoretical model, cognitive behavioral therapy, the Good Lives model for offender rehabilitation, and relapse prevention congruent with standards of practice across the country. These treatment models are supported by research consistent with evidence based practices (EBP), and their integration is a natural progression in the treatment of sex offenders. The program is designed for offenders to reside at and remain in programming until they are released from DOC. As offenders enter and exit the SORT Program on an individualized basis, the number of offenders participating in the program at any particular time fluctuates. In 2019, 112 offenders participated in the SORT Program and attended at least 337 sex offender-specific group sessions.

Virginia Sexually Violent Predator (SVP) Act §37.2-900 et seq.

"In 1999, the Virginia General Assembly created a process for committing for inpatient treatment those individuals who have committed 'sexually violent offenses' and who, based on established criteria, are found by a court to be likely to reoffend."[4] The screening process is conducted by DOC toward the end of an offender's sentence. Offenders who are screened as high risk are given a comprehensive evaluation.

[3] Hanson, R. K., Harris, A. J. R., Scott, T., & Helmus, L. (2007). *Assessing the risk of sexual offenders on community supervision: The Dynamic Supervision Project* (Corrections Research User Report 2007-05). Ottawa, Ontario: Public Safety Canada.

[4] Virginia Office of the Attorney General, Sexually Violent Predators Civil Commitment Section webpage.

They are further reviewed by the Commitment Review Committee,[5] the Office of the Attorney General and ultimately the courts. Offenders that are adjudicated as SVP can be civilly committed for up to an indefinite period of time or conditionally released at the conclusion of their incarceration. Committed offenders are remanded to the DBHDS inpatient facility, the VCBR. Offenders who are conditionally released must abide by a conditional release plan developed by DBHDS and are supervised in the community by specially-trained DOC probation and parole officers.

Sex Offender Treatment in Other States

Offenders who have committed sexual offenses are a diverse group with varied treatment needs. There is no one evidence based sex offender treatment or curriculum that will work for everyone. However, practices should be based on the latest research, which recommends focusing on dynamic risk factors.[6] Some examples of these changeable risks are intimacy deficits and problems with self-regulation. The DOC conducted a brief survey of other state correctional departments regarding sex offender treatment.[7] Of the 25 states who responded, answers varied widely. Two states reported offering no sex offender treatment, and others reported multi-year, phased programming. The vast majority of states designed their own treatment programs, often incorporating published workbooks or curricula adapted from other programs. Over half of the responding states indicated that the evidence-based component of their treatment was use of Cognitive Behavioral techniques. The Virginia DOC's SORT Program includes almost all of the resources referenced in the survey responses and cognitive behavioral interventions are a core component of every offender's treatment plan. According to the answers obtained from the survey, it appears that the DOC is providing a standard of care, with research-informed and evidenced based components, consistent with that of other states.

Current Methodology

For this study, the DOC hired a wage mental health services analyst. Working closely with both DOC and DBHDS, this analyst was dedicated to analyzing relevant data maintained by both agencies. This was a significant undertaking as each agency has different information and multiple methods for retaining it. To assess an appropriate sample size, the analyst reviewed SVP data from a six-year period (2012-2018). The data was difficult to extract because it involved going through data from both agencies. A total of 413 cases fit this criteria and were considered in the workgroup's study (see Appendix E for details).

Analysis

Between CY2012 and CY2018, DOC screened 4,605 offenders under the SVP Act of which 790 (17.2%) met the statutory criteria to undergo a full, comprehensive SVP evaluation. 413 offenders (52.3%) of the evaluated offenders proceeded through the court process and were adjudicated SVP. Among the 413 adjudicated SVP offenders, 340 (82.3%) were committed to VCBR and 69 (16.7%) received conditional release to the community. In addition, 160 (38.7%) offenders, less than half of the 413 adjudicated SVP offenders, had been referred to the SORT Program during their incarceration. In the end, 42 offenders successfully participated in the program. Of the SORT Program offenders that were deemed SVP, 28.6% were conditionally released. This is greater than the 16.7% of all SVP offenders that were conditionally released (see Appendix E for details).

Workgroup Findings

1. **Screening for sex offender treatment needs should occur earlier in an offender's sentence.** DOC's goal is for all offenders incarcerated for a sexual offense to participate in sex offender

[5] Per Code of Virginia §37.2-902, the Commitment Review Committee shall be comprised of three full-time DOC staff, three full-time DBHDS staff and one assistant or deputy attorney general.

[6] Association for the Treatment of Sexual Abusers. (2014). *ATSA Practice Guidelines for the Assessment, Treatment, and Management of Male Adult Sexual Abusers.* www.atsa.com.

[7] Survey conducted via the Correctional Leaders Association by the DOC Research – Strategic Planning Unit, June 2020.

treatment appropriate for their risk level prior to release. At DOC, offenders participate in treatment relatively close to release in order to maximize its effectiveness. The current referral and screening process typically occurs within several years of an offender's release. Due to the accessibility issues noted below and time constraints associated with other reentry programming, scheduling can be a challenge.

2. **Accessibility of sex offender treatment while incarcerated varies based on several factors**, including but not limited to staffing, offender security level, facility security level, and medical needs. An average of 570 sex offenders are released annually.[8] Due to limited resources, approximately half of those released participate in some level of sex offender programming while incarcerated.
3. **Other DOC programming can also mitigate a sex offender's risk.** Research indicates that programming offered to the general offender population such as cognitive behavioral, re-entry, vocational, and mental health programs can reduce the risk of sex offender recidivism.[9] These types of intervention address risk factors known to contribute to risk for sexual re-offense and can supplement sex offender-specific treatment.
4. **Multiple factors affect the amount and type of sex offender programming DOC is able to offer.** Offenders are screened for the therapeutic group after completing a psychoeducational program and only considered for this group if assessed at a medium or high risk for sexual re-offense. The average sexual offender recidivism rate is low (13.7%), and most sexual offenders are low risk.[10] Therefore, psychoeducational programming will suffice for the majority of those with sexual offenses, and less than half need to proceed to the therapeutic group. A low number of psychoeducational feeder groups, offenders with limited time left on their sentences, and a lack of qualified staff for these more complex programs contribute to the lack of therapeutic groups.
5. **Referrals for the SORT Program have been variable.** The SORT Program is currently dependent on referrals submitted by staff, which has been inconsistent in the past. The DOC has worked diligently to modify its offender database in an attempt to track referrals and maximize efficiency. The updated system makes it easier to filter referrals and complete administrative review. This report debuted shortly before the onset of the COVID-19 pandemic, which has temporarily slowed its implementation in the field.
6. **Analysis of DOC and DBHDS data suggest that participation in the SORT Program may mitigate commitment to VCBR.** DOC and DBHDS data for offenders adjudicated as SVP between 2012 and 2018 was analyzed for this report. Despite the referral rate for the SORT Program being less than 50%, the preliminary data indicates that the SORT Program may mitigate an offender's likelihood of being civilly committed to the VCBR upon release (see Table 5 in Appendix E). Of the SORT Program offenders that were deemed SVP, 28.6 percent were conditionally released. This is greater than the 16.7 percent of all SVP offenders receiving conditional release (see Appendix E for details). Further research will be necessary to draw more robust conclusions due to the small sample size, different agency datasets and changes in SVP screening process.
7. **Recruiting and retaining Certified Sex Offender Treatment Providers (CSOTP), a highly specialized credential, is an on-going problem.** This certification, regulated by the Virginia Board of Psychology, requires training in sex offender assessment and treatment as well as supervised experience. The CSOTP credential helps ensure that treatment providers are well trained and continue their education in the field. For quality assurance purposes, DOC requires staff providing therapeutic treatment and all of the SORT Program clinical staff to obtain a CSOTP. Only 21 of the

[8] Sex offender refers to offenders convicted of and serving time for a sexual offense.
[9] Wilson, R. J., & Yates, P. M. (2009). Effective interventions and the Good Lives Model: Maximizing treatment gains for sexual offenders. *Aggression and Violent Behavior (14)*. 157-161.
[10] Hanson, R. K., & Morton-Bourgon, K. E. (2004). *Predictors of sexual recidivism: An updated meta-analysis* (User Report 2004-02). Ottawa, Ontario: Public Safety Canada.

Department's current mental health staff hold this credential with almost half located in one region (see Appendix D for more detailed information).

8. **DOC is assessing the number and treatment needs of special needs sexual offenders.** Due to the reading and comprehension skills the current curriculum requires, the SORT Program is presently unable to provide treatment to lower functioning offenders, such as those with intellectual deficits or very low reading levels. The DOC does have a non-residential therapeutic program available for such offenders but few are referred. Since the actual number of high-risk, special needs sexual offenders who require this alternative treatment is unknown, the DOC is in the process of conducting a needs assessment to quantify the population as well as more specifically determine treatment needs.
9. **DOC and DBHDS are already collaborating on standardized sex offender treatment materials.** DOC sex offender services staff is already partnering with VCBR, Probation and Parole treatment contractors and the Office of Sexually Violent Predator Services to standardize sex offender treatment materials and assignments across these entities. This will enable offenders to progress more efficiently when changing treatment settings or providers across the continuum of care. Staff on this committee are highly trained in sex offender treatment, versed in the research and well aware of national standards of practice. Current DOC programming will incorporate these standardized components throughout all levels of sex offender treatment offered in the Department.
10. **Most offenders reviewed under the SVP Act did not qualify and were released.** 82.8% of offenders screened under the SVP review process did not qualify for additional review and were released from DOC custody to the community as scheduled (see Attachment E for more detail).
11. **Commitment to VCBR depends on multiple issues.** A myriad of factors, sex offender treatment while in prison being only one, can influence the likelihood of an offender being adjudicated as SVP or being committed to VCBR. Examples include, but are not limited to, having a viable home plan, offender-specific traits, sentencing district, and community resources.

Recommendations

The DOC has already incorporated and directed resources toward the assessment, treatment and supervision of sexual offenders. Yet, sex offender treatment services are not as extensive as needed, and increasing these services would benefit public safety. Toward that goal, the following recommendations are offered.

Short-term Strategies

1. **Screen sex offender risk at the beginning of their sentences in order to triage them to the appropriate level of treatment in a timely manner.** In addition to being able to proactively plan for treatment numbers, this will also help ensure consistency and an increase in SORT Program referrals. This strategy would require funding and two FTEs (see Appendix F for all cost estimates).
2. **Increase the number of certified sex offender treatment providers dedicated to the provision of sex offender services.** These specially trained staff will assist facilities in maintaining psychoeducational groups and be responsible for facilitating therapeutic groups for the medium to high-risk offenders. In addition, they will also be able to monitor treatment fidelity, determine treatment need for that location's specific population, and provide consultation and training. The DOC has piloted such a position in the Western Region, which has resulted in increased treatment referrals, more consistency in treatment provision and the ability for more frequent consultation on difficult cases. This strategy would require funding and three FTEs to be hired as regional mental health staff.
3. **Support cognitive counseling and treatment programs for sex offenders.** The DOC will designate specific sites, based on population of sex offenders approaching release and other relevant factors, to offer sex offender treatment. This will likely include lower level intensive reentry sites, such as St. Brides and Coffeewood Correctional Centers, but allows for flexibility as needed. Offenders at other facilities can be transferred to participate in treatment as necessary. Additional operational costs (e.g., transportation, treatment materials) would be nominal and absorbed into

current budget allocations. This strategy would require funding and 20 FTEs to include 10 cognitive counselors and 10 treatment officers dedicated to sex offender services.

4. **Improve release planning for sex offenders.** As discussed, sex offender treatment is only one piece of release planning. An increase in community resources, most notably assistance securing viable home plans prior to release from DOC, least-restrictive alternatives, and transitional housing, would have a significant impact on an offender's successful reentry into the community. This strategy would require funding and one FTE to assist with release planning.
5. **Continue needs assessment for specialized programming for lower functioning sex offenders.** Specifically, utilize the Mental Health Services Analyst to research and determine the number and specific needs of lower functioning sexual offenders currently incarcerated in DOC. Based on this information, revise and implement specialized treatment for these special needs offenders. Placement of the program and duration should be considered.

<u>Continuous and Longer-term Strategies</u>

1. **Reduce mental health staff caseload ratios from 1:15 to 1:12, increase the ability to offer additional sex offender-specific and ancillary programming, and provide additional re-entry programming to SORT program participants to strengthen the efficacy of the SORT program**. This strategy would require funding and six FTEs to include two mental health positions, two cognitive counselors and two treatment officers.
2. **Continue collaboration between DOC and DBHDS regarding sex offender treatment continuity as well as data sharing and analysis.** Specifically, retain the mental health services analyst position to assist with standardizing data collection and integration of current datasets. The current Statewide Sex Offender Treatment Subcommittee[11] should also continue to standardize treatment across the continuum of care and update these curricula as needed.
3. **Perform staffing analysis for whether additional specialized probation and parole officers are needed to provide effective supervision of sex offenders released from custody.** Ensuring that there are a sufficient number of these specialized officers will allow for more effective and efficient management of high-risk sex offenders on supervision in the community. This not only contributes to increased public safety but also increases the likelihood of the offenders adjusting to society more successfully.

Conclusion

The DOC currently provides several levels of sex offender treatment based on an offender's risk for recidivism, which appears similar in content to that provided in other states. Upon review of DOC and DBHDS datasets, it appears that participation in the SORT Program may mitigate the likelihood of an offender being committed to VCBR. While the DOC is already making advancements, such as collaborating with other providers in the continuum of care to better align pieces of the treatment system and improving DOC processes to maximize resources and efficiencies, the DOC's provision of sex offender treatment could be further augmented by moving treatment screening to the beginning of an offender's incarceration and increasing staff dedicated to providing sex offender treatment and reentry. These relatively small changes could enhance public safety and potentially avoid or reduce costly commitment following incarceration.

[11] This is an agency formed committee comprised of DOC and DBHDS staff and vendors involved in sex offender treatment and supervision. Committee membership can be found in Appendix B.

Appendix A

Workgroup Membership
The Honorable Brian J. Moran, Secretary of Public Safety and Homeland Security
The Honorable Daniel Carey, MD, Secretary of Health and Human Resources
Jae K. Davenport, Deputy Secretary of Public Safety and Homeland Security
Vanessa Walker-Harris, Deputy Secretary of Health and Human Resources
Jacquelyn Katuin, Policy Advisor to the Secretary of Public Safety and Homeland Security

Department of Corrections
Harold W. Clarke, Director
A. David Robinson, Chief of Corrections Operations
Scott Richeson, Deputy Director of Programs, Education, and Re-entry
Denise Malone, Chief of Mental Health Services
Randi Lanzafama, Chief of Sex Offender Programs
Eric Madsen, Sex Offender Screening & Assessment Unit Psychology Associate Senior
Maria Stransky, Sex Offender Program Director

Department of Behavioral Health and Developmental Services
Michael Schaefer, Assistant Commissioner – Forensic Services
Carla Zarrella, Office of Sexually Violent Predator Services Director
Anita Schlank, Virginia Center for Behavioral Rehabilitation Clinical Director

Appendix B

Statewide Sex Offender Treatment Subcommittee
Marge Bialkowski, Office of Sexually Violent Predator Services, DBHDS
Heather Boyd, Sex Offender Services Psychology Associate Senior, DOC
Cheryl Clayton, DOC Contract Treatment Provider, Radford Counseling
Marissa Coon, Sex Offender Residential Treatment Program Director, DOC
Nikki Kennedy-Amos, VCBR Senior Treatment Supervisor, DBHDS
Randi Lanzafama, Chief of Sex Offender Programs, DOC
Dustin Rock, SVP Program Specialist, DBHDS
Anita Schlank, VCBR Clinical Director, DBHDS
Maria Stransky, Sex Offender Program Director, DOC
Sarah Webster, Senior Treatment Supervisor, DBHDS
Heather Wimmer, Senior Probation & Parole Officer, DOC
Carla Zarrella, Office of Sexually Violent Predator Services Director, DBHDS

DOC Internal Subcommittee
Heather Boyd, Sex Offender Services Psychology Associate Senior, DOC
Tracy Chumura, St. Brides Correctional Center Chief of Housing and Programs, DOC
Troy Ford, Central Classification Manager, DOC
Randi Lanzafama, Chief of Sex Offender Programs, DOC
Eric Madsen, Sex Offender Screening & Assessment Unit Psychology Associate Senior, DOC
Denise Malone, Chief of Mental Health Services, DOC
James Parks, Offender Management Services Unit Manager, DOC
Scott Richeson, Deputy Director of Programs, Education, and Re-entry, DOC
Maria Stransky, Sex Offender Program Director, DOC

DOC/DBHDS Data Subcommittee
Marge Bialkowski, Office of Sexually Violent Predator Services, DBHDS
Eric Madsen, Sex Offender Screening & Assessment Unit Psychology Associate Senior, DOC
Denise Malone, Chief of Mental Health Services, DOC
Tish Rothenbach, Mental Health Services Analyst, DOC
Maria Stransky, Sex Offender Program Director, DOC
Carla Zarrella, Office of Sexually Violent Predator Services Director, DBHDS

Appendix C

Designated Sex Offender Treatment Sites

Eastern Region
- Deerfield Correctional Center
- Greensville Correctional Center
- Haynesville Correctional Center
- St. Brides Correctional Center
- Sussex II State Prison

Central Region
- Buckingham Correctional Center
- Coffeewood Correctional Center
- Dillwyn Correctional Center
- Fluvanna Correctional Center for Women
- Lunenburg Correctional Center
- Nottoway Correctional Center

Western Region
- Augusta Correctional Center
- Green Rock Correctional Center
- Marion Correctional Treatment Center
- Pocahontas State Correctional Center
- Red Onion State Prison

Appendix D

DOC Certified Sex Offender Treatment Providers (June 2020)

	MH Staff with CSOTP	MH Staff able to Supervise Staff toward CSOTP
Central Region	3	2
Eastern Region*	10	4
Western Region	0	0
Other (HQ, Community)	8	3
Total	**21**	**9**

* The Sex Offender Residential Treatment (SORT) Program is located in the Eastern Region and employs four of the 10 staff noted.

Appendix E

DOC/DBHDS Data Analysis of SVP Screenings 2012-2018

Table 1

Screening Outcome for Offenders with SVP Predicate Offenses	
Did not meet statutory criteria for a full SVP evaluation	3815 (82.8%)
Met statutory criteria for full SVP evaluation	790 (17.2%)
Total	4605

Table 2

Offenders Proceeding through SVP Evaluation/Court Process	
Not adjudicated SVP	317
Adjudicated SVP	413
Total	790

Table 3

Disposition of Offenders Adjudicated SVP	
Civil Commitment to VCBR	340
Conditional Release	69
Disposition Pending/Deceased Prior to Disposition	4
Total	413

Table 4

SORT Program Referrals for Offenders Proceeding through SVP Process	
Not referred	253
Referred	160
Total	413

Table 5

Disposition of Offenders Successfully Participating in the SORT Program who were Adjudicated as SVP	
Civil Commitment to VCBR	29
Conditional Release	12
Pending Disposition	1
Total	42

Appendix F

Cost Estimates Related to Recommendations

Positions	Assignment	Role	Salary	Salary, fully fringed with health insurance	Total
2 FTE	Offender Management Services	Psychology Associate I	$55,000	$83,100	$166,200
3 FTE	Sex Offender Services	Psychology Associate II	$70,000	$101,740	$305,220
10 FTE	Designated Treatment Sites	Counselor II	$49,000	$75,640	$756,400
10 FTE	Designated Treatment Sites	Treatment Officer	$35,500	$61,736 (includes VALORS)	$617,360
2 FTE	SORT Program	Psychology Associate I	$60,000	$89,300	$178,600
2 FTE	SORT Program	Counselor II	$49,000	$75,640	$151,280
2 FTE	SORT Program	Treatment Officer	$35,500	$61,736 (includes VALORS)	$123,472
1 FTE	Community Release	Program Administration Specialist I	$52,000	$79,368	$79,368
Grand Total					**$2,377,900**