Sand Ridge Secure Treatment Center

Programming
And
Measurement of Treatment Progress

Presentation Overview

- Introduction
- 980 Statute Requirements
- Effective Programs – Why we do what we do – based on some of the work of Robert McGrath
- Program Components
- Measuring Change

Introduction

Change

- How is it conceptualized?
- What is the underlying basis for it?
- What is done to facilitate it?
- How do we measure it?
- What are the barriers in achieving it?

How Do People Get to SRSTC?

Sexually Violent Person

Sexually violent person means a person who has been **convicted of a sexually violent offense**, has been adjudicated delinquent for a sexually violent offense, or has been found not guilty of or not responsible for a sexually violent offense by reason of insanity or mental disease, defect, or illness, and who is **dangerous because he or she suffers from a mental disorder** that makes it **likely** that the person will **engage in one or more acts of sexual violence**.

How Do People Get Out

Release Determinations
2 Reports Inform the Court

- Chapter 980.07 re-examination
- Treatment Progress Report

980.07 Re-examination

Discharge – No longer meets definition of a Sexually Violent Person, i.e., no longer likely
Supervised Release – Need to be making significant progress in treatment

Treatment Progress Report

- The **specific factors** associated with the person's risk for committing another sexually violent offense
- Whether the person is making **significant progress** in treatment or has refused treatment
- The **ongoing treatment needs** of the person
- Any **specialized needs or conditions** associated with the person that must be considered in **future treatment planning**

Significant Progress In Treatment

- **Meaningfully participating** in the treatment program specifically designed **to reduce** his or her **risk to reoffend**
- Participating in the treatment program at a level that is sufficient to allow the **identification of his or her specific treatment needs** and demonstrating, through overt behavior, a **willingness to address the specific treatment needs**
- **Demonstrating an understanding** of the thoughts, attitudes, emotions, behaviors, and sexual arousal linked to his or her sexual offending and an ability to identify when the thoughts, emotions, behaviors, or sexual arousal occur
- **Demonstrating sufficiently sustained change** in the thoughts, attitudes, emotions, and behaviors and sufficient management of sexual arousal such that one could reasonably assume that, with continued treatment, the could be maintained

Additional Considerations for SR

- It is "substantially probable" that the patient will **not engage in acts of sexual violence**
- **Treatment** and a treatment provider are **available in the community**
- The patient can be expected to **comply with treatment and the conditions of supervision**
- **A reasonable level of resources** can provide for the level of treatment, supervision, housing, and safe management of the patient

Treatment Assessments

- Assessments conducted within the Sand Ridge Secure Treatment Center (SRSTC) Treatment Department are **designed to inform treatment planning**.
- These assessments primarily focus **on identifying dynamic risk factors, measuring attainment of treatment goals, and determining a patient's responsivity issues**. The focus of these assessments is on appraising the patient's clinical needs and formulating intervention recommendations that are in the patient's best interest.
- **Assessments are <u>not</u> being conducted as part of the legal decision-making process** for the specific purpose of producing evidence to be used in a legal context. As indicated in Chapter 980.07, this is the role of the department appointed evaluator(s).
- The **SRSTC Treatment Department strives to create a complete record that accurately reflects patients' progress in treatment**. Producing a complete patient record will allow the department appointed evaluator(s) to provide an opinion as to the patient satisfying the specific legal criteria related to being placed on supervised release or discharged. The record the SRSTC Treatment Department creates is not meant to provide or imply an opinion on these legal questions.

There are Legally Required Treatment Targets

Treatment Targets Based on Legal Criteria

- <u>Consider Factors Impacting Reason for Commitment</u>
  - Offending history
  - Likelihood of engaging in sexual acts of sexual violence
  - Mental Disorder

Treatment Targets Based on Legal Criteria

- Specific Target Areas
  - **Identifying** specific factors associated with risk of offense
  - **Identifying** and understanding thoughts, attitudes, emotions, behaviors, and sexual arousal linked to offending
  - **Willingness** to address specific treatment needs
  - **Meaningfully** participate in treatment
  - **Compliance** with treatment and supervision
  - **Demonstrate** sufficiently sustained change and reasonable to assume that the change will be maintained with continued treatment
  - **Availability** of adequate community resources for treatment, supervision, housing, and safe management

Legal Targets – Simple Version

- Patient needs to (as it relates to SO risk reduction):
  - want to make change
  - know what changes need to be made
  - engage in treatment to make the change
  - demonstrate change
  - sustain change
  - make plans for resources in the community to maintain change

What Makes Change Possible?

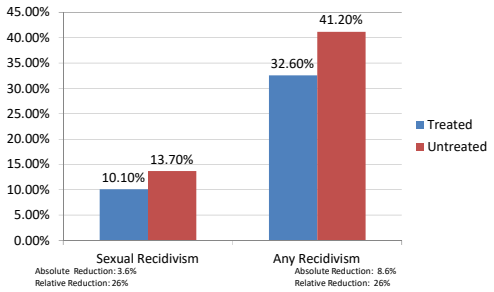
- If we define change as recidivism:
  - Research has looked at this
  - Experts who have evaluated programs have also looked at this

Schmucker & Losel (2015) A Meta-Analysis

based on McGrath Summary

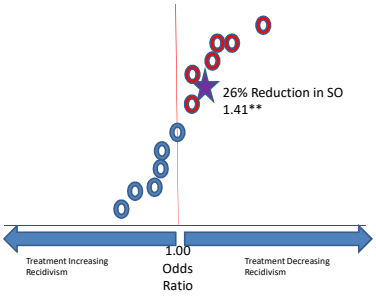
- Looked at 3000 studies on treatment effectiveness
- Very few met the qualification of being a good study
- After the review only 29 studies were of sufficient quality to be included
- Over 10,000 male sex offenders with a follow-up of over 5 years
- About 5,000 treated and about 5,000 untreated

Schmucker and Losel (2015) Recidivism



Not all Programs Performed the Same

Schmucker & Losel (2015) (Robert McGrath)



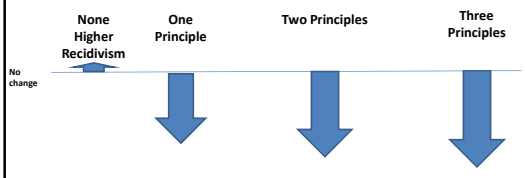
Eight Characteristics of Effective Programs

- Appropriate Program Intensity (Risk)
- Appropriate Treatment Targets (Need)
- Match Services to Learning Styles (Responsivity)
- Model of Change
- Effective Methods
- Continuity of Care
- Trained Staff
- Ongoing Monitoring and Evaluation

(McGrath, Cumming & Williams, 2014)

Programs that Adhere to RNR Have Lower Rates of Sexual Re-Offending

(Hanson et al, 2009 – 23 studies – 3,625 offenders; 5 year follow-up)



Appropriate Program Intensity

- **RISK**
- **WHO TO TREAT**
- Does the length of service and the intensity match the patient's level of risk?
- Those in the high risk show the most impact from treatment – treatment effect like an inverted U based on risk

Appropriate Treatment Targets

- **NEEDS**
- **WHAT TO TREAT**
- criminogenic needs – Dynamic Risk Factors
- Target Dynamic Risk Factors – Changeable
- Sexual pre-occupation, sexualized violence, multiple paraphilias, offense supportive attitudes, emotional congruence with children, LEIRA, lifestyle impulsiveness, poor problem solving, resistance to rules and supervision, grievance/hostility, negative social influences

Services Adjusted for Different Learning Styles

- **RESPONSIVITY**
- **HOW TO TREAT**
- The factors that impact how someone will respond to treatment
- General Responsivity – CBT – social learning
- Specific Responsivity – IQ, MH, Motivation, personality, trauma

Responsivity

- Assessment for learning styles
- Specialized Treatment Tracks
- Specialized Treatment Approaches
  - Supported Learning Program
  - Behavior Management Plans
  - Dialectical Behavior Therapy
  - Substance Use
  - Trauma Treatments
  - Gender Dysphoria

Model of Change

- Need to have a clear model of change (written, theoretically sound and with an empirical foundation)

SRSTCs Model of Change

Model of Change

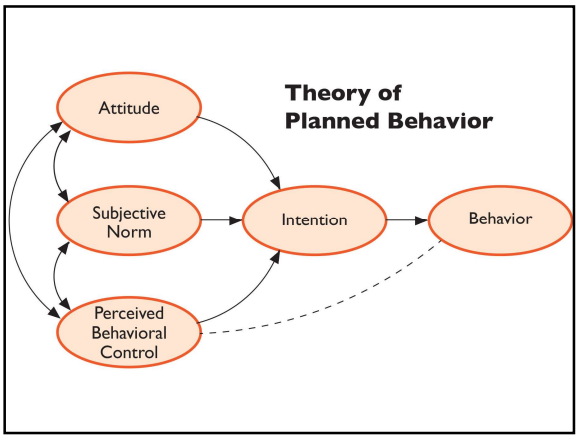
- Need to have a clear model of change (written, theoretically sound and with an empirical foundation)
- **Cognitive Behavioral** is generally the SRSTC Model
- Research has shown that the Cognitive Behavioral approach to sex offender treatment has the biggest impact on producing change compared to other approaches
- **Cognitive** - **thoughts impact the way we feel and act.** If we can change the thoughts we can change the feelings and behavior.
- **Behavior** – **behavior is learned** and has a result new behaviors can be learned to replace old behaviors

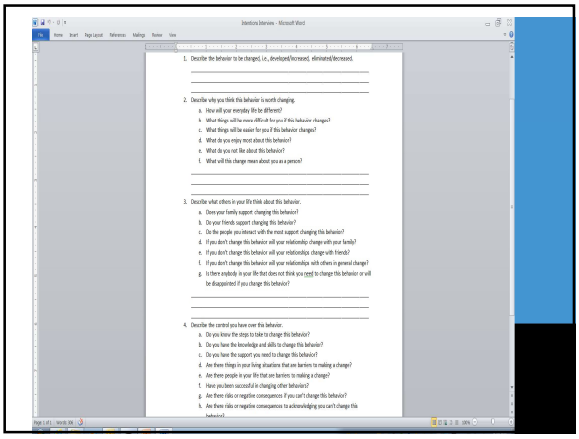
General Change Process

Statute Says Patients Should Want to Change

- Why – Purpose and Function
- Motivation
- **MEANING**
- Skills
- Demonstration
- Integration
- Maintain

Intention to Change





Physiological Assessments

- Polygraph
  - Specific, time sensitive, behaviorally focused, limited in frequency, and salient consequences
  - No set number to be conducted – used to verify and assess treatment need and progress
  - Sexual Hx, SFM, and PPG
  - Responsivity issues may impact suitability

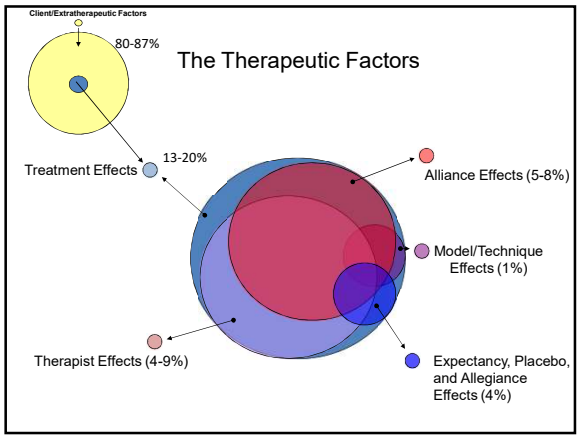
Physiological Assessments

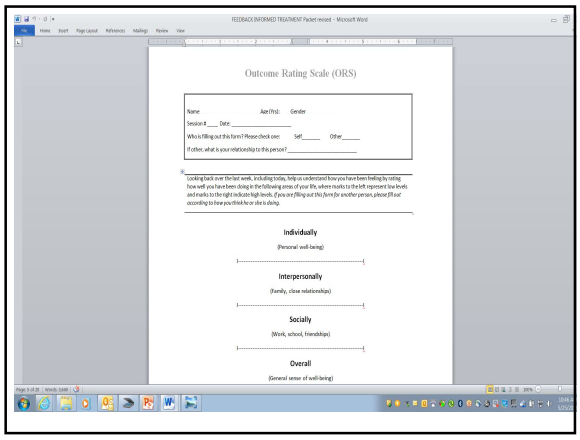
- Penile Plethysmograph
  - Assess presences of healthy and/or deviant sexual preference
  - Non-suppression – don't do anything to alter arousal
  - Suppression – use techniques and skills learned to differentially control arousal
  - Used once person has demonstrated commitment to engaging in treatment process

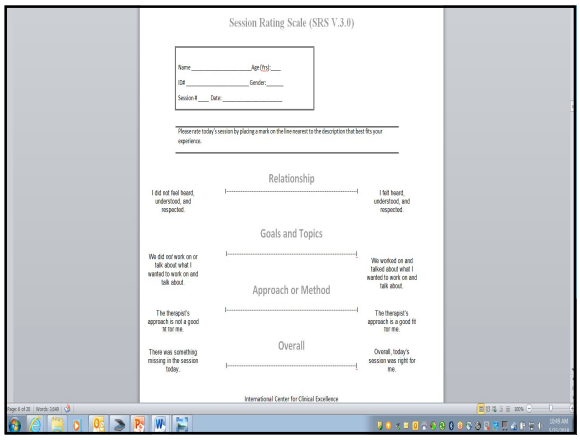
Meaning

- Who are we now?
- What should we be?

Feedback Informed Treatment


Client/Extratherapeutic Factors
80-87%
The Therapeutic Factors
Treatment Effects
13-20%
Alliance Effects (5-8%)
Model/Technique Effects (1%)
Therapist Effects (4-9%)
Expectancy, Placebo, and Allegiance Effects (4%)


Outcome Rating Scale (ORS)
Individually
Interpersonally
Socially
Overall


Session Rating Scale (SRS V.3.0)
Relationship
Goals and Topics
Approach or Method
Overall

TRAUMA TREATMENTS

MINDFULNESS

DBT

Individualized Behavior Management Plans

What Is Treated

Statute Says Should Know What Changes Need to be Made

- In general we focus on empirically based changeable risk factors associated with sexual re-offending
  - Sexual pre-occupation, sexualized violence, multiple paraphilias, offense supportive attitudes, emotional congruence with children, LEIRA, lifestyle impulsiveness, poor problem solving, resistance to rules and supervision, grievance/hostility, negative social influences
- This is done in an empirically based manner using effective methods with several key assumptions

Using Effective Methods

- Develop a good therapeutic relationship (one of the key factors in treatment outcome)
  - Firm, fair, warm, empathetic, respectful, directive, rewarding
- Some individualization
  - Recent research shows individual treatment is effective – limited number of studies
- Positive rewards more than punishers (4:1)
- Skill development should be emphasized (50% of time on skill practice)
  - Define the skill, identify usefulness of the skill, model the skill, practice the skill, give feedback
- Key factors in treatment outcome
  - Client factors, therapeutic relationship, therapeutic techniques and expectancy
- Supervisors monitor these through observation, supervision and documentation

Key Assumptions

- Therapeutic Relationship
- RNR Adherence (particular attention to specific responsivity issues)
- Desistance
- Protective Factors
- Approach Goals
- Skill Development
- Measurement

SRSTC's Way of Approaching Treatment Targets

Treatment Targets Foundation

- de Vogel, V., de Ruiter, C., Bouman, Y., & de Vries Robbé, M. (2012). *SAPROF: Guidelines for the assessment of protective factors for violence risk. 2nd Edition.* Utrecht, The Netherlands: De Forensische Zorgspecialisten.
- Mann, R. E., Hanson, R. K., & Thornton, D. (2010). Assessing risk for sexual recidivism: Some proposals on the nature of psychologically meaningful risk factors. *Sexual Abuse: A Journal of Research and Treatment, 22*, 191-217. doi: 10.1177/1079063210366039
- Maruna, Shadd. Making good: How ex-convicts reform and rebuild their lives. Washington, DC, US: American Psychological Association Making good: How ex-convicts reform and rebuild their lives. (2001). xix 211 pp. http://dx.doi.org/10.1037/10430-000

Overarching Treatment Target

- ***Meaningful Treatment Engagement***
- Statute says patients need to engage in treatment to make changes
- Essential to making change
- Indicators
  - Attendance, completing assignments, being prepared for sessions, participating, etc.
  - Contributions that support meaningful change
  - Instilling hope for the future
  - Foster group cohesiveness
  - Demonstrating and achieving treatment targets
  - Demonstration of skills through practice (role plays)
  - Application of treatment skills outside of treatment

Treatment Target Categories

- Each treatment target category includes risk factors, protective factors, and/or motivational factors
  - Future Thinking
  - Self-Management
  - Criminal Thinking
  - World View
  - Relational Style
  - Sexual Interests
  - Re-entry

Treatment Areas Further Defined

Future Thinking

- Based on idea of Desistance and Protective Factor "Life Goals"
- Pro-social identity
- Meaning and Purpose
- Hope

Self-Management

- Based on Mann et al (2010) DRFs and SAPROF
- Impulsiveness
- Self-Control
- Resistance to Rules and Supervision
- Coping
- Problem Solving
- Medication Management

Criminal Thinking

- Based on Mann et al (2010) DRFs
- Sexual Offense Supporting Attitudes
- Attitude Toward Authority
- General Criminal Thinking Errors

World View

- Based on SRA-FV construct of dysfunctional self-evaluation and desistance from crime literature
- View of Self
- Locus of Control
- Values
- Hostility

Relational Style

- Based on Mann et al (2010) and SAPROF
- Intimate Relationships
- Emotional Congruence with Children
- Callousness
- Grievance Thinking
- Empathy
- Support

Sexual Interests

- Based on Mann et al (2010)
- Sexual Preference for Children
- Sexualized Violence
- Sexual Preoccupation
- Sex as Coping
- Healthy Sexuality

Re-entry

- Based on Building Protective Factors
- Work
- Leisure Activities
- Finances
- Housing
- Professional Care

Measuring Change

Statute Says Should Demonstrate Change

Measuring Change is Difficult

- Change can be defined as the difference, either qualitatively or quantitatively, between the patient's adjustment at two points in treatment (Mosac, 1994)
- If a patient is not able to engage in the behavior targeted for change, how do you know the behavior has changed?
- How long does the absence of a problematic behavior need to occur before it is sufficient.

Basic Learning Steps Can Reflect Change

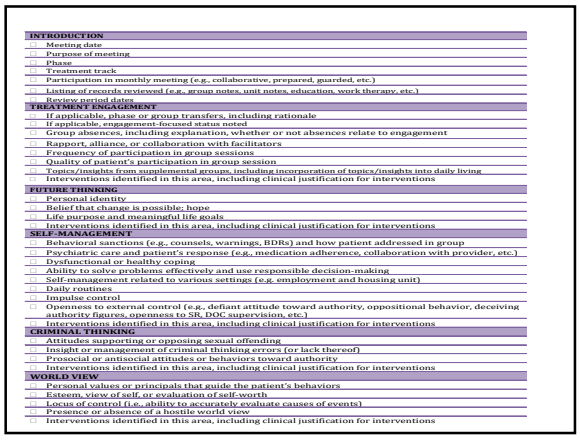
- Skills
- Demonstration
- Integration

Measuring Progress

- Individualize SMART Goals
  - Specific, measurable, achievable, realistic, time limited
- Case Conceptualization – Treatment Progress Reports
- Rolling Treatment Plans
- Group Observations and Feedback
- Feedback Informed Treatment
- Linking Tx Targets to Phase Advancement and Standardizing
- Measurement, Measurement, Measurement

Treatment Progress Summaries

TPS Reports



INTRODUCTION
- ☐ Meeting date
- ☐ Purpose of meeting
- ☐ Phase
- ☐ Treatment track
- ☐ Participation in monthly meeting (e.g., collaborative, prepared, guarded, etc.)
- ☐ Listing of records reviewed (e.g., group notes, unit notes, education, work therapy, etc.)
- ☐ Review period dates

TREATMENT ENGAGEMENT
- ☐ If applicable, phase or group transfers, including rationale
- ☐ If applicable, engagement-focused status noted
- ☐ Group absences, including explanation, whether or not absences relate to engagement
- ☐ Rapport, alliance, or collaboration with facilitators
- ☐ Frequency of participation in group sessions
- ☐ Quality of patient's participation in group session
- ☐ Topics/insights from supplemental groups, including incorporation of topics/insights into daily living
- ☐ Interventions identified in this area, including clinical justification for interventions

FUTURE THINKING
- ☐ Personal identity
- ☐ Belief that change is possible; hope
- ☐ Life purpose and meaningful life goals
- ☐ Interventions identified in this area, including clinical justification for interventions

SELF-MANAGEMENT
- ☐ Behavioral sanctions (e.g., counsels, warnings, BDRs) and how patient addressed in group
- ☐ Psychiatric care and patient's response (e.g., medication adherence, collaboration with provider, etc.)
- ☐ Dysfunctional or healthy coping
- ☐ Ability to solve problems effectively and use responsible decision-making
- ☐ Self-management related to various settings (e.g. employment and housing unit)
- ☐ Daily routines
- ☐ Impulse control
- ☐ Openness to external control (e.g., defiant attitude toward authority, oppositional behavior, deceiving authority figures, openness to SR, DOC supervision, etc.)
- ☐ Interventions identified in this area, including clinical justification for interventions

CRIMINAL THINKING
- ☐ Attitudes supporting or opposing sexual offending
- ☐ Insight or management of criminal thinking errors (or lack thereof)
- ☐ Prosocial or antisocial attitudes or behaviors toward authority
- ☐ Interventions identified in this area, including clinical justification for interventions

WORLD VIEW
- ☐ Personal values or principals that guide the patient's behaviors
- ☐ Esteem, view of self, or evaluation of self-worth
- ☐ Locus of control (i.e., ability to accurately evaluate causes of events)
- ☐ Presence or absence of a hostile world view
- ☐ Interventions identified in this area, including clinical justification for interventions

Phases of Treatment

Treatment Phase Description

- Three phase treatment model based on statutory criteria
- Phase One – Motivation, Engagement, and Self-Management
- Phase Two –Assessment and Awareness
- Phase Three – Management and Practice

Measuring Phase Advancement

Phase Advancement

- The evaluation of a patient's readiness to advance to the next phase of treatment is based on **meeting the expectations for each of the key treatment target areas in the current phase**. These treatment target areas are predetermined and defined in the Phase Review material, however, goals and objectives to meet the expectations of these target areas are individualized in the patient's treatment plan.

Phase Advancement Determination

- A **modified goal attainment scaling (GAS)** process will be used to measure a patient's progress towards advancing to the next phase of a treatment. GAS is **not used to assess which individual patient goals are achieved** in the treatment plan. However, the achievement of goals in the treatment plan, as well as other documentation, is used to determine if the phase advancement criteria are achieved. This allows for individualization treatment progress at the treatment plan level and consistency across phase advancement criteria at the phase advancement level.

Scoring

- Scores will range from +2 to -2 and will utilize the following scaling definitions:

- + 2 Much more than expected
- + 1 More than expected
- 0 Expected
- - 1 Less than expected
- - 2 Much less than expected

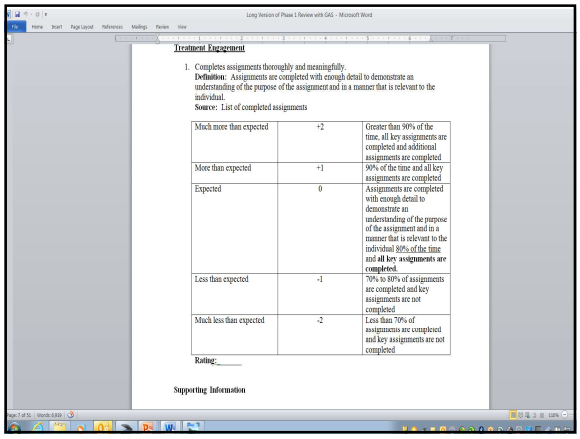
Example

- Treatment Engagement

1. Completes assignment thoroughly and meaningfully

   Definition: Assignments are completed with enough detail to demonstrate an understanding of the purpose of the assignment and in a manner that is relevant to the individual.

   Source: List of completed assignments



Treatment Engagement

1. Completes assignments thoroughly and meaningfully.
Definition: Assignments are completed with enough detail to demonstrate an understanding of the purpose of the assignment and in a manner that is relevant to the individual.
Source: List of completed assignments

Much more than expected	+2	Greater than 90% of the time, all key assignments are completed and additional assignments are completed
More than expected	+1	90% of the time and all key assignments are completed
Expected	0	Assignments are completed with enough detail to demonstrate an understanding of the purpose of the assignment and in a manner that is relevant to the individual 80% of the time and **all key assignments are completed.**
Less than expected	-1	70% to 80% of assignments are completed and key assignments are not completed
Much less than expected	-2	Less than 70% of assignments are completed and key assignments are not completed

Rating:_____

Supporting Information

Continuity of Care

- The **progress** that patients make at SRSTC should **be reinforced and strengthened** as they progress into the community
- The focus is not to just be **successful in the short-term**, but in the **long-term**
- Release planning that includes assistance with accommodations, social support and employment has shown to help with reductions in sexual offending recidivism.
- For sex offenders on probation **stable employment and sex offender treatment was associated in lower sexual recidivism**.
- **Significant others to provide support helped to produce positive treatment effect**. In the absence of significant others, volunteers, wrap around and circles of support are helpful with high risk sex offenders
- **Supervising utilizing the RNR model achieved a 16% reduction in reoffending**, whereas intensive surveillance-oriented community supervision had no impact on recidivism rates

Appropriately Selected, Trained and Supervised Staff

- Selecting staff on interpersonal skills and therapeutic styles of therapists, account for upward of 30 percent of the variance among indicators of treatment benefit
- Styles that are cold, hostile, shaming and deceptive have been shown to have no benefit and often have a negative effective on patients achieving treatment goals.
- Staff training and support should focus on:
  - Program's theoretical basis and operational aspects
    - Manualized treatment can be helpful – more consistency, measure effectiveness
    - Manualized treatment should not take away the importance of the therapeutic relationship
  - Providing supervision
  - Addressing personal challenges of staff working with population
  - Staff wellness
  - Matching therapist's expertise and style with the needs and characteristics of the patient

Ongoing Monitoring and Evaluation

- Ensure Program Integrity
  - Services delivered as designed and work to continually improve their quality
  - Operational and treatment manuals, supervising staff and checking adherence to policies are beneficial
- Evaluate Program Effectiveness
  - Programs should evaluate their effectiveness in reducing recidivism - difficult
  - Problem is that observed rates of re-offense is low (4-12%)
- Ensure Support for the Program
  - Program effectiveness is not only reliant on treatment staff, but from management, non treatment staff, and other stakeholders. Negative attitudes about sexual offenders make it difficult to gain support
  - Frontline staff enhance program effectiveness by supporting program goals
  - Connecting with others likely involved in the SOs life and creating linkages is important
  - Stable funding – Cost benefit analysis shows benefit to society exceeds its costs

Future Directions

- Identifying specific interventions to address each DRF
- Focus on paths to DRFs – commonalities
- Establishing 1:1 relationships between patient behavior, path to DRF and risk assessment
- Deviant sexual preference assessment, measurement, and interventions – Dual Control Model and Dual Process Model of Sexualized Thinking
- Utilizing SFM log and polygraph to determine purpose of sexual fantasies and role in offending
- Measuring intentions (theory of planned behavior)

Sand Ridge
secure treatment center

Jason Smith, Psy.D.
SRSTC Treatment Director
Jasonw.smith@dhs.wisconsin.gov