

Committee Report, Vol. 13, No. 2
**The Lincoln Regional Center's Sex Offender
Services Program**

August 2006

**Performance
Audit Section**

*Legislative Audit and Research Office
Nebraska Legislature*

Legislative Performance Auditing

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Membership on the Committee includes the Speaker of the Legislature, chairpersons of the Executive Board and the Appropriations Committee, and four other members of the Legislature, chosen by the Executive Board. The Committee's responsibilities include selecting audit topics; defining the scopes of audits; adopting recommendations based on reports prepared by the Performance Audit Section (Section); holding public hearings and sponsoring legislation, as necessary, in conjunction with audits; and monitoring agency compliance with Committee recommendations.

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Services Program**

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Prepared by
**Angela McClelland
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Editing
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I. Key Findings

Key Findings & Recommendations

Legislative Performance Audit Committee Report

The Lincoln Regional Center's Sex Offender Services Program

Because of recent incidents involving sex offenders who re-offended after being discharged from the Lincoln Regional Center (LRC), the Legislative Performance Audit Committee (Committee) asked the Performance Audit Section (Section) to assess the adequacy of LRC's sex offender program discharge procedures. Based on this audit, the Committee makes the following findings and recommendations.

PROGRAM SAFEGUARDS

The Committee found that the sex offender program's (program's) transfer and discharge procedures for sex offenders committed to treatment by mental health boards lack adequate safeguards, which may jeopardize public safety. In fact, the Committee found that the risk to public safety had been unnecessarily increased in one case in which the program contradicted its own standard practice by releasing a sex offender who had not completed treatment; that individual subsequently committed another assault. The Committee believes that LRC program staff take seriously their responsibility to protect public safety by striving to discharge only those individuals least likely to re-offend. Nevertheless, under the transfer and discharge procedures in place at the time of this audit, it is possible that other discharge decisions were made that unnecessarily increased the risk to public safety, or that such decisions could be made in the future.

Specifically, the Committee found that:

- the written policies regarding discharge decisions are not comprehensive;
- the reasoning behind discharge decisions is not documented;
- discharge decisions are ultimately made by one person; and
- other staff with potentially valuable insights are unsure whether or not their opinions are considered.

Recommendations

Based on these findings, the Committee recommends that program staff develop comprehensive policies dictating how transfer and discharge decisions will be made. Additionally, the Committee recommends that:

- the policies include the discharge criteria; define the roles of key personnel in the decision-making processes; and require documentation of the reasoning behind discharge decisions;
- the program staff should take steps to improve the accountability of release decisions made by the program psychiatrist, such as requiring other clinical staff, including the relevant psychologist and social worker to weigh in formally on discharge decisions; and

- Nebraska statutes should require the program to develop, maintain, and adhere to written policies or administrative regulations governing the transfer and discharge of sex offenders treated in the program. At a minimum, the statutes should specify the primary components to be included in the transfer and release policies or administrative regulations. The Legislative Performance Audit Section shall draft, in consultation with Department of Health and Human Services representatives, legislation proposing such statutory language for introduction by the Committee during the 2007 legislative session.

CHANGES IN CIVIL COMMITMENT POLICIES

Recent policy changes contained in LB 1199 (2006) are likely to cause an increase in both the number of sex offenders that LRC's sex offender program must treat and the program's capacity for doing so. It is unclear whether the anticipated increase in capacity will be adequate to meet the increased need for services.

Recommendations

Based on these findings, the Committee recommends that the program carefully monitor the trends in mental health board commitments and the effects of those trends on the program's ability to meet the needs of sex offenders in treatment.

**Legislative Performance Audit Committee
Legislative Audit and Research Office**

August 2006



II. Performance Audit Section Report

Performance Audit Section Report
**The Lincoln Regional Center's Sex Offender Services
Program**

Prepared by
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INTRODUCTION

The state of Nebraska provides mental health services to people who cannot afford private care or have been committed to public institutions in the interest of public safety. The state delivers these services through three psychiatric hospitals known as regional centers, which are located in Hastings, Lincoln, and Norfolk. One of the mental health services offered at the regional centers is treatment for sexually assaultive behavior, which is provided primarily by the Lincoln Regional Center (LRC).

Because of recent incidents involving sex offenders who re-offended after being discharged from LRC, public interest in sex offender issues has increased dramatically. As a result, on 9 November 2005, the Legislative Performance Audit Committee directed the Legislative Performance Audit Section to audit LRC's adult Sex Offender Services Program. In general, the Committee directed the Section to assess the adequacy of LRC's procedures for discharging sex offenders.

Section I of this report provides an overview of the program, the population served, program expenditures, and the length of treatment for current participants. Sections II through V answer the specific questions posed in the scope statement for this audit.

This audit was conducted in accordance with generally accepted government auditing standards for performance audits. The methodologies used are described briefly at the beginning of each section with further detail included at the end of the report.

We appreciate the program staff members' cooperation and assistance during the audit.

SECTION I: The Lincoln Regional Center's Sex Offender Services Program

In this section, we provide an overview of the Lincoln Regional Center's Sex Offender Services Program, the population it serves, its expenditures, and the lengths of treatment for current participants.

Program Administration and Description of Services

The Lincoln Regional Center (LRC) is part of the Department of Health and Human Services (Department), one of three agencies that administer the state's health and human services programs. LRC provides several behavioral health treatment programs, which are housed in several buildings on the LRC campus. LRC is managed by a Chief Executive Officer (CEO), who is appointed by the Department director.

One of LRC's treatment programs is the Sex Offender Services Program (program), the state's primary treatment program for adult sex offenders. A Program Director administers the program and manages most of the program's staff, including 11 full-time psychologists and social workers, and 68 other full-time staff members who treat and supervise the sex offenders. LRC also employs a psychiatrist to work, on a part-time basis, with program participants; the psychiatrist reports directly to the CEO.

Most sex offenders are admitted to the program under the provision of two state statutes—the Nebraska Mental Health Commitment Act and the Convicted Sex Offender Act.¹ Generally, the Nebraska Mental Health Commitment Act empowers mental health boards, which are established by district courts across the state, to involuntarily commit to LRC for treatment sex offenders found to be mentally ill and dangerous. The Convicted Sex Offender Act authorizes LRC to admit for treatment incarcerated sex offenders who volunteer, and are approved for, treatment.

Although sex offenders who participate in the program are admitted through different means, the treatment they receive is the same. The two-step treatment program is residential; participants live on the LRC campus while undergoing treatment.

After admission to the program, the first step in treatment is intensive sex offender-specific therapy. This step, called inpatient services, can serve up to 64 offenders at one time. Offenders must progress successfully through this step before advancing to the second step of the program, called community-transition services.

Community-transition services focus less on sex offender-specific therapy and more on helping program participants develop the skills needed to succeed in the community following discharge. This step can serve up to 16 offenders at one time. Program participants must progress successfully through community-transition services before being considered for discharge from the program.

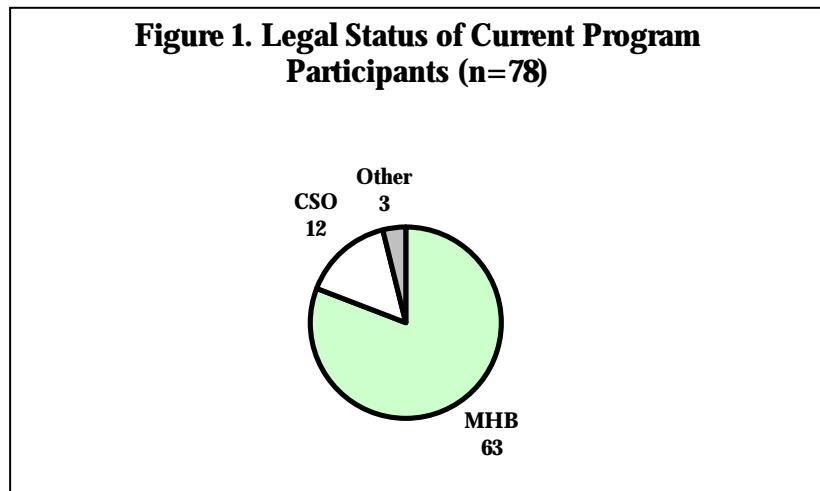
Sex offenders are discharged from the program in different ways depending on the legal means by which they were admitted into the program. For committed offenders, the responsibility for the discharge decision rests primarily with the program's psychiatrist. The psychiatrist plays a smaller role, however, in the discharge of incarcerated offenders, who may be released at the end of their sentences. The differences in the discharge procedures for these two groups are discussed in more detail in Sections II and III.

After discharge from the community-transition services component, some sex offenders may volunteer for or be required to participate in post-discharge treatment provided by LRC. This treatment consists primarily of weekly support group meetings, led by clinical staff.

Population Served

Most sex offenders are male, and the program's population reflects that fact. Of the 82 adult sex offenders currently being treated in the program, 78 are male and four are female. Because there are so few female sex offenders, we omitted them from this audit.

Of the 78 male sex offenders currently in the program, 63 (81%) were committed to LRC under the Nebraska Mental Health Commitment Act; 12 (15%) are incarcerated sex offenders admitted to the program through the Convicted Sex Offender Act; and 3 (4%) either voluntarily committed themselves to LRC or were committed under a court order, such as being found not responsible by reason of insanity. This breakdown is displayed in Figure 1.



Note: CSO stands for convicted sex offender and MHB stands for mental health board commitment.

Figure created by the Legislative Performance Audit Section.

Expenditures

The program is funded almost entirely with state general funds, although it receives a small amount of federal funds.

The program is not a discrete item in LRC's budget, which made it difficult for us to obtain actual program costs. Consequently, we worked with program staff and Health and Human Services System Finance and Support agency staff to estimate those costs.

For FY2004-05, we estimate that the program spent about \$7.3 million. Based on our estimate of actual program costs and the program's capacity, we found that inpatient services cost about \$91,000 per sex offender. For community-transition services, we found that treatment costs about \$87,000 per sex offender.

Table 1.1 shows the breakdown of the total program costs for each program component and the cost per sex offender.

| Table 1.1 Estimated Program Expenditures FY2004-05 | | | |
|---|-----------------------|-----------------|--|
| Program Component | Estimated Cost | Capacity | Estimated Cost per Sex Offender |
| Inpatient | \$5,850,000 | 64 | \$91,000 |
| Community-Transition | \$1,390,000 | 16 | \$87,000 |
| Post-Discharge | \$90,000 | NA | NA |
| Total | \$7,330,000 | | |

Note: Figures are rounded to the nearest \$10,000.

Table created by the Legislative Performance Audit Section.

Length of Treatment

As of 15 May 2006, there were 78 sex offenders in the program: 63 in inpatient services and 15 in community-transition services. Program staff suggested that a sex offender who is highly motivated to complete treatment could complete the first step, inpatient services, in as little as 18 months; however, they indicated it is unusual for a sex offender to do so. They do not suggest a limit for the maximum amount of time necessary to complete the program.

Finding: On average, sex offenders have spent 2.8 years in inpatient services treatment. However, a few have been in treatment more than 15 years.

We found that, on average, the 78 sex offenders currently in the program had been in inpatient services treatment for 2.8 years. The actual length of inpatient services treatment for each sex offender ranged from less than a month to more than 15 years. The lengths of treatment for all 78 sex offenders are shown in Figure 2.

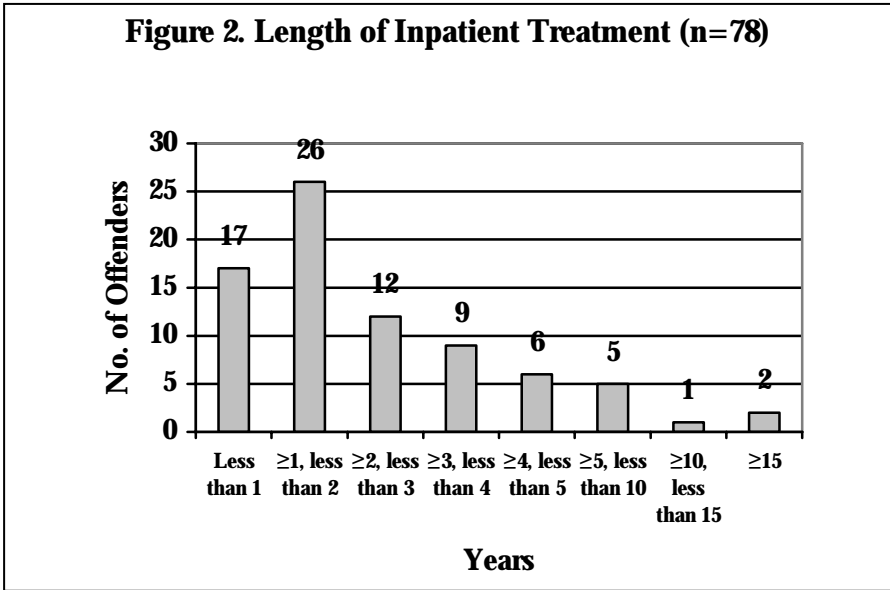


Figure created by the Legislative Performance Audit Section.

For the program’s second step, community-transition services, program staff expect sex offenders will participate in community-transition services for six to nine months. We found that, on average, the current participants had been receiving community-transition services for six months. The actual length of community-transition services for each sex offender ranged from less than a month to a little more than two years.

Previous Participation

Finding: Some sex offenders currently in the program have previously spent a considerable amount of time in the program.

Of the 78 sex offenders currently in the program, 59 (76%) were participating for the first time, but 19 (24%) had previously participated in the program. Two of the 19 sex offenders had previously participated in the program twice, and one person had previously participated three times.

In most cases, the previous length of treatment was relatively short—less than two years. In a few cases, however, it was significantly longer. The longest single previous length of treatment was for more than six years. In addition, the combined length of treatment for the sex offender who was in his fourth round of treatment was 8.54 years, which was in addition to his current length of treatment, which to date has lasted 4.39 years.

Notes

¹ Neb. Rev. Stat. secs. 71-901 to 71-962 and Neb. Rev. Stat. secs. 29-2922 to 29-2936, respectively.

SECTION II: The Program’s Discharge Procedures for Committed Offenders

As explained in Section I, the majority of program participants are sex offenders committed to the program by a decision of a mental health board pursuant to the Nebraska Mental Health Commitment Act (committed offenders) or are convicted sex offenders who are found by LRC to be amenable to treatment and choose to participate in the program while serving their sentences (incarcerated offenders).

In the scope statement for this audit, the Committee directed the Section to assess whether the program’s discharge procedures adequately protect public safety by allowing the release of only those committed offenders who are least likely to pose a danger to society. In this section, we discuss the discharge procedures for committed offenders and address the Committee’s question about that process. We discuss the discharge of incarcerated offenders in Section III.

Finding: The program’s transfer and discharge procedures for committed offenders lack adequate safeguards, which may jeopardize public safety.

We found that the program’s transfer and discharge procedures for committed offenders lack adequate safeguards, which may jeopardize public safety. Following is a detailed discussion of our findings.

Discharge Requirements

Under the Nebraska Mental Health Commitment Act, a sex offender may be committed to the program only if he is found to be mentally ill and dangerous, and if a less restrictive treatment environment is insufficient to reduce his potential dangerousness.¹ Similarly, a sex offender must be released if treatment is no longer needed or if his needs can be met in a less restrictive environment.²

The program’s internal policies, specifically its Discharge Protocol (protocol), state that the path to discharge begins with completion of the program’s first step—inpatient services—and advancement to community-transition services. Although the protocol does not explicitly state that the program participant must also complete community-transition services as a prerequisite to discharge, the program staff—including the Chief Executive Officer (CEO) and clinical psychologists—asserted that this is the case. The psychiatrist alone disagreed, arguing that some sex offenders do not need to complete community-transition services prior to discharge.

The decisions to advance a program participant through inpatient services and into community-transition services also have a potential

impact on public safety. Because of the significance of these decisions, we discuss them before discussing the discharge decision itself.

Completing Inpatient Services

In inpatient services, a sex offender must participate in mandatory individual and group treatment and demonstrate positive behaviors, such as admitting guilt, accepting responsibility, and identifying his assault cycle. As his behaviors improve, he earns additional privileges, which are grouped into “levels.” To be eligible for advancement from inpatient services to community-transition services, the protocol states that the program participant must complete all assigned therapeutic groups and reach the highest privilege level.

Program staff report using an internally developed scoring system—the Goal Attainment Scale (GAS)—to quantify a sex offender’s progress through the privilege levels. These assessments are made periodically, as determined in program policies. For each assessment, individual staff members score the program participant on a number of desired behaviors, using a five-point scale; offenders are given more points for better behavior.

Finding: The GAS scores, which serve as a basis for important treatment decisions, are not kept in sex offenders’ medical files, which may prevent proper access to them. Moreover, documentation pertaining to the reasoning behind GAS scoring is not retained.

The GAS score is a threshold criteria—program personnel will not consider moving a program participant to a higher level of privilege until his GAS score reaches a certain level. Similarly, a program participant will not be considered for advancement to community-transition services without a high enough GAS score. Despite the importance of these GAS scores, we found that no GAS information is maintained in sex offenders’ files. Instead it is maintained separately by various program staff. In addition, the only GAS data available at all relates to the final scoring; documentation explaining why program staff scored an individual in a particular way is not systematically maintained.

Program staff could not adequately explain why GAS information is not maintained in sex offenders’ files. One explanation offered was that program staff are concerned that, if sex offenders have access to the GAS scores via their files, they will behave badly towards staff who give them low scores. Another explanation offered was that some program staff are concerned that judges and attorneys might misinterpret scores subpoenaed for a mental health board hearing or other legal proceeding. In addition, the CEO and the program’s psychiatrist gave us conflicting information as to whether the GAS scores would even be included when a sex offender’s medical file is subpoenaed.

Finding: Purposely separating the GAS scores from the rest of the medical files raises serious ethical and legal concerns.

We believe that purposely separating the GAS scores from the rest of the medical files raises serious ethical and legal concerns. Not only

does it result in an incomplete medical file, but also it removes from evidence a vital piece of treatment documentation that might be relevant to a legal proceeding.

Discharge

Finding: LRC's discharge procedures contain little detail about the criteria an offender must meet in order to be discharged.

While participating in community-transition services, the step of the program prior to discharge, the protocol requires the participant to maintain the positive behaviors developed through inpatient services treatment and to make additional progress, such as finding a job, developing a support network, and learning to budget for independent living. However, the protocol does not indicate specifically which criteria a sex offender must meet in order to be discharged.

Although all clinical staff—including the program's psychiatrist, psychologists and social workers—are actively involved in assessing and treating sex offenders, the program's psychiatrist is ultimately responsible for deciding when to discharge a committed offender. This responsibility has been delegated to the psychiatrist by the CEO, as permitted under the Nebraska Mental Health Commitment Act.³ The CEO told us that he would intervene to prevent a sex offender's discharge if program staff brought concerns about that individual to his attention—although, in his 18-month tenure, no one has done so.

Under current law, the psychiatrist does not need the applicable mental health board's approval to discharge a committed sex offender. Rather, the psychiatrist is required only to notify the board at the time of the sex offender's release. However, the Legislature changed this policy during the 2006 legislative session through the passage of LB 1199 (2006). When the bill takes effect, LRC will be required to notify relevant parties of a sex offender's pending discharge at least 90 days prior to its occurrence.⁴

Assessment of the Program's Discharge Decision-Making

Finding: The reasoning behind some clinical decisions is not documented in a conspicuous location in offenders' medical files.

To assess how well the program follows its own discharge protocol, we reviewed four program participants' medical files and interviewed the vast majority of program staff. We were only able to review a small number of files because we found that, while the decisions to transfer a program participant to community-transition services or discharge him from the program are recorded in the files, the reasoning behind those decisions is not contained in a single, identifiable location in the files. Instead of being able to review one or two documents from the files, we had to read entire portions of files. Each such review took several days, which made it impossible for us to review more than a few files within the timeframe for this audit.

To select files for review, we asked program staff to provide us with the names of program participants who represented different treatment outcomes. In addition, we identified one program participant who appeared to have been discharged in a manner inconsistent with the program’s discharge procedures. A brief description of the discharge status and current status of those sex offenders represented in our file review is shown in Table 2.1.

| Table 2.1: Cases Selected for In-Depth File Review | | |
|---|---|--|
| Case | Discharge Status | Current Status |
| 1 | Sex offender discharged after completing LRC treatment. | Not convicted of a subsequent sexual offense.* |
| 2 | Sex offender discharged after completing LRC treatment. | Convicted of a subsequent sexual offense. |
| 3 | Convicted Sex Offender began treatment but was unsuccessful and was returned to Corrections. | Completing prison sentence. |
| 4 | Sex offender spent several years in LRC’s program and was discharged without completing LRC inpatient or community-transition services. | Convicted of a subsequent sexual offense. |

Table created by the Legislative Performance Audit Section.

* Data only available for Nebraska convictions. See Section V for further discussion.

Absence of Documentation of Decision-Making

Finding: The reasoning behind some significant clinical decisions cannot be discerned, even from a thorough review of medical files.

In the files reviewed, we found a significant amount of documentation pertaining to both the day-to-day treatment of sex offenders and the chronology of significant clinical decisions, such as those involving transfers and discharges. We identified a gap, however, between the documentation of day-to-day events and the clinical decisions to which they gave rise. The sex offenders’ files that we reviewed contained few indications of the reasoning behind important clinical decisions.

For example, the files contained no notes from the regular clinical staff meetings, despite the fact that sex offenders’ treatment progress, or lack thereof, is regularly discussed at such meetings. Program staff confirmed that no one maintains an official record of the issues addressed in these meetings.

More specifically, in two of the four cases reviewed (cases #1 and #4), we were unable to determine from the file documentation why the sex offenders were transferred to community-transition services or discharged from the program at the times they were. In case #1, the sex offender was clearly progressing through treatment; however, there was no explanation of why he was approved for transfer to community-transition services at that particular point in time.

Finding: In one case, a sex offender was released without completing inpatient services or community-transition services treatment at LRC, which we believe contradicted the program's standard practice and consequently increased the risk to public safety unnecessarily.

Case #4 was far more troubling. This sex offender was released without completing inpatient services or community-transition services treatment, which we believe is contrary to the program's standard practice of requiring sex offenders to complete both steps prior to discharge, and we could not ascertain from the documentation why this was so. Program staff assert that completion of both program components is necessary in order to reduce the sex offender's risk of re-offending; however, the program's psychiatrist, who was primarily responsible for the discharge decision, disagrees with this assertion. When asked about this apparent contradiction, he stated that the sex offender was able to meet his personal treatment goals without completing inpatient services or community-transition services treatment at LRC, thereby qualifying for discharge.

*National Standards Regarding
Documentation of Clinical Decisions*

Finding: National standards for sex offender treatment support the need to document the reasons for clinical decisions.

National standards for sex offender treatment support the need to document the reasons for clinical decisions. The Association for the Treatment of Sexual Abusers (ATSA) is one of the foremost professional organizations dealing with the treatment of sex offenders. ATSA's standards of professional conduct direct its members to "clearly articulate their reasons for making recommendations with regard to treatment, case management, or supervision requirements."⁵

LRC does not claim formal compliance with ATSA standards, although program staff agreed that it is fair to compare the program to these standards. In most instances, we found that the program does meet the standards. When it comes to following ATSA's guidelines regarding the documentation of clinical decisions, however, that is clearly not the case.

Staff Perspectives on Discharge Decision-making

In addition to conducting file reviews, we interviewed the vast majority of program staff who have worked in the program for a significant period of time. We asked them to describe both the discharge decision-making process as they understand it and their roles in that process.

Finding: Some program staff are concerned about the way discharge decisions are made.

Our interviews confirmed that the psychiatrist decides unilaterally when to move a sex offender to community-transition services or discharge him from the program. Clinical staff expressed a variety of opinions about the reasoning behind these decisions. Some claimed to have no concerns whatsoever about the way such decisions are made, while others expressed considerable unease with them, at least in some specific cases.

Staff also expressed mixed feelings about whether their concerns regarding sex offender treatment are given due consideration. Some alleged having felt pressured by the psychiatrist to inflate a sex offender's GAS scores, which would cause that sex offender to move through inpatient services more quickly. A few even said that they no longer document problems in offenders' behavior, or even make their supervisors aware of them, because they believe that no one pays attention to their concerns.

Notes

¹ Neb. Rev. Stat. sec. 71-921.

² Neb. Rev. Stat. sec 71-935(2).

³ Section 71-936 charges the administrator with both determining when a sex offender should be discharged and notifying the appropriate mental health board of that decision; however, section 71-904 defines "administrator" as "the administrator or other chief administrative officer of a treatment facility *or his or her designee*." (Emphasis added.)

⁴ LB 1199 (2006), Slip Law, page 33, section 86. Effective date 14 July 2006.

⁵ The Association for the Treatment of Sexual Abusers, "Practice Standards and Guidelines for the Evaluation, Treatment, and Management of Adult Male Sexual Abusers" (2005), Section D-24, pg. 18.

SECTION III: The Program's Discharge Procedures for Incarcerated Offenders

In Section II, we discussed the program's discharge procedures for committed offenders. In this section, we discuss the program's role in the discharge of convicted sex offenders who have been found amenable to, and volunteered for, treatment (incarcerated offenders) as provided by the Convicted Sex Offender Act.

Specifically, we address the scope statement question regarding the extent to which LRC influences the post-discharge treatment of incarcerated sex offenders through its interactions with the Department of Correctional Services (Corrections) and the state's mental health boards. To answer this question, we interviewed program staff about the extent of their involvement in such cases.

Finding: Program staff have limited influence in the post-discharge decisions for incarcerated offenders.

In general, we found that program staff have limited influence in the post-discharge decisions for incarcerated offenders. The extent of the influence they do have is described below.

Discharge of Incarcerated Offenders

Incarcerated offenders who participate in the program are physically located at LRC, but they remain in the legal custody of Corrections. LRC is responsible for these sex offenders' treatment but has no authority to discharge them into the community prior to completion of their sentences.

Incarcerated offenders participating in the program are discharged in one of three ways. First, if an incarcerated sex offender has completed inpatient services, but he still has time left to serve before he is eligible for parole, he will be sent back to Corrections to serve out his sentence. Once the sex offender returns to Corrections, LRC has no influence in his post-discharge treatment.

Second, if the incarcerated offender participating in the program is eligible for parole and has made appropriate progress in inpatient services, program staff may encourage the Nebraska Board of Parole to parole the sex offender to community-transition services, where he will continue treatment. Program staff can have some influence in the post-discharge

treatment of a paroled sex offender if he completes the community-transition services component of the program with time left to serve on parole. In that case, program staff can recommend post-discharge treatment be included as part of the sex offender's conditions of parole.

Finally, if an incarcerated offender participating in the program completes his sentence but has not completed the inpatient services, program staff may request that the appropriate mental health board commit him to LRC to finish treatment. If the mental health board does so, the discharge procedures and opportunity for post-discharge treatment are the same as those discussed in Section II of this report. If the mental health board chooses not to commit the sex offender, LRC has no authority to require continued treatment; however, the sex offender may choose to participate voluntarily.

SECTION IV: Interaction with Mental Health Boards and the Department of Correctional Services

In this section, we analyze how decisions by the Department of Correctional Services (Corrections) to pursue mental health board commitments for convicted sex offenders about to be released from prison impact the Lincoln Regional Center's (LRC's) Sex Offender Services Program (program). Specifically, we emphasize the issue of LRC's limited treatment capacity versus the growing demand for its services.

Corrections' Process for Requesting Commitments

According to Corrections personnel, when a convicted sex offender is 30 to 90 days from completion of his criminal sentence, staff psychologists assess whether he is safe to release into the community. If not—specifically, if they believe that the sex offender is a mentally ill and dangerous person, as defined in the Nebraska Mental Health Commitment Act¹—the supervising psychologist will send a letter to the county attorney of the county in which the sex offender is incarcerated, requesting the commencement of civil commitment proceedings.

Finding: Neither Corrections nor any other entity regularly tracked the number of requests Corrections made to initiate civil commitment proceedings, or the disposition of those requests.

Historically, the county attorney exercises sole discretion in deciding whether to assent to that request by filing with the district court a petition for civil commitment. If such a petition is filed, a mental health board will hold a hearing to decide whether to order the commitment; however, if no petition is filed, the sex offender will be released into the community when his sentence expires.

At the time of this audit, neither Corrections nor any other entity regularly tracked the number of requests that Corrections made to initiate civil commitment proceedings or the disposition of those requests. We note that Corrections staff were able to compile request totals when requested to do so by the Section; however, they did not have access to information regarding the disposition of those requests.

Analysis of Commitment Requests

Finding: Between 2001 and 2005, the majority of sex offenders referred for mental health board commitment by Corrections were not committed.

We asked Corrections staff to tell us how often, between 2001 and 2005, agency psychologists had requested county attorneys to file petitions for mental health board commitment hearings. We then assessed which of the sex offenders identified in those requests had been committed to LRC.

We found that Corrections' letters to county attorneys have resulted in relatively few mental health board commitments. As reflected in Table 3.1 below, between 2001 and 2005, Corrections referred 135 sex offenders for civil commitment; 36 of those referred (27%) were committed, but 99 (73%) were not.

| Table 3.1: Corrections MHB Referrals vs. Actual Commitments | | | |
|--|--------------------------------|-------------------------|-----------------------------|
| Calendar Year | Number of Offenders | | |
| | Referred by Corrections | Committed to LRC | Not Committed to LRC |
| 2001 | 44 | 14 | 30 |
| 2002 | 27 | 3 | 24 |
| 2003 | 25 | 8 | 17 |
| 2004 | 25 | 7 | 18 |
| 2005 | 14 | 4 | 10 |
| Total | 135 | 36 | 99 |

Note: Referral information provided by Corrections. Commitment information provided by HIM staff at LRC. Totals compiled by the Section.

Table created by the Legislative Performance Audit Section.

The 99 requests for hearings that did not result in commitments were submitted to 44 counties across the state. (We did not contact the county attorneys of these counties to verify that commitments had not been pursued or to seek their explanations for such outcomes, because such a project was outside the scope of this audit.)

LB 1199 Commitment-Process Changes

At the time of this audit, Corrections was not required to notify county attorneys of the pending release of dangerous sex offenders, and county attorneys were not required to act upon such requests or to explain why they chose not to do so.² However, that changed with the passage of LB 1199 (2006).

Finding: The changes that LB 1199 (2006) makes to the sex offender commitment process are expected to increase the number of sex offenders committed to the program.

LB 1199 requires that, at least 90 days prior to a sex offender's release, "the agency with jurisdiction over the individual shall provide notice [of a pending release] to the Attorney General, the Nebraska State Patrol, the prosecuting county attorney, and the county attorney in the county in which an individual is incarcerated, supervised, or committed."³ In addition, within 45 days of receiving such notice, the county attorney must inform the Attorney General whether he or she intends to initiate civil commitment proceedings.

LB 1199 further facilitates the civil commitment of sex offenders through the creation of the Sex Offender Commitment Act. Resembling closely the current Mental Health Commitment Act, the purpose of this law is "to provide for the court-ordered treatment of sex

offenders who have completed their sentences but continue to pose a threat of harm to others.”⁴ The law strives to accomplish this by establishing new, more precise, standards for the civil commitment of sex offenders.

These two changes are expected to increase the number of sex offenders committed to the program. According to the Chief Executive Officer (CEO) of LRC, the program will soon begin expanding its capacity. At this time, however, it is impossible to assess whether the projected expansion will meet the increased need. Several factors influencing such an assessment are discussed below.

Impact of Increased Commitments on LRC

Finding: A significant increase in mental health board commitments cannot be accommodated unless sex offenders currently in treatment are moved through the program more rapidly or more beds are added.

Currently, the program is operating at capacity, so any significant increase in the number of sex offenders committed to it cannot be accommodated unless either the sex offenders currently undergoing treatment are moved through the program more rapidly or more beds are added.

Finding: A significant increase in mental health board commitments may result in longer stays in treatment because these sex offenders may be less motivated in treatment.

In addition, a significant increase in the number of commitments may result in more sex offenders remaining in the program for extended periods of time. Unlike incarcerated offenders, who must volunteer to participate in treatment, committed offenders are most often committed against their wills. Some committed offenders are, therefore, less motivated to work toward treatment goals and take longer to progress in treatment—if they progress at all.

Finding: Should the number of mental health board commitments outpace the anticipated increase in capacity, LRC may eventually be unable to serve the needs of any incarcerated offenders under the Convicted Sex Offender Act.

Finally, an increase in commitments may worsen an existing tension between the need to serve both committed offenders and incarcerated offenders treated under the Convicted Sex Offender Act (Act). Under the Act, the program can defer treatment of an incarcerated offender if there is no bed available for him. The program does not have the same flexibility with a committed offender, whom LRC must accept into the program, whether a bed is available or not.

If beds are limited, this creates pressure to make room for newly-eligible incarcerated offenders by either moving other sex offenders through the program more rapidly or denying treatment to those incarcerated sex offenders waiting to be admitted. To date, we do not know of any incarcerated offenders who have been denied treatment; however, this could happen if the increase in mental health board commitments outpaces the program’s increased capacity.

As mentioned above, plans are underway to increase the program’s capacity. According to the CEO, beginning 1 July 2006, the program will expand into the Norfolk Regional Center. This expansion is expected to result in an increased capacity of approximately 30 new

Finding: The Department of Health and Human Services plans to open more sex offender treatment beds at the Norfolk Regional Center.

admissions per year for the next two years. At the same time, LRC will be making some changes to the program itself.

According to the CEO, after 1 July 2006, all newly-admitted sex offenders will begin the program at NRC, where they will participate in the initial stages of inpatient sex offender services treatment. After progressing through those stages, sex offenders will be transferred to LRC to undergo more advanced inpatient services treatment, in preparation for moving to the community-transition services component of the program. Although the transformation of NRC into a sex offender treatment facility will result in sex offenders being housed in two separate locations, the CEO asserts that the content of the treatment offered at NRC will be identical to that currently provided at LRC.

Notes

¹ Neb. Rev. Stat. sec. 71-908.

² Neb. Rev. Stat. sec. 71-921. This section directs the county attorney to file a petition for a mental health board commitment only if he or she concurs that the subject is mentally ill and dangerous, and no less restrictive form of treatment would suffice.

³ LB 1199 (2006), Slip Law, page 33, section 86.

⁴ LB 1199 (2006), Slip Law, page 24, section 58.

SECTION V: Recidivism of Treated vs. Untreated Sex Offenders in Nebraska

In the scope statement for this audit, the Committee instructed us to compare the recidivism rate for sex offenders who completed the program's treatment to that of sex offenders who received no treatment. In this section, we discuss sex offender recidivism studies in general and describe our analysis.

Introduction

Obtaining accurate recidivism data for sex offenders is extremely difficult due to the nature of the crimes involved. According to one national association:

“The vast majority of actual sex offenses committed against youth and adults go unreported and undetected; consequently, all methods of assessing risk of future sex offenses rely on re-arrests and reconvictions and produce underestimates or relative risk.”¹

The U.S. Department of Justice concurs that “sexual assault is a vastly underreported crime,” warning that reliance on “measures of recidivism as reflected through official criminal justice system data obviously omit offenses that are not cleared through arrest of those that are never reported to police.”² In short, all recidivism studies are merely reflections of how often sex offenders are apprehended, not how often they actually offend.

Finding: We acknowledge that all recidivism studies, including our own, are likely to produce significant underestimates of actual re-offense rates and should be viewed with caution.

Similarly, it is important to note that the likelihood of recidivism increases dramatically the longer a sex offender, treated or not, remains free. Thus, recidivism studies covering a relatively short span of time are likely to underestimate the true long-term danger of re-offense posed by sex offenders.

We acknowledge that all recidivism studies, including our own, are likely to produce significant underestimates of actual re-offense rates and should be viewed with caution.

Description of the Section's Recidivism Analysis

In designing our analysis, we consulted with the program's clinical staff and an independent expert in the field of sex offender treatment. Following is a description of the types of offenders and offenses included in our analysis.

Offenders

We defined “treated” sex offenders as those who had progressed through both the inpatient services and community-transition services portions of the program. The clinical staff asserted that these are the program participants who have “successfully” completed treatment. We selected treated sex offenders released between 1 October 2001, when the community-transition services component became operational, and 30 June 2003. The ending date was selected to permit at least a two-year period—the minimum we believed to be legitimate for this type of study—after the discharge of the most recently released sex offenders.

Based on these criteria, we had a population of 25 treated male sex offenders. Of these 25, 19 (76%) were diagnosed as pedophiles and 6 (24%) were diagnosed with other psychological disorders.

For our untreated sex offenders comparison group, we selected 25 convicted male sex offenders released from the Department of Correctional Services (Corrections) during the 1 October 2001 and 30 June 2003 time period. To match the types of diagnoses of the treated group with the types of convictions of the untreated group, we selected 19 untreated sex offenders who had been convicted of sexual assault on a child, and 6 sex offenders who had committed other types of sexual offenses. We also matched the comparison group according to the treated sex offenders’ release years and race.

Offenses

We had intended to analyze both state and nation-wide convictions but were unable to access the national data in the timeframe of this audit. Consequently, our analysis is based solely on state convictions. We included all convictions except those for traffic violations.

Results of the Section’s Recidivism Analysis

Finding: The untreated sex offenders had a higher recidivism rate for all offenses and, on average, committed more offenses, which may suggest that treatment played a role in reducing recidivism.

We first calculated the recidivism rates—or the percentage of sex offenders in each group who had convictions after their discharge from LRC or Corrections—based on convictions for all types of offenses. We found that the untreated sex offenders had a higher recidivism rate and, on average, committed more offenses, which may suggest that treatment played a role in reducing recidivism.

Of the 25 untreated sex offenders, eight (32%) had at least one conviction, and those eight individuals had a total of 31 convictions among them. Of the 25 treated offenders, five (20%) had at least one conviction, and those five individuals had a total of 12 convictions among them.

Finding: When broken down by offense, the results of the recidivism rate analysis are inconclusive.

The results are less clear when broken down into convictions for specific types of offenses. For example, we calculated the recidivism rate for each group based on violent crime (defined as sexual and non-sexual assault) convictions. We found that untreated sex offenders had a slightly higher recidivism rate for these offenses—12% compared to 8% for treated sex offenders. However the actual numbers are so small—three offenders from the untreated group compared to two in the treated group—that we should exercise caution in attributing too much meaning to them.

In addition, the only sexual assault conviction was received by a *treated* sex offender. While this conviction stands out because it runs counter to the program’s intentions, it would be unfair to assert that treatment *caused* or increased the likelihood that sex offenders would be convicted of sexual offenses. It is just as likely to be a matter of chance. We expect that if this analysis were conducted again in a few more years, there would be sexual assault convictions among the untreated sex offenders as well.

The recidivism rates based on all offenses and on assaults are shown in Table 4.1.

| Table 4.1 Recidivism Rates | | |
|-----------------------------------|-------------------------------------|---------------------------------------|
| Offense | Treated Offenders (n=25) | Untreated Offenders (n=25) |
| All offenses* | 5 (20%) | 8 (32%) |
| Sexual Assault | 1 (4%) | 0 |
| Other Assaults | 1 (4%) | 3 (12%) |
| Total Assaults | 2 (8%) | 3 (12%) |

*Excluding traffic violations

Table created by the Legislative Performance Audit Section.

All of the offenses that resulted in convictions are shown in Table 4.2.

| Table 4.2 All Convictions | | |
|---|--|--|
| Offense | Convictions Received by Treated Offenders (n=5) | Convictions Received by Untreated Offenders (n=8) |
| Assault | 1 | 8 |
| Drug Offenses (primarily possession) | 1 | 4 |
| Sexual Assault | 1 | 0 |
| Solicit Prostitution | 0 | 2 |
| Violation of Sex Offender Registration Act | 1 | 2 |
| Other Criminal Offenses* | 8 | 15 |
| Total | 12 | 31 |

* “Other criminal offenses” includes offenses such as writing bad checks and theft.

Table created by the Legislative Performance Audit Section.

Significant Offenders Excluded from Our Analysis

In addition to the 25 treated sex offenders included in this study, we identified two other sex offenders released from LRC during the time period who were excluded from our analysis but warrant discussion. First, we excluded one sex offender from our analysis who, although officially discharged from LRC, had not completed the inpatient services and community-transition services components of the program. After his discharge, the sex offender committed another sexual assault and was sentenced to a lengthy prison term. This is the sex offender discussed in Section II who, according to the program's psychiatrist, met his treatment goals and was appropriately released. In contrast, other program staff argued that this sex offender did not "complete the program" and, therefore, should not be included in the program's recidivism data.

Second, we excluded a sex offender who completed treatment and was subsequently arrested for kidnapping and other charges. He was ultimately found incompetent to stand trial and was recommitted to LRC by a mental health board.

For purposes of our formal recidivism analysis, we agree that these two sex offenders should be excluded. In the first case, the sex offender cannot fairly be said to have completed the program. In the second, the sex offender has not, in fact, been convicted of another offense. Nevertheless, the first sex offender did commit another sexual offense after receiving treatment, and the second may well have committed another offense but has not been subject to criminal proceedings due to his mental limitations. We mention these cases as further evidence of why recidivism data must be viewed with extreme caution.

Notes

¹Association for the Treatment of Sexual Abusers (<http://atsa.com/ppAssesment.html>).

²Center for Sex Offender Management, "Recidivism of Sex Offenders" (May 2001) (<http://www.csom.org/pubs/recidsexof.html>).