THE INDIANA DOC’S INSOMM PROGRAM: LESSONS LEARNED FROM 15 YEARS OF TREATING AND SUPERVISING SEX OFFENDERS

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OVERVIEW

- Take Home Messages
- History and Implementation of the INSOMM
- Maximizing Program Participation and Completion
- Recidivism Risk Assessment
- Risk Based Treatment
- Sex Offender Specific Re-Entry and Community Management
- Quality Improvement and Research
- Legal Challenges
TAKE HOME MESSAGES

- An integrated system of services is vital with this population
- Make open communication and sharing of information between service providers a priority
- Use of “best practices” and where possible “EBP’s”
- Educate of stakeholders at all levels, top to bottom
- Do not be afraid to learn from mistakes
- A quality assurance program is a necessary component of a “great” program
THE INSOMM PROGRAM - HISTORY

► Implemented in 1999 by the Indiana Department of Correction
► Under private contract with Liberty Behavioral Health since 1999
► INSOMM Program Services Include:
  ► Prison Based Sex Offender Treatment
  ► Sex Offender Specific Re-Entry Services
  ► Community Based Treatment and Monitoring
  ► Training to Multiple Stakeholders
  ► Quality Assurance/Annual Recidivism Study.
THE INSOMM PROGRAM

- Phase I – Assessment
- Phase II – Facility Based Sex Offender Specific Treatment and Re-Entry
- Phase III – Community Management and Monitoring of Paroled Sexual Offenders
- Quality Assurance and Improvement
- Training and Education
MAXIMIZING PROGRAM PARTICIPATION

- In 2006, the Indiana legislature passed statute that allows the Indiana DOC to provide consequences to those persons convicted of a sex crime that refuse to participate in sex offender treatment during incarceration.
- Allows for “Code 116” violation.
  - If found guilty, allows for the demotion in credit class, loss of gain time, and loss of visitation
- Has had a significant impact on treatment participation.
- Exceptions – “Temporary Exemption from Treatment due to Ongoing Appeal or Post Conviction Relief”.
MAXIMIZING PROGRAM PARTICIPATION

- Overall philosophy of program also impacts participation
- Where possible – program should communicate the positive impact of participation in treatment.
- Program should reinforce participation, and only utilize sanctions as a last resort.
LESSONS LEARNED

- If your jurisdiction has a clear need for these services, lobby important decision makers to make it happen.
- An integrated program that includes prison based treatment and re-entry, community treatment and supervision, quality improvement and research, and training is the most effective and efficient manner to treat and manage this population.
- Getting the legislature to pass statute that allows the DOC to consequence program refusers should be a priority.
THE INSOMM PROGRAM

Phase I – Assessment
- Static 99R Risk Assessment/JSORRAT (Juveniles)
- Stable 2010 Dynamic Risk Assessment
- Psychosexual Interview
- Polygraph Assessment
- Penile Plethysmograph (PPG)
**RISK ASSESSMENT**

- **Fact:** Not All Sex Offenders Are Equally Dangerous
- **Significant Risk Differences Exist Among Sex Offenders**
  - Sex Offenders Are A Very Heterogeneous Group.
- **Sex Offense Recidivism Risk Factors** (Hanson, 2000)

<table>
<thead>
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<th>Correlation</th>
<th>Value</th>
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<tr>
<td>Sexual Deviance -PPG</td>
<td>.32</td>
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<tr>
<td>Deviant Sexual Preference</td>
<td>.22</td>
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<tr>
<td>Prior Sexual Offenses</td>
<td>.19</td>
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<tr>
<td>Treatment Dropout</td>
<td>.17</td>
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Other Risk Factors
- Male Victims (Hanson et. al., 2003)
- Unrelated Victims (Hanson et. al., 2003)
- Victims From Multiple Age Groups
- Substance Abuse/Dependence (d=.12) (Hanson & Morton-Bourgon, 2004)
- Psychopathy (d=.29) (Hanson & Morton-Bourgon, 2004)

Factors That Appear to Mitigate Risk
- Age (over 60?) (Barbaree, et. al., 2003)
- Successful Completion of Treatment (Hanson, et. al., 2002)
RISK BASED TREATMENT

- Sex Offender Treatment Does Reduce Recidivism
- Treatment Outcome Studies
  - Several studies (for example, Marshall, et. al., 2005), and meta-analyses (for example, Hanson, et. al., 2002) have demonstrated the effectiveness of sex offender treatment in reducing recidivism.
  - Some debate exists regarding which treatment components are most responsible for the treatment effect (for example, victim empathy and denial?).
  - Research does NOT support the notion that more treatment is better (Hanson & Morton-Bourgon, 2005), and DOES support the idea that treatment should be tailored to risk level and specific treatment needs (for example, Mailloux et. al., 2003).
THE INSOMM PROGRAM

- Phase II – Risked Based Sex Offender Specific Treatment
  - Risk Based Treatment (low, moderate, high)
  - Focus on:
    - Taking Responsibility for Offenses
    - Dynamic Risk Factors for Recidivism
    - Social/Interpersonal Skill Development
    - Sex Offender Thinking Errors
    - Relapse Prevention
SEX OFFENDER TREATMENT

- **Best Practice In Sex Offender Treatment**
  - Sex Offender Specific Risk Based Treatment
    - Group Therapy
    - Good Lives Model
    - Relapse Prevention
    - Sex Offender Specific Thinking Errors
    - Arousal Management and Reconditioning
  - **Sex Offender Related Treatment**
    - Social/Interpersonal Skills Training
    - Emotional Management
    - Empathy Development
THE INSOMM PROGRAM

- Phase II – Continued
- Sex Offender Specific Re-Entry
  - Sex Offender Registration Education
  - Parole Stipulation Education
  - Placement and Housing
  - GPS Risk Assessment
LESSONS LEARNED

- For key program positions, hire experienced clinicians that know how to develop programing, and that can motivate and manage people competently
- Use assessment to guide treatment programming
- Use best practices, and where possible EBP’s.
- Sex offender specific re-entry is vital
THE INSOMM PROGRAM

► Phase III – Community Management and Monitoring
► Containment Model
  ► Parole Agent
  ► District Re-Entry and Resource Coordinators
  ► INSOMM Program Network Treatment Providers
    ► Credentialing and Auditing
  ► INSOMM Program Network Polygraph Examiners
    ► Credentialing and Auditing
COMMUNITY SUPERVISION

- Community Treatment and Supervision Should Be Based on an Assessment of:
  - Offender Risk – Dynamic risk factors should be assessed every 6 months to 1 year.
  - Offender Need
  - Offender Responsiveness to Interventions and Supervision
COMMUNITY SUPERVISION

- Best Practice in Community Sex Offender Management
  - Risk based supervision
  - Polygraph examination
  - No evidence to support the effectiveness of residency restrictions
  - GPS – Research is ongoing
LESSONS LEARNED

- Risk based supervision
- Parole/probation usually cannot manage the supervision process on their own, and need managers/coordinators to assist
- Develop a network of credentialed providers
- Develop a team (containment model)
- Communication among team
QUALITY IMPROVEMENT AND RESEARCH

- Monthly, Quarterly, and Annual Utilization Data
- Annual Recidivism Study
- Internal Audits of Program Deliverables and Scope of Services
- Auditing of Credentialed Community Treatment Providers and Polygraph Examiners
- Annual Satisfaction Surveys
Three-Year Recidivism Data for IDOC Sex Offenders Released in 2009 to Parole

- Any Conviction: 15.59%
- Non-Sex Crime Conviction: 14.83%
- Sex Crime Conviction: 0.76%
Aggregate Recidivism Data for INSOMM Program Parolees
Released Between 10-01-99 thru 12-31-12

Percent of INSOMM Program Parolees With a New Conviction

- Any Conviction: 27.71%
- Non-Sex Crime Conviction: 15.82%
- Sex Crime Conviction: 4.01%
- Failure to Register Conviction: 13.41%
LESSONS LEARNED

► Must regularly assess the scope of the program, the manner of delivering services, and program utilization (performance indicators)
► Must look at program outcomes such as recidivism rates
► Recidivism research should include both aggregate and within 3 years of release
► Audit and maintain strong working relationships with community providers
LEGAL CHALLENGES

- Mandatory treatment within the DOC
- Treatment requirement that offender takes responsibility for sexual offenses
- Visitation with children in the community
- Parole stipulations
LESSONS LEARNED

- Work with and educate DOC counsel and AG’s office
- Hold your ground on the big issues and update/make changes on the small issues that improve program specificity
- Train staff to know and follow policies and procedures
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REFERENCES


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