STATE OF NEW HAMPSHIRE
DEPARTMENT OF CORRECTIONS
SEXUAL OFFENDER TREATMENT PROGRAM

PERFORMANCE AUDIT REPORT
NOVEMBER 2016

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To The Fiscal Committee Of The General Court:

We conducted a performance audit of the Sexual Offender Treatment program to address the recommendation made to you by the joint Legislative Performance Audit and Oversight Committee. We conducted this audit in accordance with generally accepted government auditing standards. Those standards require we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions. The evidence we obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

The purpose of the audit was to determine whether the Department of Corrections efficiently and effectively provided sexual offender treatment to inmates during State fiscal years 2014 to 2016.

Office of Legislative Budget Assistant

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November 2016

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ABBREVIATIONS AND GLOSSARY OF TERMS

AMHCA	American Mental Health Counselors Association
ARC	Administrative Review Committee
ATSA	Association For The Treatment Of Sexual Abusers
Board	Adult Parole Board
DMFS	Division Of Medical And Forensic Services
DOC	Department Of Corrections
ISOT	Intensive Sexual Offender Treatment
ITP	Individual Treatment Plan
GAO	Government Accountability Office
Minimum	Minimum Parole Date
Mittimus	Court-Issued Sentencing Document To Commit Someone To Imprisonment
NASW	National Association Of Social Workers
NHSP/M	New Hampshire State Prison For Men
R&D	Reception And Diagnostic
SFY	State Fiscal Year
SOT	Sexual Offender Treatment
SOTIPS	Sex Offender Treatment Intervention And Progress Scale
VASOR-2	Vermont Assessment Of Sex Offender Risk

STATE OF NEW HAMPSHIRE
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EXECUTIVE SUMMARY

During State fiscal years (SFY) 2014 to 2016, the Sexual Offender Treatment (SOT) program showed improvement in both assessing and enrolling male sexual offenders for services in a timely manner. We found the SOT program improved the timeliness of assessments considerably, with almost 70 percent of sexual offenders with minimum parole dates (minimum) in SFY 2014 and beyond assessed at least 24 months before their minimum. In SFY 2016, the program assessed 88 percent of inmates timely. This was a vast improvement compared to the three fiscal years prior to the audit period, where only 16 percent of sexual offenders were assessed timely. The increase in sexual offenders enrolled into the Intensive Sexual Offender Treatment (ISOT) program was not as significant, though some improvement was noted in offenders being enrolled at least 18 months prior to their minimum during the audit period. While less than half of all sexual offenders recommended for ISOT during the audit period were enrolled at least 18 months prior to their minimum, factors beyond the control of the SOT program such as refusal of treatment by offenders, and disciplinary issues preventing ISOT participation accounted for almost half of these enrollment delays.

Enrollment delays and inmate-caused setbacks experienced while in the program, affected an inmate's likelihood of being released on their minimum. In fact, of 83 sexual offenders in our review who had reached their minimum, only 12 (14 percent) were released timely during the audit period. While enrollment delays could have had an effect on an inmate's ability to be released timely, we found a large portion was also due to delays caused by the inmate himself. During the audit period, three-quarters of sexual offenders missed their minimum due to actions beyond the control of the SOT program including: initially refusing treatment; disciplinary action before enrollment, which caused them to start ISOT late; being removed from ISOT for disciplinary issues or non-participation; failing the polygraph examination; and not having an adequate post-release housing plan.

Our audit did not opine on whether it was in the public interest to release sexual offenders on or prior to their minimum as allowable by State law. However, we found the program's timing did not allow sexual offenders to utilize all statutory opportunities available for reducing their minimum sentence. These opportunities were also available to other inmates in the New Hampshire State prison system during the audit period. Additionally, we found the timing of the SOT program may not allow adequate time for sexual offenders to finish ISOT, complete the parole planning process (including finding adequate housing), and request a parole hearing prior to their minimum. While it is too early to definitively conclude whether the SOT program's efforts in assessing and enrolling sexual offenders had an effect on the number of those being released timely, these efforts should theoretically help to increase the number of sexual offenders eligible for timely release in the future. As Adult Parole Board (Board) members indicated, since the beginning of 2016, there were some signs of improvement as fewer sexual offenders were appearing before the Board past their minimum. As part of an ongoing monitoring and performance measurement system, the SOT program should monitor its progress towards the goal of treating offenders timely so they have the opportunity to be paroled on their minimum.

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RECOMMENDATION SUMMARY

Observation Number	Page	Legislative Action Required?	Recommendations	Agency Response
1	18	No	Re-evaluate whether there is sufficient time to complete the Intensive Sexual Offender Treatment (ISOT) program and the remainder of the parole planning process if inmates are enrolled 18 months before their minimum. Develop policies and procedures for prioritizing sexual offenders serving short minimum sentences.	Concur
2	20	No	Codify new prioritization policies and procedures to allow sexual offenders to take advantage of available sentence reduction opportunities.	Concur
3	22	No	Work with case managers to relay information about offenders close to being discharged from ISOT.	Concur
4	26	No	Codify the Administrative Review Committee and develop policies and procedures outlining its role, responsibilities, scope of authority, and practices in the sexual offender treatment process.	Concur
5	27	No	Formally develop policies regarding outside employment of therapeutic staff and establish a process to help staff determine whether an actual or perceived conflict of interest may exist.	Concur
6	30	No	Develop goals and objectives linked to program mission, performance measures with benchmarks, policies to compare actual performance against established measures, and a system to share performance data.	Concur

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BACKGROUND

Sexual Offender Treatment (SOT) services were provided through the Department of Corrections (DOC) Division of Medical and Forensic Services (DMFS). According to the SOT program's mission statement, it strives to "provide comprehensive, ethical, and evidence based assessment, management and treatment to incarcerated offenders in a multi-disciplinary, clinically focused setting aimed at providing rehabilitative opportunities to offenders while protecting the public and reducing recidivism." DOC policy required it to "provide all sexual offenders with access to appropriate sexual offender treatment services" based on their clinical needs, to "eliminate sexual victimization through responsible and ethical treatment of incarcerated offenders." While policies did not specify a timeframe for treating male sexual offenders, DOC personnel generally conducted a risk and needs assessment within two years of an inmate's minimum parole date (minimum) and enrolled them into the program within 18 months of their minimum. Due to the timing of services and other factors, sexual offenders sentenced to long terms of incarceration potentially remained in prison several years before receiving an initial SOT assessment, while those sentenced to shorter terms or re-incarcerated due to parole violations were likely assessed and enrolled sooner.

A contractor provided female offenders individualized treatment at the New Hampshire Correctional Facility for Women, while DOC personnel provided treatment for male offenders at the New Hampshire State Prison for Men (NHSP/M) in Concord. Inmates residing in the Northern New Hampshire Correctional Facility in Berlin were moved to the NHSP/M for Intensive Sexual Offender Treatment (ISOT) services. Due to the fact that less than one percent of sexual offenders were female, our audit focused on activities related to the SOT program offered at the NHSP/M.

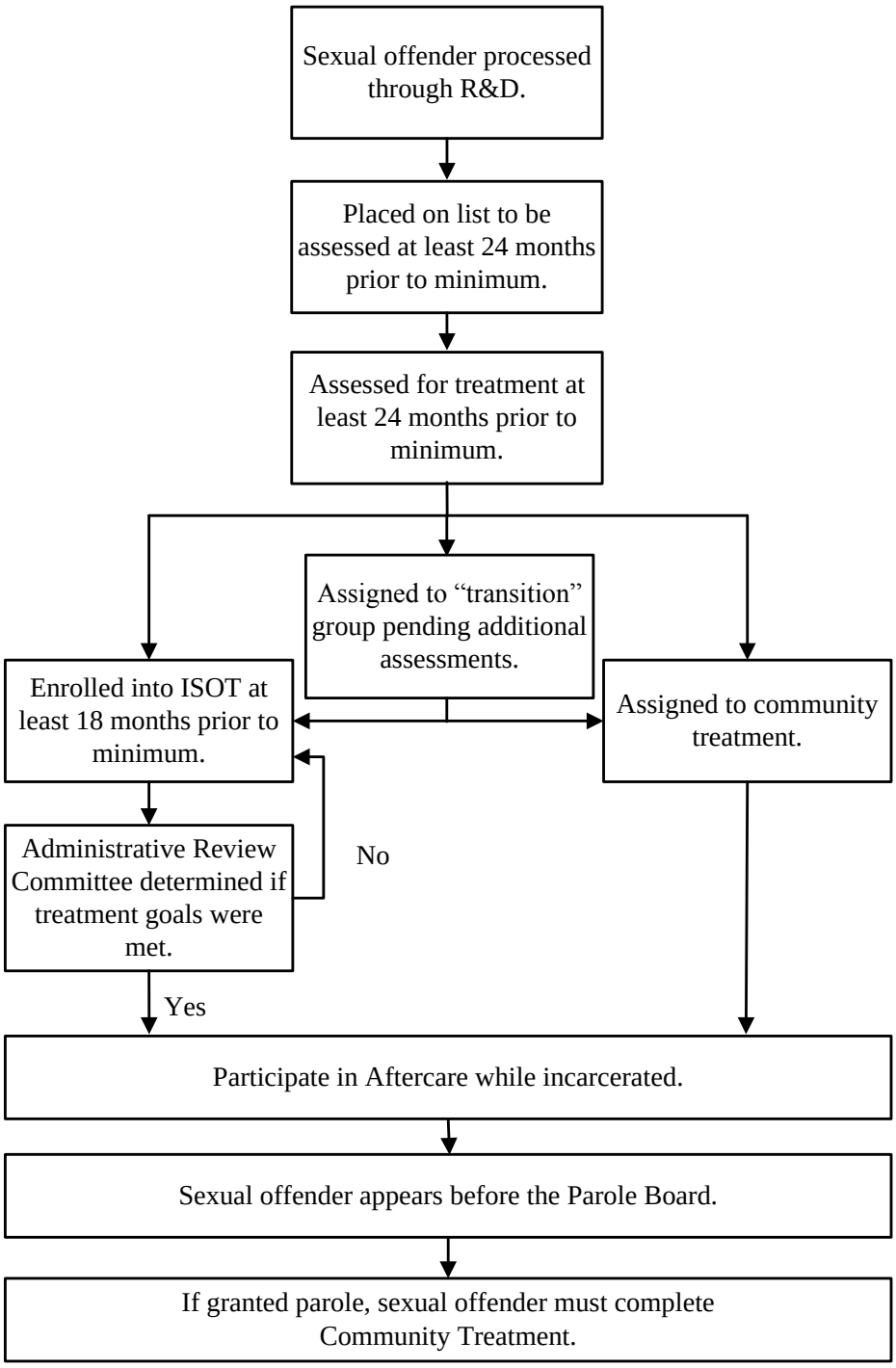
Male Sexual Offender Treatment Process

Like other inmates, sexual offenders entering prison either as first time offenders or as parole violators were processed through the NHSP/M's Reception and Diagnostic (R&D) Unit, where they were assessed for overall risk, appropriate housing placement, and needed services. Those convicted of a sexual-based crime or committing an offense with sexual overtones, were flagged for SOT assessment and placed on a list with other sexual offenders requiring assessment for treatment. They were prioritized for an initial assessment based on the date of their minimum. As inmates approached two years of their minimum, SOT staff assessed them for the types and level of services to address their treatment needs. Based on their risk factors and other treatment needs, offenders were placed into one of two treatment models: ISOT, which was offered in a therapeutic community setting within the NHSP/M, or community treatment. Offenders whose needs were more difficult to determine were placed in a transition group for further assessment. Parole violators, who generally returned to prison for shorter sentences, had to be triaged for assessment as soon as possible due to their impending release dates, which could have affected when other inmates would be assessed. Based on their violation and the outcome of their assessment, violators could be placed in a program specifically for parole violators, which aimed to help them maintain techniques previously taught. If their violations were indicative of risky

behavior based on their previous offense, they may be required to repeat ISOT. Depending on the circumstances, some parole violators reached their maximum sentence date before completing the program. Figure 1 illustrates the male sexual offender treatment process for first time sexual offenders.

Figure 1

Male Sexual Offender Treatment Process



Source: LBA analysis of DOC information.

Assessment

As a male sexual offender approached two years of his minimum, he was scheduled for a comprehensive assessment with an SOT clinician to determine recidivism risk level, medical and psychiatric needs, substance abuse or chemical dependency issues, and other criminal risk factors. The clinician employed a combination of assessment tools to determine each inmate's risk for sexual recidivism, with the tools used being dependent on the type of offense committed. Those committing a physical offense (i.e., sexual assault, felonious sexual assault, and aggravated felonious sexual assault), generally received the following assessments:

- *Static-99R*: evaluates recidivism risk based on static or unchangeable factors such as age, prior number of charges, and past convictions;
- *Vermont Assessment of Sex Offender Risk (VASOR-2)*: addresses re-offense risk, offense history, treatment history, abnormal sexual tendencies, and the use of violence;
- *Sexual Offender Treatment Intervention and Progress Scale (SOTIPS)*: evaluates behaviors which are amenable to change and the treatment progress of sexual offenders; and
- *ABEL Assessment for Sexual Interest*: a tool used to evaluate the pedophilic interests of male offenders, if needed.

According to the VASOR-2 manual, the assessment "is designed for use with adult males who have been convicted of one or more qualifying sex offenses" including physical offenses and non-contact offenses such as exhibitionism, voyeurism, and internet luring. However, SOT staff reported no risk assessments existed for perpetrators of non-physical sexual offenses (i.e., exhibitionism, voyeurism, or possessing child pornography). Therefore, SOT staff did not assess offenders committing these offenses using VASOR-2 or Static-99R. For this population, SOTIPS was consistently used and ABEL was used as necessary. All sexual offenders, regardless their offense, also received a staff-created psychosexual assessment which included general questions about the inmate's background, family dynamics, sexual history, current offense, and other pertinent areas. Results of these assessment tools were used to determine whether an offender would be placed in community treatment or the ISOT program.

Community Treatment

Sexual offenders assessed as presenting a low, and some presenting a moderate, risk of re-offending, who met other criteria, were generally placed in community treatment. Offenders placed in community treatment were required to attend bi-weekly or monthly group therapy aftercare sessions depending on their treatment needs, and upon release from prison, were required to obtain treatment through DOC-approved therapists outside of the prison at their own expense.

Offenders placed in community treatment were usually first-time sexual offenders with no prior criminal history, had short minimum sentences, and had not had multiple disciplinary reports while in prison. They must not have been court-ordered to complete a sexual offender treatment program while in prison, and their offenses must not have included penetration of any type. Finally, offenders had to have a strong outside community support system, and access to a sexual offender treatment provider.

ISOT In The Therapeutic Community

Offenders not meeting the community treatment criteria, or those assessed as presenting moderate to high risk of re-offending, were placed in the ISOT program. This included those who: were convicted of a prior sexual offense, had a moderate to extensive criminal history, were previously enrolled in ISOT, or used force to commit sexual assault. Offenders minimizing their offenses, those with poor social skills or emotional issues, or those with strongly ingrained cognitive distortions were also placed in ISOT. These offenders participated in a therapeutic community and followed a self-paced curriculum, which we estimated typically took 12 months to complete. The program consisted of the following components:

- *Orientation and Readiness* prepared inmates for the SOT community by introducing them to program expectations and familiarizing them with the intensive treatment process. This included enhancing social, communication, self-help, and emotional regulation skills; creating treatment goals; and introducing group therapy concepts. Clinicians developed a diagnosis and treatment plan, as well as assessed inmate cognitive abilities. Inmates had to demonstrate their understanding of the treatment process and exhibit motivation to continue to the next phase.
- *Core and Cycle*, the primary ISOT treatment stage, consisted of group therapy sessions several times weekly. It was task-based, allowing inmates to internalize principles at their own pace and could last several months to over a year. Progress was measured in terms of completion of treatment goals and maintenance of therapeutic gains, not the length of time in the program. Inmates learned to identify irrational beliefs and cognitive distortions fueling their behavior, identify boundaries, accept responsibility for their behavior, develop alternative coping strategies, and control deviant fantasies and arousal. They also learned to identify triggers and high-risk situations which could lead to negative behavior, as well as how to pre-emptively avoid occurrences through proactive decision-making. ISOT participants had to pass a polygraph exam during this phase of treatment to move on to the next phase.
- *Maintenance* focused on helping inmates develop relapse prevention plans and required inmates to create a contract summarizing their offending cycle, outline risk factors which may lead them to re-offend, and identify a support system for when they were released from prison.

  Before being discharged from ISOT, an inmate's case was brought before the Administrative Review Committee (ARC), which performed an external review to ensure treatment goals were satisfactorily met. The ARC consisted of seven behavioral health clinicians, one of whom worked in the SOT program. Inmates remained in the therapeutic community while awaiting the ARC's review, continuing to attend group sessions. If the ARC determined treatment goals were met, it recommended outside treatment options to the Adult Parole Board. However, if the ARC determined goals had not been met, it may recommend the inmate remain in ISOT.

After completing ISOT, offenders were placed in aftercare, which allowed inmates additional opportunities to practice skills acquired during treatment through weekly or monthly group sessions until their release from prison. If treatment goals were not maintained, or inmates

showed signs of sexual inappropriateness, they could be returned to ISOT for additional services. Once released from prison, inmates were required to obtain aftercare through DOC-approved providers in the community.

Offenders not making sufficient progress, or exhibiting behavior problems were encouraged to make changes. However, if behaviors did not improve, or the offender remained uncooperative, he was referred to the ARC for recommendations, which may include termination from the program. Recommendations for program termination required approval by the DMFS Deputy Director. Additionally, security staff may remove an offender from the program for substantiated security reasons. Offenders may also be removed from ISOT for certain violations including participating in a sexual act involving or witnessed by others; being physically aggressive, assaultive, or threatening; using, soliciting, or selling drugs or alcohol; not adhering to the treatment contract; exhibiting behaviors that were determined to be dangerous to himself or other inmates; being abusive towards the staff; being disruptive; or receiving the most severe level disciplinary report. Offenders wishing to return to the ISOT community had to submit a request to the SOT Administrator and follow all ARC recommendations.

Male Sexual Offender Population

Unaudited data provided by the DOC indicated 751 male sexual offenders were housed in the prison system on May 31, 2016, with 303 offenders within 24 months of, or already exceeding, their minimum. Another 448 sexual offenders were not within two years of their minimum. Table 1 shows the 303 male sexual offenders within 24 months of or exceeding their minimum, including those enrolled in ISOT and community treatment, those who declined treatment, and sexual offenders awaiting assessment.

Table 1

Male Sexual Offenders Within 24 Months Of, Or Exceeding, Their Minimum Parole Date; As Of May 31, 2016

	Number	Percent[1]
Intensive Sexual Offender Treatment		
Enrolled	113	
Completed Successfully	12	
Removed from Program[2]	17	
Other[3]	34	
ISOT Subtotal	***176***	***58***
Community Treatment	***40***	***13***
Declined Treatment	***37***	***12***
No Treatment Needed	***28***	***9***
Not Yet Assessed	***22***	***7***
Total	**303**	

Notes:

[1] Total does not equal 100 percent due to rounding.

[2] Reasons for removal included disciplinary issues, non-participation, medical, or voluntary withdrawal from the program.

[3] "Other" included inmates who participated in, but were no longer enrolled, or no additional information was available in the electronic file.

Source: LBA analysis of unaudited DOC data.

Program Staffing

Program staff conducted assessments of all inmates identified as sexual offenders, provided aftercare services, and delivered the ISOT program to offenders housed in the NHSP/M. Offenders assigned to ISOT were housed in a community treatment unit consisting of 12 rooms, each with eight beds, allowing 96 sexual offenders to participate in ISOT at any given time. Treatment while participating in the ISOT program took place primarily through group sessions conducted in staff offices or a hallway close to where participants were housed. During the audit period, there were no dedicated rooms or space to hold group sessions. Treatment groups occurred five days per week, with staff members operating four treatment groups a day.

The SOT program had five full-time authorized positions: one Program Administrator, one Senior Psychiatric Social Worker, one Psychiatric Social Worker, and two Clinical Mental Health Counselors. Since February 2015, one position in the Medical Records Unit provided some administrative support by scheduling assessment appointments for sexual offenders, recording results, and scanning documents into the DOC's file management system. However, this position was not dedicated full time to the SOT program and was also required to fulfill other duties external of the program. Prior to February 2015, the SOT program did not have any administrative support. At the end of June 2016, one Clinical Mental Health Counselor and the

Senior Psychiatric Social Worker positions, clinical positions which provided group treatment to sexual offenders, were vacant.

During the 36 month audit period, the program was fully staffed for 16 months; less than half of the time. Table 2 breaks down staffing patterns by State fiscal year (SFY) and shows the program was fully staffed for most of SFY 2014. However, it experienced turnover in key positions starting in SFY 2015, including the Program Administrator leaving in fall 2015. During the Program Administrator's absence, one staff member served as the Acting Administrator while also conducting ISOT group sessions. Despite staffing challenges during the audit period, the SOT program improved the timeliness of assessments and showed some improvement in enrolling sexual offenders into ISOT. This was partially due to a lag when assessing and enrolling inmates for the ISOT program. For example, the SOT program assessed 88 percent of inmates with minimums in SFY 2016 at least 24 months prior to their minimum. However, these assessments would have been conducted in SFY 2014 when the program was mostly fully staffed. Lower SOT program staffing levels experienced during SFY 2016 may result in a decline of inmates with minimums in SFYs 2018 and later who are assessed and enrolled timely.

Table 2

Sexual Offender Treatment Program Staffing Level, By SFY

	Percent Of Months At Each Staffing Level		
Number Of Staff Positions Filled	**2014**	**2015**	**2016**
Five (fully staffed)	67%	33%	33%
Four	33%	67%	33%
Three	0%	0%	33%

Source: LBA analysis of SOT staffing levels.

Female Sexual Offender Treatment

According to DOC policy, a woman convicted of sexually-related charges was required to be assessed for treatment two years prior to her minimum. Unlike the male offender population, there were no tools for assessing recidivism risk; therefore, treatment was based on an individualized treatment plan addressing each offender's specific needs. Treatment addressed key components of a woman's offending cycle, accountability, responsibility, identifying and challenging distorted thinking, improving coping and emotional management skills, and maintaining supportive and equitable intimate relationships. At the end of treatment, women were administered a polygraph exam and, similar to male sexual offenders, were reviewed by the ARC to determine whether all treatment goals had been met.

Two contracted behavioral health clinicians who were certified forensic counselors provided female SOT and behavioral health services. According to DOC management and staff serving female sexual offenders, very few female inmates required sexual offender treatment services while in prison, as this population usually did not commit violent sexual offenses and had different treatment needs.

Data Systems And Data Limitations

During the audit period, the DOC used four systems to capture SOT program data:

- *CORIS*, an electronic offender management system, was used to track inmates as they moved through the correctional system. CORIS contained the offender's personal information, prior offense history, current offense, sentence, classification, disciplinary record, housing assignment, and other items. SOT staff utilized CORIS to gain additional information about the inmate's offense and sentence, as well as enter notes regarding treatment and information on completed sexual offender assessments.
- *CHOICES* was software used by all DMFS clinical staff to track medical and mental health records. SOT staff entered clinical notes and looked up offender mental health and medical records using CHOICES. CHOICES also contained discharge summaries outlining outcomes of mental health programs the offender participated in, including ISOT.
- *FileHold*, an electronic document management system, provided SOT staff access to offender records including medical, mental health, sentencing, and legal documents which had been scanned into the DOC's databases since November 2015.
- *SOT Compliance List* was used by SOT staff to track the status of sexual offenders in the correctional system. The list was updated daily using information automatically generated from CORIS. However, according to SOT staff and DOC management, during the earlier parts of the audit period, this list was not always up-to-date as the staff member responsible for entering other information into the *Compliance List* was often pulled to perform other tasks.

We decided to access information from CORIS, CHOICES, and FileHold to collect data on sexual offenders. However, we encountered some limitations due to the availability of electronic documents in FileHold. According to SOT staff, older paper files were still being scanned into FileHold. Due to time limitations and the volume of paper files we would need to review, we chose not to review the paper files. As a result, we were unable to collect some information needed for our review of offender files including: copies of some assessments (that contained the assessment date), sentencing documents, and discharge documents. In the absence of the dates on the physical document, we collected dates for these events if we found them referenced in other documents. For example, if FileHold did not contain a copy of an inmate's assessment, but the discharge summary referenced an assessment date, we recorded the date found in the discharge summary. If we could not determine an actual date, we recorded this data as missing.

Missing data impacted some analysis in this report. If data elements needed to conduct a particular analysis were missing, we excluded that inmate's data from that specific analysis. For example, some files may have contained the date an assessment was conducted and the date the offender completed ISOT, but not the date the offender was enrolled into ISOT. We used this inmate's data to calculate compliance with the assessment goal. However, we excluded this inmate's data from analyses of program duration and whether the inmate was enrolled into ISOT timely.

TIMELY ASSESSMENT, ENROLLMENT, AND RELEASE

Were male sexual offenders assessed and enrolled in a timeframe that promoted program completion prior to their minimum released dates? If not, what factors may have prevented sexual offenders from completing the program prior to their minimum and where can backlogs and delays occur?

For most sexual offenders, Sexual Offender Treatment (SOT) was the last program they needed to complete before being considered for parole. According to Department of Corrections (DOC) and SOT management, the program was offered near the end of an inmate's incarceration to increase the likelihood principles learned during treatment would be retained upon release. DOC policies did not specify a timeframe for treating male sexual offenders. However, SOT staff generally aimed to conduct a risk and needs assessment at least 24 months prior to an inmate's minimum parole date (minimum) and aimed to enroll those requiring the Intensive Sexual Offender Treatment (ISOT) program at least 18 months prior to their minimum.

We found the SOT program improved the timeliness of assessments considerably during the audit period and showed some improvement in enrolling sexual offenders into ISOT timely, increasing the chance sexual offenders may be released at their minimum. We found almost 70 percent of inmates with minimums in State fiscal years (SFY) 2014 to 2016 were assessed at least 24 months prior to their minimum. In contrast, only 16 percent of those with minimums in SFYs 2011 to 2013 were assessed at least 24 months prior to their minimum. To further improve the opportunity for sexual offenders to be released on their minimum, the DOC and SOT management could better coordinate with the inmate's case manager to start the parole planning process earlier. They could also re-examine the timing of program enrollment to accommodate offenders who may need more time to complete the program, while still allowing sufficient time to complete the parole planning process. Additionally, the timing of the program itself may prevent sexual offenders from utilizing available opportunities to further reduce their minimum sentence, which could in turn help reduce prison overcrowding and save the State money. According to the DOC's Director of Administration, the annual marginal cost (i.e., the annual cost of adding one additional inmate) of a general population inmate during SFY 2016 was $5,006 per inmate, or $13.72 per day.

Timely Assessment

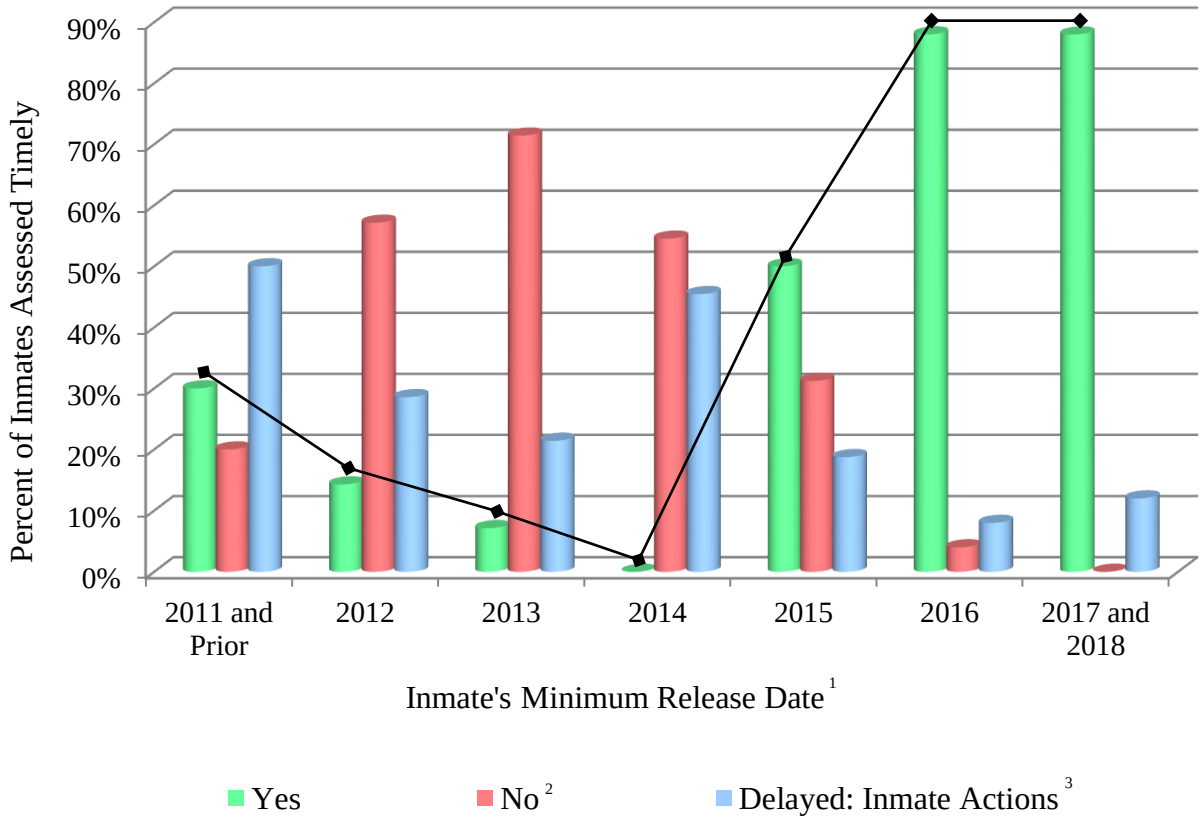
The SOT program improved the timeliness of assessments during the audit period. For sexual offenders with minimums in SFY 2015, the SOT program assessed 50 percent (eight of 16 in our sample) at least 24 months prior to their minimum (i.e., in SFY 2013). Eighty-eight percent of sexual offenders with minimums in SFY 2016 (22 of 25 in our sample) were assessed at least 24 months prior to their minimum (i.e., in SFY 2014), and an additional 88 percent with minimums in SFYs 2017 and 2018 (22 of 25 in our sample) were assessed timely (i.e., in SFY 2015 and 2016). As shown in Figure 2, this is a considerable improvement compared to none of the 11 inmates in our sample with minimums in SFY 2014 who were assessed timely.

While the SOT program had some issues timely assessing sexual offenders with minimums prior to SFY 2015, factors beyond the control of the SOT program also contributed to untimely

assessment. For example, for sexual offenders with minimums in SFY 2014, four refused to be assessed; however, two later requested to be treated, causing a delay in assessing them timely.

Figure 2

Percent Of Sexual Offenders Assessed Timely, By SFY Of Inmate's Minimum



Notes:

[1] Inmates needed to be assessed at least two years prior to their minimum. For example, inmates with minimums in SFY 2015 needed to be assessed in SFY 2013 to be considered timely.

[2] Within the control of the SOT program, but not assessed timely.

[3] Not assessed timely because inmate actions, such as refusing treatment or disciplinary issues prior to being assessed, caused delays.

Source: LBA analysis of a sample of sexual offender files.

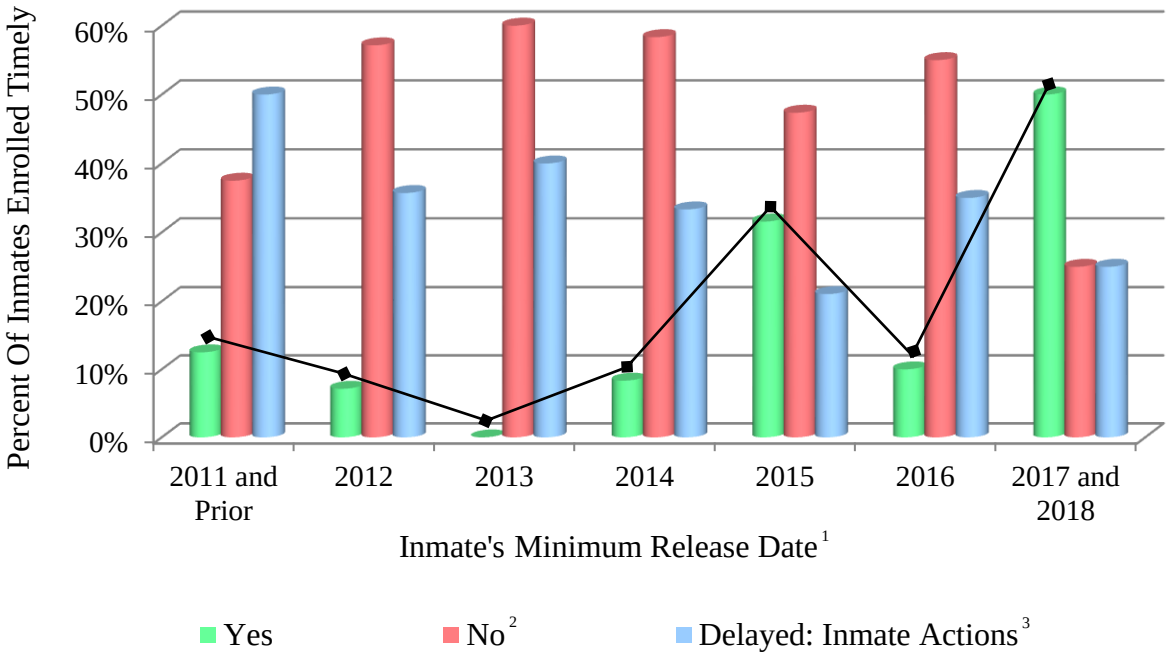
Timely Enrollment

We saw some improvement in the percent of sexual offenders who were enrolled into ISOT at least 18 months prior to their minimum during the audit period. However, the improvement was not as significant as for assessment. Fifty percent or fewer of sexual offenders who were recommended for ISOT in each fiscal year were enrolled at least 18 months prior to their minimum. As shown in Figure 3, we found enrollment trends were similar to those of

assessments, with improvement noted in enrolling sexual offenders with minimums in 2015 and beyond. Despite a decline in the percent of sexual offenders enrolled timely in SFY 2016, the percentage rebounded from ten percent of offenders being enrolled timely in SFY 2016 to 50 percent for those with minimums in SFYs 2017 and 2018, indicating these inmates may have a better chance at being released at their minimum.

Figure 3

Percent Of Sexual Offenders Enrolled Timely, By SFY Of Inmate's Minimum



Notes:

[1] Inmates needed to be enrolled into ISOT at least 18 months prior to their minimum. For example, inmates with minimums in SFY 2015 needed to be enrolled between SFYs 2013 and 2014 to be considered timely.

[2] Within the control of the SOT program, but not enrolled into ISOT timely.

[3] Not enrolled into ISOT timely because inmate actions, such as refusing treatment or disciplinary issues prior to being enrolled, caused delays.

Source: LBA analysis of a sample of sexual offender files.

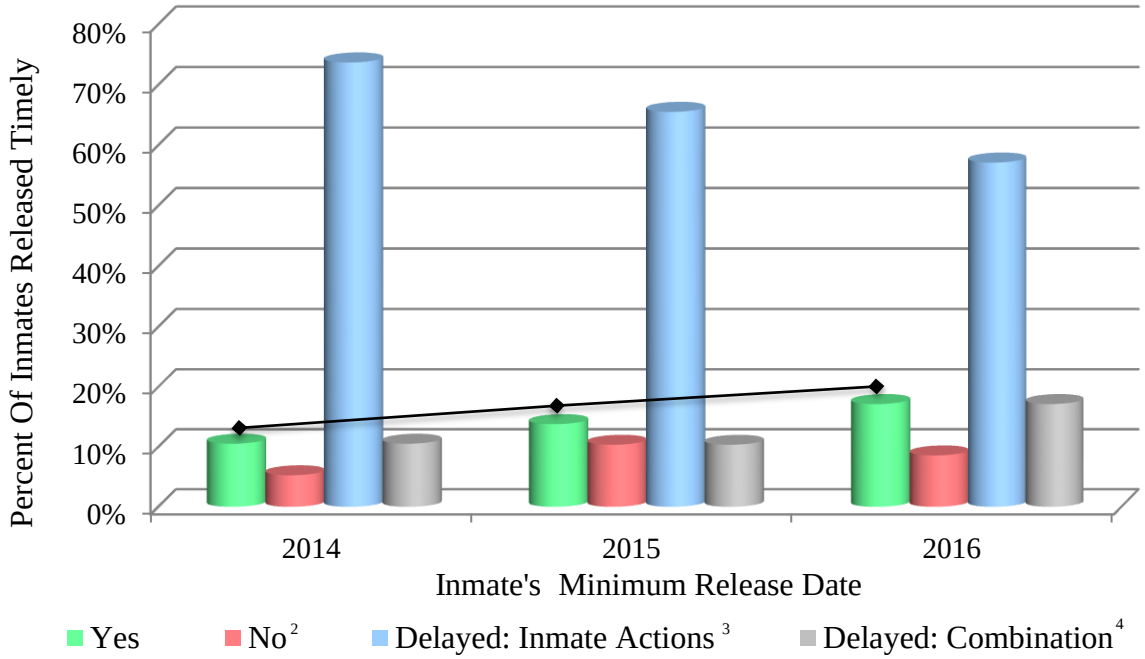
Factors beyond the control of SOT staff continued to be an issue in enrolling sexual offenders into ISOT. Twenty-one percent with minimums in SFYs 2015 (four of 19 in our sample), 35 percent with minimums in 2016 (seven of 20 in our sample), and 25 percent with minimums in 2017 and 2018 (six of 24 in our sample) refused to be treated, had disciplinary issues preventing them from being enrolled timely, or other self-imposed reasons for delays. Of these sexual offenders who were not enrolled into ISOT timely, we found, on average, they were enrolled almost 23 months late. In other words, they were not enrolled into ISOT until, on average, five months after their minimum had passed.

Timely Release

Any delay in the assessment or enrollment phases, and delays experienced while in the program itself, could affect an inmate's chances of being released on their minimum. We found the majority of inmates in our sample were not released by their minimum. Of 151 sexual offenders who reached their minimum, only 13 were released timely. Figure 4 shows release information for sexual offenders with minimums in SFY 2014 and later. According to Adult Parole Board (Board) members, in the past, most sexual offenders were in prison past their minimum; however, since the beginning of 2016, there had been fewer sexual offenders appearing before the Board past their minimum.

Figure 4

Percent Of Sexual Offenders Released On Their Minimum, By SFY Of Inmate's Minimum [1]



Notes:

[1] Twenty cases where the inmate's minimum was less than 18 months were excluded from analysis.

[2] Not released at minimum solely due to the program enrolling the inmate late.

[3] Not released at minimum due to inmate's actions including: delayed enrollment due to initially refusing to be treated, disciplinary issues preventing timely enrollment, removal from the program, or issues finding adequate housing.

[4] Not released at minimum due to inmate's actions combined with the program enrolling the inmate late.

Source: LBA analysis of a sample of sexual offender files.

Of sexual offenders who were not released on their minimum, we found a large percentage was attributed to delays caused by the inmate himself. As shown in Figure 4, at least half of sexual offenders not released on their minimum each year missed their minimum because of factors beyond the control of the SOT program. Table 3 shows some of the reasons sexual offenders in our sample were delayed, affecting their chance of being released on their minimum during SFYs 2014 to 2016. Some sexual offenders may have been delayed by a combination of these factors. For example, some sexual offenders may have initially refused to be treated, were removed several times for disciplinary or other issues, and failed the polygraph multiple times. Table 3 shows the main reasons affecting sexual offenders' chances of being released by their minimum.

Table 3

Inmates Actions Affecting Release At Their Minimum, SFYs 2014 To 2016

Reasons For Delay	SFY Of Inmate's Minimum			
	2014	2015	2016	Total
Failed Polygraph	4	4	9	**17**
Removal - Disciplinary Issues	5	6	2	**13**
Late Enrollment - Inmate Initially Refused Treatment	4	3	3	**10**
Housing Issues	1	3	4	**8**
Removal - Other[1]	0	4	1	**5**
Late Enrollment - Disciplinary Issues Prior To Enrollment	0	0	4	**4**
Refused To Be Treated – Never Enrolled Into ISOT	2	2	0	**4**
Removal - Lack of Progression/Non-Participation	0	2	0	**2**
Voluntarily Serving Out Their Maximum Sentence	0	3	0	**3**
Other Reasons[2]	5	7	13	**25**

Notes:

[1] "Removal - Other" includes inmates removed for medical, mental health, or personal reasons; or by court order.

[2] "Other Reasons" includes: inmates serving a sentence of less than one year, non-participation in aftercare, additional requirements ordered by the Board, legal disputes over deportation status, or for unknown reasons.

Source: LBA analysis of a sample of sexual offender files.

Observation No. 1

Re-Evaluate The Timing Of Intensive Sexual Offender Treatment Program Enrollment

The timing of the ISOT program enrollment may not be sufficient to allow sexual offenders who encounter setbacks during treatment, are enrolled late, or who have short minimum sentences to complete the program prior to their minimum. ISOT, a self-paced program, was typically the last program sexual offenders needed to complete in prison prior to being considered for parole. However, after completing ISOT, most inmates still had to develop a parole plan and request a parole hearing, which according to a DOC case manager, on average, takes approximately two months. The timing of ISOT may not allow the maximum number of inmates to meet the 18-month timeframe, potentially causing them to overstay their minimum and costing the State additional funds.

Sexual Offenders Experiencing Setbacks

In our review of 243 sexual offender files, we found 90 had completed ISOT at the time of our review. The remaining did not complete, were not enrolled in, or were still in the process of completing ISOT. The 90 sexual offenders completing ISOT generally finished the program in 12 months. However, we found 23 of the 90 sexual offenders who completed ISOT (26 percent) were removed from the program at least once while 25 inmates (28 percent) failed the polygraph exam at least once, causing delays amounting to several months beyond the average for all participants. Sexual offenders who were removed from the program at least once generally completed ISOT in 21.5 months, while those who failed a polygraph exam at least once finished ISOT in 14.7 months.

Based on these averages and the additional time needed for parole planning, an inmate enrolled in ISOT exactly 18 months prior to his minimum and removed from the program would miss his minimum by 5.5 months, or 165 days.

Sexual Offenders Enrolled Late

Costs could increase if inmates were not enrolled into ISOT timely to begin with. While we found the SOT program was showing improvement in enrolling inmates into ISOT timely, we found six of 24 inmates (25 percent) with minimums in SFY 2017 and 2018 were not enrolled into ISOT at least 18 months prior to their minimum with no documented reasons for the enrollment delay. Five of these inmates were enrolled five months or more after the goal. Factors beyond the program's control also prevented some inmates from starting the program 18 months prior to their minimum. For instance, of 151 inmates requiring ISOT, we found 41 were not enrolled at least 18 months prior to their minimum due to disciplinary issues or initially refusing to be treated.

Sexual Offenders With Short Minimum Sentences

The SOT program did not have formal policies or procedures for assessing and enrolling sexual offenders with minimum sentences shorter than 24 months. According to SOT staff and management, the flow of inmates with shorter sentences made it difficult to prioritize sexual

offenders for assessment and enrollment as offenders with shorter sentences may bump inmates who have been waiting to enter the program. In our sample of 243 sexual offenders, 80 (33 percent) were serving a minimum sentence of two years or less. This shortened incarceration period made it difficult for SOT staff to assess and enroll inmates at least 18 months prior to their minimum. On average, inmates with short minimum sentences waited six months after entering prison before receiving an assessment and 13 months before being enrolled into ISOT, leaving them five months or less to complete the program. As a result, only seven inmates with short minimum sentences were released by their minimum, while 58 exceeded their minimum. Lack of criteria requiring these sexual offenders be assessed and enrolled within a certain number of months after entering the prison hindered SOT staff's ability to facilitate more timely release for this population.

Other states like Vermont, Massachusetts, Rhode Island, and Maine enrolled offenders into intensive sexual offender treatment earlier in their sentences than New Hampshire. Massachusetts in particular allowed inmates to start the three-year treatment program at least six years before their minimum.

Recommendations:

We recommend the DOC re-evaluate whether enrolling inmates 18 months prior to their minimum is adequate for most sexual offenders to finish the ISOT program with sufficient time to complete the remainder of the parole planning process prior to their minimum parole date.

We also recommend the DOC establish policies and procedures defining timelines for assessing and enrolling sexual offenders with short minimum sentences.

Agency Response:

We Concur.

While we believe that 18 months is adequate for most sex offenders to finish ISOT and prepare for parole, we should review the timeline to allow enough time for all who enter the program. We also need to consider sentence reduction options and how they impact the enrollment timeline. We are aware that other states do admit individuals earlier in their sentence. However, it is difficult to make program comparisons because of the structure of the programs. For example, a program may be longer and might be less intensive while offering groups to meet two to three times a week. In comparison, we offer group meeting two times per day. Other factors affecting a direct comparison are that peer supports may be a more integral part of the program and staff to client ratios may vary. For example, Massachusetts brings offenders in six years prior to their minimum sentence but their assessment phase runs approximately two years. They are then admitted into their three year program. Massachusetts has forty staff assigned to work with this difficult population.

We agree that timelines should be established within our policies and procedures and based on program capacity.

Observation No. 2

Develop Prioritization Policies And Procedures For Sentence Reduction Opportunities

During the audit period, the SOT program did not consistently account for opportunities which could have reduced an inmate's minimum sentence when assessing and enrolling sexual offenders.

Sentence Reduction As Part Of An Inmate's Mittimus

Some sentencing documents (i.e., mittimus) allowed for the suspension of a portion of an inmate's minimum sentence upon successful completion of ISOT. For example, the sentencing court may allow an inmate sentenced to a minimum of seven years to reduce his minimum sentence by two years if he successfully completed ISOT. While the mittimus was missing in the electronic case file for a large portion of the 243 sexual offender files we reviewed, we found at least five cases where the inmate's mittimus allowed a sentence reduction upon the completion of ISOT.

According to SOT staff, for most of the audit period, inmates were scheduled based on their actual minimum date, not the minimum they could be eligible for if they successfully completed ISOT. For example, an inmate with the potential to reduce his minimum sentence by two years would typically be prioritized based on his seven-year minimum instead of a potentially reduced minimum of five years. As a result, some inmates may have been kept in prison longer than necessary even though an earlier minimum parole date was allowed by the court, costing the State additional funds for the longer period of incarceration. According to DOC staff, in the spring of 2016, the process was changed to prioritize inmates with the potential for a sentence reduction for treatment sooner. However, this new process was not formally documented in DOC policy.

Petition For Suspended Sentence

RSA 651:20 allowed any person sentenced to prison to petition the sentencing court to suspend the remainder of their sentence after completing a portion of their minimum sentence. Inmates serving a minimum sentence of six years or more could file a petition for a suspended sentence once they have served four years or two-thirds of their minimum sentence, whichever was greater. For minimum sentences shorter than six years, the inmate was required to complete two-thirds of their minimum sentence before filing a petition for a suspended sentence. Statute required the DOC Commissioner to determine which inmates were suitable to petition.

The process for reviewing whether inmates were suitable to petition for a suspended sentence was outlined in DOC Policy and Procedure Directive 1-48, which required inmates to complete all DOC and court-ordered programming, participate in and complete all treatment goals, and remain discipline free for a certain time period. Essentially, sexual offenders were required to complete ISOT before being determined suitable for a suspended sentence.

Due to the programming and treatment requirements, and since sexual offenders were not assessed until at least 24 months prior to their minimum parole date, sexual offenders may not be able to take advantage of the opportunity to petition for a suspended sentence, as allowed in

statute. For example, a sexual offender sentenced to a minimum of nine years in prison may be eligible to petition for a suspended sentence after serving six years. However, he would not be assessed for SOT until two years prior to his minimum, or in the seventh year of incarceration. Our review of 243 sexual offender files found 14 inmates (six percent) filed a petition for a sentence reduction and none were granted. Without earlier assessment and enrollment in SOT programming, sexual offenders may not be able to utilize this mechanism to petition for a suspended sentence.

Earned Time Credit

RSA 651-A:22-a allowed inmates to petition for a one-time reduction in their sentence for successfully completing specific programs while incarcerated. During the audit period, inmates could take advantage of reductions of up to 13 months off their minimum and maximum sentences for completing programs including earning a high school diploma, a high school equivalency certificate, or a college degree; or for completing vocational programming, mental health programming, or the family connections program. The statute was amended in August 2016 to allow inmates to take advantage of earned time reductions of up to 21 months.

ISOT was typically the last program sexual offenders needed to complete in prison prior to being considered for parole, and participants were prohibited from enrolling in other programs while in treatment. Therefore, other programs for which inmates could apply towards earned time were generally completed prior to entering ISOT. However, the placement of ISOT 18 months prior to an inmate's minimum may prevent sexual offenders from being able to fully utilize this mechanism to reduce their minimum sentence. By not ensuring sexual offenders were enrolled into treatment timely to allow them to utilize all opportunities available to reduce their minimum sentence, the State may have incurred additional incarceration costs.

Recommendation:

We recommend the DOC formally codify new prioritization policies and procedures. Formal procedures should consider how: information for each sentence reduction type will be collected, tracked, and monitored; each type will be considered when prioritizing inmates for assessment; and how each type will be used to enroll sexual offenders into ISOT.

Agency Response:

We Concur.

The Department of Corrections Offender Records Bureau does currently document all sentence reductions within our offender management system. However, we will review and develop prioritization requirements to ensure that each sentence reduction type will be collected, tracked, and monitored to ensure each inmate has the ability to use sentence reduction options.

The corrective action plan will include reviewing policies and procedures as it pertains to sentence reduction opportunities.

Observation No. 3

Establish A Process For Timely Coordination With Case Managers

After completing ISOT, sexual offenders were required to develop a parole plan and request a hearing before the Adult Parole Board (Board). According to a DOC case manager, the parole process typically takes inmates two months. However, given the difficulties sexual offenders may have in finding suitable housing, it may be beneficial to start the parole planning process earlier.

Once finished with ISOT, we found the most common reason sexual offenders were not granted parole was because their housing plan was denied by the Board. Depending on the circumstances, sexual offenders may not be able to return to their home if the person they were convicted of abusing was still residing there. Other circumstances may also render their home an unsuitable housing choice. In our file review of 243 sexual offenders, we found 116 appeared before the Board. Of these, we were able to document at least 16 (14 percent) were denied parole specifically due to an inadequate housing plan. By delaying inmates who successfully completed the ISOT program and were eligible for parole from being released, the DOC unnecessarily incurs costs.

According to a case manager, more planning time would benefit sexual offenders; however, case managers were generally unaware of when a sexual offender was estimated to be discharged from ISOT. In the past, case managers received a list of inmates completing ISOT, allowing them to contact the inmate to begin the parole planning process. However, during the audit period, the onus was on the inmate to keep the case manager apprised of their anticipated completion. A case manager reported it would be beneficial to get a list of sexual offenders getting ready to go before the Administrative Review Committee so parole planning can be started as soon as possible.

Recommendation:

We recommend SOT management work with case managers to establish a process for relaying information about sexual offenders who are close to being discharged from the ISOT program. The process should consider the timing of when case managers should be made aware of impending discharges, as well as an effective process to relay this information to case managers.

Agency Response:

We Concur.

We will establish a process whereby SOT management shall communicate with case managers information relative to the inmates timelines and potential discharge dates to help case managers with parole planning for those inmates.

PROGRAM OPERATIONS

Were Sexual Offender Treatment program services delivered efficiently and effectively?

As discussed in the previous section, the Sexual Offender Treatment (SOT) program showed improvement in assessing and enrolling sexual offenders during the audit period. Additionally, program elements incorporated into the curriculum aligned with practices recommended by most industry leaders in sexual offender treatment, as well as other New England states. However, we found the program could benefit from codifying the Administrative Review Committee (ARC) and developing policies to address potential conflicts of interest when its clinical therapeutic staff also provide services to the general public.

Sexual Offender Treatment Practices Recommended By Industry Associations

New Hampshire's program appeared to align with practices recommended by industry sources including the Association for the Treatment of Sexual Abusers (ATSA), the Center for Sex Offender Management, and the Vera Institute. Table 4 shows these treatment components, their level of incorporation into the SOT curriculum, and the number of other New England states also incorporating these practices. Of nine practices recommended by the majority of these industry associations, five were fully incorporated into New Hampshire's SOT curriculum including:

- Cognitive behavior therapy, which focuses on changing behavior and cognitive patterns to reduce recidivism. The curriculum utilized by SOT clinicians focused on identifying irrational beliefs and distortions which led to the offense, identifying triggers and risky situations which could lead to negative behavior, and helping offenders develop alternative coping strategies.
- Assessing static and dynamic recidivism risk factors to identify both unchangeable factors (e.g., past criminal history, age at first offense, number of prior incarcerations, and the offense), and those which are amenable to change and can be targeted during treatment (e.g., lifestyle, relationships, substance abuse, sexually deviant preoccupations, and antisocial behaviors). During the assessment phase, SOT staff used Static-99R to assess static risk factors, and the Vermont Assessment of Sex Offender Risk and the Sexual Offender Treatment Intervention and Progress Scale (SOTIPS) to assess dynamic risks prior to placing offenders into Intensive Sexual Offender Treatment (ISOT) program or community treatment.
- Focusing treatment on criminal risk factors most associated with recidivism including antisocial behavior and cognitive distortions; family, marital, and social relationships; substance abuse issues; and personality disorders. As discussed above, the curriculum focused on treating dynamic risk factors. In addition, before completing ISOT, offenders were required to create a relapse prevention plan which required them to summarize their offending cycle, outline risk factors which led them to commit their offense, and identify a support system to help them keep from relapsing.
- Creating individualized treatment plans by establishing treatment goals. Before beginning treatment, clinical staff developed a diagnosis and treatment plan for each offender

outlining treatment goals and identifying how the offender would work towards achieving those goals.

- Assessing inmates on a continual basis to determine whether dynamic risk factors have changed. During the audit period, clinicians used SOTIPS to reassess sexual offenders participating in ISOT every six months, and again at the end of treatment.

Table 4

Industry-Recommended Sexual Offender Treatment Practices

Recommended Treatment Component	Practice Incorporated In New Hampshire?	Number Of Other New England States Also Incorporating Practice
Cognitive behavioral therapy	Yes	5
Assessment of static and dynamic risk factors	Yes	4
Focus on criminal risk factors	Yes	3
Individualized treatment plan utilized	Yes	2
Inmates assessed on a continual basis	Yes	1
Risk, needs, and responsitivity approach	Partially	4
Accommodation for special populations (e.g., non-native English speaking, developmentally disabled)	Partially	3
Transition to community treatment	Partially	2
Document inmate treatment progress	Partially	0

Source: LBA analysis of other New England states, recommended industry, and New Hampshire practices.

Four other practices were partially incorporated into the program, including:

- Using a risk, needs, and responsitivity approach to match inmate recidivism risk level with treatment intensity. This approach required treatment and supervision to be longer in duration and applied more frequently as re-offending risk increased. While the SOT program used an approach which identified each offender's risk and needs, and allowed those with low re-offense risk to receive treatment in the community, all offenders recommended for ISOT received a similar level of treatment.
- Providing accommodations to special inmate populations such as developmentally disabled and non-native English speakers. SOT provided some flexibility for those with developmental disabilities by allowing them to start the program earlier, and offered at least one inmate the program materials in Spanish. However, it was limited in providing services to inmates with severe developmental disabilities and other non-native speakers.
- Transitioning inmates to community treatment through collaboration with clinicians, case managers, parole officers, and community treatment providers. We found some evidence of communication with case managers regarding some offenders' treatment progress and

community providers had access to parole conditions placed on the inmate. However, there was no direct collaboration between parole officers or community providers.

- Documenting inmate treatment progress. SOT clinicians were required to use CHOICES to document clinical progress. However, SOT staff and management stated documentation was not always completed timely.

Sexual Offender Treatment Programs In Other New England States

Sexual offender treatment programs in other New England states differed from New Hampshire in terms of timeframe for assessment and program duration. As shown in Table 5, all New England states assessed sexual offenders for treatment needs and risk at least four years prior to the offender's minimum release date (minimum) or when they entered the prison system. Most New England states timed the enrollment of sexual offenders similar to New Hampshire and did not build in additional time for completion. The exception was Massachusetts that allowed sexual offenders to enroll six years prior to their minimum to complete a program which could take three and a half years.

Table 5

Timing Of Sexual Offender Treatment Services In New England States

State	Population	Staff	Inmate To Staff Ratio	Timing Of Assessment	Timing Of Enrollment	Program Duration
New Hampshire	750	5 FT	150:1	2 years before minimum	All offenders: 18 months before minimum	6 to 18 months
Vermont	500	8 FT 1 PT	59:1	Prison entrance Psychosexual assessment 3 months before enrollment	High: 24 months before minimum Medium: 1 year before minimum Low: Not specified	High: 21 months to 2 years Medium: 1 year Low: 6 months
Maine[1]	Did Not Provide	3 FT 1 PT	NA	4 years before minimum	3 years before minimum	3 years
Massachusetts	1500	40 FT	38:1	6 years before minimum	6 years before minimum	18 to 42 months
Rhode Island	400	2 FT 1 PT	160:1	4 years before minimum	4 years before minimum	4 years
Connecticut[2]	Did Not Provide	6 FT	NA	Prison entrance	Variable	1 year

Notes:

[1] Staff only worked in the intensive program. Community treatment was provided by contractors.
[2] An additional, unquantified number of staff also contributed additional time to the program.

Source: Conversations with New England states' sexual offender treatment program administrators.

Observation No. 4

Establish The Administrative Review Committee In Rule And Develop Policies And Procedures

Even though the ARC had a lot of power in granting sexual offenders a discharge or terminating and removing them from ISOT, the DOC did not formally establish the ARC in rule or document its operations in policy and procedure directives.

While the ARC did not review sexual offenders recommended for community treatment, it performed an external review to ensure ISOT participants satisfactorily met their treatment goals and, if necessary, recommended further treatment. The ARC was also responsible for determining whether participants should be terminated and removed from the program, as well as when they may return. If the ARC determined treatment goals were met, it granted the participant a discharge and submitted its recommendations for parole restrictions or further treatment to the Adult Parole Board (Board). According to Board members, it did not grant sexual offenders parole unless the ARC granted a discharge from the ISOT program. Additionally, the ARC's recommendations were usually incorporated into the offender's parole conditions.

RSA 21-H:13, III, required the DOC to promulgate administrative rules relative to management and operation of rehabilitation related programs, including counseling and therapy. Administrative rules are meant to prescribe or interpret agency policy, procedure, or practice binding on persons outside the agency, whether members of the public or personnel in other agencies. Formal rulemaking provides the opportunity for public and legislative oversight, and provides greater certainty and accountability in agency interactions with outside parties. The contract ISOT participants signed indicated any violation of program rules may be referred to the ARC and its role was discussed in the handbook given to all ISOT participants. However, the ARC's role in the sexual offender treatment process and its responsibilities were not formalized in administrative rules or DOC policy and procedure directives.

Without rules, policies, or procedures describing the ARC's roles, responsibilities, and scope of authority, the DOC risks uncertainty and irregularities when performing its function. One Board member stated the Board was under the impression the ARC reviewed all sexual offenders including those who were recommended for community treatment. In addition, ARC members reported that because there was no manual or document outlining its responsibilities, they learned their duties through participating in meetings and asking other ARC members.

Recommendations:

We recommend DOC management formally codify the ARC and ensure policies and procedures outlining its role, responsibilities, scope of authority, and practices in the sexual offender treatment process are developed. The DOC should consider:

- **the population of sexual offenders subject to the ARC's review;**
- **its authority in terminating and removing participants from, as well as returning participant to, the ISOT program;**

- **its role in granting a discharge from the program; and**
- **its responsibility as it pertains to interactions with the Parole Board.**

Agency Response:

We Concur.

We will codify the Administrative Review Committee in rule and policy.

Observation No. 5

Establish A Policy Addressing Outside Employment

The DOC did not have a policy to help mitigate potential conflicts of interest, which may arise when SOT staff also provided therapeutic services to sexual offenders outside of the prison.

Paroled sexual offenders were generally required to participate in an aftercare treatment program outside of prison as a condition of their parole. During the audit period, one SOT clinician conducted assessments of sexual offenders to determine the level of treatment needed while also working as a therapist providing aftercare treatment for sexual offenders on parole. During our review of 243 sexual offender files, we found at least five instances where parolees who had been assessed for sexual offender treatment while incarcerated were receiving aftercare treatment with this clinician while on parole. Division management also identified one additional clinician providing services in the community.

The American Mental Health Counselors Association (AMHCA), the National Association of Social Workers (NASW), and ATSA have all promulgated ethics guidelines discouraging this type of relationship. Specifically:

- the AMHCA states, "[m]ental health counselors do not evaluate, for forensic purposes, individuals whom they are currently counseling or have counseled in the past. In addition, mental health counselors do not counsel individuals they are currently evaluating, or have evaluated in the past, for forensic purposes."
- the NASW prohibits social workers from engaging in dual relationships with clients or former clients. According to the NASW, dual relationships occur "when social workers relate to clients in more than one relationship, whether professional, social, or business."
- the ATSA guidelines state, "[m]embers recognize that there may be potential conflicts of interest when they provide both evaluation and treatment services to the same person. When it is necessary to fulfill both functions, (for example, in rural settings or institutions) members take reasonable steps to manage and resolve any conflict in the best interests of the client and the community."

DOC policy required employees avoid actual or the appearance of a conflict of interest, and prohibited employees from participating in matters with which they may have a private interest. However, the policy did not provide examples of what may be considered a conflict of interest.

In April 2016, Division of Medical and Forensics management issued a memo prohibiting staff from holding positions in the community where they may be in contact with past or current inmates in the community. Additionally, the DOC Assistant Commissioner has requested the issue be brought before the State Ethics Committee for an opinion.

Accountability is key to the successful application of public resources and authority. According to the U.S. Government Accountability Office (GAO), codes for ethical conduct and moral standards should be comprehensive in nature and directly address specific issues such as conflicts of interest. By not establishing clear standards regarding outside employment of DOC staff, the Department risks not being able to identify or mitigate potential conflicts of interest.

Recommendations:

We recommend SOT management, in collaboration with DOC management, formally develop and implement comprehensive policies regarding outside employment of its therapeutic clinical staff. Formal policies should consider whether it is appropriate for DOC employees to serve inmates in a private therapeutic setting while they are on parole as well as a process to identify other types of clients which may not be appropriate for DOC staff to treat in a private therapeutic setting.

We also recommend the DOC establish a process to help staff determine whether an actual or perceived conflict of interest may exist.

Agency Response:

We Concur.

The Department requested a review by the State's Ethics Committee in July of 2016 to guide our policy development. In the interim, we require staff to write a letter to their administrator who then meets with the employee to determine if a conflict of interest could arise. We will work with State Personnel through Human Resources and our Attorney General Legal Counsel to include this observation in appropriate policies.

Performance Measurement Systems

According to the GAO, performance measurement "focuses on whether a program has achieved its objectives, expressed as measurable performance standards." A performance measurement system facilitates comparing actual performance levels with pre-established targets to determine whether program results are achieved. Used correctly, performance measurement improves accountability and identifies areas of possible improvement. Additionally, performance measures can help a program define what it wants to accomplish through formally articulated goals and objectives, gauge progress towards meeting these goals, and improve decision-making. In fact, the GAO states, "Legislators, oversight bodies, those charged with governance, and the public need to know whether…government programs are achieving their objectives and desired outcomes." To be most effective, performance measurement systems should be aligned with organizational benchmarks or goals.

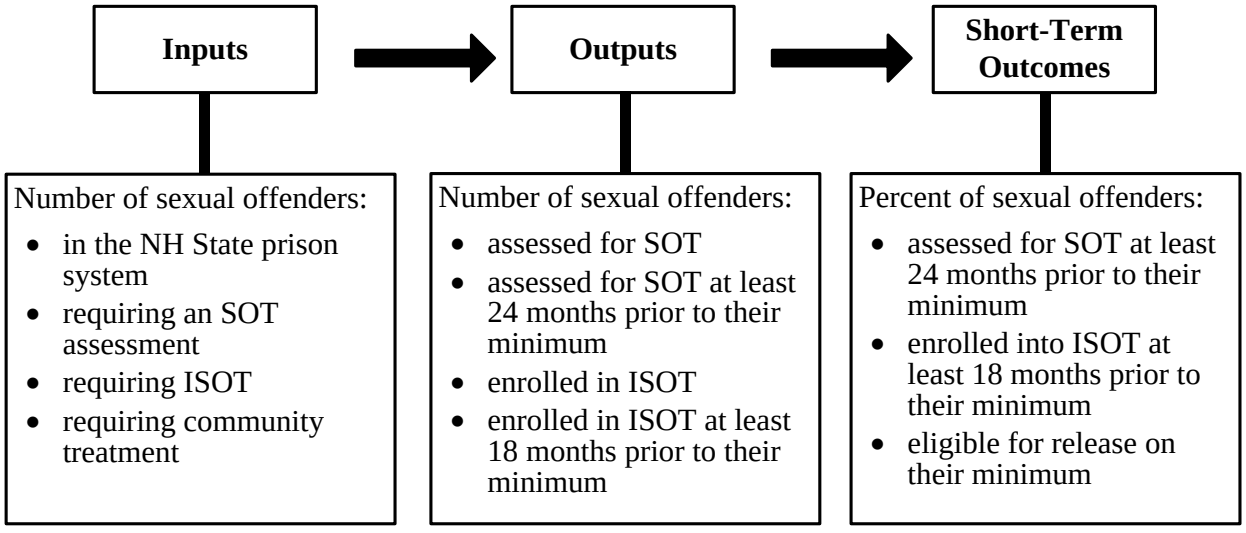
The SOT program had some policies and procedures outlining the assessment and treatment processes for treating inmates identified as sexual offenders. However, there were no formal goals and objectives associated with this mission, nor did it have formal mechanisms for evaluating progress towards these informal goals. Additionally, the SOT program did not capture or report any type of output data, hindering management's ability to gauge progress towards program goals or identify improvements to the program.

SOT management could use performance measures to gauge different aspects of its activities including inputs, outputs, and outcomes. Inputs are the resources the SOT program uses to meet its goals. Outputs, in turn, are the product of processes used to meet program goals, and outcomes are the impact of the service provided. After performance measures are established for inputs, outputs, and outcomes, the organization should set clear performance targets. Monitoring performance could allow management to correct weaknesses and enhance strengths.

Figure 5 illustrates an example of how performance measures could be used to gauge the timeliness of SOT program activities. Sexual offenders enter the New Hampshire prison system and are identified for an SOT assessment. Based on the assessment, they may be assigned to the ISOT program or referred for community treatment with a provider in the community upon their release from prison. These elements constitute the program's inputs and are represented numerically. Inmates assigned to ISOT are prioritized for treatment based on their minimum and are enrolled when one of the 96 treatment beds become vacant. The increase in the percent of inmates assessed and enrolled timely are the program's outcomes or desired results. Inmates meaningfully participating in each stage of ISOT will complete the program and are given recommendations for support in the community upon their release on parole. By participating in SOT services, sexual offenders increase their potential to be eligible for release on their minimum. Appendix B contains more detailed examples of performance measures and how they link to the SOT's mission, goals, and objectives.

Figure 5

Example Of Sexual Offender Treatment Program Performance Measures



Source: LBA analysis of SOT documents and conversations with SOT staff.

Observation No. 6

Establish A Performance Measurement System

The SOT program did not have a system to evaluate whether activities were contributing to its overall goal or whether it was meeting its informal assessment and enrollment objectives. According to SOT staff and DOC management, the overall goal of the SOT program was to reduce sexual recidivism; however, it did not have a system to measure whether this goal was being achieved. SOT staff were unaware of whether the recidivism rate for sexual offenders was being tracked and there were no objectives or benchmarks associated with this goal, making measurement problematic were it to occur. The program also did not have a system to evaluate whether it was meeting its informal assessment and enrollment objectives, and none of the SOT program's expressed goal or objectives addressed the program's mission to provide services based on the sexual offender's clinical needs.

Tracking Recidivism

While the DOC tracked the general recidivism rate for all offenders annually, the last assessment of sexual offender recidivism was conducted on sexual offenders released from prison in 2010. This study only reported recidivism rates for sexual offenders as a whole and did not compare differences between inmates who had completed the ISOT program versus those who had been paroled and required to seek treatment with a provider in the community. Comparing these two groups could help gauge whether sexual offenders completing ISOT had a lower sexual recidivism rate than sexual offenders who had not, potentially demonstrating some level of program effectiveness. Understanding whether untreated offenders committed new offenses at higher rates than those completing ISOT may help DOC and program management to determine whether ISOT should be expanded to more offenders.

Timely Assessment And Enrollment

While SOT policies did not specify a timeframe for treating male sexual offenders, DOC personnel reported they generally conducted a risk and needs assessment at least two years prior to an inmate's minimum and enrolled those recommended for ISOT into the program at least 18 months prior to their minimum. However, the program did not analyze whether, or to what extent, these targets were being met. While SOT staff were aware on a case-by-case basis whether specific inmates were assessed and enrolled within these timeframes, there was no way to determine whether the program was meeting these targets in the aggregate.

Collecting SOTIPS Assessment Scores

SOT staff also conducted a SOTIPS as part of the initial assessment and at the completion of the ISOT program. The SOTIPS measures 16 dynamic risk factors that have been empirically linked to sexual offending behavior, and are potentially amendable to change by SOT services. Copies of beginning and ending SOTIPS assessments with corresponding scores were retained in some offenders' files or referenced in other clinical documents. Further, clinicians reviewed, on a case-by-case basis, whether individual offenders' scores decreased as treatment progressed. However, there was no program-wide system to track or compare these scores. Our analysis of SOTIPS

scores found some indication of programmatic success, indicating ISOT may have had some positive effect on decreasing these 16 dynamic risk factors. While sexual offenders not participating in ISOT did not have an ending SOTIPS score, our file review of 243 sexual offender files found only 39 files where both SOTIPS scores were available. For the subset where both scores were available, 38 sexual offenders (97 percent) lowered their SOTIPS scores after completing ISOT. On average, offenders lowered their score by 17 points on a 48 point scale. Additionally, we found 74 percent (29 of 39) of offenders scored as a low risk after completing ISOT versus only five percent (two of 39) during the initial assessment.

Reporting Program Performance

While the DOC published an annual report, SOT performance information was not included in these reports, nor was information readily available to DOC management, the public, or Legislators. DOC annual reports did not include even basic information such as the number of sexual offenders entering the program annually, the number completing the program, or reasons for non-completion of the program. Without a system to track, monitor, or report on performance information, the SOT program risked misunderstandings about the program and whether it was meeting its goal and objectives.

Recommendations:

We recommend SOT, in conjunction with DOC management, develop:

- **goals and objectives linked to each of the program's mission;**
- **performance measures with formal corresponding benchmarks, to track and determine whether it is achieving the desired level of performance;**
- **policies and procedures for regularly measuring SOT performance against benchmarks and evaluating effectiveness; and**
- **a system to share performance measurement data with DOC management, the public, and the Legislature.**

Agency Response:

We Concur.

The Department will establish performance measurements related to the DOC and program mission and client outcomes as it pertains to the sexual offender treatment program. The Department will examine opportunities to implement measures as it pertains to participation in the sexual offender treatment program and recidivism rates, the comparison of actuarial scores and change (e.g., SOTIPS, Static-99R, etc.) and comparative analysis using industry standards to measure program efficacy.

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OTHER ISSUE AND CONCERN

In this section, we present an issue we consider noteworthy, but did not develop into a formal observation. The Department of Corrections (DOC), Sexual Offender Treatment (SOT) program, and the Legislature may wish to consider whether this issue deserves further study or action.

Improve Coordination Of Information Given To The Adult Parole Board

Adult Parole Board (Board) members reported the type of information relayed to Board members when considering a sexual offender for parole could be improved. For each sexual offender completing the Intensive Sexual Offender Treatment (ISOT) program, the Board received a list of recommendations for further treatment or restrictions which were eventually incorporated as parole conditions. For example, based on the offender's crime, it was not uncommon for SOT clinicians to recommend restrictions on computer, internet, or social media use; prohibitions on frequenting specific places; or further counseling for other underlying issues. While all Board members stated these recommendations were helpful, members also reported other information such as the sexual offender's assessment scores, treatment progress, level of participation in treatment, and whether they showed signs of accepting responsibility for their crime would also be helpful for making parole decisions. However, this information was not directly provided by the ISOT program.

Board members reported receiving less information regarding sexual offenders assigned to community treatment. While SOT staff provided recommendations for further treatment and restrictions for offenders completing ISOT, Board members did not receive similar recommendations for offenders required to obtain treatment with a provider in the community after their release. For example, they did not have information regarding whether it would be appropriate to prohibit internet, social media, or cell phone use; whether the offender should be restricted from having contact with minors; or other conditions. Additionally, members reported assessment scores used to determine an offender's recidivism risk were not made available to Board members.

We found discharge information for which sexual offenders have granted a release was available to the Board through the DOC's electronic mental health records system. However, members may not have been fully aware of how to access it or where within the system this information was located.

We suggest SOT management work with the Board to identify what information is currently available and where it can be found. We also recommend SOT management collaborate with the Parole Board to increase information sharing regarding sexual offenders recommended for community treatment.

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APPENDIX A
OBJECTIVE, SCOPE, AND METHODOLOGY

Objective And Scope

In April 2016, the Fiscal Committee approved a joint Legislative Performance Audit and Oversight Committee recommendation to conduct a performance audit of the Sexual Offender Treatment (SOT) program within the Department of Corrections (DOC). We held an entrance conference with the DOC that same month. Our performance audit focused on the following question:

Did the DOC efficiently and effectively provide sexual offender treatment to inmates from State fiscal years 2014 to 2016?

Specifically, we focused on determining:

- *whether the DOC assessed and enrolled inmates in the SOT program in a timeframe to promote completion prior to their minimum parole dates;*
- *factors which may have prevented inmates from completing the SOT program prior to their minimum parole dates;*
- *whether SOT was delivered efficiently and effectively; and*
- *areas where delays and backlogs may have occurred within SOT.*

Less than one percent of sexual offenders were female, and services to female sexual offenders were provided by a contractor at the New Hampshire State Prison for Women in Goffstown. Additionally, male sexual offenders residing in the Northern New Hampshire Correctional Facility in Berlin were transferred to the New Hampshire State Prison for Men (NHSP/M) in Concord for treatment. Therefore, our audit focused on activities related to the SOT program offered at the NHSP/M.

Methodology

To gain an understanding of the SOT program and its management controls, we:

- reviewed relevant State laws, rules, and DOC policy and procedure directives; SOT manuals for male and female offenders; SOT assessment manuals and procedures; DOC and SOT budget information, websites, management documents, organization charts, and annual reports; SOT staffing documents; SOT staff licensing information; agendas, minutes, and other documents from Legislative committees; prior LBA audits and audits from other states; relevant newspaper articles; and information provided by other stakeholders;
- interviewed current DOC staff responsible for administering SOT, Adult Parole Board members and administrative staff, and other parties of interest;

- visited the SOT program housing unit in the Hancock Building at NHSP/M; and
- researched other states operating programs similar to SOT, instances of program backlogs in other states, and sexual offender treatment industry standards.

To determine how efficiently and effectively the DOC provided sexual offender treatment to inmates between State fiscal years (SFY) 2014 to SFY 2016, we:

- analyzed summary program data and waitlists provided by SOT staff;
- collected data (see sampling methodology below) and analyzed the timeliness of SOT staff with assessing, enrolling, and releasing inmates;
- analyzed SOT expenditure data and personnel changes;
- researched sentence reductions and their use by incarcerated sexual offenders;
- collected and analyzed data regarding potential SOT staff conflicts of interest;
- reviewed SOT staff qualification requirements;
- reviewed Administrative Review Committee oversight procedures and practices; and
- reviewed ISOT disciplinary policies and practices.

Review Of Sexual Offender Files

We reviewed a random sample of electronic files consisting of inmates in the New Hampshire State prison system who had been identified as sexual offenders during our audit period. Our file review was designed to show recent SOT performance in timely assessment, enrollment, and release of sexual offenders. The DOC provided a list of 1,133 inmates who were in the prison system at any point during SFYs 2014, 2015, and 2016. We reduced our population by excluding inmates who had minimum parole dates two years after the end of our audit period (i.e., inmates with minimums of June 30, 2018 or later), leaving us with 659 inmates. Based on a 95 percent confidence level with a five percent margin of error, we established a sample size of 243 inmates. Because the list of inmates had been provided alphabetically, we randomized the list by assigning a random number to each record and reorganizing the list using this randomly assigned number. Using a random number generator, we randomly selected 243 inmate names from the population. SOT staff oriented us to the three electronic systems containing relevant sexual offender data. We collected data at the DOC between July 19 and August 19, 2016.

During our review of 243 sexual offender files, we encountered some limitations due to the availability of electronic documents in FileHold and some information not being documented in the three systems. FileHold was implemented in November 2015 and older paper files were still being scanned into the system. Due to time limitations and the volume of paper files we would need to review, we did not review the paper files. As a result, we were unable to collect all documents needed to review offender files including copies of some assessments, sentencing documents, and discharge documents. In some instances, these dates were also not documented in CORIS, the DOC's offender management system, or CHOICES, the Division of Medical and Forensic Services' medical records system. Instead of collecting dates from paper files, we collected dates for these events if we found them referenced in other documents, mental health notes, or CORIS notes. For example, if FileHold did not contain a copy of an inmate's

assessment but the discharge summary referenced an assessment date, we recorded the date found in the discharge summary. If we could not determine an actual date, we recorded this data as missing.

Missing data impacted some analysis in this report. If data elements needed for a particular analysis were missing, we excluded that inmate's data from that specific analysis. For example, some files may have contained the date an assessment was conducted and the date the offender completed ISOT, but not the date the offender was enrolled into ISOT. We used this inmate's data to calculate compliance with the assessment goal; however, excluded this inmate's data from analyses of program duration and whether the inmate was enrolled into ISOT timely. As a result, we reported our findings in this report within the context of our sample and did not project the results to the general population.

Analysis Of Sexual Offenders Serving Minimum Sentences Of 24 Months Or Less

Inmates entering prison spent, on average, one month in the Reception and Diagnostic Unit, and for security reasons, SOT staff could not conduct a sexual offender risk assessment during this time. Therefore, we excluded all sexual offenders serving minimum sentences of 24 months or less from our analysis of timely assessment. Depending on the length of their minimum sentence, they may have also been excluded from our analysis of timely enrollment. For example, an inmate serving a minimum sentence of 18 months or less would have been excluded from both analyses. However, an inmate serving a minimum of 24 months would have only been excluded from the calculation of timely assessment.

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APPENDIX B
POTENTIAL SEXUAL OFFENDER TREATMENT PROGRAM PERFORMANCE MEASUREMENT SYSTEMS

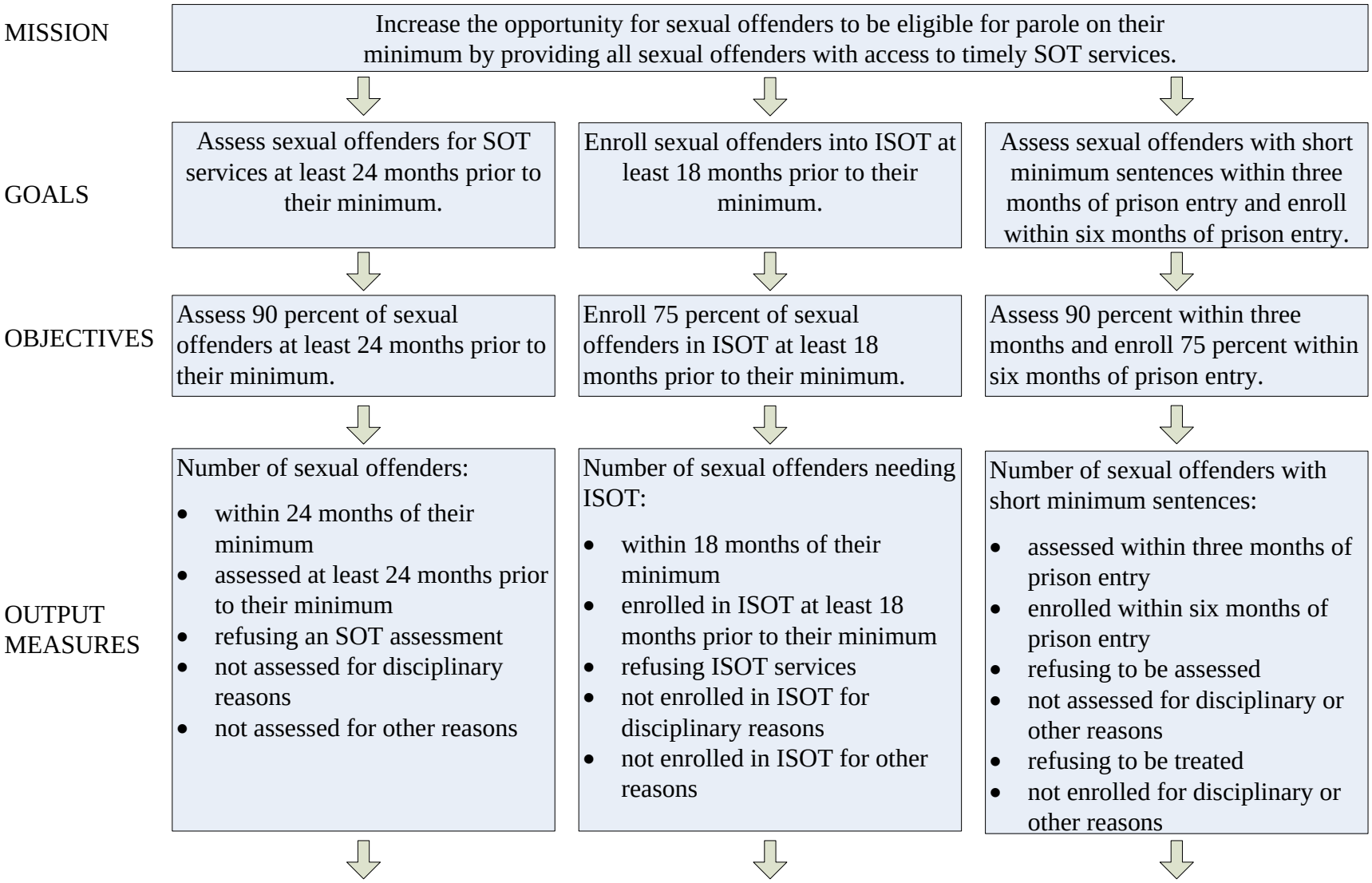
Performance measurement focuses on whether a program achieved its goals and objectives, which are expressed as measurable performance standards. A performance measurement system facilitates comparing actual performance levels to pre-established targets (i.e., goals and objectives) to determine whether program results were achieved. Performance measurement systems require identifying the agency's mission (i.e., what it wants to accomplish), establishing measureable goals and objectives for achieving the mission (i.e., how it will accomplish the mission), and establishing output and outcome measures to gauge agency progress towards its goals and objectives.

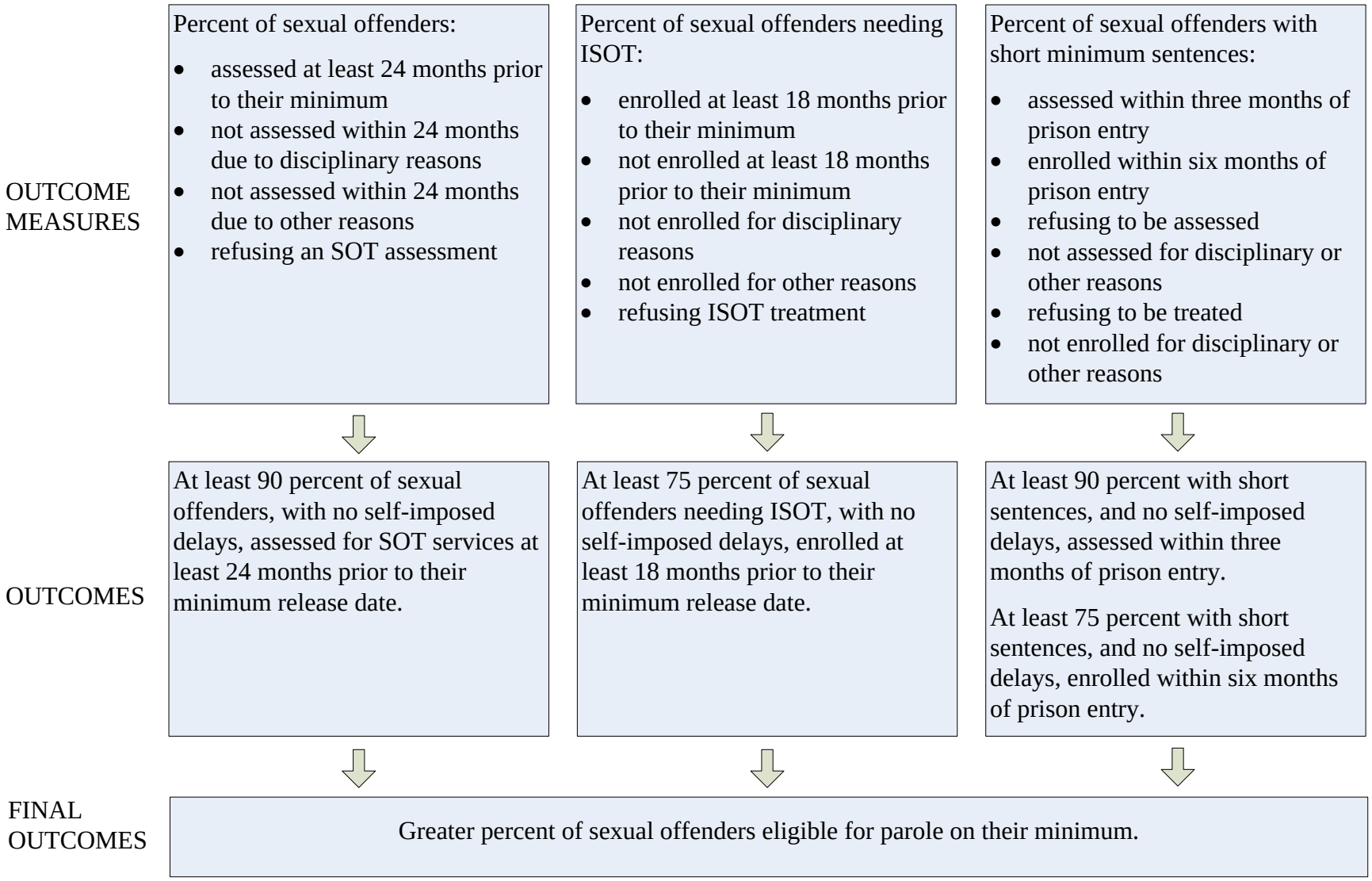
Figure 6 shows an example mission, with supporting goals, objectives, performance measures, and outcomes which may be applicable to sexual offender treatment that we developed for demonstration purposes. The mission is represented as the results the program intends to achieve, while goals define the specific activities conducted to achieve the mission. Objectives define the standards to which the agency will compare its results, and the measures quantify the results the agency produced. Outcomes define the results expected to be achieved and the final outcomes show the activity's link to the mission.

For example, Figure 6 identifies goals, objectives, and measures intended to increase the opportunity for sexual offenders to be eligible for parole on their minimum. Goals include assessing offenders for Sexual Offender Treatment (SOT) program services at least 24 months prior to their minimum, enrolling them at least 18 months prior to their minimum, assessing those serving minimum sentences shorter than 24 months within a specific number of months after entering prison (e.g., three months), and enrolling this population within a specific number of months after entering prison (e.g., six months). Objectives may include assessing, for arguments sake, 90 percent of sexual offenders at least 24 months prior to their minimum, enrolling 75 percent at least 18 months prior to their minimum, assessing 90 percent of offenders serving short minimum sentences within three months of entering prison, and enrolling 75 percent of this population within six months of entering prison. To measure this, program staff could separately track assessment and enrollment information for inmates with short sentences and those with minimum sentences longer than 24 months. These results could then be compared to a set target (e.g., 90 percent of sexual offenders assessed within 24 months) or compared over several years (e.g., ten percent increase sexual offenders assessed within 24 months compared to the previous year). An increase in sexual offenders assessed and enrolled timely should result in an increase in those eligible for parole on their minimum.

Figure 6

Performance Measurement Model:
Increase The Opportunity For Sexual Offenders To Be Eligible For Parole On Their Minimum





Source: LBA analysis of SOT documents and interviews with SOT staff.

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APPENDIX C
STATUS OF PRIOR AUDIT FINDING

The following is the status of one observation applicable to this audit found in our prior report issued in November 2012, entitled *Department of Corrections, Nonsecurity Staffing*. A copy of the prior report can be accessed online at our website http://www.gencourt.state.nh.us/LBA/default.aspx.

No.	Title	Status
8.	Provide Sexual Offender Treatment Services In A Timely Manner	● ● ○

Status Key

Fully Resolved	● ● ●
Substantially Resolved	● ● ○
Partially Resolved	● ○ ○
Unresolved	○ ○ ○

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