

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

*August 2006*

**Performance  
Audit Section**

*Legislative Audit and Research Office  
Nebraska Legislature*

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

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*Prepared by*  
**Angela McClelland  
Lance Lambdin**

*Editing*  
**Martha Carter**

**PERFORMANCE AUDIT SECTION**

Legislative Audit and Research Office • Nebraska Legislature  
State Capitol • Box 94945 • Lincoln, NE 68509-4945 • (402) 471-2221

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## *I. Key Findings*

# Key Findings & Recommendations

Legislative Performance Audit Committee Report

## *The Lincoln Regional Center's Sex Offender Services Program*

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

### **PROGRAM SAFEGUARDS**

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

Specifically, the Committee found that:

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

### **Recommendations**

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

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

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

### **CHANGES IN CIVIL COMMITMENT POLICIES**

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

#### **Recommendations**

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

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

**August 2006**



*II. Performance Audit Section Report*



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

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*Prepared by*  
**Angela McClelland  
Lance Lambdin**

*Editing*  
**Martha Carter**

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# INTRODUCTION

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

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

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

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

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

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

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

## **Program Administration and Description of Services**

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

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

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

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

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

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

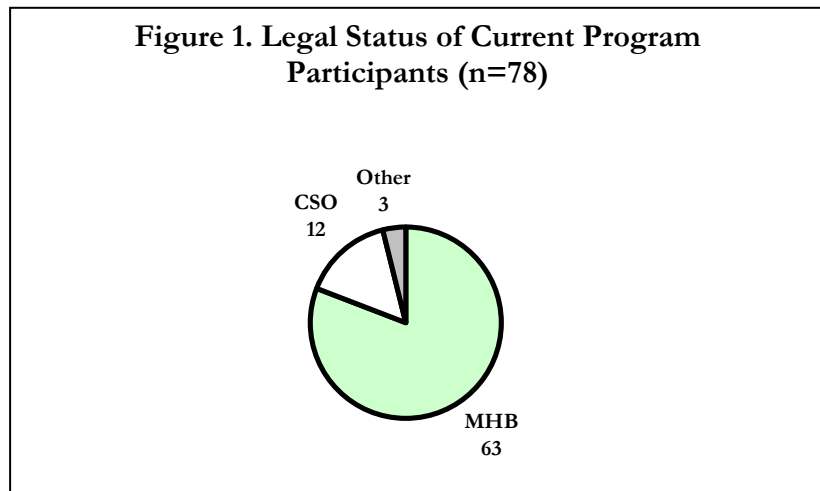
Sex offenders are discharged from the program in different ways depending on the legal means by which they were admitted into the program. For committed offenders, the responsibility for the discharge decision rests primarily with the program's psychiatrist. The psychiatrist plays a smaller role, however,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

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

### Population Served

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

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



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

Figure created by the Legislative Performance Audit Section.

## Expenditures

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

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

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

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

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

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

Table created by the Legislative Performance Audit Section.

## Length of Treatment

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

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

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

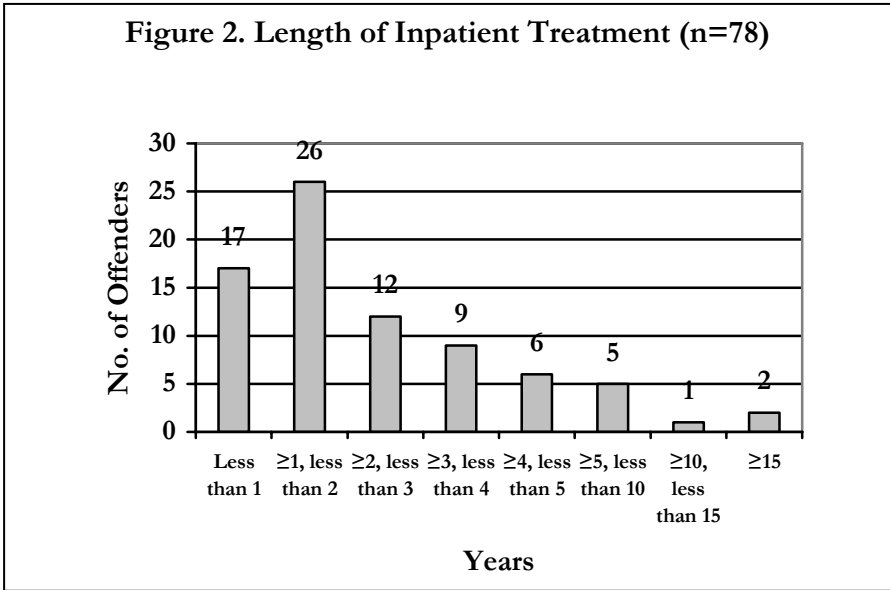


Figure created by the Legislative Performance Audit Section.

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

*Previous Participation*

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

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

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

**Notes**

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

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

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

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

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

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

### Discharge Requirements

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

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

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



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

### *Completing Inpatient Services*

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

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

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

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

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

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

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

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

### *Discharge*

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

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

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

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

### **Assessment of the Program's Discharge Decision-Making**

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

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

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

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

Table created by the Legislative Performance Audit Section.

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

*Absence of Documentation of Decision-Making*

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

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

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

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

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

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

*National Standards Regarding  
Documentation of Clinical Decisions*

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

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

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

*Staff Perspectives on Discharge Decision-making*

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

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

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

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

## Notes

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<sup>1</sup> Neb. Rev. Stat. sec. 71-921.

<sup>2</sup> Neb. Rev. Stat. sec 71-935(2).

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

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

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

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

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

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

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

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

### Discharge of Incarcerated Offenders

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

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

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

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

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

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

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

### Corrections' Process for Requesting Commitments

According to Corrections personnel, when a convicted sex offender is 30 to 90 days from completion of his criminal sentence, staff psychologists assess whether he is safe to release into the community. If not—specifically, if they believe that the sex offender is a mentally ill and dangerous person, as defined in the Nebraska Mental Health Commitment Act<sup>1</sup>—the supervising psychologist will send a letter to the county attorney of the county in which the sex offender is incarcerated, requesting the commencement of civil commitment proceedings.

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

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

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

#### *Analysis of Commitment Requests*

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

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



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

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

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

Table created by the Legislative Performance Audit Section.

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

#### *LB 1199 Commitment-Process Changes*

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

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

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

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

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

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

### Impact of Increased Commitments on LRC

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

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

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

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

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

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

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

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

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

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

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

## Notes

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<sup>1</sup> Neb. Rev. Stat. sec. 71-908.

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

<sup>3</sup> LB 1199 (2006), Slip Law, page 33, section 86.

<sup>4</sup> LB 1199 (2006), Slip Law, page 24, section 58.

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

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

### Introduction

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

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

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

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

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

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

### Description of the Section's Recidivism Analysis

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

## *Offenders*

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

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

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

## *Offenses*

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

### **Results of the Section’s Recidivism Analysis**

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

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

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

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

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

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

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

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

\*Excluding traffic violations

Table created by the Legislative Performance Audit Section.

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

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

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

Table created by the Legislative Performance Audit Section.

## Significant Offenders Excluded from Our Analysis

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

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

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

## Notes

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

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

***III. Committee Findings and Recommendations  
and Fiscal Analyst's Opinion***





## Performance Audit Committee Recommendations

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On 25 July 2006, in accordance with Neb. Rev. Stat. sec. 50-1211(1) of the Legislative Performance Audit Act, the Legislative Performance Audit Committee convened to consider the findings and recommendations contained in the Performance Audit Section's draft report entitled *The Lincoln Regional Center's Sex Offender Services Program* and the Department of Health and Human Services' response to the draft report. The Committee adopted the following recommendations.

### *The Lincoln Regional Center's Sex Offender Services Program*

**Finding 1:** On average, sex offenders in the Sex Offender Services Program (program) have spent 2.8 years in inpatient services treatment. However, a few have been in treatment more than 15 years.

**Finding 2:** Some sex offenders currently in the program have previously spent a considerable amount of time in the program.

**Discussion:** We question whether sex offenders who have been in the program for extended periods of time, or those who have received treatment, been released, and been re-admitted several times, can be considered to be *progressing* through treatment. Given that treatment costs about \$100,000 per sex offender, per year, the financial impact of such individuals remaining stagnant in the program is significant. Despite these concerns, we did not find anything the program can do to eliminate the factors that result in some committed offenders remaining in treatment indefinitely.

**Recommendation:** No recommendation.

### *The Program's Discharge Procedures for Committed Offenders*

#### *Goal Attainment Scale Scores*

**Finding 3:** The Goal Attainment Scale (GAS) scores, which serve as a basis for important treatment decisions, are not kept in sex offenders' medical files, which may prevent proper access to them. Moreover, documentation pertaining to the reasoning behind GAS scoring is not retained.

**Finding 4:** Purposely separating the GAS scores from the rest of program participants' medical files raises serious ethical and legal concerns.

**Discussion:** We found the program staff's explanations for maintaining this documentation separately from the offenders' medical files unconvincing.

**Recommendation:** Program staff should maintain the GAS scores in each offender's medical file. Program staff should also retain the documentation that provides the basis for those scores. If program staff believe that offenders may misuse this information, they should develop a policy that would permit the removal of the information as needed. Any such policy should require, however, that the information be returned to the offender's file at least temporarily whenever the file is made available for a legal proceeding and permanently after the offender has been discharged.

#### *Documentation of Discharge Decision-Making*

**Finding 5:** LRC's discharge procedures contain little detail about the criteria an offender must meet in order to be discharged.

**Finding 6:** The reasoning behind some clinical decisions is not documented in a conspicuous location in offenders' medical files.

**Finding 7:** The reasoning behind some significant clinical decisions cannot be discerned, even from a thorough review of medical files.

**Finding 8:** National standards for sex offender treatment support the need to document the reasons for clinical decisions.

**Discussion:** Clinical decisions regarding both transfer of an offender from inpatient services to community-transition services, a significant step towards discharge, and discharge itself are significant not only to the offender but also to the public. Given the nature of the crimes involved and their traumatic impact upon individuals and the community alike, the program should be held to a high standard of accountability in making these decisions.

**Recommendation:** Program staff should develop comprehensive policies dictating how transfer and discharge decisions will be made. Policies should include the discharge criteria, define the roles of key personnel in the decision-making processes, and require such decisions to be documented.

**Recommendation:** Clinical staff should immediately begin documenting the reasoning behind transfer and release decisions.

*Program Safeguards*

**Finding 9:** The program's transfer and discharge procedures for committed offenders lack adequate safeguards, which may jeopardize public safety.

**Finding 10:** In one case, a sex offender was released without completing inpatient services or community-transition services treatment at LRC, which we believe contradicted the program's standard practice and consequently increased the risk to public safety unnecessarily.

**Finding 11:** Some program staff are concerned about the way discharge decisions are made.

**Discussion:** Although research indicates that treatment may reduce recidivism for some sex offenders, no treatment program can guarantee that individuals it releases will not re-offend. Regardless, the program should ensure that it has taken all reasonable steps to reduce the risk of re-offense before a sex offender is released.

As reflected in findings five through eleven, we believe that the program is not doing everything it should to reduce risks to public safety because it lacks effective safeguards on transfer and discharge decisions. Specifically, we found that: 1) the written policies regarding the decisions are not comprehensive; 2) the reasoning behind the decisions is not documented; 3) the decisions are ultimately made by one person; and 4) other staff with potentially valuable insights are unsure whether or not their opinions are considered. In addition, although the CEO indicated that he would consider intervening in a discharge if program staff brought concerns to his attention, we believe this is unlikely to happen because staff may be hesitant to bypass their immediate supervisors or the psychiatrist.

The absence of these safeguards means that one person alone is responsible for the discharge decision without having to explain the decision and without a meaningful review by anyone else. In one of the four cases we reviewed, the sex offender was discharged despite the fact that he had neither completed the inpatient portion of the program nor been assigned to participate in the transition program and there was no documentation in the file explaining why that offender was not required to complete the program before he was discharged. After discharge, he committed another sexual assault.

Having been able to review only a small number of cases, we cannot say with certainty whether other sex offenders were discharged without completing the program. Based on our interviews with program staff, we believe that they take seriously their responsibility to protect public safety by striving to discharge only those individuals least likely to re-offend. Nevertheless, under the transfer and discharge procedures in place at the time of this audit, it is possible that other discharge decisions were made that unnecessarily increased the risk to public safety, or that such decisions could be made in the future. Given the traumatic impact of sexual assault on individuals and communities alike, even one such case is cause for serious concern and, rather than being dismissed as a mere anomaly, should serve as impetus for corrective action within the program.

**Recommendation:** The discharge policies should be clarified to require committed offenders to successfully complete both inpatient services and community-transition services prior to discharge. If program staff choose to make an exception and discharge an offender who has not completed both components of the program, the policies should require program staff to document the reasoning for this decision in the sex offender's medical files.

In addition to improving its discharge policies, the program should take other steps to improve the accountability of release decisions. These steps could include requiring clinical staff to weigh in formally on discharge decisions, either in writing or via discussions with the CEO.

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

### ***The Program's Procedures for Incarcerated Offenders***

**Finding 12:** Program staff have limited influence in the post-discharge decisions for incarcerated offenders.

**Recommendation:** No recommendation.

***Interaction with Mental Health Boards and the  
Department of Correctional Services***

*Impact of Increased Commitments on LRC*

**Finding 13:** Between 2001 and 2005, the majority of sex offenders referred for mental health board commitment by the Department of Correctional Services (Corrections) were not committed.

**Finding 14:** The changes that LB 1199 (2006) makes to the sex offender commitment process are expected to increase the number of sex offenders committed to the program.

**Finding 15:** A significant increase in mental health board commitments cannot be accommodated unless sex offenders currently in treatment are moved through the program more rapidly or more beds are added.

**Finding 16:** A significant increase in mental health board commitments may result in longer stays in treatment because these sex offenders may be less motivated in treatment.

**Finding 17:** Should the number of mental health board commitments outpace the anticipated increase in capacity, LRC may eventually be unable to serve the needs of any incarcerated offenders under the Convicted Sex Offender Act.

**Finding 18:** The Department of Health and Human Services plans to open more sex offender treatment beds at the Norfolk Regional Center.

**Discussion:** Recent policy changes are likely to increase both the number of sex offenders the program must treat and the program's capacity for doing so. What is unclear at this point is whether the increased capacity will be adequate to meet the increased need.

**Recommendation:** The program should carefully monitor the trends in commitments and the effects of those trends on the program's ability to meet the needs of both committed and incarcerated offenders.

*Other Issues*

**Finding 19:** Neither Corrections nor any other entity regularly tracked the number of requests Corrections made to initiate civil commitment proceedings or the disposition of those requests.

**Discussion:** Under LB 1199 (2006), county attorneys must, within 45 days of receiving notice of the pending discharge of incarcerated sex offenders, notify the Attorney General whether they intend to initiate civil commitment proceedings against such individuals.

**Recommendation:** Although not responsible for the disposition of these requests, LRC is impacted by their results. LRC should work with the other agencies involved to ensure that these requests and their ultimate dispositions are tracked.

***Recidivism of Treated vs. Untreated  
Sex Offenders in Nebraska***

**Finding 20:** We acknowledge that all recidivism studies, including our own, are likely to produce significant underestimates of actual re-offense rates and should be viewed with caution.

**Finding 21:** The untreated sex offenders had a higher recidivism rate for all offenses and, on average, committed more offenses, which may suggest that treatment played a role in reducing recidivism.

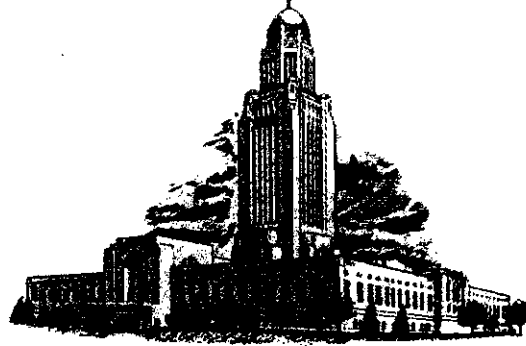
**Finding 22:** When broken down by offense, the results of the recidivism rate analysis are inconclusive.

**Recommendation:** No recommendation.

# State of Nebraska

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June 5, 2006

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**LEGISLATIVE RESEARCH**

Cynthia Johnson, Director  
Performance Review Audit Section  
Room 1201 - State Capitol  
Lincoln, NE 68509

Dear Cynthia:

This letter is written in reference to your request for our opinion as to whether the Department of Health and Human Services (HHS) can implement the recommendations of the performance audit of the Lincoln Regional Center's Sex Offender Services Program with the current appropriation provided to the agency.

The recommendations regarding the maintenance of GAS scores in offenders' medical files; the retention of documentation of these scores; and the need to develop policies to insure the information is available should not have a fiscal impact for HHS. Since it is clear the information exists, the staff will need to alter or develop procedures and policies to include the information in an offender's file. It is assumed these changes can be accomplished with existing resources.

Likewise, the recommendations relating to the development of policies dictating transfer and discharge decisions; the documentation of the reasoning for these decisions; and the formal opportunity for clinical staff to have input on discharge decisions can be implemented by existing staff. The documentation of reasons for transfers and discharges as well as a formal mechanism for input from clinical staff may incrementally increase the workload for staff, but no additional fiscal resources should be needed.

Cynthia Johnson

June 5, 2006

Page 2

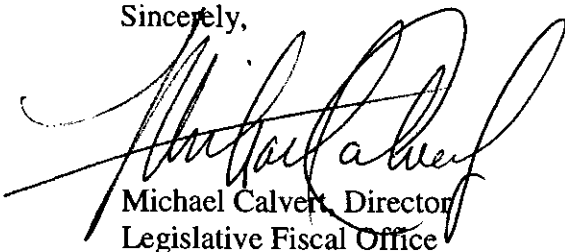
The report recommends that discharge policies should be clarified to require committed offenders to successfully complete both inpatient and community-transition services prior to discharge. If an exception is made, then policies should be developed to document deviations from required services. The report indicates that only one offender was released in the time period studied prior to completing inpatient and community-transition services. Since the one release appears to be an exception from the norm that all offenders complete both treatment phases, there should be no fiscal impact to have a required policy to require such treatment and document exceptions.

The recommendation for the Lincoln Regional Center to work with the Department of Corrections, the Attorney General and county attorneys to track requests made by the Department of Corrections to initiate civil commitment proceedings and the disposition of the requests should not have a fiscal impact for HHS because any tracking would in all probability be assigned to other entities.

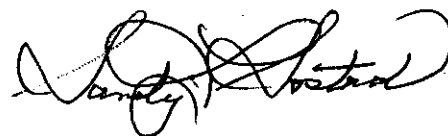
The findings and discussion in the report indicate there will likely be an increase in the number of sex offenders committed to the program for treatment and also the resources committed to the program per recent legislation (LB 1199). The fiscal impact of increased capacity for the sex offender treatment program has been addressed by the appropriation provided in LB 1199A. The study recommendation for the agency to monitor trends in commitments to see whether those trends enable the program to meet the needs of committed and incarcerated offenders will not have a fiscal impact for HHS to do the monitoring. However, it is possible the trends in commitments related to LB 1199 may indicate the need for additional capacity for the sex offender program which would have a future fiscal impact for the state.

In summary, it is our opinion the Department of Health and Human Services will be able to implement the recommendations of the audit of the Lincoln Regional Center's Sex Offender Services Program within its existing appropriation.

Sincerely,



Michael Calvert, Director  
Legislative Fiscal Office



Sandy Sostad, Program Analyst  
Legislative Fiscal Office





*IV. Background Materials*

## **BACKGROUND MATERIALS**

The “background materials” provided here are materials (in addition to the Section’s report) that were available to the Committee when it issued the findings and recommendations contained in Part III of this report. They include:

- the Section’s draft findings and recommendations (provided for context);
- the agency’s response to a draft of the Section’s report;
- the Section Director’s summary of the agencies’ response; and
- Appendix A: Audit Methodology.

# Performance Audit Section Draft Findings and Recommendations (June 2006)

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***Note:** The Section's draft findings and recommendations contain language that was revised after the Section received the agency response. Please refer to the Committee's findings and recommendations (Part III of this report) for the revised language.*

In this section, we present our draft findings and recommendations based on the analyses presented in Sections I through V.

## *The Lincoln Regional Center's Sex Offender Services Program*

**Finding 1:** On average, sex offenders in the Sex Offender Services Program (program) have spent 2.8 years in inpatient services treatment. However, a few have been in treatment more than 15 years.

**Finding 2:** Some sex offenders currently in the program have previously spent a considerable amount of time in the program.

**Discussion:** We question whether sex offenders who have been in the program for extended periods of time, or those who have received treatment, been released, and been re-admitted several times, can be considered to be *progressing* through treatment. Given that treatment costs about \$100,000 per sex offender, per year, the financial impact of such individuals remaining stagnant in the program is significant. Despite these concerns, we did not find anything the program can do to eliminate the factors that result in some committed offenders remaining in treatment indefinitely.

## *The Program's Discharge Procedures for Committed Offenders*

### *Goal Attainment Scale Scores*

**Finding 3:** The Goal Attainment Scale (GAS) scores, which serve as a basis for important treatment decisions, are not kept in sex offenders' medical files, which may prevent proper access to them. Moreover, documentation pertaining to the reasoning behind GAS scoring is not retained.

**Finding 4:** Purposely separating the GAS scores from the rest of program participants' medical files raises serious ethical and legal concerns.

**Discussion:** We found the program staff's explanations for maintaining this documentation separately from the offenders' medical files unconvincing.

**Recommendation:** Program staff should maintain the GAS scores in each offender's medical file. Program staff should also retain the documentation that provides the basis for those scores. If program staff believe that offenders may misuse this information, they should develop a policy that would permit the removal of the information as needed. Any such policy should require, however, that the information be returned to the offender's file at least temporarily whenever the file is made available for a legal proceeding and permanently after the offender has been discharged.

#### *Documentation of Discharge Decision-Making*

**Finding 5:** LRC's discharge procedures contain little detail about the criteria an offender must meet in order to be discharged.

**Finding 6:** The reasoning behind some clinical decisions is not documented in a conspicuous location in offenders' medical files.

**Finding 7:** The reasoning behind some significant clinical decisions cannot be discerned, even from a thorough review of medical files.

**Finding 8:** National standards for sex offender treatment support the need to document the reasons for clinical decisions.

**Discussion:** Clinical decisions regarding both transfer of an offender from inpatient services to community-transition services, a significant step towards discharge, and discharge itself are significant not only to the offender but also to the public. Given the nature of the crimes involved and their traumatic impact upon individuals and the community alike, the program should be held to a high standard of accountability in making these decisions.

**Recommendation:** Program staff should develop comprehensive policies dictating how transfer and discharge decisions will be made. Policies should include the discharge criteria, define the roles of key personnel in the decision-making processes, and require such decisions to be documented.

**Recommendation:** Clinical staff should immediately begin documenting the reasoning behind transfer and release decisions.

### *Internal Control*

**Finding 9:** The program's discharge procedures for committed offenders are inadequate to protect public safety because they contain insufficient internal controls.

**Finding 10:** In one case, a sex offender was released without completing inpatient and community-transition services treatment at LRC, which we believe contradicts program policies.

**Finding 11:** Some program staff are concerned about the way discharge decisions are made.

**Discussion:** We conclude, based on these findings and those mentioned above dealing with inadequate documentation, that there is little effective internal control over the decisions regarding transfer and discharge. The need for internal controls, or checks and balances, on a program's actions will vary depending on the risk involved in the various actions. Decisions about whether or not to discharge sex offenders have far-reaching effects.

As reflected in findings five through eleven, we found a lack of effective internal controls on transfer and discharge decisions. Specifically, we found that: 1) the written policies regarding the decisions are not comprehensive; 2) the reasoning behind the decisions is not documented; 3) the decisions are ultimately made by one person; and 4) other staff with potentially valuable insights are unsure whether or not their opinions are considered. In addition, although the CEO indicated that he would consider intervening in a discharge if program staff brought concerns to his attention, we believe this is unlikely to happen because staff may be hesitant to bypass their immediate supervisors or the psychiatrist.

We identified one case in which a sex offender was released without completing the program, and that individual committed a subsequent sexual assault. Even one such case is serious and, rather than being dismissed as a mere anomaly, should serve as impetus for corrective action within the program.

**Recommendation:** The discharge policies should be clarified to require committed offenders to successfully complete both inpatient services and community-transition services prior to discharge. If program staff choose to make an exception and discharge an offender who has not completed both components of the program, the policies should require program staff to docu-

ment the reasoning for this decision in the sex offender's medical files.

In addition to improving its discharge policies, the program should take other steps to improve the accountability of release decisions. These steps could include requiring clinical staff to weigh in formally on discharge decisions, either in writing or via discussions with the CEO.

### *The Program's Procedures for Incarcerated Offenders*

**Finding 12:** Program staff have limited influence in the post-discharge decisions for incarcerated offenders.

### *Interaction with Mental Health Boards and the Department of Correctional Services*

#### *Impact of Increased Commitments on LRC*

**Finding 13:** Between 2001 and 2005, the majority of sex offenders referred for mental health board commitment by the Department of Correctional Services (Corrections) were not committed.

**Finding 14:** The changes that LB 1199 (2006) makes to the sex offender commitment process are expected to increase the number of sex offenders committed to the program.

**Finding 15:** A significant increase in mental health board commitments cannot be accommodated unless sex offenders currently in treatment are moved through the program more rapidly or more beds are added.

**Finding 16:** A significant increase in mental health board commitments may result in longer stays in treatment because these sex offenders may be less motivated in treatment.

**Finding 17:** Should the number of mental health board commitments outpace the anticipated increase in capacity, LRC may eventually be unable to serve the needs of any incarcerated offenders under the Convicted Sex Offender Act.

**Finding 18:** The Department of Health and Human Services plans to open more sex offender treatment beds at the Norfolk Regional Center.

**Discussion:** Recent policy changes are likely to increase both the number of sex offenders the program must treat and the program's capacity for doing so. What is unclear at this point is

whether the increased capacity will be adequate to meet the increased need.

**Recommendation:** The program should carefully monitor the trends in commitments and the effects of those trends on the program's ability to meet the needs of both committed and incarcerated offenders.

#### *Other Issues*

**Finding 19:** Neither Corrections nor any other entity regularly tracked the number of requests Corrections made to initiate civil commitment proceedings or the disposition of those requests.

**Discussion:** Under LB 1199 (2006), county attorneys must, within 45 days of receiving notice of the pending discharge of incarcerated sex offenders, notify the Attorney General whether they intend to initiate civil commitment proceedings against such individuals.

**Recommendation:** Although not responsible for the disposition of these requests, LRC is impacted by their results. LRC should work with the other agencies involved to ensure that these requests and their ultimate dispositions are tracked.

#### *Recidivism of Treated vs. Untreated Sex Offenders in Nebraska*

**Finding 20:** We acknowledge that all recidivism studies, including our own, are likely to produce significant underestimates of actual re-offense rates and should be viewed with caution.

**Finding 21:** The untreated sex offenders had a higher recidivism rate for all offenses and, on average, committed more offenses, which may suggest that treatment played a role in reducing recidivism.

**Finding 22:** When broken down by offense, the results of the recidivism rate analysis are inconclusive.



June 21, 2006

Ms. Cynthia Johnson  
Director of Research  
Performance Audit Section  
Nebraska Legislative Research Division  
PO Box 94945, State Capitol  
Lincoln NE 68509-4945

Dear Ms. Johnson:

This letter is in response to your June 1, 2006 correspondence concerning the Performance Audit Section review of the Lincoln Regional Center Sex Offender Program. We have reviewed your report and provided the Agency response in the designated column of the worksheet. On June 20, 2006, Bill Gibson and representatives from the Sex Offender Program met with Angie McClelland, Lance Lambdin, and Martha Carter to review the responses. Changes have been incorporated in the Agency response that reflect the discussion of that meeting. It is my understanding that this report will now be reviewed by the Legislative Performance Audit Committee. If they have questions or comments, the Agency will have an opportunity to respond prior to the release of this report.

If you have any questions regarding the Agency responses to the review, please contact Bill Gibson, CEO, at 479-5388, or my office at 479-9106.

Sincerely,

A handwritten signature in cursive script that reads "Nancy Montanez".

Nancy Montanez  
Director, Health and Human Services



**LINCOLN REGIONAL CENTER'S RESPONSE TO  
LEGISLATIVE PERFORMANCE AUDIT RECOMMENDATIONS**

Findings	Recommendations	Agency Response
<p>1. On average, sex offenders in the Sex Offender Services Program have spent 2.8 years in inpatient services treatment. However, a few have been in treatment more than 15 years.</p>	<p>No recommendation.</p>	<p><b><u>Not Applicable/No response</u></b></p>
<p>2. Some sex offenders currently in the program have previously spent a considerable amount of time in the program.</p>		
<p>3. The Goal Attainment Scale (GAS) scores, which serve as a basis for important treatment decisions, are not kept in sex offenders' medical files, which may prevent proper access to them.</p>	<p>Program staff should maintain the GAS scores in each offender's medical file. Program staff should also retain the documentation that provides the basis for those scores. If program staff believe that offenders may misuse this information, they should develop a policy that would permit the removal of the information as needed. Any such policy should require, however, that the information be returned to the offender's file at least temporarily whenever the file is made available for a legal proceeding and permanently after the offender has been discharged.</p>	<p><b><u>Agrees and will implement</u></b> The Lincoln Regional Center (LRC) Sex Offender Services Program has developed a form titled <i>Global Attainment Scores</i> (GAS) to record each individual offender's GAS scores (see Appendix A). This form will be inserted in each offender's file and in all newly admitted offenders' files. The form will reflect all individual GAS scores to date as well as all scores from this date forward. A policy will be developed delineating the situations that would warrant the removal of the form from offenders' files (e.g., an offender's misuse of the information). The policy will make clear that the form must be returned to offenders' files whenever the file is made available for a legal proceeding and permanently at the time the offender is discharged. All policies developed as a response to this audit will be approved by LRC Policy Committee.</p>
<p>4. Purposely separating the GAS scores from the rest of the program participants' medical files raises serious ethical and legal concerns.</p>		

<p>5. LRC's discharge procedures contain little detail about the criteria an offender must meet in order to be discharged.</p>	<p>Program staff should develop comprehensive policies dictating how transfer and discharge decisions will be made. Policies should include the discharge criteria, define the roles of key personnel in the decision-making processes, and require such decisions to be documented.</p>	<p><b><u>Agrees and will implement</u></b>  Program staff will delineate comprehensive policies dictating how transfer and discharge decisions are made. These policies will include clear discharge criteria, define the roles of key personnel in the decision-making processes, and require such decisions to be documented. These policies will be in accordance with the National Standards related to the treatment of sex offenders. Furthermore, clinical staff will immediately begin documenting all reasoning behind transfer and release decisions. A multidisciplinary team meeting will occur prior to the transfer or release of any offender in the program. Prior to these meetings, each discipline will be expected to review the offender's file so that they can make recommendations based upon the offender's progress in treatment, and other relevant factors such as family and/or community support, community services available to the offender, his assessed risk level and the availability of resources and/or services that can help to manage the offender's risk. All recommendations will be recorded on a form titled <i>Transfer/Discharge Recommendations</i> (see Appendix B) along with the attending psychiatrist's report explaining the decision to transfer or discharge the offender. The <i>Transfer/Discharge Recommendations</i> form will be a permanent part of the offenders' medical file.</p>
<p>6. The reasoning behind some clinical decisions is not documented in a conspicuous location in offender's files.</p>	<p>Clinical staff should immediately begin documenting the reasoning behind transfer and release decisions.</p>	
<p>7. The reasoning behind some significant clinical decisions cannot be discerned, even from a thorough review of medical files.</p>		
<p>8. National standards for sex offender treatment support the need to document the reasons for clinical decisions.</p>		

<p>9. The program's discharge procedures for committed offenders are inadequate to protect public safety because they contain insufficient internal controls.</p>	<p>The discharge policies should be clarified to require committed offenders to successfully complete both inpatient services and community transition services prior to discharge. If program staff choose to make an exception and discharge an offender who has not completed both components of the program, the policies should require program staff to document the reasoning for this decision in the sex offender's medical files.</p>	<p><b><u>Disagrees with finding but will implement recommendations</u></b></p>
<p>10. In one case, a sex offender was released without completing inpatient and community-transition services treatment at LRC, which we believe contradicts program policies.</p>	<p>The discharge policies should be clarified to require committed offenders to successfully complete both inpatient services and community transition services prior to discharge. If program staff choose to make an exception and discharge an offender who has not completed both components of the program, the policies should require program staff to document the reasoning for this decision in the sex offender's medical files.</p>	<p>The LRC Sex Offender Program disagrees with the finding that the current discharge procedures are inadequate to protect public safety because they contain insufficient internal controls. Clinical staff's discharge decisions are first and foremost concerned with public safety. Additionally, the Sex Offender Program has internal controls built into the program. For example, members of the treatment team routinely score (i.e., GAS scores) every patient based upon their progress. Offenders' GAS scores are a reflection of such things as their willingness to take responsibility for their sexually assaultive behaviors, their understanding of their sexual assault cycle, and their participation and progress in relapse prevention groups. Based upon current treatment literature, these are all factors that indicate progress in treatment and have also been shown to reduce risk of reoffense. Offenders must demonstrate significant progress as reflected by the GAS scores before they are considered for the community transition phase of treatment. Offenders are expected to maintain treatment gains in community transition phase in order to be considered for discharge. Furthermore, LRC now completes a Risk Assessment for each offender that aids in making discharge and placement decisions and provides recommendations for managing risk in the community.</p>
<p>11. Some program staff are concerned about the way discharge decisions are made.</p>	<p>In addition to improving its discharge policies, the program should take other steps to improve the accountability of release decisions. These steps could include requiring clinical staff to weigh in formally on discharge decisions, either in writing or via discussions with the CEO.</p>	<p>LRC acknowledges that there have been instances where, based upon clinical judgment and the availability of community services, clinical staff modified the treatment and discharge practices that were in place. These situations were unique and occurred on an infrequent basis. It is important to note that the internal controls as described above were adhered to for all but a small number of discharged offenders.</p>

Specifically, since January, 2001, LRC has discharged 139 offenders. Of this 139, 39 were discharged to correctional facilities and 94 were admitted into the SOS-R transition program. The transition unit did not open until October, 2001. Of the remaining six offenders, two challenged their MHB decision and were released by county MHB against the recommendations of the program. Two were discharged to other HHS treatment facilities. One was discharged to his family and one was discharged to a group home. One reoffended and is the case referred to in #11. The other continues to attend aftercare on a regular basis and has not posed a risk to public safety. In short, only 2 offenders out of the 139 were released into the community without following the existing protocol. Therefore, it is our opinion that these situations occurred so infrequently that it would be inaccurate to conclude that the current discharge procedures are inadequate to protect public safety because they contain insufficient internal controls. It is our opinion that the changes in policies and practices outlined in this document will further enhance our internal controls and eliminate the possibility of discharges outside standard procedures unless there is documented rationale and clinical justification for departing from standard procedures.

LRC concedes that the **procedures for, and documentation of**, discharge and placement decisions has been inadequate. To remedy this situation, discharge policies will stipulate that the reasoning behind all transfer and discharge decisions must be thoroughly documented. Additionally, the GAS scores will be added to each offender's medical file and will provide a clear indication of the offender's progression through treatment. Raw data sheets of individual staff scoring of GAS forms will also be kept indefinitely in secure files.

		<p>As noted, most offenders who were committed by a county Mental Health Board do complete both components of the program (i.e., inpatient and community transition). However, there are circumstances where it would not clinically be in the offender's best interest to be placed in the transition program (e.g., cognitively impaired individuals who will not be discharged to a community setting). If clinical staff make the decision to discharge an offender who has not completed both inpatient and transition components of the program, clinical staff will document the reasoning for this decision in the offender's file. The CEO's office will be notified for final disposition.</p> <p>Discharge and transfer meetings, as described above, will provide an opportunity for all professional staff to voice their concerns and/or support for transfer and discharge decisions. As noted, each disciplines' statement will be included in a formal document that will be a part of the offender's medical record.</p>
<p>12. Program staff have limited influence in the post-discharge decisions for incarcerated offenders.</p>	<p>No Recommendation</p>	<p><b><u>Not Applicable</u></b></p>
<p>13. Between 2001 and 2005, the majority of sex offenders referred for mental health board commitment by the Department of Correctional Services (Corrections) were not committed.</p>	<p>The program should carefully monitor the trends in commitments and the effects of those trends on the program's ability to meet the needs of both committed and incarcerated offenders.</p>	<p><b><u>Agrees and will implement</u></b></p> <p>LRC administrative and clinical staff have already begun to receive information from the Department of Correctional Services regarding the numbers of individuals that Corrections is recommending for civil commitment. Further meetings are scheduled to develop policies dictating formal and frequent communication between the two agencies. Additionally, LRC clinical staff, in collaboration with Norfolk Regional Center staff, are in the process of expanding and developing changes in programming for committed sex offenders. With the combined resources of NRC and LRC it is expected that the Sex Offender Services Program can accommodate the treatment needs of greater numbers of both incarcerated and committed offenders.</p>

<p>14. The changes that LB 1199 (2006) makes to the sex offender commitment process are expected to increase the number of sex offenders committed to the program.</p>		
<p>15. A significant increase in mental health board commitments can not be accommodated unless sex offenders currently in treatment are moved through the program more rapidly or more beds are added.</p>		
<p>16. A significant increase in mental health board commitments may result in longer stays in treatment because these sex offenders may be less motivated in treatment.</p>		
<p>17. Should the number of mental health board commitments outpace the anticipated increase in capacity, LRC may eventually be unable to serve the needs of any incarcerated offenders under the Convicted Sex Offender Act.</p>		
<p>18. The Department of Health and Human Services plans to open more sex offender treatment beds at the Norfolk Regional Center.</p>		
<p>19. Neither Corrections nor any other entity regularly tracked the number of requests Corrections made to initiate civil commitment proceedings or the disposition of those requests.</p>	<p>Although not responsible for the disposition of these requests, LRC is impacted by their results. LRC should work with the other agencies involved to ensure that these requests and their ultimate dispositions are tracked.</p>	<p><b><u>Agrees and will implement</u></b> As reported above, steps have been taken to insure ongoing communication between Sex Offender administrative staff and Corrections.</p>

<p>20. We acknowledge that all recidivism studies, including our own, are likely to produce significant underestimates of actual reoffense rates and should be viewed with caution.</p>		
<p>21. The untreated sex offenders had a higher recidivism rate for all offenses and, on average, committed more offenses, which may suggest that treatment played a role in reducing recidivism.</p>		
<p>22. When broken down by offense, the results of the recidivism rate analyses are less conclusive.</p>		





**Lincoln Regional Center  
Sex Offender Services  
Transfer/Discharge Recommendations**

ate: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Score at Last TPR: \_\_\_\_\_ Level: \_\_\_\_\_

Length of Stay: \_\_\_\_\_

Psychiatrist's Report (Please see Psychiatric Update for full report)

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Sex Offender Therapists' Report:

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Nursing Report:

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Recreation Therapist Report

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Occupational Therapist Report

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Social Worker's Report:

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Psychologist Risk Report (Refer to Risk Assessment for additional recommendations):

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JUL 24 2006

LEGISLATIVE RESEARCH

July 18, 2006

Ms. Cynthia Johnson  
Director of Research  
Performance Audit Section  
PO Box 94945, State Capitol  
Lincoln NE 68509-4945

Dear Ms. Johnson:

We have reviewed the changes made by the Legislative Performance Audit Section to the draft report language for the Lincoln Regional Center sex offender program audit. We agree with the changes you have made.

Respectfully,

Nancy Montanez, Director  
Health and Human Services

## DIRECTOR'S SUMMARY OF AGENCY RESPONSE

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*On 21 June 2006, the Nebraska Department of Health and Human Services (HHS) submitted a response to a draft of the Performance Audit Section's report prepared in conjunction with this audit. Neb. Rev. Stat. §50-1210 requires the Section Director to "prepare a brief written summary of the response, including a description of any significant disagreements the agency has with the section's report or recommendations." The director's summary of the response follows.*

In her response, the HHS director agreed to implement all of the Section's recommendations and indicated that Lincoln Regional Center sex offender program staff are changing existing procedures to address the Section's concerns. Although they agreed to implement all of the recommendations, HHS representatives took issue with the original wording of one finding. We discussed the issue with the HHS representatives and ultimately agreed that the original language could have been misconstrued. We clarified the language in question, and the HHS representatives supported our revisions.

## APPENDIX A: Audit Methodology

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This audit was conducted in accordance with generally accepted government auditing standards for performance audits. The methodologies we used to answer each of the scope statement questions are described briefly at the beginning of each section. This appendix provides additional details.

### Introduction

The Norfolk Regional Center currently serves a small number of adult sex offenders.

The Lincoln Regional Center (LRC) also administers a juvenile sex offender program; however, because the adult and juvenile programs differ significantly in their admissions, treatment, and release processes, the Committee restricted the scope of this audit to the adult program.

### Section I: LRC's Sex Offender Services Program

#### *Gender Differences in Sex Offender Treatment*

One resource for the statement that most sex offenders are male is "Myths and Facts About Sex Offenders" (August 2000) (<http://www.csom.org/pubs/mythsfacts.html>).

The program is currently serving four female sex offenders, who are housed and treated separately from the male sex offenders. Because there are so few female sex offenders and because research indicates their treatment should be different from that provided to male sex offenders, we omitted them from this audit. (One resource for the statement that female sex offenders need a different type of treatment is "An Overview of Sex Offender Management" (July 2002) ([http://csom.org/pubs/csom\\_bro.pdf](http://csom.org/pubs/csom_bro.pdf)).

#### *Demographic Information on Current Program Participants*

We calculated the: 1) legal status of current program participants; 2) length of inpatient and community-transition services; and 3) number of commitments using data provided by LRC on each current offender. We did not independently verify the information provided by LRC.

We calculated the total length of inpatient services treatment for all 78 sex offenders, as well as the length of previous commitments to the program. We also calculated the length of community-transition

services treatment for the 15 sex offenders in that part of the program.

Our calculation of a sex offender's length of inpatient treatment began with the date he was admitted to the program. For sex offenders who were still in inpatient treatment at the time of the audit, we used an ending date of 15 May 2006, which was the date when we received the information from LRC. For offenders who had completed inpatient treatment, the ending date was the date they began community-transition services. Our calculation of an offender's length of community-transition treatment began with the date of their transfer to that treatment and ended with 15 May 2006.

Each "commitment" is a period of time in which the offender was committed to LRC. The offender was discharged from LRC in between the commitments.

#### *Estimated Program Costs*

We generally rely on the state's accounting system—the Nebraska Information System, or NIS—for information on the expenses of programs we audit. In this case, however, the program's expenses are not a discrete line in the agency's budget. Consequently, we had to work with program staff and the Health and Human Services Finance and Support Agency (Finance and Support) to develop estimated actual expenses. In short, we combined the actual direct expenses that were known with estimates based on the number of staff and offenders for the unknown direct and indirect costs.

We note that these estimates are lower than those used by LRC in projecting its costs for FY2005-06, which reflect a cost of \$108,000 per sex offender in inpatient services. However, Finance and Support staff were unable to explain the difference.

We started with the program's direct costs, which are reflected in three budget subprograms:

- Subprogram 410, Forensic Services (includes male inpatient sex offender services);
- Subprogram 470, Sex Offender Residential Transitional Program (includes female sex offender services and male community-transition services); and
- Subprogram 519, Sex Offender Aftercare.

The difficulty in calculating the program's actual expenses was compounded by the fact that subprogram 410 includes direct expenses for all patients in LRC's forensic unit, not just those in the sex of-

fender program. The Finance and Support staff could not break out the sex offender expenses from the general forensics expenses, so we used the following methodology to compile our own estimate of direct inpatient costs:

- For the Personal Services Costs, we had the LRC Human Resources Manager calculate the percentage of personal services expenses paid to sex offender program staff (48% of the total personal services costs);
- For Operating/Travel Costs, we calculated the percentage of operating expenses used by sex offender patients. (There are 64 inpatient sex offenders. The total capacity of the forensics program is 107. Therefore, the sex offenders would account for approximately 60% of the operating expenses.)

We also had to estimate the program’s indirect costs, which are not reflected in the above subprograms. To do so we developed estimates of:

- Indirect facility costs (physical plant, laundry services, food, and facility administration); and
- Indirect HHSS support costs (Finance and Support Agency staff time).

The following tables reflect our final calculations.

**Sex Offender Program Actual Cost Estimates for FY2004-05**

*Inpatient Estimate FY2004-05*

Type of Expense	Actual for Forensics	% used by sex offender program	Estimated actual for sex offender program
Personal Services	\$6,423,398.25	48% (66 of 137.5 forensics employees)	\$3,083,231.16
Operating/Travel Expenses	\$1,267,124.04	60% (64 of 107 forensics patients)	\$760,274.42
Indirect Facility Costs	\$2,821,606.00	60% (64 of 107 forensics patients)	\$1,692,963.60
Indirect HHSS Support Costs	N/A	\$4,754.48 times 66 employees	\$313,795.68
<b>Total</b>	<b>\$10,512,128.29</b>		<b>\$5,850,264.86</b>

*Community-Transition (Male Sex Offenders) Estimate FY2004-05*

<b>Type of Expense</b>	<b>Actual/Estimated Actual for all Residential</b>	<b>% used by male sex offenders</b>	<b>Actual/Estimated Actual for ONLY MALE Community-Transition</b>
Direct Costs	\$1,159,117.91	76% (16 of 21 beds)	\$880,929.61
Indirect Facility Costs	\$555,883.00	76% (16 of 21 beds)	\$422,471.08
Indirect HHSS Support Costs (\$4,754.48 times 23 employees)	\$109,353.04	76% (16 of 21 beds)	\$83,108.31
<b>Total</b>	<b>\$1,824,353.95</b>		<b>\$1,386,509.00</b>

*Aftercare Estimate FY2004-05*

<b>Type of Expense</b>	<b>Notes</b>	<b>Actual/Estimated Actual</b>
Direct Costs	N/A	\$69,464.02
Indirect Facility Costs	None	\$0.00
Indirect HHSS Support Costs	\$4,754.48 times 5 employees	\$23,772.40
<b>Total</b>		<b>\$93,236.42</b>

**Section II: Discharge Procedures for Committed Offenders**

*Case Studies*

We had planned to select a random sample of sex offenders for our file review relating to the program's discharge procedures. This became impossible within the audit timeframe, however, when we realized we would not be able to identify one or two documents for review and would, instead, have to read thoroughly large portions of the files, including handwritten notes.

Program staff confirmed that the reasoning for these decisions is not contained in a single, identifiable location in the sex offenders' files. They agreed also that it would be valuable to have such documentation more readily accessible.

Without a random sample, we cannot identify with any statistical degree of certainty the likelihood that our findings represent what we would have found if we had looked at all of the program participants' files. However, based on our experience reviewing these case files, the lack of written guidance about how discharge decisions should be made, and the absence of other meaningful internal controls on the

decision-making process, we believe that there is a very high likelihood that our findings do represent the type of documentation that would be found in the other files. In addition, we asked program staff to identify files that contained relatively recent documentation to counter the possibility that we were reviewing documentation based on outdated policies.

We asked program staff to identify cases with these outcomes: 1) a sex offender who completed the program and was not convicted of a subsequent offense; 2) a sex offender who completed the LRC program and *was* convicted of a subsequent sexual offense; and 3) a convicted sex offender who did not complete treatment and was returned to prison.

For our four cases studies, we reviewed all of the documentation in the sex offender's medical file relating to his behavior and progress for a period beginning approximately 12 months prior to his move to community-transition services and continuing through the offender's discharge from LRC and participation in post-discharge services, when applicable. The materials we reviewed included: notes made by security and nursing personnel, who interact with offenders daily; reports of the social work, psychological, and psychiatric personnel, who interact with the offenders periodically (often weekly or bi-weekly); and correspondence between LRC and both the Nebraska Board of Parole and the mental health boards.

#### *Interviews with Program Staff*

Following is the list of questions we asked all program staff as well as questions tailored to inpatient services, community-transition services, and clinical staff.

#### Questions for All Staff Interviewed

- What is your position, what are your job duties?
- How long have you worked in the sex offender program?
- Describe a typical treatment team meeting for us.
- Do you participate in treatment team meetings? Do you know if anyone keeps minutes of those meetings?
- Do you generally agree with the clinical decisions regarding the transition and discharge of sex offenders?
- If you do not agree with a clinical/treatment team decision, are your concerns documented anywhere?
- Can you think of any instances where you felt an offender was progressed through the program inappropriately?



- Have you ever felt pressured to score a sex offender more favorably so that he would move through the program more quickly than his progress merited?
- How is the sex offender program managing to serve all of the sex offenders committed to treatment now that Hastings is closed?
- Do you think things have changed or are going to change now that there is a new Chief Executive Officer?

#### Questions for Inpatient Ward Staff

- Do you feel that your opinions regarding sex offender conduct and/or treatment progress are adequately considered in treatment team meetings?
- In your opinion, what things do you want to see in a sex offender's words and behavior before you think he is ready for transfer to community-transition?

#### Questions for Residential Ward Staff

- Do you feel that your opinions regarding sex offender conduct and/or treatment progress are adequately considered in treatment team meetings?
- In your opinion, what things do you want to see in a sex offender's words and behavior when he is transferred to community-transition?
- In your opinion, what things do you want to see in a sex offender's words and behavior before he is discharged into the community?

#### Questions for Clinical/Professional Staff

- Do you participate in the clinical meetings on Wednesdays and Fridays? Can you describe for us what is addressed in these meetings?
- Are minutes kept of the clinical meetings? If not, why not?
- Do you feel that your opinions regarding sex offenders' treatment progress are adequately considered in meetings?
- In your opinion, what things do you want to see in a sex offender's words and behavior before he is transferred to community-transition?
- In your opinion, what things do you want to see in a sex offender's words and behavior before he is discharged into the community?
- Can you explain for us the GAS scoring process and the patient risk assessment scoring process? Do you know why the GAS scores are not included in the medical files?

- What do you do with a patient that you believe has reached “maximum benefit” from the treatment but is still dangerous? Do you feel that LRC can legally keep the patient in the program if he is not benefiting from treatment?
- What are your opinions about LRC’s liability for sex offenders who are discharged into the community? Are they LRC’s problem after they are discharged?
- Are you involved with aftercare treatment? If so, describe for us what goes on in an aftercare group. How do you discern progress or problems? What is the process if a sex offender stops coming?
- Do you know what the current plans are regarding sending sex offenders to Norfolk?
- How many sex offenders are housed on the psych wards in the forensics building? Do they receive sex offender treatment while they are on the psych wards?
- To your knowledge, have any incarcerated offenders been sent back to Corrections to make room for incoming mental health board commitments?

## **Section V: Recidivism of Treated vs. Untreated Sex Offenders in Nebraska**

In preparation for our recidivism study, we consulted with Dr. Mario Scalora, a licensed psychologist and professor in the Department of Psychology at the University of Nebraska. Dr. Scalora is an expert in the areas of sex offender research and treatment. We informed the Chief Executive Officer (CEO) of LRC of our intention to draw upon Dr. Scalora’s professional expertise in carrying out our recidivism study. The CEO agreed that Dr. Scalora would be an appropriate authority upon whom to rely for guidance.

### *Control Group*

To obtain a comparable sample of untreated offenders for use as a control group, we asked Corrections to provide us with a list of all incarcerated sex offenders discharged between 1 October 2001 and 30 June 2003 who had not participated in the sex offender treatment programming offered at Corrections. Corrections provided us with the requested information on 222 offenders meeting our criteria. We removed from that list all offenders who had voluntarily participated in or were mental health board committed to sex offender treatment at LRC.

We divided this final list into two categories: 1) those convicted of a sexual offense against a child; and 2) those convicted of other sexual offenses. Choosing a stratified random sample of offenders, we made sure that, for each year of our study, the number of untreated offend-

ers discharged from Corrections matched the number of treated LRC offenders, and the proportion of child sexual offenders roughly matched the number of pedophiles in the LRC group.

# PERFORMANCE AUDIT COMMITTEE REPORTS

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## ***Performance Audit Reports***

- *The Nebraska Medicaid Program's Collection of Improper Payments (May 2005)*
- *The Lincoln Regional Center's Billing Process (December 2004)*
- *Nebraska Board of Parole (September 2003)*
- *Nebraska Department of Environmental Quality: Administering the Livestock Waste Management Act (May 2003)*
- *HHSS Personal-Services Contracts (January 2003)*
- *Nebraska Habitat Fund (January 2002)*
- *State Board of Agriculture (State Fair Board) (December 2001)*
- *Nebraska Environmental Trust Board (October 2001)*
- *Nebraska Department of Roads: Use of Consultants for Preconstruction Engineering (June 2001)*
- *Department of Correctional Services, Inmate Welfare Fund (November 2000)*
- *Bureau of Animal Industry: An Evaluation of the State Veterinarian's Office (March 2000)*
- *Nebraska Ethanol Board (December 1999)*
- *State Foster Care Review Board: Compliance with Federal Case-Review Requirements (January 1999)*
- *Programs Designed to Increase The Number of Providers In Medically Underserved Areas of Nebraska (July 1998)*
- *Nebraska Department of Agriculture (June 1997)*
- *Board of Educational Lands and Funds (February 1997)*
- *Public Service Commission: History of Structure, Workload and Budget (April 1996)*
- *Public Employees Retirement Board and Nebraska Public Employees Retirement Systems: Review of Compliance-Control Procedures (March 1996)*
- *Leaking Underground Storage Tank Program (December 1995)*
- *School Weatherization Fund (September 1995)*

- *The Training Academy of the Nebraska State Patrol and the Nebraska Law Enforcement Training Center (September 1995)*
- *Nebraska Equal Opportunity Commission (January 1995)*
- *The Interstate Agricultural Grain Marketing Commission (February 1994)*

## ***Preaudit Inquiries***

- *Implementation of the Nebraska Information System (NIS) (November 2005)*
- *The Lincoln Regional Center Psychiatrists' Work Commitments (September 2005)*
- *The Nebraska State Patrol's Record of its Investigation of State Treasurer Lorelee Byrd (November 2004)*
- *HHSS Public Assistance Subprograms' Collection of Overpayments (August 2004)*
- *NDEQ Recycling Grant Programs (October 2003)*
- *HHSS Reimbursement and Overpayment Collection (August 2003)*
- *Grain Warehouse Licensing in Nebraska (May 2003)*
- *HHSS Personal-Services Contracts (July 2002)*
- *Livestock Waste Management Act (May 2002)*
- *Nebraska Telecommunications Universal Service Fund (April 2001)*
- *State Board of Health (November 2001)*
- *State Board of Agriculture (State Fair Board) (August 2001)*
- *Game and Parks Commission Cash Funds (August 1999)*
- *Education Technology (January 1998)*
- *Nebraska Research and Development Authority (April 1997)*
- *Nebraska's Department of Agriculture (June 1996)*
- *Nebraska's Department of Correctional Services Cornhusker State Industries Program (April 1996)*
- *DAS Duplication of NU Financial Record-Keeping (February 1995)*