PERFORMANCE AUDIT REPORT

Larned State Hospital: Reviewing the Operations of the Sexual Predator Treatment Program, Part 2

A Report to the Legislative Post Audit Committee
By the Legislative Division of Post Audit
State of Kansas
April 2015

R-15-006

Legislative Division of Post Audit

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April 28, 2015

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This report contains the findings, conclusions, and recommendations from our completed performance audit, *Larned State Hospital: Reviewing the Operations of the Sexual Predator Treatment Program, Part 2*. The audit was requested by the House Appropriations committee and Senate Ways and Means committee.

In its response, the agency disagreed with a number of the report findings in Question One. The agency appears to have made a number of recent changes to the program, most of which were implemented after the time period covered by our audit work. We commend the agency for making these changes, but do not believe they affect the report's findings. The agency generally agreed to implement or has begun implementing all the audit recommendations. More information on this issue can be found in ***Appendix E*** on page 51.

We would be happy to discuss the findings, recommendations, or any other items presented in this report with any legislative committees, individual legislators, or other state officials.

Sincerely,

Scott Frank
Legislative Post Auditor

This audit was conducted by Lynn Retz, Matt Etzel, Ashly LoBurgio Basgall and Daniel McCarville, Chris Clarke *was* the audit manager. If you need any additional information about the audit's findings, please contact Lynn Retz at the Division's offices.

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Larned State Hospital: Reviewing the Operations of the Sexual Predator Treatment Program

The Sexual Predator Treatment Program was established in 1994 and has been provided primarily through the Larned State Hospital. The program provides control, care and treatment for convicted sex offenders who have completed their prison sentences but have been determined by a judge or jury to be sexually violent predators and involuntarily committed to the custody of the Secretary of Kansas Department for Aging and Disability Services.

In 2005, Legislative Post Audit issued a report on the Sexual Predator Treatment Program. In that report, we estimated the size of the offender population could increase to about 235 offenders by 2015. The reasons for this included the continuing commitment of new offenders to the program and Kansas' stringent requirement that the risk of a reoffense be reduced to "practically nil" before an offender would be released from the program. The statutory standard focuses on community safety by requiring that in order for release the sexually violent predator's mental abnormality or personality disorder has so changed the person is safe to be at large.

As of December 2014, the program had 243 residents, with 227 residents at Larned State Hospital, eight residents at Osawatomie State Hospital and eight at Parsons State Hospital. Agency officials estimate that in the coming years the program will grow by 18 offenders per year.

Legislators have expressed concern about the growing size of the offender population, employee workload, and working conditions at the Larned facility. They would like to know how Kansas' program compares to other state programs in terms of cost and treatment, what actions could be taken to limit program growth, and whether the Larned facility is being adequately managed.

This performance audit answers the following questions:

1. **How does Kansas' Sexual Predator Treatment Program compare to similar programs in other states and best practices?**

2. **What actions could be taken to reduce the resident population of the Sexual Predator Treatment Program?**

A copy of the scope statement for this audit approved by the Legislative Post Audit Committee is included in ***Appendix A***. The scope statement includes three questions. In May 2013, the Legislative Post Audit Committee decided to split the audit into two parts and delay work on questions one and two. Part 1 covered question three and was released in September 2013. This audit answers questions one and two. For reporting purposes we made minor changes to the wording for question two.

Our audit work included a variety of steps designed to help us answer question one. We reviewed the Kansas Constitution, state statutes, as well as federal and state case law to identify the program's legal requirements, and compared those requirements to the program elements at Larned State Hospital. We interviewed Kansas Department of Aging and Disability officials and Larned State Hospital staff to understand the services offered through the program. We visited the facility and reviewed documents concerning the population, services, and treatment plans for a sample of residents. Some of our findings are based on this sample of resident records. These findings are not projectable to the program as a whole. We also collected staffing and expenditure data and surveyed staff. In identifying research-based guidance, we reviewed literature and spoke with individuals who work in this field. Additionally, we contacted other state officials concerning their program requirements, and expenditures.

For question two, we collected and analyzed population data for the Sexual Predator Treatment Program since its inception. We interviewed program staff, agency officials, and other potential stakeholders to identify various options, consequences, barriers or limitations to address population issues. In addition, we considered actions taken by other states to address program population issues. We developed an in-house model to project population growth for the program if no changes are made to the program. We then compared that projection to six potential options. Our methodology is described in more detail in ***Appendix B.***

Due to the audit's scope, our work on internal controls was limited to management oversight of the program. We reviewed steps officials take to ensure services are provided, and reviewed how they collect and utilize data to manage the program.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and

conclusions based on our audit objectives. We believe the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

We took steps to check the accuracy, completeness and validity of data provided by agency officials including population demographics, expenditure and staffing data. We made adjustments as necessary to ensure accuracy and reasonableness of the data. Expenditure data for Larned State Hospital was used for calculating cost per resident and is likely understated making our projections conservative. After adjustments, the data were reliable enough for our purposes. For the projections in question two, we believe the assumptions and data provides a reasonable basis for our estimates and conclusions. However, the information should be viewed as an indicator of what the future population and costs may look like and not as absolute fact.

Our findings begin on page 11, following a brief overview of the Sexual Predator Treatment Program.

In 1994, the Legislature Created a Civil Commitment Program for Sexual Predators Through the Sexually Violent Predator Act

The desire to protect Kansas communities by providing for the control, care and treatment of sexually violent predators until they are no longer a danger prompted the Legislature to act. Through the 1994 Sexually Violent Predator Act, the Legislature created a separate civil commitment for the long-term control, care, and treatment of sexual predators.

The goal of the Sexual Predator Treatment Program is to prevent sexual predators from reoffending after their release. Statutes require sexual predators remain committed until their abnormality or disorder has changed and they are deemed "safe" to be allowed to return to society. Functionally, Kansas has set a very high standard for release from the program, with the goal being "no new victims."

A district court determines whether a sexual predator is likely to reoffend and should be civilly committed. The commitment process is multi-staged and rigorous. When an individual appears to meet the criteria of a sexually violent predator, notice is provided to the Attorney General and Department of Corrections multi-disciplinary team. If it is determined the individual meets the definition of a sexually violent predator, the Attorney General may file a petition for commitment. Once that happens, Larned State Hospital professionals complete an evaluation of the individual. There is a civil trial to determine whether the individual charged or convicted of a sexually violent offense suffers from a mental abnormality or personality disorder that will make that person likely to engage in repeat acts of sexual violence if not treated. If the judge or jury finds beyond a reasonable doubt this is the case, the individual is committed to the program. For the last three years, the Attorney General's office has reviewed about 270 offenders per year. On average, only 13 each year were committed to the Sexual Predator Treatment Program.

The seven-phase treatment program is primarily administered at Larned State Hospital. Although the program is civil rather than criminal, the facilities have many characteristics that are similar to prisons, including locked doors, perimeter fencing, and security staff. The rights of committed individuals are generally restricted and include confinement to their assigned residential units, controlled movement within the facility, and no access to the Internet. These measures are intended to facilitate control by providing for the safety and security of the public and persons committed to the program.

The treatment program has seven phases. The first five phases are provided at Larned State Hospital. The last two phases—known as reintegration—are provided at Osawatomie and Parsons State Hospitals. Residents on phase seven are considered to be on transitional release status. Residents who complete all seven phases are conditionally released from the program. District courts monitor residents who are conditionally released into the community for at least five years. After that period, a resident is eligible for final discharge from the program by the court.

Although admission to the program is involuntary, participation in treatment is voluntary. This is because residents have a statutory right to refuse treatment. However, residents who decline treatment remain confined to the facility and are not eligible to advance to reintegration facilities. According to program staff, about 40% of residents at Larned State Hospital were not participating in treatment as of December 2014.

As of December 2014, the Sexual Predator Treatment Program Had 243 Residents and the Population Was Continuing to Grow

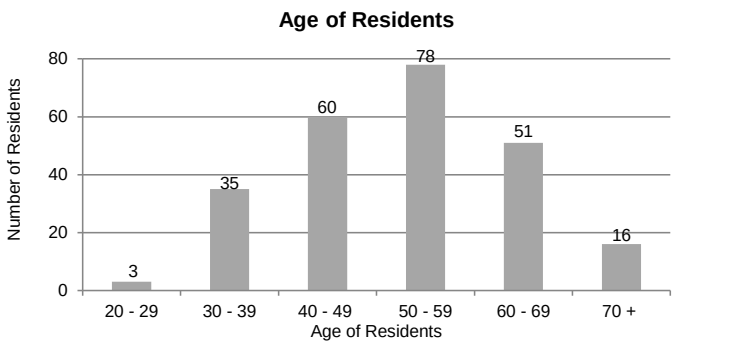
The first sex offender was committed to the program in October 1994. In 1997, after the U.S. Supreme Court ruled Kansas' sexually violent predator law was constitutional, the program began to grow rapidly and has continued to do so.

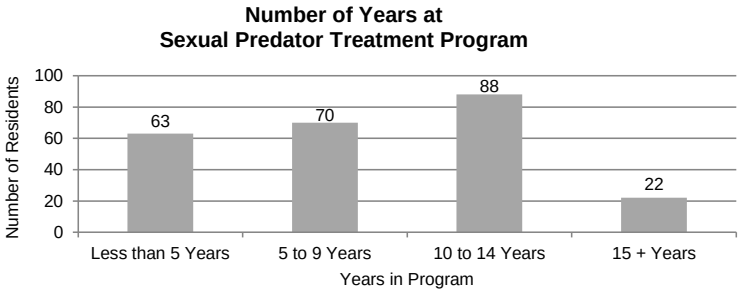
As of December 2014, the program housed a population of 243 residents—227 at Larned and eight each at the reintegration facilities in Osawatomie and Parsons. Although the program is not legally restricted to males, all residents admitted to date have been male. ***Figure OV-1*** on the next page summarizes residents' age, number of years they have spent in the program and treatment phase as of December 2014. As the figure shows, most residents are between 40 and 59 years old, most are in phase two or three of treatment, and the majority have been in the program more than five years.

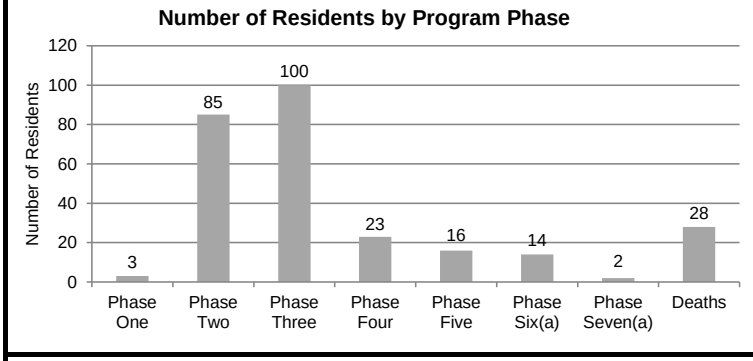
Because the program continues to add residents while very few have been released, the population will continue to grow well into the future. Since the program began, only three residents have completed the program. In addition, 13 residents have been released by court order for technical reasons, while another 28 residents have died before completing the program. Based on assumptions about death rates and program completion rates, we estimate the program will exceed its current capacity between 2017 and 2020. Further, we estimate the number of residents will

continue to grow and reach 300 to 330 residents within the next 10 years. We discuss this in more detail in Question 2 on page 21 of this audit report.

Figure OV-1
Select Demographic Information for Sexual Predator Treatment Program Residents (As of December, 2014)







(a) Located at Osawatomie and Parsons State Hospitals.
Source: Larned State Hospital (audited).

The Department for Aging and Disability Services (KDADS) has considered a number of options to address population growth, but so far has taken limited action. Officials told us they have considered four primary actions to address the population concerns, including:

- **Increase the number of individuals from 8 to 16 at Osawatomie and Parsons State Hospital reintegration facilities**. Phases six and seven are the reintegration phases, with phase seven referred to

as "transitional release." As of February 2015, statute limits the number of individuals on transitional release to no more than eight per county. Increasing the number of beds would allow more residents to continue to progress through the program. At the time of this report, KDADS officials supported legislation which would double the number of available beds in the reintegration facilities from 8 to 16 each. This option is discussed in further detail in Question 2 on page 31.

- **Establish alternative environments for medically infirm and elderly residents, as well as residents with disabilities.** Officials told us alternative facilities would allow them to tailor the program to meet the needs of the individuals in these particular areas. Further, it would create additional capacity at Larned for future residents. However, to date officials have not identified how to implement these changes. This option is discussed in further detail in Question 2 on pages 28 and 29.

- **Improve residents' participation to facilitate increased program completion rates**. Officials acknowledge the motivation of residents is an issue that limits participation and ultimately limits the number of individuals eligible to complete the program. As of December 2014 about 40% did not participate in treatment. Officials have not identified specific ways to improve motivation, but these could include increased benefits or access to special activities. Several officials told us if residents saw an increase in the number of individuals progressing to the reintegration facilities, it could improve participation and lead to more individuals progressing through the program.

- **Implement a risk assessment tool to evaluate residents' progress.** At the time of this audit, the program did not utilize a risk assessment tool as part of the treatment process. A risk assessment would allow staff to appropriately separate residents based on risk, identify the treatment services and intensity needed, and measure treatment progress. These measures could help residents progress through the program. Additionally, a 2013 Task Force appointed by the Secretary of KDADS made this recommendation for the program. Program officials said they are in the process of implementing aspects of a risk assessment tool.

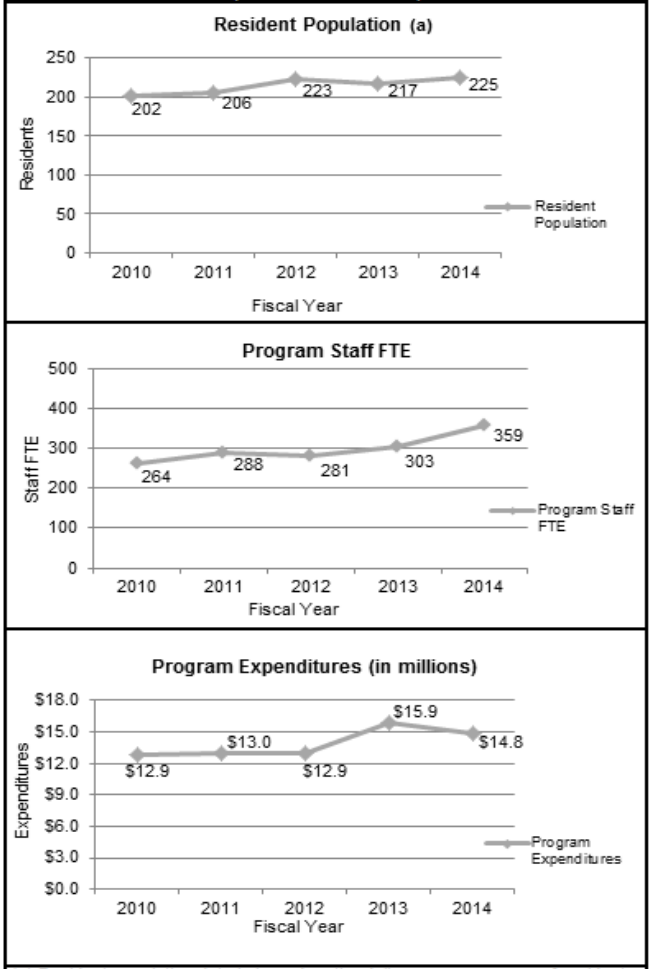
The Program's Staffing and Expenditures Have Also Grown Since 2010

The Sexual Predator Treatment Program employs a number and variety of staff at various locations. Having adequate staff helps ensure delivery of treatment and the safety and security of both residents and staff. Program staff generally fall into one of two categories:

- Direct care staff – These employees tend to residents' daily activities. Examples include mental health and developmental disability (MHDD) technicians and nurses, as well as activity therapists and psychologists.

- Non-direct care staff – These employees perform work that does not directly involve program residents. Examples include administrative positions and maintenance workers.

Figure OV-2
Summary of Sexual Predator Treatment Program Operations
(FY 2010 - FY 2014)



(a) Resident population data is based on the daily average census of residents at Larned State Hospital only. This is unaudited data provided by agency officials.
Source: Larned State Hospital and Legislative Research (unaudited)

Most of the positions are classified as direct care staff, and salaries and benefits account for the highest percentage of expenditures. ***Figure OV-2*** on the left summarizes the growth in the program population, staffing and expenditures. As the figure shows, there has been an increase in all three areas in the last five years.

In fiscal year 2014, the program had about 359 authorized positions, a 36% increase from 2010. Although there has been an overall increase in authorized positions since fiscal year 2010 for Larned State Hospital program staff, there has continued to be an increase in vacant positions. According to unaudited information from officials, as of February 2015 the program had about a 38% vacancy rate for nurses and MHDD technicians. This represents about an 8% increase in vacancies from April 2013. The Larned State Hospital Superintendent told us the vacancies were due to a limited labor pool.

Our 2013 performance audit of the program also identified issues with staffing. That audit found that many positions were vacant and that staff had significant overtime. In fact, overtime increased 80% from 2011 to 2012. Even with the overtime, the audit found that the program failed to meet internal minimum staffing goals. We noted the remote location of the program, the limited pool of applicants, and undesirable working conditions all likely contributed to staffing shortages. In this current audit, staff told us overtime continues to be an issue for the program.

In fiscal year 2014, the program had about $14.8 million total expenditures, a 15% increase from 2010. Officials explained the program increase was in part due to adding the reintegration

facility at Parsons State Hospital and a wage increase for some direct care staff positions in the last couple of years.

The Constitutionality of Involuntary Civil Commitment Has Been Challenged in Kansas and Other States

Civil commitment laws have been politically and legally contentious because they allow for involuntary confinement of sexually violent predators after they have served their prison sentence. Despite the controversy, the U.S. Supreme Court has upheld their constitutionality.

In 1997, the U.S. Supreme Court ruled Kansas' Sexually Violent Predator Act was constitutional. In *Kansas v. Hendricks*, the court ruled the civil commitment process was not punishment, as long as treatment was a goal of detainment and individuals were released upon a showing they were no longer dangerous. Additionally, the court stated it was not a second prosecution for the same crime and did not violate an offender's due process rights. Since the court ruling, many other states including Iowa, Missouri, and Nebraska have enacted similar civil commitment programs. In all, 20 states have implemented programs for sexually violent predators.

Recent federal lawsuits in Minnesota and Missouri could affect Kansas' program. The Minnesota program has more than 700 residents, with only two having been conditionally released since inception of the program in 1994. Plaintiffs are seeking relief from the current program as well as punitive and compensatory damages. They contend Minnesota's program violates civil rights and is unconstitutional for several reasons. Plaintiffs argue the program uses a one-size-fits-all approach that does not provide adequate treatment, fails to provide for less restrictive alternatives to confinement, and fails to conduct periodic risk assessments, all of which contribute to indefinite confinement. Ultimately, the plaintiffs argue the program is punitive and does not provide adequate treatment because so few residents have been discharged. The federal trial started in February 2015 and the judge will have about 60 days following its conclusion to issue his ruling.

Additionally, a class action federal lawsuit is pending in Missouri that raises similar constitutional challenges of Missouri's program. That case is set for trial in April 2015.

Question 1: How does Kansas' Sexual Predator Treatment Program Compare to Similar Programs in Other States and Best Practices?

The recommended practices for sexual predator programs emphasize individualized treatment (p. 11). However, Kansas' program generally did not adhere to the recommended practices, while other states' programs we reviewed generally did (p. 12). The Kansas Sexual Predator Treatment program met many legal requirements, although there were several exceptions (p. 16).

In addition, residents did not necessarily arrive at the reintegration facilities with the skills to be successful (p. 18). Additionally, program officials had not maintained appropriate records and documentation to effectively manage the program (p. 18). Policies and program guidance were outdated and not adhered to (p. 20). We also found until recently, KDADS had not filed annual reports with the legislature as required by statute (p. 20).

The Recommended Practices for Sexual Predator Programs Emphasize Individualized Treatment

The purpose of the Sexual Predator Treatment Program is to provide long-term control, care, and treatment of sexually violent predators. However, Kansas statutes do not define treatment, and there are no universally agreed-upon best practices that specify what a treatment program should include. However, the Association for the Treatment of Sexual Abusers (ATSA) and others have put out research-based guidance for the treatment of sexually violent predators. Officials from three other states we spoke with generally agreed with the research, which emphasizes the benefits of individualized treatment. Research indicates programs with targeted treatments and periodic reviews contribute to program success. For purposes of this report, we refer to this guidance as recommended practices. See ***Appendix D*** for more information.

- **Each resident should be assessed when they enter the program and periodically reassessed thereafter.** Risk assessment tools identify an individual's risk of reoffending, which helps to determine the intensity of treatment they need. Further, comprehensive assessments identify and measure factors such as cognitive functioning and the presence of other issues such as substance abuse or depression. Staff should conduct periodic assessments to gauge progress, identify specific risk factors, and adjust treatment plans.

- **Treatment should be individualized to address the unique needs of each resident.** The risk, need, responsivity (RNR) model is widely accepted as a guiding principle for sex offender treatment. In this

model, the risk of reoffending governs the type and intensity of treatment. Additionally, treatment is further individualized based on other factors such as an individual's mental health, learning style and intellectual ability.

- **Annual evaluations should determine whether the resident continues to meet criteria for commitment and evaluations should be conducted by an impartial party.** Periodic evaluations should determine whether the individual still meets the commitment criteria or should be released to a less restrictive environment. In addition, the review should be used to continuously evaluate the individual's progress and modify their treatment appropriately. Finally, a qualified individual who is impartial and not responsible for delivery of treatment services should complete the evaluations. This helps ensure the review is unbiased.

- **Residents with intellectual or developmental disabilities should have separate, specialized treatment programs.** Research has shown residents do best when grouped with other residents who have similar learning styles, cognitive abilities, or disabilities. Additionally, to assist an individual's progress through treatment, the program should alter the program expectations to the individual's skills and abilities. The program criteria for individuals with such issues as comprehension limitations, or challenges with language, reading, or completing daily living activities should not be the same as for those without these disabilities. Simply offering the same treatment model at a slower pace is not considered sufficient.

Kansas' Program Generally Did Not Adhere to These Recommended Practices, While Other States' Programs We Reviewed Generally Did

Kansas' treatment program was not individualized, so all residents received what was essentially the same treatment. The Kansas program consisted of several phases of treatment. Each phase requires participating actively in treatment, meeting specified attendance requirements for certain activities, and completing a number of tasks. At the time of this audit all residents had to complete the same requirements to progress from one phase to the next. As a result, Kansas' program was not individualized in several areas:

- **Kansas did not use an assessment tool that explicitly evaluates the risk of reoffending.** Under the widely recommended RNR model, each resident's risk of reoffending governs the type and intensity of treatment they receive. Further, risk factors should be assessed for each resident both before and during treatment to ensure it is appropriately individualized. Kansas' program used two assessments that were not designed to assess the risk of reoffending. One assessment was used in all programs at Larned State Hospital and measured such areas as risk for falling or suicide. The other assessment measured such factors as the residents' outlook and participation. Although these assessments may aid program staff, they are not tools for assessing the treatment needs or risk of reoffending.

Program officials told us they are implementing a new type of risk assessment tool specific to sex offenders. While this is a good first step, research holds that comprehensive assessments utilizing multiple tools are necessary to measure risk of reoffending and assess treatment needs.

- **Kansas did not create sufficiently individualized treatment plans.** The program focused solely on treating sexual disorders with all residents completing the same curriculum. The treatment has been the same for each resident regardless of individual's specific issues such as schizophrenia, alcoholism, borderline personality disorder, or trauma. This is contrary to recommended practices which emphasize addressing these specific issues in addition to sexual predator treatment.

- **Kansas' annual review did not appear to meet recommended practices.** Recommended practices indicate the individual's mental condition should be reevaluated periodically. These evaluations measure whether the resident still meets the criteria for commitment, should be completed by an impartial individual, and should be used by staff to modify treatment. The annual reviews conducted in Kansas did not measure the resident's mental condition to determine if they met criteria for continued commitment. Instead, staff reviewed medical records, any available progress notes, previous annual reviews, and court records. In addition, the reviewer talked with staff who had regular contact with the resident. Additionally, in Kansas a staff member who was previously responsible for delivering treatment services completed the reviews, rather than an independent third party. The current superintendent of Larned State Hospital indicated he would be open to contracting out the annual examinations.

- **In Kansas, individuals with intellectual and developmental disabilities had the same requirements and received the same treatment as all other residents, but at a slower pace.** Generally, these individuals were on what is called the "parallel track." Contrary to recommended practices mentioned earlier, Kansas did not employ a standardized assessment procedure to identify residents' cognitive limitations or other type of disabilities. In fact, residents could opt to transfer between the parallel track and traditional treatment. Additionally, Kansas did not target the treatment to appropriately address these additional factors but simply slowed the traditional program down for this group. Aside from this extended timeframe, program expectations were the same for these individuals which was not in line with recommended practices. KDADS officials have acknowledged a one-size-fits-all approach is no longer appropriate for these residents, but had not taken steps to modify these practices.

The treatment programs in three other states provided more individualized treatment than Kansas. We contacted officials in several states concerning their entrance criteria, exit criteria, and treatment model. We also gathered information on the number of

admissions and discharges. Many of the states we contacted were reluctant to share information. However, we were able to gather program-specific information about Iowa, Washington, and Wisconsin. The programs in those states have between 101 and 312 residents, compared to 243 residents in Kansas. Further, these states have a similar multi-step commitment process, with a judge or jury making the final determination about commitment. In general, these states' programs were in line with recommended practices, as described below:

- **Iowa, Washington, and Wisconsin utilized assessment tools that evaluate behavior, intelligence and criminal risks.** These states evaluated residents using risk assessments when they enter the program and as part of the annual review process. This facilitates placing each individual within the program based on the risk they will reoffend, as well as other underlying issues such as mental health or potential disabilities. Kansas did not use a similar type of assessment.

- **The other states appeared to provide treatment that focused on the needs of the individual.** Generally, the other states used assessment tools to identify the resident's individual needs. Treatment was planned around those identified needs such as diminished cognitive skills, physical limitations, and other mental health issues. Washington and Wisconsin's programs relied on the professional judgment of the treatment team and occasionally assessments to determine when a resident was ready to progress to the next stage. In contrast, residents in Kansas progressed to the next stage when they had completed specific phase requirements such as attending a certain number of sessions and completing assignments.

- **All three states conducted annual reviews that appeared to be consistent with recommended practices.** Programs in Iowa, Washington, and Wisconsin used annual risk assessments to determine if the residents' mental condition still met the criteria for continued commitment. Wisconsin and Washington had the assessments conducted by people who were independent and not responsible for delivering treatment services.

- **Two of the three states identified residents with intellectual or developmental disabilities and modified the treatment program accordingly**. Washington did an assessment to determine whether residents had special needs and if so, modified treatment to meet those needs. Further, Washington housed the residents with special needs in separate units. Wisconsin also assessed residents and developed the treatment plan to accommodate their disabilities. Officials emphasized it should not be the same treatment as provided to individuals without disabilities.

Additionally, other states had some unique programming approaches. For example, Washington maintained a separate unit for phase one residents who opt-out of treatment in an effort to

isolate the negative environment they create from those who want to participate in treatment. Also, Iowa has expanded vocational opportunities for residents because program officials think this is important to ensure success at reintegration.

Kansas placed a greater emphasis on non-clinical requirements to progress to the next stage than other states we looked at. The Kansas program had a set curriculum for all residents that required at least eight hours a week of recreation and leisure classes, which include walking, swimming, and arts and crafts. Additionally, residents generally were required to take a minimum of one to four hours a week of classes such as anger management and relationship skills, depending on what phase they were in. Finally, the program requirements for individual and group therapy were the lowest at zero to three hours per week. Other states we contacted generally required more frequent individual and group therapy sessions than Kansas. Further, these states did not require that all residents complete set hours in recreation and leisure activities. Instead, in those states, recreation and leisure activities were encouraged for all residents, but may have been required on an individual basis.

The recreation and leisure activities in Kansas were managed by non-clinical staff, but carried a significant amount of weight for the residents to progress to the next phase of treatment. Program staff told us even if a resident was ready to progress to the next phase of treatment from a clinical standpoint, the resident could be held back for failure to meet the recreation and leisure requirement. For example, we found three recent instances where residents had completed all required treatment therapy sessions and courses (such as anger management), and completed other phase requirements. These residents applied to the treatment team to move on to the next phase of treatment, but were denied because they had not completed enough hours either walking or in the library. These residents must now wait at least another three months before they can re-apply to the treatment team. One of them has been denied advancement for more than a year and a half because he had not completed the required recreation and leisure hours. Program officials acknowledged that residents can be denied advancement to the next treatment phase for failure to meet the required recreation and leisure hours. However, officials did not think this happened frequently.

Iowa, Washington, and Wisconsin have conditionally released and discharged more residents than Kansas. Kansas, Washington, and Wisconsin began operating their sexual predator

treatment programs in the early 1990s, and Iowa began operating its program in 1999. ***Figure 1-1*** below summarizes the conditional release and discharge information for the four states. Conditional release is generally a probationary period in the community and discharge is completion of the program. As the figure shows, none of the other states had a significantly larger program than Kansas, and all three have released far more residents. Data on reoffending was not readily available, though Wisconsin had recently started capturing limited data and estimated its rate of reoffending was between 3% to 5%.

Figure 1-1
Conditional Release and Unconditional Discharge of Residents from Inception of Program to 2014

State	Wisconsin	Washington	Iowa	Kansas
Year Established	1994	1990	1999	1994
Current Population	312	258	101	243
# Conditionally Released	122	70	12 (a)	2
# Unconditionally Discharged	118	40	20	3

(a) This number was calculated in 2013.
Source: Kansas' and other states' Sexual Predator Treatment Program Data (unaudited)

Kansas' Sexual Predator Treatment Program Met Many Legal Requirements, Although There Were Several Exceptions

Kansas' Sexually Violent Predator Act established the Sexual Predator Treatment Program. The statutes cover a number of different areas including commitment, transitional and conditional release, discharge, resident rights, and rules of conduct. We reviewed and compared program services and activities to statutes to determine if legal requirements were met.

Kansas appeared to adequately address most statutory program requirements. The legal requirements include a multi-step review process for commitment, as well as the right to petition the court for conditional release and discharge from the program. Additionally, statutes protect rights of the program residents including the right to refuse treatment, medication, or to perform labor. Further, residents are to have a grievance process, the right to individual religious worship, and access to both mail and telephone. It appears from our on-site visits, interviews with staff, review of various resident files and demographic records that Kansas generally met these specific legal requirements.

However, Kansas' program <u>may not</u> have adequately addressed other statutory requirements. In addition to the requirements discussed in the previous section, statutes also required the program offer rehabilitation and educational services

that are appropriate for the individual's condition. However, these services were not clearly defined by statute. We talked with program staff about their understanding of these terms. We also talked with officials in other states about how their states interpreted similar requirements. Our findings are summarized below.

- **Kansas did not provide traditional education services, such as GED completion**. Officials from sexual predator treatment programs in other states told us educational services typically include high school diploma equivalents, GEDs, and adult basic education. Kansas did not provide these types of services. Program staff told us educational services included classes involving relapse prevention, anger management, self-concept, relationship skills, budgeting and money management, stress management, and strategies for motivation. Kansas also provided vocational training courses and employment opportunities, which could satisfy the requirement for education. While these classes and vocational training are important, we would expect educational services to also include basic adult education such as reading and GED opportunities, as was done in other states.

- **Kansas provided several rehabilitation services, but did not provide substance abuse rehabilitation which research recommends**. The program provided speech, physical, and occupational therapy on an individual basis. However, the program did not provide treatment for drug or alcohol addiction. Two studies we reviewed stated that sexual predator treatment programs should also address other risk factors such as addiction. A KDADS official told us the rehabilitation requirement in statute was fulfilled by accommodations for physical and cognitive impairments. Additionally, staff said the program was not designed to provide rehabilitation such as addiction recovery services. However, other states we contacted provided a range of services to include physical, mental and addiction rehabilitation as part of the sexual predator treatment.

- **Kansas did not annually evaluate each resident's mental condition**. Statutes required each resident have an annual exam to assess the resident's mental condition. The particulars of the exam were not defined in statute, but the exam is used to determine whether the resident still meets the criteria for commitment. Kansas staff prepared an annual report for each resident, but it was essentially a progress check on whether the resident was meeting phase requirements. Other states provided a comprehensive exam that includes risk assessments to determine if the individual continued to meet the criteria for commitment.

Senate Bill 149 was introduced in the 2015 legislative session and would address many aspects of the Sexually Violent Predator Act. At the time of this report, if SB 149 passes it would strike the statutory requirements that the program provide both rehabilitation and educational services.

OTHER FINDINGS

Residents Did Not Necessarily Arrive at the Reintegration Facilities with the Skills to be Successful

Residents must transition from Larned State Hospital to one of the reintegration facilities in order to complete the final two phases of their treatment. Reintegration is to prepare the residents for conditional release back into the community. Residents assume more responsibilities and gain additional privileges, are expected to obtain a job and display the skills to be able to function in the community.

Staff at the reintegration facilities stated residents often lacked some basic skills essential to reintegrate into the community. For example, staff told us residents often arrived without the skills necessary to get a job, including a lack of basic computer skills and knowledge of how to search and apply for jobs. Additionally, they told us residents generally had not gained basic daily living skills such as how to cook or shop for themselves, and that they may lack employment experience because vocational training opportunities at Larned were limited. Staff also stated residents often arrived without a realistic plan for how to react to community circumstances that could put them at risk of reoffending. The lack of a cohesive program to ensure residents arrive with the proper skills potentially extends the length of time required at the reintegration facilities.

Program Officials Had Not Maintained Appropriate Records and Documentation to Effectively Manage the Program

Adequate records are an integral part of a treatment environment. They allow staff to determine what services should be made available to a resident and to track a resident's progression through treatment. Additionally, appropriate documentation permits management to monitor and adjust the program as necessary. However, we found several issues concerning adequate documentation.

The program did not track phase participation or progression. Instead, residents or individual therapists were charged with keeping a single paper copy of the document that captured what tasks a resident has completed in order to progress to the next phase. Often the document was incomplete or staff could not produce it. This created a risk residents would have to repeat tasks because it was not documented what tasks were completed. Additionally, staff could only estimate the frequency of participation. As a result, management was unable to determine how long it took the average resident to complete each phase. For example, management and staff were unaware that about 50% of

individuals on the parallel track appeared to participate fully in treatment, had on average been in the program for about ten years, yet had not progressed past phase three. Phase participation and progression information would be necessary to identify and address programmatic problems and identify individuals, and groups of individuals, whose progress was delayed.

We could not tell if residents had received the treatment they should. Treatment plans are completed every 90 days for each resident. We reviewed 26 treatment plans to check whether residents were getting the services called for in the plans. Nearly half the treatment plans and associated progress notes we reviewed contained insufficient documentation of whether the treatment services in the plan were actually provided to the resident. Additionally, we found the files did not always track whether the resident was participating in treatment, which is necessary for progress through the program. Our sample is not projectable. However, this lack of information could cause problems for treatment providers who lack information about individual residents' history and could result in residents having to repeat requirements.

The program did not maintain thorough records of service cancellations. Occasionally classes and sessions were canceled for staff absences or because of weather. Although staff collected some cancellation data for vocational activities, recreational activities, and some courses, they did not track cancellations for individual or group therapy sessions. This prevented management from ensuring services were made available or knowing the frequency or reason for such cancellations.

Without sufficient data, management cannot effectively manage several program aspects. Data on program operations can provide management with valuable information that would allow them to continually monitor, evaluate, and modify the program. Specifically, data allows management to monitor such things as staffing levels, trends in cancellations, staff performance, the availability of program services, resident participation, and the rate of progression. However, management did not generally maintain adequate documentation or when it was available, they did not review it. This prevented officials' from effectively managing the program. Officials told us they are in the process of reviewing ways to improve the tracking of phase progression and service cancellations.

Policies and Program Guidance Were Outdated and Not Adhered To

Adherence to policies and program guidance ensures residents receive proper and consistent treatment. Additionally, staff and residents must be able to rely on the accuracy of information for meeting program requirements and understanding expectations. It is essential for management to ensure policies are followed and program guidance is accurate.

Staff were not adhering to Progress Review Panel policy requirements. The panel approves resident entrance into, progression through, and regression back from phases five, six and seven. According to KDADS policy, the panel should consist of seven designated voting members and several designated advisory members. For several years, the panel has been comprised of only five voting members. Additionally, the role of one of the advisory members has historically not been filled. This potentially prevents residents from receiving an adequate review. Officials thought they had been in compliance with the policy and state they are in the process of reviewing and updating policies.

Resident handbooks were outdated and inaccurate. The handbook for residents at Larned was dated November 2013, but it contained some information that was six years old. For example, it listed treatment services that were no longer offered and inaccurate requirements for individual therapy. The handbook for residents in the reintegration facilities (Parsons and Osawatomie), dated November 2014, provided inaccurate requirements for attending support groups. This increased the risk that residents were not aware of what the expectations were in order to progress to the next phase. Officials have told us they are in the process of updating the handbooks.

Until Recently, KDADS Had Not Filed Annual Reports with the Legislature as Required by Statute

K.S.A. 59-29a11(e) requires KDADS to submit an annual report to the Governor and to the Legislature detailing activities related to the transitional release and conditional release of sexually violent predators. This requirement became effective in 2010 when Larned was part of the Department of Social and Rehabilitation Services, but no reports have ever been submitted. Officials at KDADS, who assumed responsibility for the program in 2012, told us they were unaware of this requirement. In the course of this audit, they filed a report in March 2015.

Question 2: What Actions Could be Taken to Reduce the Resident Population of the Sexual Predator Treatment Program?

Unless changes are made, the Sexual Predator Treatment Program will exceed capacity in the next few years and will continue to grow for the foreseeable future (p. 21). We evaluated the impact of six different options to reduce the program's resident population (p. 24). Option 1 is to treat low-risk residents in a community setting, which would reduce the resident population and reduce program costs (p. 26). Option 2 is to treat medically infirm residents in a secured nursing facility, which would reduce the resident population but would not significantly affect program costs (p. 28). Option 3 is to treat residents on the "parallel track" in a separate secured facility, which would reduce the resident population, but potentially increase costs (p 29). Option 4 is to expand the number of reintegration slots from 16 to 32, which would not reduce the resident population (p. 31). Option 5 is to limit the time a resident can occupy a slot in a reintegration facility, which would not significantly reduce the resident population at Larned State Hospital (p. 33). Finally, Option 6 is to begin sexual predator treatment before the offender is released from prison, which would not significantly impact resident population and could increase costs (p. 34). Finally, we found statutory housing restrictions make it difficult for residents to leave the program (p. 36).

Unless Changes Are Made, the Sexual Predator Treatment Program Will Exceed Capacity in the Next Few Years and Will Continue to Grow for the Foreseeable Future

As of December 2014, the program housed 243 residents – about 92% of the program's physical capacity. The program operates seven housing units at Larned State Hospital, one unit at Osawatomie State Hospital, and one unit at Parsons State Hospital. In total, these facilities have the physical capacity to house 264 residents.

The population continues to grow because far more sex offenders are committed to the program each year than are released. Since 2005, an average of about 15 sexually violent predators have been committed to the program each year. However, only three residents have ever completed the program since it was established in 1994. Because far more residents enter the program each year than exit it, the program has grown steadily over time.

Few residents exit the program because most never progress past the early phases of treatment. Residents must participate in treatment to progress through the seven phases necessary to

complete the program. According to program officials, it should only take about 2.5 years for residents participating in treatment to complete the first three phases of the program. As of December 2014, 185 (76%) of the program's 243 residents were on phases two and three. On average, these residents have been in the program for about eight years.

That is due in part to the fact that many residents elect to not participate in treatment. About half of the residents on phase two and three were not participating as of December 2014. Low resident morale or unwillingness to confront the challenges of therapy may result in non-participation.

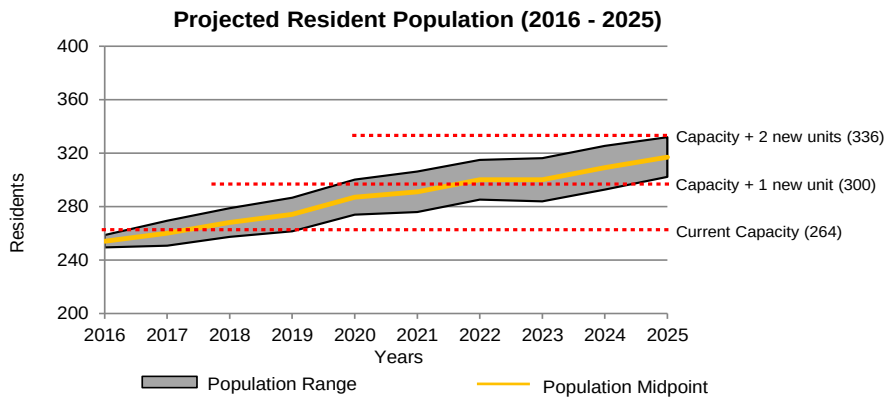
Based on current trends, we project the program population will exceed its current space limits in the next few years and will continue to grow into the foreseeable future. We created a computer simulation to project future trends and evaluate options to reduce the program's resident population. The underlying data for the model consists of historical admission data, resident demographics, death data, mortality tables and treatment progression data. Based on this historical resident data, the model simulates future program population with similar characteristics. Finally, we calculated a 95% confidence interval around the model data in order to generate a range for the future population. We made several assumptions in order to project this population, which are described in more detail in ***Appendix B***.

We first projected what the resident population might look like in the future if no changes are made to the program. This projection assumes current population trends remain constant into the future. ***Figure 2-1*** on the next page shows our analysis. As the figure shows, if no changes are made to the program, the resident population would exceed its current physical capacity between 2017 and 2020. Additionally, near the year 2060 the number of resident deaths and the number of residents committed to the program will be roughly the same. This will cause the population to stabilize at about 500 residents, as shown in ***Appendix C.***

Recent changes to the state's minimum sentencing requirements under Jessica's Law could affect the program's future population. Passed in 2006, Jessica's Law increased the minimum sentencing for certain first time sex crimes to mandatory life imprisonment with eligibility for parole after 25 years. This law could reduce the number of offenders committed to the program in the future, as offenders will remain incarcerated for longer periods under this

law. As of fiscal year 2014, 376 offenders have been convicted under Jessica's Law. As discussed in ***Appendix B***, we accounted for the effect this law could have on the program population in our model.

Figure 2-1
Baseline Projection of Resident Population



(a) The population range represents a 95% confidence interval from the midpoint.
Source: LPA generated model of resident population.

We further estimate program costs will more than double by 2025. Based on our model, we estimate the population will increase by 60 to 90 residents over the next 10 years. We also estimated the increase in program costs associated with this population growth. These costs represent an increase over the fiscal year 2014 Larned State Hospital program expenditures of about $14 million and would make the estimated total program costs in 2025 between $26 and $34 million. Our cost estimate included annual operating costs and capital outlay costs. Specifically,

- we estimate the program's annual operating costs could increase between $5 and $7 million by 2025. Operating costs include the ongoing expenses for the staff and services necessary to treat this population. Expenditure data for the Larned State Hospital program is likely understated and therefore our estimates are conservative.

- we estimate the program would also incur up to $13 million in capital outlay costs to build additional 36-bed units. We determined that adding 60 to 90 new residents by 2025 would require program officials to build one to two additional 36-bed units. We did not inflate future costs.

An insufficient local labor force will create staffing problems for the program as it grows. As discussed in the overview on page 9, the program continued to experience significant vacancy and overtime issues. Because officials have trouble filling

positions, it is unlikely officials could staff the additional housing units needed by 2025. The Superintendent of Larned State Hospital agreed it is unlikely they could find enough employees in the area to staff one additional housing unit. Therefore, the additional capacity may need to be built in a different part of the state.

FINDINGS RELATED TO REDUCING THE RESIDENT POPULATION

We Evaluated the Impact of Six Different Options to Reduce the Program's Resident Population

We evaluated six options that could potentially reduce the program's resident population. We identified these options through interviews with program officials, other stakeholders, and officials from other states. We also reviewed reports from other states regarding their sexual predator treatment programs. These options are:

- Treat low-risk residents in a community setting (page 26).
- Treat medically infirm residents in a secured nursing facility (page 28).
- Treat residents with intellectual or developmental disabilities in a separate secured facility (page 29).
- Double the total number of reintegration slots at Parsons and Osawatomie from 16 to 32 (page 31).
- Limit the amount of time residents can occupy a reintegration slot (page 33).
- Begin sexual predator treatment while the offender is still in prison (page 34).

Using the same population model described on page 22, we estimated the impact these six options could have on the resident population and program costs through 2025. We compared the results of these models to two baseline projections:

- the estimated resident population in 2025 if no changes are made to the program (about 300 to 330 total residents).
- the total estimated cost of the program in 2025 if no changes are made to the program (about $26 to $34 million in 2014 dollars).

Future program costs include both operating costs and capital costs. Operating costs include the staff and services necessary to treat these individuals. Capital costs are associated with building 36-bed living units to house residents. These will be incurred to expand the physical capacity of the program as the population grows. For the purpose of this report we focus on population and

cost projections over the next 10 years (through 2025). ***Appendix C*** has additional information for each option with projections out to 2090. Finally, we did not adjust future program costs to account for inflation, so all estimates of future costs are in current (2014) dollars.

The results of these comparisons are discussed in detail in the following sections. ***Figure 2-2*** below provides a summary of each option. As the figure shows, not all of the options reduce the resident population over time.

Figure 2-2
Summary of the Baseline and the Six Options to Reduce the Number of Residents Committed to the Sexual Predator Treatment Program

Scenario	Population by 2025	Total Cost by 2025 (a)
Baseline (if no changes are made to the program)	**300 - 330 residents**	**$26 million - $34 million**
Options to Reduce the Program Population	**Impact on Population by 2025 (compared to baseline)**	**Impact on Costs by 2025 (compared to baseline)**
Option1: Treat low-risk residents in a community setting (page 26). Under this option, low-risk sexually violent predators would be treated in a community setting rather than be committed to Larned State Hospital.	Decrease 35 - 40 residents (12%)	Decrease $7.5 to $8 million
Option 2: Treat medically infirm residents in a secured nursing facility (page 28). This option would remove the 23 current, and any future, residents who are medically infirm and would treat them in a separate secure nursing facility.	Decrease 45 - 50 residents (15%)	No change
Option 3: Treat residents with intellectual or developmental disabilities in a separate secured facility (page 29). This option would remove the 37 current, and any future, residents with intellectual or developmental disabilities from the main resident population and would treat them in a separate secure facility.	Decrease 45 - 50 residents (13 - 16%)	Increase $6.5 to $8 million
Option 4: Double the total number of reintegration slots at Parsons and Osawatomie from 16 to 32 (page 31). This option would double the physical capacity at reintegration housing to allow more residents to progress the final phases of program treatment.	No Significant Change	Increase $5 million
Option 5: Limit the amount of time residents can occupy a reintegration slot (page 33). This option would send residents at reintegration housing back to Larned State Hospital if officials agree the resident is not on track to complete the program within four to six years. This would allow more residents to advance to these final phases of treatment.	No Significant Change	No Change
Option 6: Begin sexual predator treatment while the offender is still in prison (page 34). This option would provide sex predator treatment to offenders currently in prison. Credit for sex predator treatment completed in prison would carry forward with offenders if committed to the Sexual Predator Treatment Program.	No Significant Change	Increase $600,000 to $2 million

(a) We did not adjust future costs for inflation. As such, all future costs are in 2014 dollars.
Source: LPA projection of future program population and costs.

Option 1: Treating Low-Risk Residents in a Community Setting Would Reduce the Resident Population and Reduce Program Costs

Historically, all offenders who have been determined to be sexually violent predators were committed to the program at Larned State Hospital, regardless of the risk they will reoffend. The option described in this section would establish a second track for low-risk sexually violent predators to be monitored and treated in the community rather than Larned State Hospital. Only low-risk sexually violent predators would be eligible for the community track, all others would still be committed to the residential program at Larned.

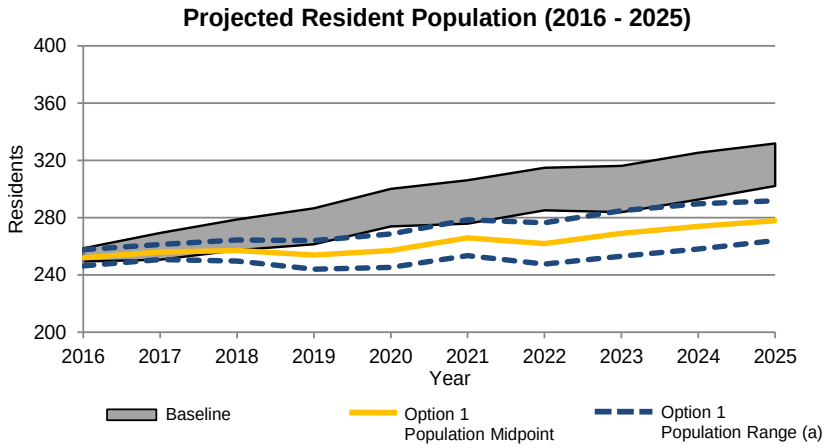
New York treats low-risk residents separately, assigning them to a community based model. In 2007, New York established the Strict and Intensive Supervision and Treatment (SIST) Program to treat low-risk sexually violent predators in the community. Officials from New York told us they evaluate several risk factors to determine which offenders to recommend to the SIST program, including hostility records, flight risk, and mental health diagnosis.

Since the SIST program began in 2007 through 2013, New York courts have committed 152 individuals to the program for community treatment. As of 2013, three of these 152 sexually violent predators had been charged with a reoffense for a sex crime while receiving treatment in the community. New York established a number of strategies and techniques to effectively manage the risk of reoffense, including:

- Consistent check-ins and monitoring of offenders by parole officers. Parole officers' caseloads are no more than 10 to ensure adequate time to monitor each SIST offender.
- Mandatory GPS tracking, polygraph testing, specification of residence, strict curfews, and other related requirements.
- Mandatory attendance and participation in treatment.
- Failure to meet any mandatory requirements could result in an offender being committed to the secured treatment facility.

We estimate adopting a similar option in Kansas would decrease the resident population by about 40 residents (12%) by 2025. We projected the impact that treating low-risk offenders in a community setting could have on the future resident population. We compared the results of this analysis to our baseline projection in ***Figure 2-3*** on the next page. As the figure shows, treating low-risk offenders in a community setting could reduce the resident population at Larned by about 40 residents by 2025 compared to the baseline.

Figure 2-3
Option 1: Comparison of Projected Resident Populations without Low-Risk Sexually Violent Predators



(a) The population range represents a 95% confidence interval from the midpoint.
Source: LPA generated model of SPTP resident population.

By reducing the population, we estimate this option would also reduce projected program costs by about $7.5 to $8.0 million (22% to 31%) by 2025. Without changes the total estimated costs to the program is $26 to $34 million to operate by 2025 (in 2014 dollars). Treating low-risk offenders in the community would reduce the Larned population, reduce operating costs and eliminate additional capital costs for one to two additional units. However, treating offenders in the community would also include certain monitoring costs such as GPS tracking, polygraph testing, sexually violent predator treatment, and specialized parole officers. Taking all of these factors into account, we estimate total program costs would be reduced by $7.5 to $8.0 million by 2025, a 22% to 31% decrease.

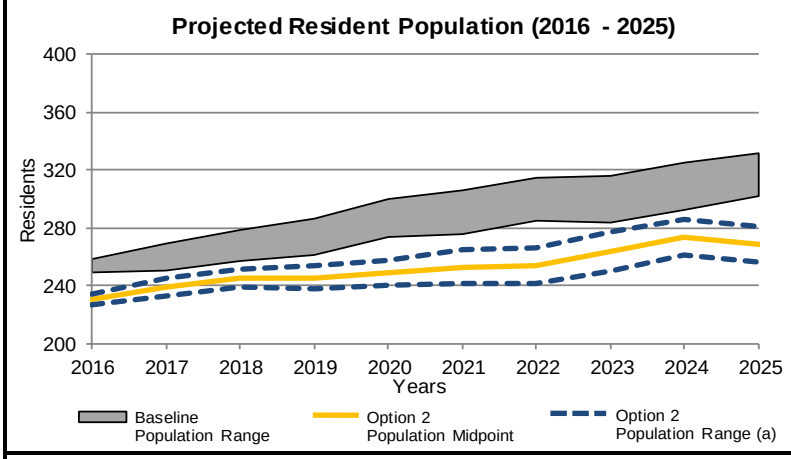
Although feasible, serving low-risk residents in the community would require a significant change in treatment philosophy, including a willingness to increase the risk of reoffending. Historically, the state has used a secured institutionalized approach to treat sexually violent predators. That approach creates very little risk of reoffending, but is also very costly and likely unsustainable. By contrast, this option introduces a community-based approach for treatment. Although this model introduces more risk of reoffense, it appears manageable by utilizing strategies and techniques, similar to New York's method. KDADS officials were generally agreeable to pursuing this option but stated it would likely face significant resistance from the community.

Option 2: Treating Medically Infirm Residents in a Secured Nursing Facility Would Reduce the Resident Population, But Would not Significantly Affect Program Costs

As of January 2015, 23 residents had severe medical issues and might be better served in a nursing facility. According to program officials, the medical needs of this population are increasingly difficult and expensive to care for and treat at Larned State Hospital. The option described in this section would transfer medically infirm residents to a secure nursing facility. There, residents would receive medical care in a more appropriate setting while still being offered sexually violent predator treatment.

We estimate treating the medically infirm in a separate nursing facility would decrease the resident population at Larned by about 45 to 50 residents (15%) by 2025. We projected the impact that treating medically infirm residents in a separate secure facility could have on the future resident population. We compared the results of this analysis to our baseline projection in ***Figure 2-4*** below. As the figure shows, treating medically infirm residents in a secured nursing facility would reduce the resident population at Larned by about 45 to 50 residents by 2025 compared to the baseline.

Figure 2-4
Option 2: Comparison of Projected Resident Populations without Medically Infirm Residents



(a) The population range represents a 95% confidence interval from the midpoint.
Source: LPA generated model of SPTP resident population.

It is unlikely this option would reduce the projected program costs by 2025, but it could alleviate capacity issues at Larned. The cost to staff and build a new nursing facility for medically infirm residents is roughly the same as the cost to treat this population at Larned under the baseline analysis. Specifically, under both options the state would need to construct one to two

units and treat roughly the same number of residents. With this option one of those units would be off-campus so the medically infirm could be treated separately. As such, this does not reduce the program's projected cost by 2025. However, reducing the population at Larned could help address issues with a limited local labor market, which currently contributes to a high rate of vacancies and excess overtime.

Based on current population and health status of some residents, we made assumptions about the aging and frail population. As a result, this option does not require more than one 36-bed nursing facility. We did not estimate the nursing facility population beyond 2025. However, it is likely the number of residents transferred to a secure nursing facility would grow significantly over time as the population ages.

KDADS officials agreed that treating medically infirm residents in a separate facility would benefit all residents. This would allow medically infirm residents to receive care and treatment in a more appropriate setting given their high medical needs. In addition, this would allow treatment staff at Larned to focus on providing treatment to residents most capable of participating. This option would require a new secured nursing facility be established in the state specifically for this population. Additionally, the facility would need its own dedicated nursing and program treatment staff. It is worth noting that several other states also struggle with how best to treat medically infirm sexually violent predators. However, at this point no other states we reviewed have determined the best way to treat this population of residents.

Option 3: Treating Residents on the "Parallel Track" in a Separate Secured Facility Would Reduce the Resident Population, But Potentially Increase Costs

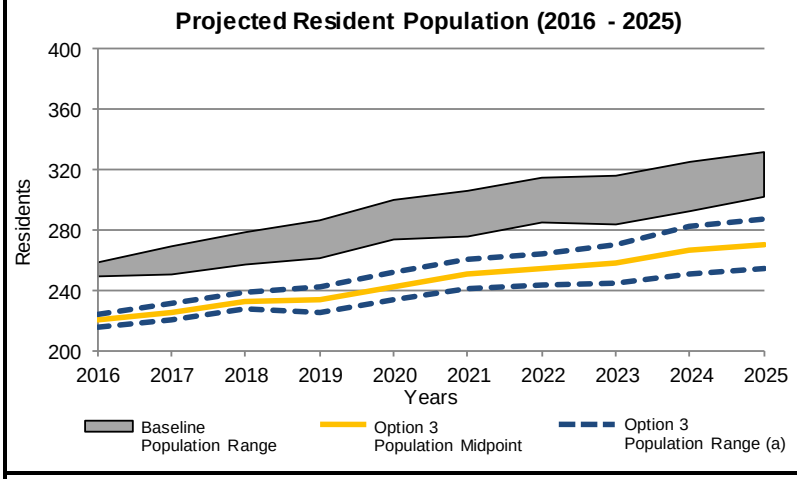
As of December 2014, 38 residents with intellectual or developmental disabilities were being served on the program's "parallel track." The parallel track is intended to treat residents with identified learning disabilities. This option would move residents with intellectual or developmental disabilities from the main population at Larned, and treat them in two separate secured facilities. The cost estimate below includes the cost to build these facilities as well as the cost for treatment staff.

Providing treatment in a separate facility would likely be more beneficial for residents with intellectual or developmental disabilities. Residents on the parallel track do not appear to progress through treatment. As of December 2014, the 38 residents on the parallel track had been in the program for an average of 10

years. Although about half of these residents participate in treatment, they are still on the early phases of the program.

We estimate this option would decrease the resident population at Larned State Hospital by about 45 to 50 residents (13% to 16%) by 2025. We projected the impact that treating residents with intellectual or developmental disabilities in a separate secure facility could have on the future resident population. We compared the results of this analysis to our baseline projection in ***Figure 2-5*** below. As the figure shows, treating these residents in a separate secure facility would reduce the resident population at Larned by about 45 to 50 residents by 2025. In addition, reducing the population at Larned could help address issues with a limited local labor market, which has contributed to a high rate of vacancies and excess overtime.

Figure 2-5
Option 3: Comparison of Projected Resident Populations without Parallel Track Residents



(a) The population range represents a 95% confidence interval from the midpoint.
Source: LPA generated model of SPTP resident population.

We estimated on average, the separate facilities to house residents with intellectual and developmental disabilities over the next 10 years would be about 40 to 60 residents. We did not estimate this population beyond 2025. However, it is likely the number of residents transferred to these facilities would grow over time because the program population continues to grow over time.

We estimate this option would increase program costs by about $6.5 to $8.0 million by 2025. Without any changes, we estimate the program will cost a total of $26 to $34 million to operate in 2025 (in 2014 dollars). Treating residents with intellectual and

developmental disabilities in a separate facility would increase operating costs and require two to three new facilities. Taking all of these factors into account, we estimate the total program costs would be increased by $6.5 to $8.0 million in 2025, a 23% to 26% increase.

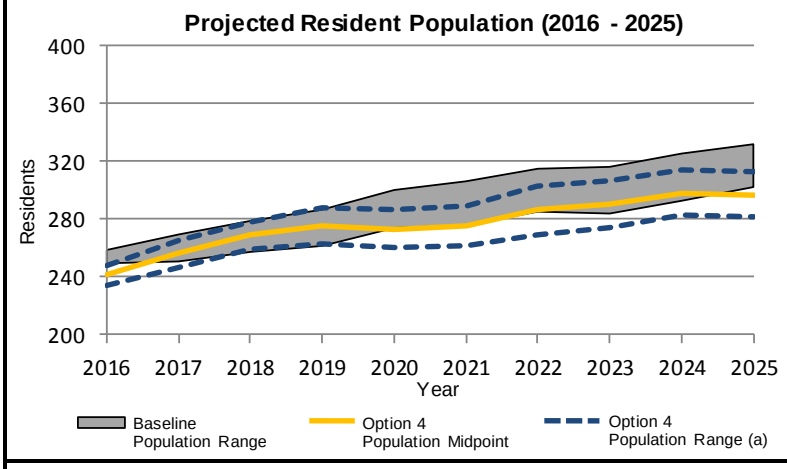
KDADS and Larned officials generally agreed that residents with intellectual or developmental disabilities would be better treated in a separate secure facility. Officials with KDADS told us residents on the program's parallel track can be taken advantage of by other residents. As such, treating them separately would result in a safer, more constructive treatment environment. Additionally, KDADS officials told us these residents would likely benefit from treatment designed for individuals with intellectual or developmental disabilities. It is worth noting that other states also struggle with how best to treat sexually violent predators with intellectual or developmental disabilities. However, at this point no other states we reviewed appeared to have taken action on this issue.

Option 4: Expanding the Number of Reintegration Slots from 16 to 32 Would Not Reduce the Resident Population

Residents must transition from Larned State Hospital to one of two reintegration facilities in order to complete the final two phases of their treatment. The reintegration facilities are at Osawatomie and Parsons State Hospitals and can accommodate eight residents each. As of February 2015, both facilities were full. As a result, no additional residents can advance to reintegration housing until space becomes available. Doubling the number of residents allowed at each house would give more residents a chance to advance to the final phases of treatment necessary for their release.

Because reintegration facilities house so few residents compared to Larned it does not appear that expanding the number of slots would significantly reduce the resident population by 2025. We projected the impact that doubling the number of reintegration beds could have on the future resident population. We compared the results of this analysis to our baseline projection in ***Figure 2-6*** on the next page. As the figure shows, doubling the number of reintegration beds does not significantly reduce the resident population by 2025. However, it is possible given enough time this option could allow more residents to exit the program. Further, it is possible that in combination with the option to limit time at the reintegration facilities, discussed below on page 33, this option could potentially reduce the program population over time.

Figure 2-6
Option 4: Comparison of Projected Resident Populations with 32 Reintegration Beds



(a) The population range represents a 95% confidence interval from the midpoint.
Source: LPA generated model of SPTP resident population.

However, we estimate doubling the reintegration slots would increase program costs by $5 million by 2025. Without any changes, we estimate the program will cost a total of $26 to $34 million to operate in 2025 (in 2014 dollars). Expanding the number of reintegration slots would not reduce the Larned population nor would it reduce costs. This is primarily the result of additional capital costs of roughly $3.5 million to construct or remodel two new reintegration houses needed to double the number of reintegration beds. Furthermore, annual operating costs would also increase by an estimated $1.7 million by 2025 because of the additional staff the reintegration facilities would need to hire to treat twice the number of residents. Taking all of this into account, we estimate the total program costs would be increased to $31 to $39 million in 2025, a 15% to 20% increase.

Even though this option would increase costs, it may prove beneficial because it could increase motivation and help avoid a potential bottleneck. Because both reintegration facilities are full, no additional residents can advance to the final phases of the program until space becomes available. Residents are aware that it could be several years before space at these facilities becomes available. Program officials told us this knowledge demotivates them from participating in the treatment necessary to progress to these final phases. Doubling the beds at each facility creates more opportunities for residents to progress through treatment. This

could increase resident morale and participation in treatment, and possibly reduce the future population of residents in treatment.

This option could require amending state law, but KDADS officials said it was feasible. As of the time of this audit, statute limited the number of sexually violent predators on transitional or conditional release to no more than eight per Kansas County. Officials with KDADS indicated this limit prevents them from expanding the number of available beds. Senate Bill 149, introduced during the 2015 Session, would double the number from eight to 16 per county. Both KDADS and program officials agreed that this would benefit residents, as more of them would be allowed to progress through the program.

Option 5: Limiting the Time a Resident Can Occupy a Slot in a Reintegration Facility Would Not Significantly Reduce the Resident Population at Larned State Hospital

The program had no limits on how long residents can remain in the reintegration facilities, which potentially blocks others who are ready to progress. The 16 beds at the two reintegration facilities are full. No one has progressed on from reintegration in the last year. This option would send residents back to Larned State Hospital if officials agree the resident is not on track to complete the program within four to six years.

Limiting the time at a reintegration facility would help ensure slots are available for residents who are more likely to transition into the community. Because both reintegration facilities are currently full, no additional residents can advance to the final phases. One resident has been there for about nine years and one has been there for five years but still on phase six. Setting a time limit would create openings in reintegration housing for residents possibly more capable of progressing through the final two program phases.

However, because only a few residents would be sent back to Larned, it does not appear this option would reduce the projected program resident population or costs. Although this option potentially allows more residents to enter the reintegration facilities, it does not appear to be enough to significantly reduce the resident population. That is because the reintegration facilities only have 16 residents and it is unlikely very many would need to be sent back. Additionally, the program needs the same number of additional housing units and staff in this option as it would in the baseline. As such, operating and capital costs in 2025 are about the same as the baseline cost in 2025.

Agency official agreed that putting a time limit on a resident's time at a reintegration facility would benefit the residents. Program staff and KDADS officials generally agreed with this option. Specifically, the directors of the reintegration facilities agreed it would be helpful to send residents that do not appear ready to complete the reintegration phases back to Larned for further development. In the meantime, this would open up a space for any residents who are ready to progress to reintegration. Further, this is a relatively easy change to make and could be more effective if done in combination with the option to double the number of reintegration beds previously discussed on page 31.

Option 6: Beginning Sexual Predator Treatment Before the Offender is Released From Prison Would Not Significantly Impact Resident Population and Could Increase Costs

Currently, no treatment for sexually violent predators is offered while in prison, so offenders cannot start treatment until they are committed after their release. The Department of Corrections offers sex offender treatment to inmates in prison. However, no sexually violent predator treatment is offered. Unlike sexually violent predators, sex offenders do not necessarily have a mental abnormality making it likely they will reoffend. As such, their treatment is very different from sexually violent predator treatment. This option would allow inmates to participate in sexual predator treatment in prison. Offenders could then apply credit earned for completing sexually violent predator treatment in prison towards their treatment if committed to the state's Sexual Predator Treatment Program.

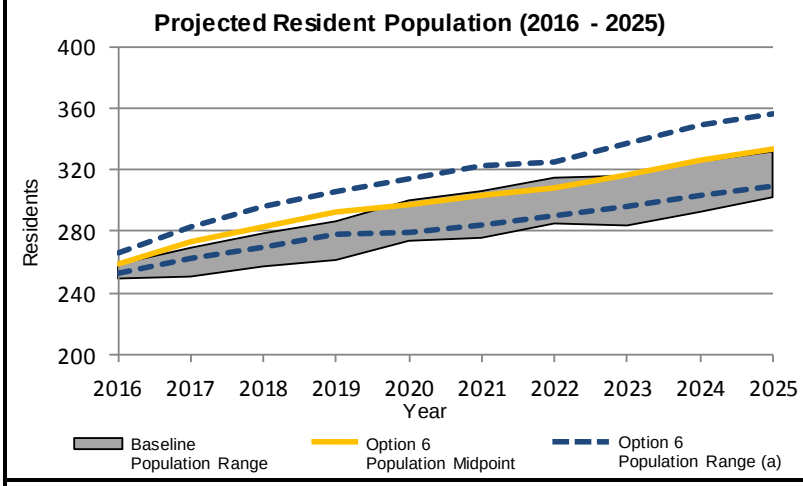
Offenders who began treatment while serving their prison sentence could shorten their civil commitment time. Under this option, offenders would begin sexual predator treatment while in prison. If committed to the Sexual Predator Treatment Program, credit earned for treatment completed in prison would transfer to Larned with the offender. For example, if the offender completed phase one of treatment while in prison, they would begin on phase two once they were committed to the program.

In 2014, New York established a program to provide sexual predator treatment to offenders in prison. Officials with New York told us they are generally pleased with the level of participation in this program. However, because it is relatively new it is too early to determine the effect it could have on New York's sexually violent predator treatment program resident population.

However, this option does not significantly reduce resident population because the time savings are small compared to the time still needed to complete the program. We projected the impact that providing sexual predator treatment to prisoners could

have on the future resident population. We compared the results of this analysis to our baseline projection in ***Figure 2-7*** below. As the figure shows the resident population slightly increases.

Figure 2-7
Option 6: Comparison of Projected Resident Populations with Prison Based Sexual Predator Treatment



(a) The population range represents a 95% confidence interval from the midpoint.
Source: LPA generated model of SPTP resident population.

However, given the substantial overlap between the two scenarios, we do not believe this option would result in any significant change to the resident population. Receiving treatment while in prison would in theory reduce the time it takes a resident to complete the program at Larned by a year or two. However, the credit received for treatment in prison is only a small portion of the time needed to complete the program. Additionally, residents also still need to wait for space to become available at the reintegration facilities.

In addition, we estimate this option would increase projected program costs by about $600,000 and $2 million by 2025. Without any changes, we estimate the program will cost a total of $26 to $34 million to operate by 2025 (in 2014 dollars). Offering sexual predator treatment does not significantly reduce the Larned population overt time, operational costs would be similar to the baseline. Further, there would be additional costs of $600,000 to $2 million start treatment programs in the prisons. Taking all of this into account, we estimate the program costs would be increased to $26 to $36 million in 2025, a 2% to 5% increase.

Providing sexually violent predator treatment in the prisons would require coordination between KDADS and the Department of Corrections to ensure prison-based treatment is effectively managed. Additionally, the Superintendent of Larned State Hospital had concerns regarding the consistency of treatment residents would receive in prison compared to the treatment residents receive at Larned. Although a challenge, this option does appear feasible given New York currently operates a prison based treatment program for sexually violent predators. However, KDADS officials should consider the limited benefits, additional costs, and challenges this option poses before pursuing it.

OTHER FINDINGS

Statutory Housing Restrictions Make it Difficult for Residents to Leave the Program.

Kansas statutes currently prohibit sexually violent predators on transitional or conditional release from living within 2,000 feet of specific locations such as a licensed child care facility, a place of worship, or a residence where a minor resides. Program officials told us this limitation makes it very difficult for residents to find housing in the community, which is a requirement for exiting the program. No such uniform restriction exists for paroled sex offenders. Rather, any housing restrictions for sex offenders are made on a case-by-case basis by parole officers. Although we did not model the impact of a change to this prohibition, applying a case-by-case approach to sexually violent predators would likely allow a few more residents to exit the program.

Conclusion

The Sexual Predator Treatment Program was established more than 20 years ago to protect the public from violent sex offenders with a high risk of reoffending. The program is meant to provide long-term control, care, and treatment for these offenders. Over time, the program population has steadily grown as offenders are consistently committed into the program but few are ever released.

The findings of this audit have identified two important concerns with the Sexual Predator Treatment Program that need to be addressed. First, the program's treatment model has not kept up with the research-based, recommended practices we saw in other states. These recommended practices emphasize individualized treatment plans that address the specific needs of the individual residents. The treatment plans should be based on robust assessment tools that identify the risk of reoffending as well as other factors such as learning styles, intellectual abilities and other mental health issues. The Kansas program lacks the same level of individualization.

The second concern is with the continuing growth of the program population. Given the state's current statutes and policies on committing and releasing residents, the population will continue to grow over time. Without any statutory and policy changes, the resident population will likely exceed the physical capacity of the Larned facility in the next couple of years. Given the difficulties the program has had in keeping adequate staffing levels, it would appear the program has already grown beyond what the labor market in and around Larned can support. Whether it is tightening the statutory commitment criteria, improving the treatment model, accepting more risk, or relocating the program, something is going to have to change, because the current model cannot be sustained.

Recommendations for Executive Action

1. To address better align the program with current research-based recommended practices, KDADS and program officials should:

    a. Implement appropriate assessment tools that identify the residents' risk of reoffending, as well as the presence of other factors that could affect treatment such as intellectual and development disabilities, addiction, trauma, and mental health issues (page 11).

b. Develop individualized treatment plans based on the results of the various assessment tools (pages 11 to 12).

c. Conduct periodic reviews to assess the residents' progress, reassess specific risk factors, and modify the treatment appropriately (page 11).

d. Modify the annual mental exams to assess whether resident's mental condition continues to meet commitment criteria, and have the exam conducted by impartial staff (page 12).

e. Establish treatment criteria that is tailored for residents with intellectual or developmental disabilities (page 12).

f. Reevaluate the need for, and extent of, non-clinical criteria for residents to advance to the next phase of treatment (page 15).

g. Develop a plan for implementing these and other changes deemed appropriate. Identify the need for any additional resources and develop a strategy for obtaining those resources.

2. To address issues related to management of the program, KDADS and program officials should:

a. Implement a process to review the program's services to ensure residents have the necessary skills to progress successfully to reintegration facilities and eventually transition back into the community (page 18).

b. Develop and implement a process to ensure appropriate program data are maintained to track treatment services, cancellation of services, phase progression and participation data (pages 18 to 19).

c. Utilize this program data to continually evaluate staffing and program services (pages 18 to 19).

d. Establish and implement a process to periodically review policies and procedures as well as resident documents to ensure accuracy and proper implementation (page 20).

3. To address the population growth KDADS and program officials should

    a. Develop a strategic plan for addressing the program's population growth. As part of that plan, consider the options presented as part of this audit (page 24).

    b. Examine the feasibility of relocating some or all of the Sexual Predator Treatment Program to an area of the state with a larger labor market that will increase the number of potential job applicants (pages 23 to 24).

APPENDIX A
Scope Statement

This appendix contains the scope statement approved by the Legislative Post Audit Committee for this audit on March 22, 2013. The audit was requested by the House Appropriations committee and Senate Ways and Means committee.

Larned State Hospital: Reviewing the Operations of the Sexual Predator Treatment Program

Kansas' Sexual Predator Treatment Program was established in 1994, and has been provided primarily through the Larned State Hospital. The program provides treatment for convicted sex offenders who have completed their prison sentences but have been determined by the courts to be violent sexual offenders in need of involuntary inpatient treatment.

In 2005, Legislative Post Audit issued a report on the Sexual Predator Treatment Program. In that report, we estimated that the size of the offender population could increase to about 235 offenders or more by 2015. The reasons for this included the continuing commitment of new offenders to the program and Kansas' stringent requirement that the risk of a re-offense be reduced to "practically nil."

As of January 2011, the Sexual Predator Treatment Program at Larned State Hospital had almost reached full capacity with 200 of 214 available beds filled. SRS officials estimate that, in the coming years, the program will grow by about 18 offenders per year.

Legislators have expressed concern about the growing size of the offender population, employee workload, and working conditions at the Larned facility. They would like to know how Kansas' program compares to other state programs in terms of cost and treatment, what actions could be taken to limit program growth, and whether the Larned facility is being adequately managed.

A performance audit in this area would address the following questions:

1. **How does Kansas' Sexual Predator Treatment Program compare to similar programs in other states and best practice?** To answer this question, we would work with Larned State Hospital Officials to determine the program's statutory requirements, its cost, admission and exit criteria, treatments provided, and the effectiveness of those treatments. As part of that work, we would determine whether the program provides services to offenders that are not required by the Kansas Constitution. Further, we would review program data to determine how many offenders have been committed, released, returned, or are still in the program since it began. We would work with officials in a sample of other states to collect similar information. We would also review academic literature and contact officials from relevant organizations such as the Center for Sex Offender Management to identify best practices or benchmarks related to sex offender programs. Based on that cumulative information, we would assess how Kansas' program compares to other states and best practices in terms of its structure, cost, treatment, and results. We would perform additional work in this area as needed.
2. **What actions could be taken to reduce the number of offenders committed to**

Kansas' Sexual Predator Treatment Program? To answer this question, we would assess possible long- and short-term options for reducing offenders committed to the program. One long-term option we would assess is amending Kansas Sentencing Guidelines to lengthen the time that a convicted offender stays in prison. We would work with officials from the Department of Corrections, the Kansas Sentencing Commission, and any other relevant agencies to determine how changing sentencing guidelines for sex-related crime might affect the program's offender population over time. A short-term alternative we would assess is making changes to the process for committing a sex offender to the Sexual Predator Treatment Program. We would work with officials from the Attorney General's office and any other relevant agencies to determine the consequences of adopting stricter screening criteria and other similar program changes. To the extent possible, we would develop cost estimates for any long- or short-term options we identify. We would perform additional work in this area as needed.

3. **Is the Sexual Predator Treatment Program appropriately managed to ensure the safety and well being of program staff and offenders?** To answer this question, we would look for or would work with other states to develop acceptable workload standards and staffing ratios. We would compare the program's current staffing level to those standards and identify any potential problem areas. We would also survey program staff and review offender complaints to identify issues concerning employee and offender safety, as well as employee working conditions. To the extent possible, we collect program information relevant to any potential issues we identify such as security or safety incidents, regulatory citations, offender complaints, and program accreditation results. For concerns raised by staff or offenders that have merit based on information we are able to collect, we would follow-up with program managers to determine what actions they have taken or plan to take to address these issues. We would perform additional work in this area as necessary.

Estimated Resources: 3 LPA staff
Estimated Time: 6 months (a)

(a) From the audit start date to our best estimate of when it would be ready for the committee. This time estimate includes a two-week agency review period.

APPENDIX B
Population Model Methodology

This appendix contains a detailed description of the methodology used and assumptions made in our work to project the future resident population of the Sexual Predator Treatment Program (program).

Methodology and Assumptions for the Population Model

Number of Residents Entering the Program:
We used historical resident data to estimate how many residents would enter the program in each of the years we modeled. Specifically, we determined the total number of residents committed to the program per year from 2007 – 2014. This time frame assures that we capture the early effects of Jessica's Law, which lengthens the prison sentence. This would potentially reduce the future number of offenders entering the program annually. As a result, our model assumed that between 11 and 18 new residents would enter the program each year. Every number in this range had an equal chance of being selected.

Resident Age:
We used historical resident data to determine the average age of residents when they entered the program. We determined that the average age at entry is 44 years old. The minimum age at entry is 18. Once in the model, each resident ages one year for every year modeled.

Resident Age at Death:
We used historical resident data to determine the age at death for the 28 residents that have died in the program since it opened in 1994. We calculated the cumulative probability of dying at each age and plotted a line through these probabilities. The equation of this line is the basis for how lifespans are generated in the simulation. This method may understate residents' true lifespans because in the years the program has been operational only 28 people have died. Therefore, the living residents may yet have long lifespans. Without any empirical measure to suggest how long their lifespan may be, we added 10% to the randomly generated age to account for this uncertainty. (Example: if a resident was projected to die at age 60, we adjusted that to 66.)

Resident Progression Through Treatment:
We assumed that not all residents would progress through treatment once in the model. Specifically, non-participating, medically infirm, and parallel track residents do not progress through treatment in the model. These residents are randomly selected based on probabilities derived from historic resident data. Any resident able to progress has a randomly determined number of years needed to complete their treatment at Larned State Hospital and in reintegration facilities. The number of years to complete the program was also derived from historic resident data. Each year a resident may make one year's worth of progress through treatment. Finally, in our model a resident that completed treatment at Larned State Hospital is not allowed to progress to reintegration facilities until space becomes available.

Recidivism:
There is a chance that residents who complete the program could reoffend in the community, go back to prison, and ultimately end up back at the Sexual Predator Treatment Program. To account for this we analyzed a meta-analysis examining 85 other offender recidivism studies. This analysis concluded that 36% of sex offenders would commit another offense. As such, we assumed any resident that completes the program would have a 36% chance of reentering the program at a later time. If a modeled resident was selected as a recidivist, they would be entered back into the program the same year that they completed the program. This is because our model could not assess the time it would take for the resident to complete the criminal justice process and come back at a later date after serving a prison sentence.

Back to Corrections:
Residents of the program sometimes commit a criminal offense while committed at Larned State Hospital. It is likely that residents are sent to the Department of Corrections to serve a new prison sentence. We used historical resident data to determine that 5% of residents reoffended while in the Sexual Predator Treatment Program and were sent back to the Department of Corrections. We applied this percentage to the modeled resident population.

Methodology and Assumptions Specific to our Six Options

Treating Low Risk Offenders in the Community:
This option would allow low-risk sexually violent offenders to be treated in a community model rather than at Larned State Hospital. We assumed that roughly 30% of incoming residents would be considered low-risk. We built this assumption into the model. During modeling, any new resident assigned as low-risk was diverted from the main resident population. Our 30% assumption was based on the proportion of offenders that entered New York's community treatment program for sexually violent predators in the program's first year (2007 – 08).

Treating Medically Infirm Residents in a Secured Nursing Facility:
As mentioned previously, residents age one year for every year modeled. We assumed that when a resident reaches 65 years old they would have a two-thirds chance of becoming medically infirm. This assumption is based on an AARP data report. In this option, the model removes any residents that become medically infirm from the population.

Expanding Reintegration Housing Slots from 16 to 32:
This option required us to manually increase the available number of slots in reintegration housing from 16 to 32. Under this model, residents cannot progress to reintegration housing until space becomes available.

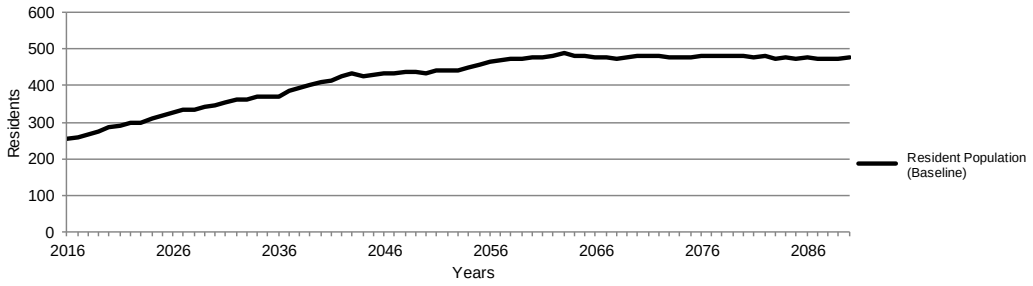
Treating Residents on the Program's Parallel Track in Separate Secured Facility:
This option would remove the residents with intellectual or developmental disabilities assigned to the program's parallel track. We assumed that every incoming resident had a 16% chance of being assigned to the program's parallel track. We built this assumption into the model. During modeling, any resident assigned to the parallel track was removed from the model. Our

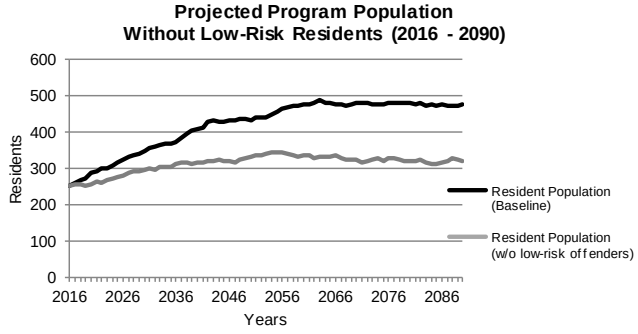
assumption of 16% was based on actual resident data regarding the number of residents currently on the parallel track.

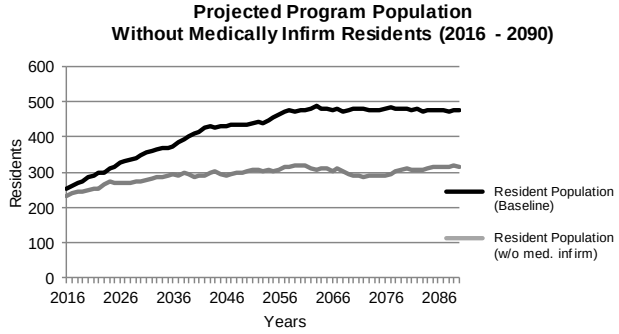
Limiting Time in Reintegration Housing:
For this option we limited the time residents could stay in reintegration housing to six years. This limit was based on estimates provided from the directors of the reintegration houses regarding the absolute maximum amount of time it should take a resident to complete the reintegration phases. Residents in reintegration housing were returned to the Larned State Hospital if they did not reach their completion date within six years.

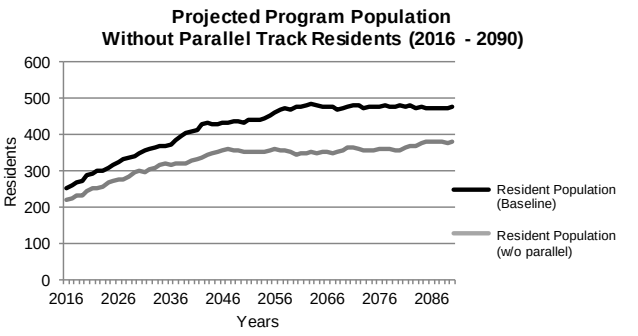
Receiving Sexual Predator Treatment in Prison:
Running this option assumes that 70% of incoming residents for each year modeled received credit for Phases I and II of sexual predator treatment while in prison. To account for this we reduced the time it would take for these residents to complete the treatment at Larned State Hospital by between 9 months and 3.5 years with an average credit of 1.75 years. This range and its distribution are based on historical treatment progression at Larned State Hospital.

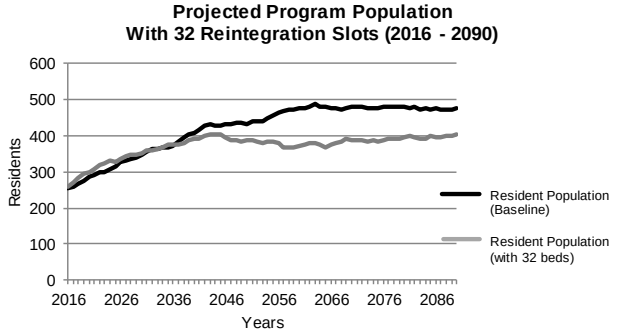
Appendix C
Long-term Projection Comparison Between the Baseline Population and the Population for Each of the Six Options (2016 - 2090)

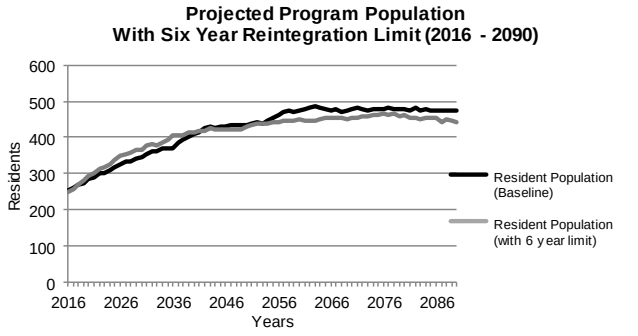


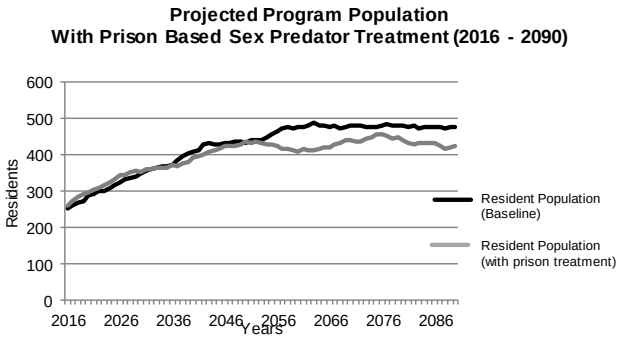












Source: LPA generated model of SPTP resident population.

APPENDIX D
Research-Based Guidelines

This appendix contains citations to the guidelines, studies and reports the Association for the Treatment of Sexual Abusers (ATSA) and others have put out regarding the treatment of sexually violent predators. We relied on this research-based guidance in our efforts to answer question one presented in this audit.

1. ATSA Practice Guidelines for the Assessment, Treatment and Management of Male Adult Sexual Abusers 2014 (Association for the Treatment of Sexual Abusers)

2. A Model of Static and Dynamic Sex Offender Risk Assessment; Robert J. McGrath et al., (Published by the U.S. Department of Justice)

3. ATSA: Assessment, Treatment, and Supervision of Individuals with Intellectual, Disabilities and Problematic Sexual Behaviors 2014

4. Rule 706 Expert Report and Recommendations, November 2014, United States District Court, District of Minnesota, Civil No. 11-3659:

    a. Andrews and Bonta 2010. The psychology of criminal conduct 5th edition;
    b. Marlatt & Gordon 1985. Relapse Prevention: Maintenance strategies in the treatment of addictive behaviors;
    c. Marques, Wideeranders, Day, Nelson & Van Ommeren 2005. Effects of relapse prevention program on sexual recidivism: Final results from California's sex offender treatment and evaluation project (SOTEP);
    d. Marshall, Marshall, Serran & O'Brian 2011. Rehabilitating sexual offenders: A strength-based approach;
    e. GLM – Yates, Prescott & Ward 2010. Applying the Good Lives and Self Regulation Models to sex offender treatment: a practical guide for clinicians;
    f. Grove, Zald, Lebow, Snitz & Nelson, 2000. Clinical versus mechanical predication: A meta-analysis.
    g. Doren, D.M., 2005. What weight should courts give treaters' testimony concerning recidivism risk?
    h. Greensberg & Shuman, 2007. When worlds collide: Therapeutic and forensic roles.
    i. Mann, Hanson & Thornton, 2010. Assessing risk for sexual recidivism.

APPENDIX E
Agency Response

We provided copies of the draft audit report to the Kansas Department of Aging and Disability Services (KDADS) on April 1, 2015 and to the Kansas Attorney General's Office on April 8, 2015. Both agencies' responses are included as this Appendix. In addition, we have included a table listing the KDADS' specific implementation plan for each recommendation immediately after its written response.

KDADS stated they disagreed with a number of the report's findings. These findings were based on audit work generally covering program data from 2013, 2014, and early 2015. The agency appears to have made a number of recent changes to the program, many of which were implemented after the time period covered by our audit. Although we commend the agency for making these changes, we do not believe they affect the report's findings, conclusions or recommendations. As required by our audit standards, we are providing the following explanations for the six findings for which the department raised substantive disagreements:

- **KDADS disputes the finding that residents are not given assessments.** KDADS states that residents are assessed immediately before and upon entry to the program and are periodically reassessed thereafter. We reviewed program requirements, interviewed staff and reviewed resident assessment forms. We acknowledge that the program does some assessment on residents. However, on page 12 we detail the assessments in place at the time of our audit, and how those assessments fell short of research-based guidance in several areas. Specifically we found that Kansas did not use an assessment tool that explicitly assesses treatment needs or the risk of reoffending.

- **KDADS disputes the finding that the program lacks individualized treatment.** KDADS states each resident is provided individual treatment for their specific mental abnormality or disorder through individualized treatment plans and therapeutic assignments. As noted in the report on page 13, Kansas program focused solely on treating sexual disorders with all residents completing the same curriculum. Unlike the other states we reviewed, Kansas' program did not provide treatment for individual issues such as schizophrenia, alcoholism or borderline personality disorder. Recommended practices emphasize addressing specific issues in additional to sexual predator treatment.

- **KDADS disputes the finding that the annual review fails to meet statutory criteria.** KDADS states an annual examination is performed by clinical staff on each resident to determine whether the resident continues to meet the criteria for commitment in accordance with statutory requirements. LPA based this finding on interviews with program staff and detailed reviews of resident annual reviews conducted in 2013 and 2014. That work showed the agency was not assessing mental condition. The agency response details some changes the program has made in this area as of March 2015.

- **KDADS disputes the finding that the program is not abiding by recommended practices for those with intellectual or developmental disabilities.** KDADS states the treatment is comparable to many other states' programs, which also modify the pace of treatment. LPA based this finding on review of research-based guidance and detailed discussions with other state officials. The report notes several important areas where Kansas' program did not adhere to guidance or compare with these others states. These included Kansas housing residents with the general population, and not providing more specialized treatment (essentially the same treatment at a slower pace). During our work, KDADS officials acknowledged a one-size-fits-all approach is no longer appropriate for these residents.

- **KDADS disputes the finding that Kansas places greater emphasis on non-clinical requirements.** KDADS states that while the program utilizes psycho-educational courses along with activity therapy, these are components of the overall comprehensive treatment process. LPA based this finding on review of program guidelines and detailed review of resident treatment plans and progress notes. Those reviews showed many more hours were required for non-clinical activities than therapy. For example, Kansas required at least eight hours a week of walking or swimming, yet only 0-3 hours a week of individual or group therapy. We also talked with program staff and officials from other states regarding non-clinical services. Those states recommended these activities, but did not require them for all residents.

- **KDADS disputes the finding that education offered by the program may not be statutorily adequate.** LPA agrees with KDADS that the statutes do not define education. However, other states have similar statutes and we talked with officials from other states about the interpretation of "education." LPA based the finding on how other states interpret "education" for their programs. Officials from those programs in other states told us educational services typically include high school diploma equivalents, GEDs, and adult basic education.

Because the agency has made several program and process changes since our audit work was conducted, we altered the wording of our findings somewhat. Essentially, we changed the presentation of our findings from present tense to past tense. For example, we changed report language from "Kansas does not use an assessment tool that explicitly evaluates the risk of reoffending" to "Kansas did not use an assessment tool that explicitly evaluates the risk of reoffending." Because of these slight changes, the agency response language will not match the report finding language exactly.

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Kari M. Bruffett, Secretary

Sam Brownback, Governor

April 21, 2015

Mr. Scott Frank
Legislative Post Auditor
800 SW Jackson Suite 1200
Topeka, Kansas 66612

Dear. Mr. Frank:

Thank you for the opportunity to review and comment on the draft copy of the performance audit, *Larned State Hospital: Reviewing the Operations of the Sexual Predator Treatment Program (R-15-0006), Part 2*. We appreciate the time and commitment the LPA staff expended in completing Part 2 of the performance audit. We recognize the difficulty in evaluating a specialized treatment program for sexually violent predators with limited time and clinical resources.

I. Introduction and Summary

It is important for the reader to understand that throughout the report the LPA heavily relies on program specific data from only three states out of the twenty offering sexual predator treatment programs. The report lacks comparison of statutory commitment and discharge criteria, which vary widely between states and are an essential framework for comparing treatment programs. Throughout the report, the LPA acknowledges there are no universal best practices for the treatment of sexually violent predators and many other programs are faced with similar treatment issues as Kansas.

While appreciative of the work of LPA staff, KDADS and the Sexual Predator Treatment Program (SPTP) dispute, in whole or in part, a number of factual assertions, generalizations, and conclusions made in the report. The agency's more detailed response is addressed later in this letter. To summarize, the agency disputes:

- The LPA's assertion that residents are not given assessments. Residents are assessed immediately before and upon entry to the program and are periodically reassessed thereafter.
- The LPA's finding that the program lacks individualized treatment. While the residents progress through predefined phases, each resident is provided individual treatment for their specific mental abnormality or disorder through individualized treatment plans and therapeutic assignments.
- The LPA's assertions that the annual review process fails to meet statutory criteria. An annual examination is performed by clinical staff on each resident to determine whether the resident continues to meet the criteria for commitment in accordance with statutory requirements.
- The LPA's assertion that SPTP is not abiding by recommended practices for treatment of residents with intellectual or developmental disabilities. The treatment provided is comparable to many other states' programs, which also modify the pace of treatment.

- The LPA's assertion that greater emphasis is placed on non-clinical requirements to advance in the program. While the program utilizes psychoeducational courses along with activity therapy, these are components of the overall comprehensive treatment process.
- The LPA's finding that the educational and rehabilitative services the program currently offers may not be statutorily adequate. While the program does not object to providing GED courses or substance abuse rehabilitation within available funds, Kansas statutes do not specifically require these services.

KDADS also notes that the options outlined in the report would require legislative, executive, and community support as well as additional funding. Some options provided by LPA would require statutory changes in terms of where SPTP residents may be housed, court approval for conditional release to community programs, and tolerance that an SPTP resident may re-offend upon assessment of "low risk" as opposed to "virtually no risk." Moreover, only one option provided by LPA alleges a result that would reduce the overall resident population, by placing certain predators in the community.

II. Timeline of pertinent actions and events that have taken place since the 2013 LPA report.

To understand the full context of this report and the agency's response, KDADS believes it is important for readers to recall that this is the second report in a two-part performance audit. Part 1 was completed in September 2013 and focused primarily on program management necessary to ensure the safety and well-being of program staff and offenders. In May of 2013, the LPA committee directed that audit work related to the remaining questions be delayed until the release of the SPTP Task Force report.

The Secretary of KDADS initiated a specialized Task Force in December of 2012. The task force was drawn from many disciplines and included representatives from KDADS, SPTP, Kansas Department of Corrections (KDOC), consumer groups, and other interested persons. Over a period of almost a year, the Task Force members heard testimony from clinicians, administrators, corrections, prosecutors from the Attorney General's Office, community professionals, private practice attorneys, independent forensic psychologists, childrens' programs, and other interested organizations. The primary purpose of the Task Force was to research, review, and provide recommendations to the Secretary regarding best practices in state models, treatment, staff orientation, and juvenile prevention for violent sexual offense programs in the United States. The Task Force released a report containing recommendations to the Secretary on November 21, 2013. As a result of the Task Force Report, a Post-Task Force Internal Committee was formed to manage implementation of adopted recommendations. A number of the activities of the Post-Task Force Internal Committee and the implementation of the approved recommendations that are pertinent to this report are described below.

- The Post-Task Force Internal Committee is comprised of clinical and program staff from KDADS, Larned State Hospital (LSH), SPTP staff, and the reintegration facilities. The committee has met monthly since January of 2014 to research, review, and revise our current program in response to the SPTP Task Force Report. Over the course of the year, the committee initiated in-depth discussions with six states that have sexual predator treatment programs, including Washington, Arizona, California, Texas, Wisconsin, and Missouri. These discussions focused primarily on population size, researched based treatment options, alternative programming for individuals with intellectual, developmental, or other types of disabilities, risk assessments, how to keep residents engaged and motivated in treatment, reintegration processes, staff recruitment and retention, and issues related to governance. Representatives from these states asked questions about Kansas' program and explained how programs operated in their states. Kansas' program benefited from these discussions and has proceeded to implement a number of successful processes, procedures, and ideas gleaned from other state programs.

- In June of 2014, with the approval of the Secretary of KDADS, a committee for friends and family called the SPTP Friends and Family Advisory Committee was developed. This committee meets tri-

annually and is comprised of friends and family members of a number of SPTP residents. We believe that having support from family and friends is beneficial to residents as they progress through the treatment process.

- In February of 2015, modifications were made to the annual review process, which are described in more detail below.

- In late March, many of the members of the Post-Task Force Internal Committee along with SPTP clinical staff held a three day retreat in Wichita to review all of the materials collected throughout the year from the Post-Task Force and from clinicians. Various program materials were reviewed including the SPTP resident handbook, training manual, supervision tools, rules and property books, and researched based articles and studies containing recommended practices for the treatment of sexually violent predators. As a result of the retreat, staff are currently working on updating and revising the handbooks, manuals and supervision tools, and implementing recommended treatment modalities.

III. Agency Response to Question 1 concerning Comparison of Kansas' Program to Other States

We dispute the LPA's finding that Kansas' treatment model has not kept up with research-based, recommended practices. A primary purpose of the SPTP Task Force was to review and analyze best practices in the treatment of sexually violent predators. The Post-Task Force Internal Committee held discussions and gathered program specific data from six different states. Kansas' program offers similar treatment to nearly all of the states, including use of the Good Lives Model and individual and group based treatment.

In contrast to the report, while residents progress through predefined phases, each is provided individual treatment. SPTP Clinical staff prepare a comprehensive integrated treatment plan for every resident. The treatment plan is developed based on the resident's individual mental abnormality or personality disorder and any behavioral or treatment concerns regarding the resident. In addition, residents complete a number of therapeutic tasks, such as journaling and a relapse prevention plan, among other tasks, that are specific to their individual treatment needs. These tasks are reviewed in individual and group therapy sessions.

SPTP has created a new position of Chief Forensic Psychologist whose primary responsibility is to oversee the annual evaluation process, personally conduct annual evaluations of residents prior to requested court hearings, prepare forensic reports for submission to courts, and be available to testify at annual review hearings. The new Chief Forensic Psychologist has obtained a degree at the doctoral level and is a licensed psychologist by the Kansas Behavioral Sciences Regulatory Board. He has both forensic experience and familiarity with the treatment of sexually violent predators in programs throughout the nation. In addition, he has no assigned therapeutic duties so that professional independence can be maintained as recommended by the LPA audit.

In recent months, additional assessment tools have been added to the annual review process. LSH administration and the Chief Forensic Psychologist have worked with evaluators to ensure that thorough clinical interview is performed on each resident during the resident's annual examination. The evaluators are performing mental status exams, including risk assessment measures such as the Static-99, Sex Offender Treatment Intervention and Progress Scale (SOTIPS), and other psychological measures as needed, such as the Millon Clinical Multiaxial Inventory (MCMI). The evaluators are assessing the continued presence of psychiatric conditions and or mental abnormalities that increase the risk of reoffending. The annual examination has always been and continues to be administered pursuant to K.S.A. 59-29a08. However, its components are not static and will change in accordance with evolving standards of practice for the evaluation of sexually violent predators.

In addition, this quarter, as a result of the Post-Task Force retreat, additional assessment and objective measurement tools are being incorporated into the Comprehensive Integrated Treatment Plans. SOTIPS, a statistically-derived dynamic measure designed to aid clinicians in assessing risk, treatment, and supervision needs is now being utilized. The scale consists of 16 dynamic risk factors empirically linked to sexual offending. SOTIPS is designed to help treatment staff estimate each resident's level of dynamic risk and need for supervision and treatment. SOTIPS will assist treatment staff in identifying specific, objective, measurable goals for each resident.

Kansas' program offers a slower paced treatment option, called the parallel program, for individuals with intellectual, developmental, or other learning disabilities. Nearly all of the residents in the parallel program are housed on the same unit to aid in treatment and to provide additional protection for these residents. While we are not necessarily opposed to making the recommended changes in Option No. 3, the report acknowledges that other state programs offer similar treatment and in order to separately house these residents, a new facility would need to be built in a different community and additional staff will need to be hired and specifically trained.

While Kansas' program offers psychoeducational courses and activity therapy sessions, we dispute that there is greater emphasis placed on non-clinical requirements to advance through the program. Psychoeducational courses, such as anger management, relationship skills, relapse prevention, budgeting, stress management, and strategies for motivation, along with activity therapy sessions are an important component of the treatment process because they assist the residents in accumulating and maintaining social skills that are necessary for successful reintegration into the community. Moreover, these courses and sessions are only one component of the comprehensive treatment process. Residents are provided individual and group therapy sessions.

IV. Agency Response to Question 2 concerning Population Growth

We are currently operating three (3) buildings in Larned that house 232 residents, and reintegration facilities in Parsons (Maple House) and Osawatomie (Mico House) that house 8 residents each per statute. See K.S.A. 59-29a11(b). We are currently seeking to change the statutory amount from 8 to 16 residents per reintegration facility. See Senate Bill 149, Section 9, pg. 17.

In 2014 Larned finished the construction of the Meyer building. This building will house up to 36 residents and is scheduled to open for operations in January of 2016. We believe that with the addition of the Meyer building and an average growth rate of 15 residents per year, the program will reach its physical capacity by 2018.

We are in agreement that Larned has experienced difficulties in recruiting and retaining staff for this program. Steps have been taken since the release of the first LPA report to increase recruitment efforts and to ensure wages are competitive for Mental Health/Developmental Disability Technicians (MHDDTs) and to review the hiring process and wages for all staff. Despite these efforts, the program still struggles with vacancies.

V. Agency Responses to LPA Recommendations

Recommendation No. 1:

a. Assessment tools

Recommendation: Implement appropriate assessment tools that identify the residents' risk of reoffending, as well as the presence of other factors that could affect treatment such as intellectual and developmental disabilities, addiction, trauma, and mental health issues (pages D-12 to D-13).

Response/Action: Each resident is assessed immediately before and upon entry to the program and is periodically reassessed thereafter. The assessment takes into account the presence of factors that could affect the treatment of each resident, including but not limited to, factors that aid in determining whether a resident has an intellectual or developmental disability. As indicated above, SPTP has begun incorporating SOTIPS, and additional measure to identify the level of risk each resident displays as he moves through the therapeutic program, along with the Static-99, and other relevant psychological measures such as the following: the Minnesota Multiphasic Personality Inventory, Second Edition (MMPI-2), WAIS (Wescheler Adult Intelligence Scale), Substance Abuse Subtle Screening Inventory (SASSI), Trauma Symptom Inventory, Second Edition (TSI-2), Wide Range Achievement Test (WRAT), and other relevant measures.

b. *Individualized Treatment*

Recommendation: Develop individualized treatment plans based on the results of the various assessment tools (page D-13).

Response/Action: The SPTP currently provides individualized treatment plans for all residents. SPTP has been incorporating SOTIPS into each individual treatment plan to assist staff in identifying specific, objective, measurable goals for each resident. In addition, we will continue researching and reviewing additional programming concepts that will be built into our program.

c. *Periodic Reviews*

Recommendation: Conduct periodic reviews to assess the residents' progress, reassess specific risk factors, and modify the treatment appropriately (page D-13).

Response/Action: SPTP staff have and will continue to review and revise treatment plans every 90 days and will continue to update the plans as needed to ensure individualized treatment is being provided. The SOTIPS risk assessment tool, along with the other mental status and risk assessment tests previously identified, will assist staff in periodic reviews of resident progress. These tools provide objective measures to reassess specific risk factors and will assist staff in modifying individual treatment when appropriate.

d. *Annual Examinations*

Recommendation: Modify the annual mental exams to assess whether resident's mental condition continues to meet commitment criteria, and have the exam conducted by impartial staff (page D-13).

Response/Action: The annual examination has always been and continues to be administered in accordance with K.S.A. 59-29a08. In recent months, as a result of recommendations from the Post-Task Force Internal Committee, KDADS has developed an independent Chief Forensic Psychologist position to work with clinical examiners to ensure a thorough clinical interview is performed on each resident, each resident's treatment records are reviewed, and that treatment staff who work closely with the resident are interviewed regarding the resident's treatment progression. The examiners are currently performing additional risk assessments and mental status exams, including such tests as the Static 99, Sex Offender Treatment Intervention and Progress Scale (SOTIPS), and Millon Clinical Multiaxial Inventory (MCMI), as needed. The examiners are assessing the continued presence of psychiatric conditions and or mental abnormalities that increase the risk of reoffending. The Chief Forensic Psychologist does not provide treatment to the residents and is not officed at Larned State Hospital, which adds a level of independence to the annual review process.

e. *Treatment for residents with Intellectual and Developmental Disabilities*

Recommendation: Establish treatment criteria that is tailored for residents with intellectual or developmental disabilities (pages D-13).

Response/Action: Kansas' program provides curriculum that is tailored to meet the needs of residents who may require additional accommodations for their treatment plan based on an intellectual or developmental disability. Residents are assessed before being placed in the parallel program. SPTP will continue to consult with other Sexual Predator Treatment Programs, including those specifically mentioned in the report to explore treatment options, processes, and procedures to enhance the parallel treatment program.

f. *Phase Criteria*

Recommendation: Reevaluate the need for, and extent of non-clinical criteria for residents to advance to the next phase of treatment (page D-15).

Response/Action: During the March retreat, the SPTP Post-Task Force Internal Committee began reviewing and reassessing the clinical phases and criteria required in each. While the provision of psychoeducational courses and activity therapy are valuable components to the overall treatment process, the extent to which these courses and sessions are utilized is currently being reviewed.

g. *Implementation plan for recommended changes*

Recommendation: Develop a plan for implementing these and other changes deemed appropriate. Identify the need for any additional resources and develop a strategy for obtaining those resources.

Response/Action: Based on findings from the SPTP Task Force, the Post-Task Force Committee has already reached out to several states regarding programming. LSH will continue to consult with these states, as well as reach out to the specific states mentioned in the report to gather information on the programming and recommended practices their programs are utilizing. The Post-Task Force Internal Committee will continue to meet monthly to review all data collected and continue to work on meeting our goals and objectives stemming from both the Task Force Report and the LPA audit. Therefore, we will continue to develop a plan for implementing Recommendation 1 and other changes deemed appropriate by the Post-Task Force Internal Committee.

Recommendation No. 2:

a. *Skills for reintegration*

Recommendation: Implement a process to review the program's services to ensure residents have the necessary skills to progress successfully to reintegration facilities and eventually transition back into the community (pages D-16 to D-17).

Response/Action: The current SPTP curriculum is designed to provide residents with the necessary skills and resources to successfully progress to the reintegration facility. On March 25-27, 2015, the Post-Task Force Internal Committee held a retreat and identified additional curriculum enhancements. Additional courses will be offered to increase the residents' readiness for reintegration. By June 30, 2015, we will reassess and make modifications to programming as needed regarding work and life related skills.

b. *Tracking treatment services*

Recommendation: Develop and implement a process to ensure appropriate program data are maintained to track treatment services, cancellation of services, phase progression and participation data (pages D-17 to D-18).

Response/Action: The SPTP program currently tracks program data. By August 1, 2015, SPTP will have a system to improve tracking of treatment service hours, cancellation of services, phase progression, and participation data. This process will be based on computerized tracking using the Plexus system at LSH (internally developed computer program).

c. *Evaluation of program services*

Recommendation: Utilize this program data to continually evaluate staffing and program services (pages D-18).

Response/Action: By August 1, 2015, SPTP will have in place a system to track treatment service hours, cancellation of services, phase progression, and participation data. This data will be reviewed on a quarterly basis to evaluate staffing and program services.

d. *Review of policies and procedures*

Recommendation: Establish and implement a process to periodically review policies and procedures as well as resident documents to ensure accuracy and proper implementation.

Response/Action: The program has a policy review process in place in which a weekly meeting is held with the Program Director to review policies, however, additional meetings are held when necessary. Every two years, the collective policies for SPTP will be reviewed. Staff will receive training on new SPTP policies as they are implemented (e.g. computer based training, hands on training, or classroom instruction depending on the policy/staff needs). During the periodic reviews, if there are issues concerning the application of the policies, the issues will be resolved and staff will be retrained.

Recommendation No. 3:

a. *Population Growth*

Recommendation: Develop a strategic plan for addressing the program's population growth. As part of that plan, consider the options presented as part of this audit (pages D-23 to D-24).

Response: KDADS is currently tracking program growth for SPTP. KDADS will work with key stakeholders in developing a strategic plan to address population growth. Moving forward with any of the options listed on pages D-23-24, would require collaboration with the Governor, the Attorney General, the Legislature, and the community.

b. *Relocation of the program*

Recommendation: Examine the feasibility of relocating some or all of the Sexual Predator Treatment Program to an area of the state with a larger labor market that will increase the number of potential job applicants.

Response: KDADS will examine the feasibility of relocating the SPTP program. However, relocating some or all of the program would be costly and would require collaboration with the Governor, the Attorney General, the Legislature, and the community. In addition, there are zoning statutes that may affect this process.

KDADS/LSH appreciates the time and effort that LPA staff took to evaluate the program and its operations. The report will serve as an additional resource for our internal review committee in its continuing evaluation of all aspects of the program and will assist in developing additional policies and training.

Thank you for allowing us an opportunity to respond to the recommendations made in the LPA audit.

Sincerely,

Kari Bruffett
Secretary

Itemized Response to LPA Recommendations

Audit Title: Larned State Hospital: Review of the Sexual Predator Treatment Program, Part 2

LPA Recommendation	Agency Action Plan
1. To better align the program with research-based recommendations practices, KDADS and program officials should:	
a. Implement appropriate assessment tools that identify the residents' risk of reoffending, as well as the presence of other factors that could affect treatment such as intellectual and development disabilities, addiction, trauma, and mental health issues.	Each resident is assessed immediately before and upon entry to the program and is periodically reassessed thereafter. The assessment takes into account the presence of factors that could affect the treatment of each resident, including but not limited to, factors that aid in determining whether a resident has an intellectual or developmental disability. As indicated above, SPTP has begun incorporating SOTIPS, an additional measure to identify the level of risk each resident displays as he moves through the therapeutic program, along with the Static-99, and other relevant psychological measures such as the following: the Minnesota Multiphasic Personality Inventory, Second Edition (MMPI-2), WAIS (Wescheler Adult Intelligence Scale), Substance Abuse Subtle Screening Inventory (SASSI), Trauma Symptom Inventory, Second Edition (TSI-2), Wide Range Achievement Test (WRAT), and other relevant measures.
b. Develop individualized treatment plans based on the results of the various assessment tools.	The SPTP currently provides individualized treatment plans for all residents. SPTP has been incorporating SOTIPS into each individual treatment plan to assist staff in identifying specific, objective, measurable goals for each resident. In addition, we will continue researching and reviewing additional programming concepts that will be built into our program.
c. Conduct periodic reviews to assess the residents' progress, reassess specific risk factors, and modify the treatment appropriately.	SPTP staff have and will continue to review and revise treatment plans every 90 days and will continue to update the plans as needed to ensure individualized treatment is being provided. The SOTIPS risk assessment tool, along with the other mental status and risk assessment tests previously identified, will assist staff in periodic reviews of resident progress. These tools provide objective measures to reassess specific risk factors and will assist staff in modifying individual treatment when appropriate.

d. Modify the annual mental exams to assess whether resident's mental condition continues to meet commitment criteria, and have the exam conducted by impartial staff.	The annual examination has always been and continues to be administered in accordance with K.S.A. 59-29a08. In recent months, as a result of recommendations from the Post-Task Force Internal Committee, KDADS has developed an independent Chief Forensic Psychologist position to work with clinical examiners to ensure a thorough clinical interview is performed on each resident, each resident's treatment records are reviewed, and that treatment staff who work closely with the resident are interviewed regarding the resident's treatment progression. The examiners are currently performing additional risk assessments and mental status exams, including such tests as the Static 99, Sex Offender Treatment Intervention and Progress Scale (SOTIPS), and Millon Clinical Multiaxial Inventory (MCMI), as needed. The examiners are assessing the continued presence of psychiatric conditions and or mental abnormalities that increase the risk of reoffending. The Chief Forensic Psychologist does not provide treatment to the residents and is not officed at Larned State Hospital, which adds a level of independence to the annual review process.
e. Establish treatment criteria that is tailored for residents with intellectual or developmental disabilities.	Kansas' program provides curriculum that is tailored to meet the needs of residents who may require additional accommodations for their treatment plan based on an intellectual or developmental disability. Residents are assessed before being placed in the parallel program. SPTP will continue to consult with other Sexual Predator Treatment Programs, including those specifically mentioned in the report to explore treatment options, processes, and procedures to enhance the parallel treatment program.
f. Reevaluate the need for, and the extent of, non-clinical criteria for residents to advance to the next phase of treatment.	During the March retreat, the SPTP Post-Task Force Internal Committee began reviewing and reassessing the clinical phases and criteria required in each. While the provision of psychoeducational courses and activity therapy are valuable components to the overall treatment process, the extent to which these courses and sessions are utilized is currently being reviewed.
g. Develop a plan for implementing these and other changes deemed appropriate. Identify the need for any additional resources and develop a strategy for obtaining those resources.	Based on findings from the SPTP Task Force, the Post-Task Force Committee has already reached out to several states regarding programming. LSH will continue to consult with these states, as well as reach out to the specific states mentioned in the report to gather information on the programming and recommended practices their programs are utilizing. The Post-Task Force Internal Committee will continue to meet monthly to review all data collected and continue to work on meeting our goals and objectives stemming from both the Task Force Report and the LPA audit. Therefore, we will continue to develop a plan for implementing Recommendation 1 and other changes deemed appropriate by the Post-Task Force Internal Committee.

2. To address issues related to management of the program, KDADS and program officials should:	
a. Implement a process to review the program's services to ensure residents have the necessary skills to progress successfully to reintegration facilities and eventually transition back into the community.	The current SPTP curriculum is designed to provide residents with the necessary skills and resources to successfully progress to the reintegration facility. On March 25-27, 2015, the Post-Task Force Internal Committee held a retreat and identified additional curriculum enhancements. Additional courses will be offered to increase the residents' readiness for reintegration. By June 30, 2015, we will reassess and make modifications to programming as needed regarding work and life related skills.
b. Develop and implement a process to ensure appropriate program data are maintained to track treatment services, cancellation of services, phase progression and participation data	The SPTP program currently tracks program data. By August 1, 2015, SPTP will have a system to improve tracking of treatment service hours, cancellation of services, phase progression, and participation data. This process will be based on computerized tracking using the Plexus system at LSH (internally developed computer program).
c. Utilize this program data to continually evaluate staffing and program services.	By August 1, 2015, SPTP will have in place a system to track treatment service hours, cancellation of services, phase progression, and participation data. This data will be reviewed on a quarterly basis to evaluate staffing and program services.
d. Establish and implement a process to periodically review policies and procedures as well as resident documents to ensure accuracy and proper implementation.	The program has a policy review process in place in which a weekly meeting is held with the Program Director to review policies, however, additional meetings are held when necessary. Every two years, the collective policies for SPTP will be reviewed. Staff will receive training on new SPTP policies as they are implemented (e.g. computer based training, hands on training, or classroom instruction depending on the policy/staff needs). During the periodic reviews, if there are issues concerning the application of the policies, the issues will be resolved and staff will be retrained.
3. To address the population growth KDADS and program officials should:	
a. Develop a strategic plan for addressing the program's population growth. As part of that plan, consider the options presented as part of this audit.	KDADS is currently tracking program growth for SPTP. KDADS will work with key stakeholders in developing a strategic plan to address population growth. Moving forward with any of the options listed on pages D-23-24, would require collaboration with the Governor, the Attorney General, the Legislature, and the community.
b. Examine the feasibility of relocating some or all of the Sexual Predator Treatment Program to an area of the state with a larger labor market that will increase the number of potential job applicants.	KDADS will examine the feasibility of relocating the SPTP program. However, relocating some or all of the program would be costly and would require collaboration with the Governor, the Attorney General, the Legislature, and the community. In addition, there are zoning statutes that may affect this process.

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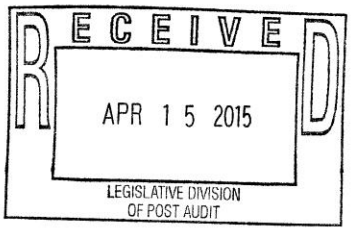

Mr. Scott Frank
Legislative Post Auditor
800 SW Jackson, Suite 1200
Topeka, KS 66612

Dear Mr. Frank:

Thank you for the opportunity to review and comment on the draft Legislative Post Audit Report "Larned State Hospital: Reviewing the Operations of the Sexual Predator Treatment Program." As always, we have appreciated the courtesy and professionalism of the auditors during this process.

The Attorney General's Office wishes to highlight two points from the report. First, as noted at page D-5, for each of the past three years the Attorney General's Office has reviewed about 270 offenders being released from the Department of Corrections who appear to meet the criteria of a sexually violent predator; on average, only 13 each year were committed to the Sexual Predator Treatment Program. This confirms the State of Kansas applies this statute in a conservative manner.

Second, the current goal of "no new victims" should be maintained. While arguments for lowering that standard might be appealing for some interests, the State should prioritize the interests of innocent Kansans who would be more likely to become victims of violent crimes if this standard of safety were relaxed.

Thank you for the opportunity to provide this response.

Sincerely,

Derek Schmidt

Derek Schmidt
Kansas Attorney General