GUIDED SELF-HELP

A NEW APPROACH TO TREATMENT OF SEXUAL OFFENDERS

ANNUAL REPORT, JULY 1976 - JUNE 1977
TREATMENT CENTER FOR SEXUAL OFFENDERS
WILLIAM D. VOORHEES JR., M.D., CLINICAL DIRECTOR
MAUREEN SAYLOR, M.A., DIRECTOR

THE PROGRAM DESCRIBED IN THIS REPORT WAS THE RECIPIENT OF THE 1971 SIGNIFICANT ACHIEVEMENT AWARD OF THE AMERICAN PSYCHIATRIC ASSOCIATION

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL & HEALTH SERVICES
WESTERN STATE HOSPITAL
FORT STEILACOOM, WASHINGTON
GIULIO di FURIA, M.D., SUPERINTENDENT

DEDICATION

This is dedicated to the memory of George J. MacDonald, M.D., September 2, 1920 to April 15, 1977.

Dr. MacDonald was one of the prime movers, innovators, and developers of the Sex Offender Treatment Program at Western State Hospital. He began his work with the Program in September of 1965. It was under his direction that the Program became recognized and gained credibility with the courts as an alternative to incarceration for the sexual offender.

PROGRAM DESCRIPTION

A GUIDED SELF-HELP APPROACH

TO

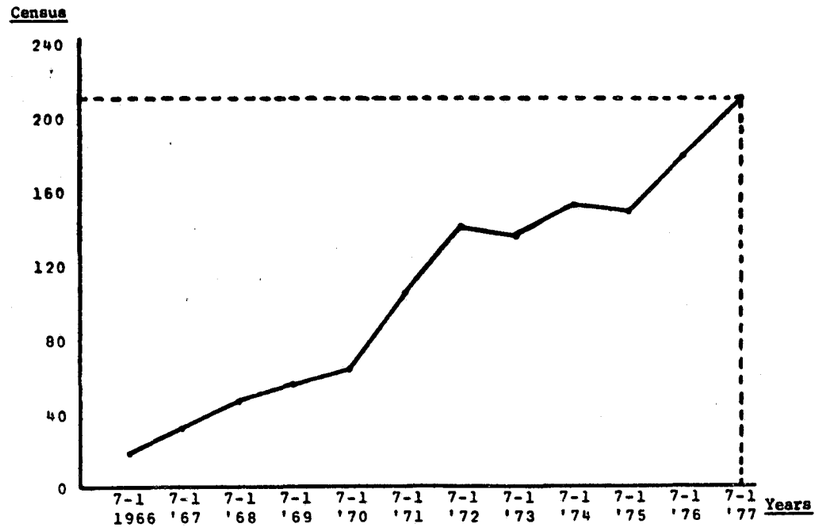
TREATMENT OF THE HABITUAL SEXUAL OFFENDER

HISTORY

In 1951 the Washington State Legislature passed a law providing for the legal commitment of sexual offenders to state mental hospitals for 90-day evaluation or for treatment until they were judged safe to be at large in the community. The law became known as the Sexual Psychopath Law and for several years after its passage the three state hospitals admitted habitual sex offenders but regarded them as dangerous and unwelcome criminal intruders into the communities for sick people. They were kept in securely locked wards and isolated from the rest of the patients and their care was largely custodial.

With no treatment available and little hope of regaining their freedom, the offenders were discontented and restless and many managed to escape. The resulting public clamor and a general investigation of hospital conditions led to the allocation of increased funds and major reforms. In 1958 for the first time sexual offenders in Western State Hospital were brought together for staff directed group therapy. Giulio di Furia, M.D., now Superintendent of Western State Hospital, and Hayden L. Mees, Ph.D., a psychologist who is now Professor of Psychology at Western Washington State College, were instrumental in developing the program. In September of 1965 George J. MacDonald, M.D., became the clinical director of the then existent program. The treatment program that evolved represents a significant contribution by mental health professionals to the field of adult corrections.

In December, 1966, the hospital was given state-wide responsibility for evaluating and treating sexual offenders. Since that time as can readily be seen from the graph below, the program has increased from approximately 20 patients in 1966 to an all time high of 212 in June of 1977.



The program began as one group of 12 men who met once a week in a two hour therapy session led by a staff member. As the men began to feel that they belonged to a socially approved group that could really understand and help them, escapes decreased significantly. Gradually the guided self-help approach was more fully developed and the offenders themselves were given more and more responsibility for conducting psychotherapy groups and governing themselves in all aspects of their daily routine.

TREATMENT APPROACH

The program developed from necessity and evolved through trial and error, but three basic precepts have remained unchanged. The first is that deviant sexual behavior is learned behavior and therefore subject to modification if methods can be developed to break up old habit patterns and teach new ones. The second is that sexual offenders following the example set by Alcoholics Anonymous and other groups can do a great deal to help each other overcome their deviant behavior if given the right kind of direction and guidance by the staff. That belief forms the basis of the program's guided self-help approach. The third precept is that the hospital environment and the process for relearning acceptable behavior must replicate and confront the realities of living in the community as much as possible, otherwise treatment is merely another institutional experience that is probably worse than no treatment at all.

The core of the treatment model revolves around peer group therapy, with offenders treating other offenders under the guidance and supervision of a professional therapist. Unlike traditional group therapy where the therapist intervenes and does direct therapy, in this model the therapist is the teacher, the observer and the director of what occurs in the session. He/She is the monitor of group process and responsible for perpetuating healthy group structure and process.

Each offender spends a minimum of 25 hours a week in group therapy. The sessions are led by group leaders, offenders who have been elected by their peers to represent the group and organize its basic functioning. Participants in the therapy session are expected to be honest in revealing deviant feelings, thoughts and behavior.

In addition to the inpatient groups each therapy group has an outpatient meeting for its outpatient members one evening a week and a married couples group that also holds weekly sessions.

Both men and women volunteers work with the program and they meet with inpatient groups once a week. They participate in role-playing and psychodrama sessions. The presence of the women volunteers is considered highly important because of the opportunity it provides in increasing the residents' social skills. Most of the men are emotionally insecure and often socially inept in dealing with adult women.

In addition to therapy sessions, each of the residents work 30 hours a week (5 days a week) without pay in the laundry, kitchen, geriatric wards or other industrial areas of the hospital. The work assignment is viewed as an important part of the offenders' treatment and is another opportunity for him/her to learn and demonstrate concerns for other human beings.

On admission to the program an offender is assigned to a treatment group as an observation member and oriented to group and program procedures and policies and

values. During the first 10 to 14 days he/she is required to complete a biographical data sheet and to write his/her autobiography. He/She must narrate the latter to the group and answer all questions including challenges to accuracy and completeness. The offender is given extensive psychological tests and the case is carefully reviewed by staff. Within 90 days there is an evaluation by the therapy group and this is presented to the therapy supervisor who then reviews the case with the program staff to determine if the offender should be recommitted as a "sexual psychopath" for the full course of treatment. This includes deciding whether the offender is a good candidate for intensive treatment and is willing to contribute his/her share to the self-help program. After the final recommendation has been developed the offender then returns to court with these findings.

Should he/she be found to be a sexual psychopath and amenable to treatment the offender returns for a minimum of 15 months of inpatient treatment as a general member of the program. Four basic objectives are emphasized in treatment; recognition of harmful behavior patterns, understanding of their origin and operation, acceptance of responsibility for change and application of new patterns of responsible behavior in dealing with people. The offender is expected to progress in all major activities and relationships including group living, work assignments, psychotherapy, family and sexual relationships, social and recreational activities and leadership ability. Privileges are granted on the basis of behavior, by approval of the group and therapy supervisor. These include various degrees of freedom to move about the hospital grounds in spare time.

There are approximately 10 steps of progress that the offenders must accomplish within his/her given group in order to request discharge from the inpatient phase of treatment. In addition, the offender prepares a discharge contract that includes the specific conditions he/she will live under on work release and outpatient phases. The request is examined, voted upon by the group, approved by the therapy supervisor and reviewed by program staff and the Senior Staff Committee. If it is approved the offender again returns to court. With the court's approval he/she is placed on probation under the terms of the discharge contract, which requires that the offender be readmitted immediately to the hospital for a minimum of three months on work release as a voluntary patient. During that period he/she must work or attend school in the community for 40 hours a week, returning to the hospital at night. The offender attends evening inpatient meetings and the weekly outpatient meetings. As the offender proves responsibility social and overnight leaves are gradually increased and eventually he/she is permitted to live in the community full time on outpatient status. Again, after successfully completing the steps of progress of the work release phase of treatment, the offender may request discharge from this phase of treatment. The above-mentioned process again recurs. The request is made through the group, voted upon, approved by the therapy supervisor and reviewed by the Sex Offender Program staff. Following this process the offender is placed on the outpatient phase of treatment. For 18 months after leaving the hospital he/she is required to attend the weekly outpatient meetings with gradual de-escalation after six months outpatient. Continued involvement in the hospital treatment program is a specific condition of probation. The offender is jointly supervised by the treatment group and the therapy supervisor in conjunction with the probation officer. Once the offender has responsibly completed the outpatient phase of treatment, he/she may request discharge from the program. The same process used to move from one phase to another is again used.

From the beginning of treatment family members are invited to visit the offenders and become involved in the program. Wives are frequently under severe emotional strain and some are anxious and depressed. They often have trouble coping with their children, financial and school problems and community reaction to their husbands' offenses. Involvement in the program is supportive for the wives and allows the offenders, many of whom have committed offenses against children, to demonstrate their ability to interact responsibly with their family. All visitors to the program are screened and approved by the treatment group and the therapy supervisor.

JULY, 1976 to JUNE, 1977

The Sex Offender Treatment Program at Western State Hospital has come of age. This can be identified in two major ways; the program is now receiving both major recognition and criticism. No longer are we entitled to the rights and privileges of a "pilot program." We have become, whether we are fully aware or not, a "model" that others study as a method of treating sexual offenders. While recognition is more easily accepted, criticism is as vital, if not more so, to the program if it is to continue to accomplish the task at hand; that is, the rehabilitation of the sexual offender. Criticism over the past several years particularly has caused us to look deeply into our structure and functioning and make some important changes. It is from critical analysis that we learned better to do the job. Acclaim has also been forthcoming and the program has been visited and studied by treatment persons and researchers from other states and other countries. The program was one of several selected by Edward Brecker when he did his soon-to-be-published study on treatment programs for the sexual offender in the United States. We have been visited several times in the past year by our sister country, Canada. They have been studying our model as a possibility for use in a national program for sexual offenders. We were represented by a former assistant director, Robinson A. Williams, M.S.W., at the first conference for the sexual aggressives in Tennessee in the Spring of 1977.

As is often the case with programs of this nature, we have been praised nationally and criticized locally. This seems only appropriate as those who view us from a distance often see only the best of us and those we live with on a daily basis see the faults that irritate and need reassessment.

During the past year several things have occurred that have caused the program to reassess, re-evaluate and renew.

The first is the death of our long-time clinical director, George J. MacDonald, M.D. With the advent of Dr. MacDonald's death the remaining program looked at its ability to go forward. The model is self-renewing and self-perpetuating. With the help, support and guidance of Giulio di Furia, M.D., our hospital superintendent, new administrative leadership was found and the model continues revitalized.

The second major issue of concern in this last year was the escape of four offenders from a treatment group in the program. The effects of this were far reaching and reverberations are still being heard. Of major concern is the damage done to the liaison and good will of our local community. As a result of this escape a major program evaluation was undertaken at all levels of functioning, principally the manner in which residents are treated and the staff supervised. From this evaluation several changes occurred. One of these was a major security change, in that the program relinquished selected residents being able to "hold the key" to their own wards. This responsibility is now managed completely by program nursing staff. In reviewing the program model we found that it was not wanting but the management in application of it was. The major response to this revelation was closer and more in-depth management and supervision of both therapy groups and staff.

The third major consideration during the past year was the development of the Eastern State project for the sexual offender. In the Spring of 1977 we were charged with developing a pilot program to be transplanted to Eastern State Hospital at Medical Lake based on the current model in operation at Western State Hospital. Two pilot groups were formed of residents from east of the mountains and two therapists were hired to be trained to manage the two groups. The project is scheduled to begin sometime in late fall or early winter. With the advent of this project our entire program again was forced to evaluate the "model" to decide what were the essential elements that needed to be transplanted in total and what could be subject to local manipulation. Structure, function, value system and policies were reviewed. While the program will lose residents, the development of this project through closer scrutiny of internal functioning has assisted in the rebirth of many ideas. The Sex Offender Program at Western State will provide consultation and training to the Eastern State project after it is moved during its developing phases. With the development of this program it is hoped that stability will be provided for the burgeoning population in the Western State program. As this occurs more opportunity will be provided to assess and analyze the Western State program. Finally, and of concern for the future, is the development of a number of in-community programs that are treating the sexual offender. A decision must be made concerning the relationship of the Western State Hospital Sex Offender Program and these programs in order to provide a really comprehensive treatment network for the assessment, evaluation and treatment of the sexual offender.

For the coming year we have several objectives to accomplish. First, the assessment and evaluation of data and the publishing of a comprehensive reoffense study.

Second, a comprehensive effort at re-establishing better personal relationships with the community at large and the courts in particular. Better program interpretation needs to occur and those involved need to be invited to visit the program to see it actually function.

Third, we again need to concentrate our efforts in the area of educating and training those who have an intimate connection with us; namely, the superior courts in Western Washington, the prosecutors' offices and the offices of Probation and Parole. It has been several years since a systematic program for these groups was developed.

Fourth, we need to reach out and share with the therapeutic community at large. We can no longer exist in an ivory tower. We have a responsibility to share what we have learned about the treatment of the sexual offenders with the professional community, not only locally but nationally as well. If we believe as strongly as we say in what we are doing, then it is only appropriate that we engage in dialogue with others who share the same responsibility.

Fifth, it is important that we further come out of our "tower" and recognize that there are other people within Western Washington providing treatment for the sexual offender. No purpose is served and only the community hurt by arguing and quibbling with other treatment entities. The time has come for us as the oldest center in the state to provide a base for the development of a network of treatment modalities offering varying services and serving offenders at varying levels. It is our

responsibility to provide consultation and training to appropriate groups; dialogue needs to be established. Surely the courts of Western Washington begin to become confused about who should be treated in the community, who should be sent to the treatment program at Western State and who should be incarcerated. This is a decision that we with the years of experience should be assisting the courts in making. It is hoped that in late Spring or early Summer of 1978 a conference can be held at Western State Hospital to establish the kind of dialogue previously described.

Over the past several years, the last year particularly, it has become immediately apparent to the Sex Offender Treatment Program at Western State Hospital that we are no longer a child nor even an adolescent, but as a treatment program we have reached maturity and adulthood. Our goals and objectives for the future need to be directed toward not only maintenance of the very workable model that has developed, but further elaboration and interpretation of that model. We must no longer exist alone but must make connection with our own community and in the professional community nationally. We have a responsibility to do so.

TREATMENT PROGRAM FOR THE SEXUAL OFFENDER
Western State Hospital
Fort Steilacoom, Washington

STATISTICAL REPORT*

	7/74 6/75	7/75 6/76	7/76 6/77
BEGINNING OF PERIOD			
Inpatients in 90-day Observation	45	37	37
Inpatients in Full-time Treatment (25 hours of group psychotherapy per week)	98	105	124
Inpatients on Work-release	13	11	21
Outpatients (group psychotherapy 1 evening per week, 3 hours)	74	76	59
Wives in Group Psychotherapy (1 evening per week, 3 hours)	40	34	43
TOTAL, ALL PERSONS SERVED	270	263	284
ADDITIONS DURING PERIOD			
90-day Observation	140	158	182
Full-time Inpatient Treatment	99	108	132
Work-release	50	60	57
Outpatients	46	44	54
Total Offenders	335	370	425
Wives	33	58	52
TOTAL ADDITIONS	368	428	477
SEPARATIONS DURING PERIOD			
90-day Observation	148	158	178
Full-time Inpatient Treatment	92	89	103
Work-release	52	50	60
Outpatients	44	61	48
Total Offenders	336	358	389
Wives	39	49	42
TOTAL SEPARATIONS	375	407	431
END OF PERIOD			
Inpatients in 90-day Observation	37	37	41
Inpatients in Full-time Treatment	105	124	153
Inpatients on Work-release	11	21	18
Outpatients	76	59	65
Wives in Group Psychotherapy	34	43	53
TOTAL, ALL PERSONS SERVED	263	284	330

CURRENT CRIMINAL CHARGE	1/68-6/75		7/75-6/76		7/76-6/77	
	NO.	%	NO.	%	NO.	%
Rape **	101	13	42	27	52	29
Carnal Knowledge ***	68	9	11	7	32	18
Indecent Liberties	338	42	57	36	62	34
Indecent Exposure	84	11	14	9	6	4
Incest	21	3	4	3	7	4
Sodomy	67	8	13	8	3	2
Other	119	15	17	11	20	11
TOTAL	798	100	158	100	182	100

* Data as of time of admission for observation and for fiscal year July 1 through June 30.

** On 7-1-76 the Rape law was changed to First Degree Rape, Second Degree Rape and Third Degree Rape.

*** On 7-1-76 the Carnal Knowledge law was changed to First Degree Statutory Rape, Second Degree Statutory Rape and Third Degree Statutory Rape.

Revised 8/77

		1/68-6/75		7/75-6/76		7/76-6/77	
		NO.	%	NO.	%	NO.	%
CHARACTERISTICS OF VICTIM							
AGE:	0 - 12	384	48	72	46	98	54
	13 - 15	181	23	35	22	39	21
	16 - 20	94	12	27	17	21	12
	21 - +	139	17	24	15	24	13
	Total	798	100	158	100	182	100
SEX:	Male	156	20	30	19	34	19
	Female	642	80	128	81	148	81
	Total	798	100	158	100	182	100
BODY CONTACT:	No	126	16	19	12	11	6
	Yes	672	84	139	88	171	94
	Total	798	100	158	100	182	100
FORCE USED:	No	546	68	108	68	137	75
	Yes	252	32	50	32	43	24
	UNKNOWN	-	-	-	-	2	1
	TOTAL	798	100	158	100	182	100
COUNTY OF COMMITMENT:							
Adams		1	1	1	1	-	-
Asotin		11	1	1	1	1	1
Benton		17	2	2	1	6	3
Chelan		9	1	3	2	7	4
Clallam		21	3	3	2	4	2
Clark		23	3	5	3	8	4
Columbia		-	-	-	-	-	-
Cowlitz		30	4	2	1	6	3
Douglas		2	1	-	-	1	1
Ferry		-	-	-	-	-	-
Franklin		9	1	1	1	4	2
Garfield		-	-	-	-	-	-
Grant		15	2	5	3	6	3
Grays Harbor		19	2	6	4	7	4
Island		3	1	1	1	4	2
Jefferson		3	1	-	-	-	-
King		175	22	28	18	32	18
Kitsap		16	2	7	14	6	3
Kittitas		5	1	-	-	2	1
Klickitat		8	1	-	-	-	-
Lewis		18	2	5	3	4	2
Lincoln		5	1	-	-	-	-
Mason		5	1	-	-	4	2
Okanogan		11	1	6	4	3	2
Pacific		4	1	1	1	2	1
Pend Oreille		2	1	-	-	-	-
Pierce		73	9	25	16	29	16
San Juan		-	-	-	-	-	-
Skagit		5	1	-	-	-	-
Skamania		3	1	-	-	-	-
Snohomish		60	8	15	10	11	6
Spokane		92	12	14	9	10	6
Stevens		6	1	-	-	-	-
Thurston		43	5	9	6	11	6
Wahkiakum		-	-	-	-	-	-
Walla Walla		13	2	1	1	1	1
Whatcom		14	2	3	2	2	1
Whitman		1	1	-	-	-	-
Yakima		76	10	14	9	11	6
TOTAL		798	100	158	100	182	100

	1/68-6/75		7/75-6/76		7/76-6/77	
	No.	%	No.	%	No.	%
AGE OF OFFENDER AT ADMISSION:						
12 - 19	50	6	15	10	28	15
20 - 24	177	22	33	21	33	18
25 - 29	153	19	32	20	34	19
30 - 34	131	16	30	19	25	14
35 - 39	104	13	14	9	17	9
40 - 44	70	9	12	8	21	12
45 - 49	42	5	8	5	8	4
50 +	71	9	14	9	16	9
TOTAL	798	100	158	100	182	100
MARITAL STATUS:						
Single	279	35	49	31	50	28
Married	354	44	66	42	66	36
Separated, Divorced or Widowed	161	20	42	27	66	36
Unknown	4	1	1	1	-	-
TOTAL	798	100	158	100	182	100
HIGHEST SCHOOL GRADE COMPLETED:						
1 - 5	40	5	4	3	5	3
6 - 10	323	40	58	37	44	24
11	65	8	19	12	25	14
12	273	34	53	34	76	42
13+	96	12	24	15	32	18
Unknown	1	1	-	-	-	-
TOTAL	798	100	158	100	182	100
NO. OF PREVIOUS CRIMINAL CONVICTIONS FOR ANY CRIME:						
0	285	36	72	46	91	50
1	208	26	30	19	35	19
2	123	15	16	10	34	19
3	71	9	19	12	15	8
4 - +	111	14	21	13	7	4
Unknown	-	-	-	-	-	-
TOTAL	798	100	158	100	182	100
PREVIOUS INCARCERATION IN JAIL OR PRISON, MONTHS:						
0	389	49	99	63	129	71
1 - 6	141	18	22	14	20	11
7 - 12	44	6	6	4	2	1
13 - 36	112	14	16	10	15	8
37+	112	14	15	10	16	9
Unknown	-	-	-	-	-	-
TOTAL	798	100	158	100	182	100
PREVIOUS INCARCERATION IN JAIL OR PRISON:						
No prior incarceration	385	48	99	63	129	71
Sex offense involved	217	27	28	18	24	13
Other basis	196	25	31	20	29	16
Unknown	-	-	-	-	-	-
TOTAL	798	100	158	100	182	100

	1/68-6/75		7/75-6/76		7/76-6/77	
PREVIOUS COMMITMENT TO A MENTAL HOSPITAL, MONTHS:	No.	%	No.	%	No.	%
0	575	72	121	77	143	79
1 - 6	124	16	19	12	24	13
7 - 12	28	4	4	3	7	4
13 - 36	38	5	8	5	5	3
37+	33	4	6	4	3	2
Unknown	-	-	-	-	-	-
TOTAL	798	100	158	100	182	100
PREVIOUS COMMITMENT TO A MENTAL HOSPITAL:						
No prior commitment	573	72	121	77	143	79
Sex Offense involved	134	17	26	17	23	13
Other basis	88	11	11	7	16	9
Unknown	3	1	-	-	-	-
TOTAL	798	100	158	100	182	100
MONTHS OF CONFINEMENT AS A JUVENILE**						
0	606	76	113	72	135	74
1 - 6	48	6	13	8	10	6
7 - 12	33	4	9	6	8	4
13 - 36	77	10	8	5	16	9
37+	34	4	15	10	13	7
Unknown	-	-	-	-	-	-
TOTAL	798	100	158	100	182	100
ALCOHOL ABUSE, NO. OF YEARS:						
0	548	69	97	61	121	67
1 - 3	68	9	16	10	18	10
4 - 6	53	7	9	6	10	6
7 - +	129	16	36	23	33	18
Unknown	-	-	-	-	-	-
TOTAL	798	100	158	100	182	100
INTELLIGENCE QUOTIENT:						
0 - 69	16	2	-	-	2	1
70 - 89	169	21	30	19	35	19
90 - 109	257	32	74	47	72	40
110 - 129	284	36	40	25	64	35
130 - +	67	8	12	8	8	4
Unknown	5	1	2	1	1	1
TOTAL	798	100	158	100	182	100
90-DAY OBSERVATION FINDINGS REGARDING SEXUAL PSYCHOPATHY AND TREATABILITY:						
Not a sexual psychopath, no other pathology	60	8	7	4	5	3
Not a sexual psychopath but other serious pathology	70	9	8	5	7	4
Sexual psychopathy, not amenable to treatment	157	20	35	22	53	29
Sexual psychopath, amenable to treatment	502	63	102	65	111	61
No finding	9	1	6	4	6	3
Observation not completed	-	-	-	-	-	-
TOTAL	798	100	158	100	182	100

** "Juvenile" means under 18 years by Washington State law

	7/74-6/75		7/75-6/76		7/76-6/77	
DRUG ABUSE, NUMBER OF YEARS	No.	%	No.	%	No.	%
0	100	71	114	72	155	85
1 - 3	22	16	25	16	10	6
4 - 6	11	8	11	7	9	5
7 - +	7	5	8	5	8	4
Unknown	-	-	-	-	-	-
TOTAL	140	100	158	100	182	100
ETHNIC ORIGIN						
White	123	88	140	89	162	89
Black	12	9	6	4	8	4
American Indian	4	3	6	4	7	4
Oriental	-	-	-	-	-	-
Chicano	1	1	4	3	4	2
Other	-	-	2	1	1	1
Unknown	-	-	-	-	-	-
TOTAL	140	100	158	100	182	100

PROGRAM PROFILE

STATE OF WASHINGTON

TREATMENT PROGRAM FOR THE SEXUAL OFFENDER

Western State Hospital
Ft. Steilacoom, Washington

LEGAL BASIS

The 1951 "Sexual Psychopath Law," revised Washington Code, Chapter 25, Section 71.06.010.140, as amended by the 1967 legislative session, allows superior court to commit persons to state mental hospitals for 90-day evaluation or treatment until safe to be at large.

TREATMENT AND PROTECTION OF SOCIETY

The primary purpose is greater protection to society than provided by simple imprisonment. This purpose can only be achieved by a program providing the three essential elements for rehabilitation for sexual offenders--control, re-education and community reintegration.

NATURE OF OFFENDERS' DISORDER

A pattern of sexual deviation is a conscious but habitual way of seeking relief from emotional stress. The offenders' predatory or irresponsible behavior toward another human being achieves only temporary relief at best and this behavior is invariably self-defeating as it further alienates the offender from self and others.

TREATMENT PHILOSOPHY

We believe that the offender perpetuates his/her basic problem of inferiority and insecurity by self-defeating habits and relating to others in defensive and anger-producing ways. Treatment focuses on breaking up these rejection-producing behavior patterns by daily demands for rigorous self-examination, intensive involvement with others, constant demand for honest and responsible behavior and rewards and punishments based solely on responsible behavior.

ORGANIZATION OF OFFENDERS INTO GUIDED SELF-HELP GROUPS

Responsible behavior can only be gained by being given responsibility and being expected to carry it, therefore small patient groups with their own approved leadership are closely monitored and held accountable for their own custody and treatment. The staff goal is to establish standards and expectations, set limits, teach, guide, provide supplementary clinical, administrative, and program development services and to deal with the community.

HOSPITAL VERSUS PRISON AS A TREATMENT ENVIRONMENT

Effective "treatment" for the habitually irresponsible person is a re-eduational process for responsible community living, therefore it cannot be realistically

conducted within a completely artificial prison environment of massive external control and minute regulation of daily life in the absence of opportunities and temptations of community living. However, not all offenders can make constructive use of the hospital program. The program is based upon the selection of offenders who are sufficiently motivated to respond to a program providing opportunities and choices similar to community living. Close observation of the offenders' deviant and irresponsible behavior pattern through daily group psychotherapy and control fosters self-examination and behavioral change.

TREATMENT OBJECTIVES

The offender must earn his/her way to freedom not by "doing so much time" but by establishing a pattern of responsible behavior. He/She must accomplish four basic treatment objectives:

1) Recognition of antisocial behavior pattern.

2) Understanding of the origin, development and operation of these patterns.

3) Accept responsibility for deviant behavior and make a commitment to change.

4) Application while at the hospital of new patterns of behavior which will gain community acceptance.

TREATMENT MEDIA

The offender must demonstrate responsible behavior in the six major areas of daily activity: 1) group living, 2) work, 3) psychotherapy, 4) social and recreational, 5) family relationships, and 6) constructive leadership of other offenders.

CITIZEN PARTICIPATION

The program is a three-way partnership of offender, professional staff and citizen volunteers. Carefully selected citizens are intimately involved in the program--in actual treatment, in community liaison.

RETURN TO COMMUNITY LIVING

When the offender has proven readiness for responsible community living he/she is returned to the committing court with a "safe to be at large" recommendation under specific individual conditions of continuing treatment on work release and out-patient follow-up, the last and most important phases of treatment. In order to be given a hospital recommendation for release onto probation the offender must make a contract with the hospital containing satisfactory provisions for a place to live, employment, sexual and social activities and continuing group psychotherapy until he/she has proven his/her ability to function responsibly within this special accountability.

TREATMENT RESULTS

Preliminary studies over the period of time seem to indicate an 80% success rate

with 20% recidivism. A more in-depth study will be undertaken within the next two years (1978-1979).

FUTURE OF THE PROGRAM

The program has developed what appears to be an effective and extremely economical treatment system for one type of social offender. The program model is probably applicable to certain other types of offenders including drug and alcohol dependent offenders. Although very few professional staff are required, experience over the past 11 years clearly indicates that the few staff required must be persons with skills and experience, both clinical and administrative, who are able to provide effective guidance to offender groups such as these as a loss of control can easily develop. The program needs systematic evaluation and research in several areas, particularly of certain treatment methods and discharge adjustments. The program has become a demonstration laboratory in correctional rehabilitation techniques and presents a working model which is probably applicable to the rehabilitation of a large percentage of criminal offenders of all sorts.

STATE OF WASHINGTON

TREATMENT PROGRAM FOR THE SEXUAL OFFENDER

FLOW CHART OF TREATMENT PROCESS

PHASE I - EVALUATION

Commitment by Superior Court for 90-day observation and evaluation to determine whether "Sexual Psychopath" as defined by law (R.C.W. 71.06.010).

Assigned to psychotherapy group and oriented on hospital and group procedures. Completes Biographical Data Sheet and Autobiography, first 14 days.

Given extensive psychological tests and case reviewed at Intake Meeting.

Begins to participate in psychotherapy and other group activities as Trial Member.

Within 90 days evaluated by group and program staff on 1) is he/she a "Sexual Psychopath," 2) is he/she safe to be at large, 3) is he/she a good candidate for intensive treatment, 4) will he/she contribute his/her share to this self-help program.

Reviewed by Senior Staff Committee. Return to court with findings and recommendations.

If found to be a "Sexual Psychopath" and amenable to treatment, returns for

PHASE II - INPATIENT TREATMENT

Minimum of 12 months as general member and group leader. Involvement of wives in psychotherapy and social activities is strongly recommended.

Privileges earned by progress in the four basic treatment objectives: 1) recognition of his hurtful behavior patterns, 2) understanding of their origin and operation, 3) acceptance of responsibility for change, and 4) application of new patterns of responsible behavior in dealing with people.

Progress on these 4 objectives is expected in all major activities and relationships; group living, work assignment, psychotherapy, family and sexual relationships, social and recreational and leadership of other members.

Privileges earned by behavior, group vote, and approval by staff.

Requests discharge as "safe to be at large" on conditional release under specific conditions of discharge contract. Examination, vote by group, review by program staff.

Review by Senior Staff Committee. Return to court with findings and recommendations.

If court finds "safe to be at large," placed on probation under specific terms of conditional release contract recommended by hospital and returns for

PHASE III - WORK RELEASE

Readmits self to hospital for minimum of 3 months.

Employed or attends school in the community 40 hours per week, returns to hospital at night. Follows inpatient rules and supervision.

Progress followed in inpatient evening meetings and weekly outpatient meeting.

Gradual increase of social and overnight leaves as proves responsible.

When proven responsible enough to handle full-time community living, enters

PHASE IV - OUTPATIENT TREATMENT

Attends weekly evening psychotherapy group for minimum of 12 months. Attendance decrease by request, group vote, approval of hospital and parole staff. Continued participation of married couples in psychotherapy group strongly recommended.

PROGRAM PHILOSOPHY

TREATMENT IS LEARNING

Irresponsible sexual behavior is learned. Treatment therefore is a re-learning process.

THE LEARNING OBJECTIVE IS RESPONSIBLE HUMAN RELATIONSHIPS

The offender has treated other human beings as mere objects for his own use and pleasure. He must learn to govern his behavior by respect for the feelings and rights of other human beings.

THE VEHICLE OF LEARNING IS THE GUIDED SELF-HELP LEARNING GROUP

Learning happens best when the learners themselves are expected to carry the major responsibility. The role of staff is to organize, guide, and assist small self-help groups.

THE MATERIAL OF LEARNING IS EVERYDAY REALITY

If learning is to be a realistic and potent experience, treatment must reflect, magnify, and deal with the demands of community living. The learner must be faced with real choices and decisions every hour of the day, and learn to make them on the basis of honesty and concern for others.

THE PRICE OF DISCHARGE IS A PLAN AND CONTRACT FOR RESPONSIBLE COMMUNITY BEHAVIOR

A free society is held together by a network of contracts, written or unwritten, to respect each other's rights. The offender must earn his freedom with responsible daily behavior.

TREATMENT MUST CONTINUE WITH THE APPLICATION OF LEARNING UNDER COMMUNITY CONDITIONS

Treatment does not end with the termination of intensive daily treatment and institutional residence. It must continue as long as necessary while the offender is learning to apply his new knowledge and behavior under the demands and temptations of community living.

TREATMENT CENTER FOR SEXUAL OFFENDERS
WESTERN STATE HOSPITAL
FORT STEILACOOM, WASHINGTON

TREATMENT CENTER FOR THE SEXUAL OFFENDER

TELEPHONE DIRECTORY

		Group	Office
VOORHEES, William D. Jr., M.D.	Clinical Director		677
SMITH, Ardis	Information and Secretary		567
SAYLOR, Maureen	Director Therapy Supervisor	East	573
ENSIGN, Ronald	Therapy Supervisor	Brotherhood	690
HEINE, Roger	Therapy Supervisor	North	681
HOLZINGER, A. Jerry	Therapy Supervisor	Aquarius	594
JENSEN, Steve	Assistant Director Therapy Supervisor	South	545
LORING, Gilbert	Therapy Supervisor	Rainier	540
LOWRY, John	Therapy Supervisor	Sunrise	540
MOORE, Thomas	Therapy Supervisor Volunteer Coordinator	Echo	681
SLAVICH, Anne	Therapy Supervisor	West	594
TAYLOR, Lang	Therapy Supervisor	Friendship	690
WAGNER, Maria	Therapy Supervisor	Star	675
NYGAARD, James	Research & Statistics		629
MOWRER, Larry	Research & Statistics		629
BRYSON, Helga	Program Resource Specialist		629
PEDLAR, Judy	Nursing Supervisor		621
HOLBROOK, Jack	Charge L.P.N.		760

Regular Prefix 756-9
SCAN Prefix 233-1

END