SOUP Group
(Sex Offender Unified Practices Group)
January 17, 2019
Neenah DCC
24 people in attendance

II. Introductions
III. Recap of past meeting
IIII. Meeting structure/organization/resource allocation discussion
    a. Need for good representation statewide (western side of state missing)
    b. Putting together meeting requires work – who is tasked with this?
    c. Group is getting large – if too big, not as conducive to discussions
    d. Is this a place where WiATSA could offer support?
        i. WiATSA suggesting meetings throughout the state in rotating locations
        ii. Cap at 40 per location to keep size manageable
        iii. Designate treatment/supervision teams in each area to plan/lead the meetings
    e. Important to include continuum of care
        i. DAI, SRSTC, contract providers, private pay providers, etc.
    f. How to market, who to include?
        i. WiATSA has an existing list
    g. Suggestions to remain in region 4 with deliberate efforts to invite other from other areas and how to potentially expand to other areas.
    h. WiATSA sponsorship might impact DCC's access (filling out request forms, etc)?
    i. Designate/break off a contingent to take to other areas?
        i. If someone does this, under what authority (outside work role or WiATSA?)
        ii. WiATSA would had logistical aspects, individual person could operate under their regular job duties
    j. Consortium comprising DOC, DHS, and WiATSA?
        i. Concern this would trigger a memorandum of understanding (MOU) and stymie efforts
    k. Identifying purpose impacts the scope/structure
        i. Statewide versus regional focus?
    l. Next meeting, move to include other areas of state, keep meeting in Region 4, gauge level of interest from new stakeholders, pull under WiATSA, consider moving to Wausau, Madison, New Lisbon?
    m. Separate meetings by region and then one statewide meeting?
    n. Table resolution until after lunch, allowing group to give topic additional thought and to shift to next portion of agenda
IVI. Vision/Mission (recap of past topic ideas/what people have found valuable/goals)
    a. Best practice, learning/training, addressing gap between community/institution, knowledge of treatment while supervising sex offenders, what to talk about with clients during supervision meeting, prepare individuals for release, how behaviors map on to specific DRFs, more information on child pornography issues, 980 process, DOC standards, case examples for RNR, curriculum exchange, language used in treatment, polygraph, determine when treatment should be terminated, evidence during mail list, remote access to this meeting

b. A platform for WI professionals and organizations working with sexual offenders to collaborate and enhance adherence to best practices.
c. What if we stay with what we've been doing and get it polished before pushing forward? If group remains in Region 4, someone will need to volunteer to lead.
d. Taking things statewide is a dramatic change; however cannot move to WiATSA without statewide inclusion.
e. Seed it? Keep current structure, but gradually and deliberately expand to include Western stakeholders
f. How to ensure it remains valuable, not repeating information, but moving forward

VI. OSCI discussion of their CSEM treatment program

a. Huge social skills gap, no assessment of sexual interest - really strong social isolation component; want relationships but fear of rejection is high
b. 100 hour total (once a week for two hours) – one year
c. Started group with 12 people (two individuals who had much younger images, removed from treatment for lack of motivation, i.e., confrontational to facilitators, not comfortable talking, and externalizing locus of control)
d. Characterizing from addiction perspective (upping ante when adult images not effective)
e. Not assigning diagnoses or conducting Abel testing
f. At very early stages – operating for four months
g. SO2 model does not quite fit
h. Individuals whose only offense is CP possession (with no clear intent to contact)
i. Do not use CPORT as inclusion criteria
j. Use Stable to determine treatment targets
k. Much less homogeneous than originally thought
l. New Lisbon is talking about starting a similar group
m. 80 potential candidates on OSCI waiting list
n. Shame is common
o. Not much criminality
p. Patterns in needs when released to community? Social isolation and no relational skills, fear of rejection
    i. Involuntary celibates? – see women as evil and depriving them from sex (Stacys reject them, Chads get the Stacys) – higher degree of pornography use
    ii. Suggestion of 12-minute YouTube video – "Incels, are women making them?"
q. Drive to collect images and draw toward the taboo
r. No ACE, some have mentioned trauma history
s. In transitioning to community, POs can support through coaching around social skills
t. Focus on Protective Factors (SAPROF)
u. Aftercare recommendation would not be helpful, as it would put client in group with higher risk individuals. Discussion of adding follow up other to 3776C so that there is no aftercare recommended

VII. SO1

a. Recently ran the numbers, 186 guys in DAI with SO1 designation
b. Curriculum committee has been meeting to revamp SO1 curriculum
c. Historically SOT Education
d. Static score 0 or less

e. OSCI/RCI asked to pilot SO1 curriculum – Amy provided copies
    I. Needing to reduce amount of material
f. Age range 65-80
g. Not participating can impact their release.
h. Uses overlap with Carey Guides to offer continuity of language

VIII. SO4 Updates

a. Three groups have gone through their new curriculum
b. Lessons: in our quest to skill build, first phase is taking too long, have to prioritize which skills to focus on, may have focused too much on past risk factors, spend more time on current risk factors, some clients having difficulty identifying/acknowledging current risk, hard to replicate community scenarios

VIIII. Adapted Program

a. Skills System by Julie Brown

IXI. Return to discussion of mission/vision and logistics/structure of future meetings

a. Purpose
    i. Ensure we are doing evidenced-based practice
    ii. Commonality of EBP
    iii. Share resources
    iv. Continuity of care
    v. Network, sense of support from colleagues
    vi. Collaboration
    vii. Decrease isolation
    viii. Promoting positive change
    ix. Education forum
b. Controlled, deliberate expansion
c. Finalized Mission Statement: A platform for Wisconsin organizations and professionals working with sexual offenders to collaborate, share resources, and enhance adherence to evidenced-based practices.
d. WiATSA will take over management
e. Next meeting will be in Wausau – Julie will arrange for a location
f. Agenda – Wednesday, April 24th
    i. Explain what group is and the mission
    ii. RNR Review
    iii. Mapping behaviors onto dynamic risk factors (how to apply RNR to case examples)
    iv. Ideal handoff process (what happens in treatment in the institution, what happens on supervision)
    v. Supervision focus
g. Come up with list of stakeholders who might be interested
    i. Treatment Providers
        I. Institution
        II. Community
    ii. DOC Agents and Agent Supervisors
    iii. Administrators
    iv. Program and Policy Analysts

v. Social Workers/Case Manager
vi. ATTIC
vii. OARS/Karen Barter – Adult Care Consultants
viii. Goodwill – Circles of Support
ix. County Human Services/Corporation Counsel

XI. Discussion regarding individuals with intellectual disabilities and major mental illness (SRSTC Treatment Provider Jake Schuldies, LCSW)

a. Heterogeneous group of individuals
b. Impact of disability on risk varies
c. Able to engage in basic, minimal step problem-solving
d. Able to learn basic self-management skills
e. Setting up supports around the person to manage risk
f. Supporting autonomy to the degree that we can
g. OARS/NGI clients get a specialized agent
h. Agent assignment protocol varies by office
i. Some offices, sex offender designation trumps all other designations
j. MKE is the only area that has a mental health unit
k. For some clients, risk is entirely associated with mental illness. Therefore focus needs to be on treatment of mental illness
l. Support needs to be highly individualized
m. Focus on more of a recovery model
n. The worse the illness, the lower the insight
o. Importance of knowing the historical picture of risk and mental illness and what needs to be in place in the community in order for the person to continue managing risk
p. Probation status interferes with ability to access mental health care, especially after hours
q. Chapter 51 commitments used? Depends on the county
r. Much easier to get Chapter 51 while client still in institution