REPORT OF THE
DEPARTMENT OF MENTAL HEALTH, MENTAL
RETARDATION AND SUBSTANCE ABUSE SERVICES

DEVELOPMENT OF A CENTER FOR THE ASSESSMENT AND TREATMENT OF SEXUALLY DEVIANT DISORDERS

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

SENATE DOCUMENT NO. 43

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COMMONWEALTH of VIRGINIA

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To Governor Gilmore and Members of The General Assembly:

Enclosed is the Department of Mental Health, Mental Retardation, and Substance Abuse Services' report on the development of a Center for the Assessment of Sexually Deviant Disorders in response to SJR 334, 1999. This study was funded for $50,000 by the Appropriations Act of 1999.

We appreciate this opportunity to work cooperatively with the Department of Corrections, the University of Virginia, Virginia Commonwealth University, the Department of Juvenile Justice, the office of the Attorney General, the Virginia State Crime Commission, Virginians Aligned Against Sexual Assault, and private providers to describe how a Center could be organized to serve the commonwealth.

Sincerely,

Richard E. Kellogg

Richard E. Kellogg, Commissioner
DMHMRSAS

INTRODUCTION

Senate Joint Resolution 334, 1999, requested the Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS) to conduct a study on the feasibility of establishing a Center for the Assessment and Treatment of Sexually Deviant Disorders. Toward that end, DMHMRSAS convened a Work Group that included representatives of the Department of Corrections, the Department of Juvenile Justice, The University of Virginia, Virginia Commonwealth University, the Virginia Crime Commission, the Board of Psychology, Department of Health Professions, Virginians Aligned Against Sexual Assault, the Office of the Attorney General, and Sex Offender Treatment Providers (SOTP) in private practice. These members are listed at the end of this section.

A review of the available literature on sex offenders, the results of visits to civil commitment programs for sex offenders in Minnesota, Kansas, and California, and the input from the Work Group members produced the following significant findings and recommendations.

- Some sex offenders are responsive to treatment and afterward are less likely to sexually recidivate.
- Some sex offenders do not respond to treatment well and afterward remain at great risk to sexually recidivate.
- Some sex offenders will not respond to treatment at all and will always be at great risk to violently sexually recidivate.
- Establishing a specialized Center for the Assessment of Sexually Deviant Disorders is in the best interests of the Commonwealth of Virginia.
- The Center will be operated by DMHMRSAS, with security provided by the Virginia Department of Corrections.
- The Center's primary role in intervening with sex offenders should be to accurately sort sex offenders into each of the above three groups and assist in placing them in treatment settings at the level of supervision or confinement that will best prevent their gaining access to vulnerable populations and that will afford them the maximum opportunity to gain control of their sexually deviant disorder.
- Treatment should not be a function of the Center.

The complexity of creating a Center to assess sexually deviant disorders encouraged a wider examination of the project and resulted in the development of three alternative proposals. These alternatives represent a rough continuum of services, each level representing an

increase in the complexity and volume of services delivered, and the associated cost of providing assessment services to persons with sexually deviant disorders.

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Executive Summary

The 1999 General Assembly approved Senate Joint Resolution # 334 (SJR 334/Howell), an initiative requesting that the Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS), in collaboration with other state agencies, conduct a study on the feasibility of developing "[a] Center for the Assessment and Treatment of Sexually Deviant Disorders." SJR 334 further requested that DMHMRSAS review the availability of facilities and professional staff in Virginia that might be used to house and staff such a center, to review the legal issues pertinent to this type of treatment and assessment center, to survey other states, state agencies, and academic institutions regarding multi-agency utilization of such a center, and to determine the associated costs of establishing a center of this type in Virginia (Appendix A).

Background

The Governor and the General Assembly of the Commonwealth of Virginia recognize that rape, sexual assault, and sexual abuse in the Commonwealth of Virginia is a serious social problem that is harmful, difficult to treat, and costly to the community. In response, in 1997 the Commonwealth took steps to protect its citizens from sexual victimization by enacting several key pieces of legislation. Through the so called "Megan's Laws", enacted into law in 1998 and 1999 (SB369/Howell and HB570/Deeds), the Commonwealth created a system for tracking known sex offenders through mandatory registration under Virginia Code §19.2-298.1, through notification of local law enforcement of their presence in the community under Virginia Code §19.2-390.1, and by helping employers to screen sex offenders out of certain jobs under Virginia Code §19.2-390.1.B. The Commonwealth has also enacted stiffer sentences for sex offenders, including life sentences for second convictions of predicate sex crimes.

In 1999 the General Assembly passed, and the Governor signed, legislation to civilly commit sexually violent predators (Chapters 946 and 985 of the 1999 Acts of Assembly). This legislation, due to take effect January 1, 2001, requires that those sex offenders approaching the end of their confinement in the Department of Corrections, and who are still considered to be a danger to the community, undergo a clinical assessment to determine if their ability to control their sexually violent tendencies might be compromised by the presence of a "mental abnormality" or "personality disorder". Sex offenders diagnosed with such abnormalities and disorders are to be examined by the court, in a civil commitment procedure, for possible commitment as sexually violent predators. In a revised bill, the General Assembly passed Senate Joint Resolution 334 which requests the Department of Mental Health, Mental Retardation, and Substance Abuse Services, "in collaboration with the Department of Corrections, the Department of Juvenile Justice, Norfolk State University, the University of Virginia, and Virginia Commonwealth University, to conduct a study on the development of a Center for the Assessment and Treatment of (individuals with) Sexually Deviant Disorders."

SJR 334 provides this study with five guiding assumptions: (1) that research supports a conclusion that certain sex offenders benefit from treatment interventions; (2) that the Department

of Corrections currently does not have sufficient assessment or clinical treatment services for sex offenders within Virginia's prison system; (3) that the Virginia State Crime Commission recommends that sex offenders undergo a formal assessment and treatment, if indicated by conviction or a history of sexually abusing, at some time during their incarceration or community supervision; (4) that the provision of clinical sex offender treatment services should be made available to inmates while under the supervision of the Department of Corrections; and (5) that research on and development of standardized assessment instruments and treatment protocols is needed for the criminal justice system and treatment providers throughout the Commonwealth.

Using data collected from states presently practicing civil commitment of sexually violent predators as a foundation, combined with data from the Department of Corrections on sex offenders presently in their custody, the SJR 334 study identified issues relevant to establishing a Center, calculated the numbers of sex offenders to be assessed by a Center during each of five subsequent years, and examined the efficacy of present assessment procedures and their possible impact on the Center. From this data it became clear that decisions about which sex offenders would be assessed, and how they would be assessed, would greatly effect the size and cost of the Center. Because the numbers of potential assessments varied so widely, depending upon the criteria used to screen in cases, the Work Group developed a range of alternative proposals for the Center. In developing these alternative proposals, the Work Group considered three overarching questions:

1. Why is it important for the Commonwealth of Virginia to conduct state-of-the-art assessments of persons believed to have sexually deviant disorders?

2. Is a specialized Center desirable for conducting high quality, state-of-the-art assessments, and treatment of persons with sexually deviant disorders?

3. If a specialized Center is deemed necessary to this process, what should be its form and its range of functions?

Each of these questions is addressed below.

Findings and Recommendations

1. *Why is it important for the Commonwealth of Virginia to conduct state-of-the-art assessments of persons believed to have sexually deviant disorders?* It is the consensus of the SJR 334 Work Group that, given the significant negative impact of sexual abuse on the citizens of Virginia, and given the tendency of sex offenders to recidivate, specialized sex offender assessment is necessary and important to the Commonwealth of Virginia. Specialized sex offender assessments will greatly improve how the Commonwealth targets delivery of scarce treatment resources to those sex offenders who need it most and who will most benefit from access to it. It is believed that this improved service targeting and delivery will reduce overall sexual recidivism in Virginia and add to the public safety.

2. *Is a specialized Center desirable for conducting high quality, state-of-the-art assessments and treatment of persons with sexually deviant disorders?* It is the consensus of the SJR 334 Work Group that a Center for the Assessment of Sexually Deviant Disorders is a necessary step in providing the various jurisdictions in Virginia general access to highest quality specialized sex offender assessments. In addition, it is the consensus of the Work Group that such a Center would raise the quality of sex offender assessments across the state by serving as a model of excellence, training by example, teaching courses, providing consultation, and conducting research. It is also the consensus of the Work Group that the presence of such a Center would facilitate standardization of assessment and treatment protocols statewide.

3. *If a specialized Center is deemed necessary to this process, what should be its form and its range of functions?* It is the consensus of the SJR 334 Work Group that the legal and ethical sensitivity of the work conducted by the Center demands that it be staffed with the most highly trained and experienced personnel possible.

Having consensus that a Center to assess sexually deviant disorders would serve the best interests of the Commonwealth, the Work Group set to determining how this Center would be organized, whom it would serve, and what services it would provide. With this in mind, the Work Group achieved consensus on the following:

- The creation and operation of a Center to assess sexually deviant disorders is within the legal purview of the Commonwealth.

- Conducting assessments of persons thought to have sexually deviant disorders poses no ethical problems except in those cases where the assessment is for the purpose of pursuing civil commitment. Both the American Psychological Association[1] and the American Psychiatric Association[2] have issued position papers arguing against the use of psychologists and psychiatrist in civilly committing sex offenders. These groups oppose civil commitment of sex offenders on the grounds that it criminalizes mental illness and misuses the term "mental illness" to inappropriately detain persons in mental institutions. Their position is that civil commitment of sex offenders is analogous to the former Soviet Union's civilly committing political dissidents. Other members of these groups counter that such comparisons trivialize the abuse of dissidents by the former Soviet Union, ignores the fact that paraphilia is an Axis I diagnosis, and that sexually violent predators do have a DSM-IV mental disorder and represent a serious and chronic risk of harm to others. Neither body has taken the final position of instructing their members that it would be unethical to conduct or participate in civil commitment assessments of sexually violent predators. Their current position is that they are troubled by this use of civil commitment in this manner and urge their members to use caution in their work.

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[1] For access to this discussion, the reader is directed to the American Psychological Association Website (www.apa.org)

[2] For access to this discussion, the reader is directed to the American Psychiatric Association Website (www.apa.org (then click) "psychiatric news" (click "search") type "sexually violent predator" and enter. Click "Psychiatric News Back Issues".

- University representatives participating on the Work Group are reluctant to commit their institutions to a cooperative endeavor with a Center if it involves the assessment of persons being considered for civil commitment as sexually violent predators. It is the opinion of the participating University representatives, that other Virginia colleges and universities will have similar feelings about cooperating with the Center.

- The University representatives give three reasons for this reluctance. First, as noted above, professional organizations representing psychologists and psychiatrists see sex offenders as not truly mentally ill and assert that they, therefore, do not belong in mental institutions under civil commitment. They assert that they are concerned about cooperating with what they view as a misuse of their services (see "b" above). Second, these University representatives believe that participating in the activities of the Center would expose them to excessive liability from litigious clients. Third, they believe that the practice and research opportunities presented by an assessment Center are, at this time, unclear or at best limited and they can not justify committing resources to a formal relationship. Thus, the Universities are not a resource for staffing or operating the Center.

- Assessment of persons for civil commitment must be conducted with consideration not only for its overall fairness to the subject but also with an eye on defending the assessment's conclusions and recommendations in court. Therefore, either clinical psychologists or psychiatrists who are trained and experienced in working with sexually deviant disorders and in the theoretical and statistical nature of the assessment model and protocols used must conduct these assessments.

- Conducting a legal, ethical, and defensible assessment engages three principle domains: behavioral screening, clinical interviewing and actuarial prediction. The strength (the validity and reliability) of the products produced in each of these domains depends on how closely the technician, agent, or clinician follows the established standards, protocols, or usual and accepted practices for screening, actuarial assessment, and diagnosis.

- While the validity and reliability of actuarial instruments presently available to assess and predict the future dangerousness of sex offenders is less than perfect, courts in various jurisdictions have ruled them acceptable.[3]

- After reviewing the commitment rates and patterns of other states, the Work Group estimates that petitions for civil commitment will be brought in approximately 30% of all cases referred to the Center for assessment. In these cases the Work Group estimates that Center staff conducting assessments will need to spend time above and beyond the usual assessment time in order to prepare for and testify at depositions and in court. An estimation of this additional time is included in calculating the number of FTEs necessary for fully staffing each alternative Center proposal (Please see Attachments 2.2, and 2.3).

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[3] Judicial response to actuarial risk prediction protocols will, as with other scientific procedures, be variable. Courts in Minnesota, Washington, Kansas, and others have accepted these procedures as scientifically valid. Other courts, some in these same states, have not.

- It is anticipated that a certain number of cases will result in lawsuits against th Commonwealth, DMHMRSAS, the Center and its personnel; especially in the case c assessing persons for civil commitment who are believed to be sexually violent predators. Case preparation time and testimony time for these occurrences were not included in calculating the costs of the alternatives.

- In addition to personnel, operating, and legal costs, establishing a Center will carry additional high operating costs to the Commonwealth attendant to acquiring and operating the necessary assessment technology (plethysmograph, Abel Screen, and Polygraph).[4]

- Personnel resources do not presently exist in DMHMRSAS or DOC in Virginia that can quickly be converted for use as a specialized Center to assess persons with sexually deviant disorders.

Three Alternatives Proposed

One early finding of the SJR 334 Work Group was that the universe of sex offenders needing assessment and treatment is substantial. Depending on how the Center proposed by SJR 334 defines its customer base (the types of sex offenders to be assessed), the Center could easily be required to complete as many as 1000 assessments each year. It is the Work Group's opinion that some means of delimiting the number of assessments may be necessary. In response, and informed by the above, the Work Group designed three alternative proposals for a Center. To simplify this process, the Work Group elected to keep the overall organizational and staffing pattern constant for all three proposals (See Attachment 1).

These alternatives represent three ways of defining the universe of sex offenders needing assessments. The first alternative does not assess sexually violent predators but does assess various other sex offenders for DOC, DJJ, community corrections, and others. The second alternative conducts assessments for the entire range of sexual offenders including sexually violent predators. The third alternative principally assesses sexually violent predators for civil commitment and conducts annual reassessments of civilly committed sexually violent predators. This alternative conducts other types of sex offender assessments, training, and research only as time and resources permit. Although the organizational structure of each alternative is the same, staffing levels differ based on the number and types of services offered and the number and category of assessments completed. Cost estimates for each Alternative are summarized below and described in detail in Attachments 2.1, 2.2. 2.3, and 2.4.

Alternative One. In this alternative, the Center would assess all sex offenders *except* sexually violent predators. Under this alternative, sexually violent predators would be assessed by clinicians designated by the Community Service Boards. The Center would conduct research,

[4] For a more complete discussion of the plethysmograph and its use, please refer to page 12 in Chapter 3. Findings. An in depth discussion of the plethysmograph is also contained in the book, *Violent Offenders Appraising and managing risk*, by Vernon L. Quinsey, et al. (1998). Pp. 121-127.

training, and consultation and conduct assessments of adults and juveniles with sexually deviant disorders pursuant to § 19.2-300. The Center, under this alternative, would conduct approximately 545 assessments during its first full year of operation at a total cost of $1,462,864. A breakout of this amount is included in Attachment 2.1.

Alternative Two. Under this alternative, the Center would conduct assessments of persons being considered for civil commitment as sexually violent predators pursuant to §37.1-70.5B and assessments of adults and juveniles with sexually deviant disorders pursuant to §19.2-300. It would also conduct annual review assessments of persons civilly committed as sexually violent predators pursuant to §37.1-70.11B and §37.1-70.12. The Center also would conduct research, training, and consultation. Assessments conducted by the Center under Alternative Two are comprehensive and use the same types of provider personnel as Alternative One. In this alternative, the Center would conduct approximately 870 assessments during its first full year of operation for an estimated total cost of $2,636,524. A breakout of this amount is included in Attachment 2.2.

Alternative Three. Seventy-five percent of the Center's time, in this alternative, would be devoted to conducting assessments of persons being considered for civil commitment as sexually violent predators pursuant to §37.1-70.5B and to conducting annual review assessments of persons already civilly committed as sexually violent predators pursuant to §37.1-70.11B and §37.1-70.12. As resources permit, approximately twenty-five percent of capacity would be dedicated to conducting research, training, consultation, and conducting assessments of adults and juveniles with sexually deviant disorders not being considered for referral for civil commitment. Assessments conducted by the Center under Alternative Three are comprehensive and use the same types of provider personnel as Alternative One and Two. In this alternative, the Center would conduct approximately 325 assessments during its first full year of operation at an estimated total cost of $2,326,040. A breakout of this amount is included in Attachment 2.3.

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Chapter 1, Background

The treatment of sex offenders with psychotherapy, punishment, and hospitalization has a long history in the United States. The first laws committing sexual psychopaths to mental hospitals rather than prison were enacted during the 1930s. Then as now, these laws recognized the repetitive nature of sexual offending and sought to reduce sexual recidivism through treatment. By the 1960s penology was changing the way Americans thought about criminal justice and imprisonment. In an intellectual shift away from rehabilitation, the so-called New Penology asserted that criminal justice had no purpose beyond punishment. Nationally, indeterminate, and discretionary sentencing were replaced by determinant plans. Parole systems were dismantled. Sexual psychopath laws, having failed to deliver the promised rehabilitation and cure, were in general retreat and repeal.

This paradigm shift produced some unexpected results. Because of the way determinant sentences were calculated, sex offenders, even very violent sex offenders, were spending relatively short periods of time in confinement and being released without the further supervision of parole. States quickly moved to strengthen their sentencing grids and extend the sentence base for sex offenses.

During this same period, the psychological and medical treatment of sex offenders gained ascendancy. An entire industry of research and treatment emerged just at the time when the anti-rehabilitation of the New Penology was at its strongest. During the two decades of the 1980s and 1990s, treatment continued to gain supporters both inside and outside the criminal justice system and a new model for controlling criminals has emerged. This model, community containment, marries current models of clinical rehabilitation with models of criminal justice control. The result is a systems approach to reducing sexual recidivism.

In spite of these two decades of public attention, intensive research, and clinical experience there is much about sexual offending that remains undiscovered. Most significantly, it is not known why some people but not others become sex offenders. However, despite this paucity of data on the "why" of sexual abuse – its origins and etiology -- much is known about the "how" of sexual offending. For example, it is known that once they begin, sex offenders tend to persist in their abuse of others, seemingly in defiance of the punishment that attends being apprehended (Abel, et al., 1987). It is known also that many sex offenders, especially the more violent offenders, will return to sexually abusive behavior relatively soon after release from confinement (Rice, et al., 1992).

It is known that the majority of sexual offenders begin their offending careers in mid to late adolescence and continue to abuse, in large part, because doing so gives them pleasure (Abel, et al., 1987; Wolf, 1997). It is speculated that sexual offending may be so very persistent precisely because it is so powerfully reinforced by sexual gratification (Wolf & Pinkston, 1997). This may explain why sex offenders frequently have multiple, and sometimes literally hundreds of, victims.

It is these same characteristics that drive the human and monetary costs associated with sexual abuse to such staggering heights. In response, states are taking steps to reduce sexual recidivism.

There is an emerging national trend toward the long-term management of sex offenders. In increasing numbers, communities are viewing sexual abuse as both a chronic mental health a a criminal justice problem. Some states are mandating that sex offenders, once identified, be required to complete specialized sex offender treatment and be tracked systematically for life.

Using a body of legislation known generally as the "Megan's Laws" -- named after Megan Kanka, a New Jersey child who was kidnapped, raped, and murdered by a recently released sex offender living in her neighborhood -- states are creating multi-tiered systems of registration, treatment, and community notification expecting to reduce sexual recidivism by denying offenders the anonymity that facilitates their abusing.

Other states are taking the additional step of reviving civil commitment under new legislation to place and hold certain categories of offenders, the so called Sexually Violent Predators (SVP), in secure mental health treatment facilities until they are deemed safe to return to the community. While this approach is not without controversy, the United States Supreme Court has ruled it a constitutional means available to communities to protect citizens from abuse.

Virginia has taken a strong stand against sexual aggression and violence. In its 1994 shift away from indeterminate sentencing and parole, Virginia significantly increased the length of determinant sentences to be served by violent sex offenders. Following this, in 1997 the Commonwealth began enacting sex offender registration and notification laws. Individuals convicted of certain predicate crimes are automatically required to register with local law enforcement agencies pursuant to §19.2-298.1 (B), (C), and (D) of the Code of Virginia. Sex offender notification laws under §19.2-390.2 require the Virginia State Police to notify local police authorities whenever a sex offender is released back to into their area. Finally §19.2-390.1.B of the Code of Virginia provides employers access to the state Sex Offender Registry as a means for screening sex offenders out of jobs that would give them access to vulnerable citizens.

One perhaps unintended outcome of these laws is that more sex offenders are in treatment for this problem than ever before. However, treatment for sex offenders differs markedly from the psychotherapy usually associated with mental health, psychology, and psychiatry. Sex offender-specific therapy is not brief. It is both more directive, more intrusive, and of longer duration than is usual and expected in mental health. Nevertheless, the practical efficacy of the accepted clinical approach used to treat sex offenders is not well understood nor has its overall impact on reducing sexual recidivism been satisfactorily calculated. In short, there is still no known "cure" for being a sex offender.

In 1999, the General Assembly passed Senate Joint Resolution 334 to study the feasibility of establishing a "Center for the Assessment and Treatment of Sexually Deviant Disorders." Such a specialized Center would provide the triage services necessary to insure the maximum and most appropriate utilization of valuable treatment and security resources. The remainder of this document reports the results and proposed alternatives of this study.

Chapter 2: Study Design and Methodology

Design

A multidisciplinary Work Group was convened to study the structure, function, and focus of the assessment center identified in Senate Joint Resolution 334. This Work Group was chaired and managed by staff of the Department of Mental Health, Mental Retardation, and Substance Abuse Services. Other participants represented the Department of Corrections, Department of Juvenile Justice, the Office of the Attorney General, The University of Virginia's Institute for Law, Psychiatry and Public Policy, Virginia Commonwealth University, Virginians Aligned Against Sexual Assault, the Department of Health Professions, and mental health professionals from the private sector.

Senate Joint Resolution 334 provided a set of specific instructions and guiding assumptions to frame and direct the study (See Appendix A). The Work Group proceeded through the following set of tasks:

1. To identify the legal basis for the center and its operation,
2. To review how other states have approached assessing sex offenders,
3. To determine the potential number of assessments the center would complete each year,
4. To identify services currently available in Virginia,
5. To examine the efficacy, validity, and reliability of existing assessment protocols and actuarial (prediction of recidivism) instruments used in assessing sex offenders,
6. To articulate a model for an assessment center, defining its organization, operation, and costs.
7. To present this proposal for a model assessment center in a final report to the Governor and the General Assembly.

In preparation for this study, a unifying schema was developed to guide the Work Group. Based on the multiple deliverables specified by SJR 334, a set of three overarching questions was articulated. These questions are:

- Why is it important for the Commonwealth of Virginia to conduct state-of-the-art evaluations of persons believed to have sexually deviant disorders?
- Is a specialized Center desirable for conducting high quality, state-of-the-art assessments, and treatment of persons with sexually deviant disorders?

- If a specialized Center is deemed necessary to this process, what should be its form a. its range of functions?

Methodology

The SJR 334 Work Group established a knowledge-base with which to qualify the assumptions articulated in the text of SJR 334, to support answering the three overarching questions identified by the Work Group, and to guide the development of a model assessment and treatment center.

This was accomplished in three-steps: (1) data collections, (2) data analysis and consideration of the approaches taken by other states in responding to sexually deviant disorders, and (3) proposing of alternative Center models. In responding to the instructions and guiding assumptions of SJR 334, the findings and proposed alternative recommendations offered by the SJR 334 Work Group are delimited by legal, ethical, and pragmatic considerations.

To establish the legal parameters of the Center, the Work Group identified sections of the *Code of Virginia* authorizing and limiting assessments of sexual offenders. The Work Group specifically identified legal questions about an individual's right to remain silent and the inmate's subsequent use of private expert testimony; completion of assessments on inmates electing to remain silent; use of victim impact statements; pre-screening inmates before referring them to the assessment center; Freedom of Information Act exemptions for the Commitment Review Committee (CRC), records of SVP discussions, assessments, and reviews; Immunity of CRC members; the use of videotapes of assessments; and the use of penile plethysmograph, Abel Screen, and polygraph instruments as part of the assessment.

During this process the Work Group identified two concerns. The interaction between the ethical application of assessment technology and protocols (the ability to accurately predict sexual recidivism, identify sexual preferences for sexually deviant themes, and the diagnosis of mental abnormality and paraphilia) and treatment efficacy (its effectiveness in reducing recidivism). To resolve these issues we reviewed the literature on prediction both generally and specific to sexual recidivism prediction instruments currently in wide usage and on the efficacy of treatment with psychopathic and non-psychopathic sex offenders.

At a broader level, the group examined the national debate over the professional ethics of having psychiatrists and psychologists participate in the civil commitment of persons believed to be sexually violent predators. The Work Group reviewed position statements on this concern published by the American Psychological Association, the American Psychiatric Association, and the Association for Treatment of Sexual Abusers. Members of the Work Group also reviewed and discussed alternative opinions published on the Websites for both the American Psychiatric and Psychological Associations. To review national trends in assessing sexual offenders, the Work Group consulted the data generated by a survey of states having civil commitment of sexually violent predators describing their treatment approaches, housing requirements, and related costs.

Chapter 3: Findings

This study produced fifteen primary findings in eight key areas. These findings follow.

Sex offender behavior

Finding One. While sex offenders are a heterogeneous group, their behaviors show key similarities that make systematizing screening, assessment, and treatment possible. There is a growing body of literature describing each offender's typical approach, or pattern used in selecting, engaging, abusing, and controlling their victims (Conte, et al. 1989; Wolf, 1997a, 1997b). Other studies document the consistent role played by sexual-arousal-to-deviant-themes in sex offending and how consistently offenders use distorted thinking to justify their abusive actions. Deviant sexual interest and arousal plays an integral role in the offender's pattern of abusing, rewarding and reinforcing as it does the planning and execution of sexual abuse. These offenders sexually and emotionally enjoy their abusive actions.

Cognitive distortions also play a role in sexually deviant disorders and sexual abuse. Cognitive distortion is the term given to the pattern of self-deception, distorted perceiving and thinking used by offenders to convince themselves that their abusive actions are justified.

Responding to these characteristics, cognitive-behavioral approaches, therapeutic community approaches, and relapse prevention approaches all focus on the repetitive pattern used by the individual offender in selecting, engaging, abusing, and controlling his victims. This similarity of abusing characteristics and strategies among sexual offenders is useful in that the "pattern" concept furnishes treatment providers with a common and easily learned language which guides assessment and treatment.

Finding Two. The probability of recidivism for sex offenders is infinitely variable and is partially predicted by the type of sexual offenses engaged in, by the gender of their victims, by their age, by the frequency and duration of their history of sexual abusing, by the presence of other patterns of psychopathology in their personality, by their level of sexual arousal to abusive themes, by the level of aggression present in their abuse; and by the type and sophistication of sex offender treatment services available (Quinsey, Harris, Rice, & Cormier, 1998).

Using these predictor variables, sex offenders can be conceptualized very roughly into six categories along a continuum of risk for violence and probability of recidivism (Quinsey, et al., 1998): (1) Low violence risk/low recidivism rate; (2) Low violence risk/high recidivism rate; (3) Moderate violence risk/low recidivism rate (non-antisocial personality); (4) Moderate violence risk/high recidivism rate (antisocial personality); (5) High violence risk/high recidivism rate (psychopathic personality); and (6) Very high violence risk/high recidivism rate (psychopathic personality). The behavioral and personality characteristics that describe these categories have powerful implications for treatment as described below and discussed fully in a later section.

Low violence risk/low recidivism rate individuals include men who sexually abuse their o children (incest), primarily through the use of trickery, the strength of their relationship with the child and the child's dependency upon them. Historically, these individuals' recidivism rate, after discovery, is very low. It is most common for these individuals, when they do reoffend, to sexually abuse the next generation; i.e., to be caught for sexually abusing their own child and then recidivate years later with a grandchild. These individuals score low on risk prediction instruments and have few anti-social elements by history and many healthy and positive connections with their communities. Outcome studies with this group tend to show high treatment compliance and follow-through. These individuals are often seen as appropriate for outpatient treatment.

Low violence risk/high recidivism rate individuals. In addition to some incest-type offenders who also sexually abuse children other than their own, this group will include men who engage in high frequency sexually deviant behaviors such as making obscene phone calls, peeping, exposing themselves sexually without attempting to detain or touch their victim, and other non-touching, non-detaining offenses.

These individuals respond much like the men of the previous group. They tend to be compliant and cooperative. They can be good treatment candidates with long-term, close supervision and are often successfully treated in the community.

Moderate violence risk/low recidivism rate (non-antisocial personality) individuals have shown a willingness to threaten or demonstrate violence as a way of coercing their victims into being sexually compliant, without actually physically assaulting their victims. The recidivism rate is comparable to group one men but their willingness to make physical contact with their victims, to detain them, and to threaten force is greater. Overall, these individuals have fewer internal constraints on acting out their sexual abuse.

Outpatient treatment is only appropriate for these men when they are under intensive supervision and live in a controlled (work release or other confined) setting. These men also do well in low security, in-patient treatment.

Moderate violence risk/high recidivism risk (antisocial personality traits) individuals show a readiness to both threaten and use physical violence to gain sexual access to their victims. While there is still some degree of "seductiveness" to their sexual abuse, unlike men believed to fall into the risk-groups above, these individuals are prepared to use physical force to gain what they want. It is possible that the ultimate level of their violence is somewhat constrained by an awareness that their actions are antisocial and unacceptable. This doesn't stop them, but it may ameliorate the degree of violence they are willing to use. These individuals will feel badly for a time after offending, but use cognitive distortions sufficient to distance themselves from feeling culpable for their abusive actions.

These men are most appropriately treated in medium security, in-patient settings. These men often appear to be classic sociopath and may meet the historical and diagnostic threshold for consideration for civil commitment as a sexually violent predator. Treatment appears to have

little long-term impact on these men. Long-term, intensive supervision is the most effective means of preventing recidivism.

High violence risk/high recidivism rate (antisocial personality disorder) individuals are absolutely prepared to do whatever they feel is necessary to gain sexual access to their victims. Most often these individuals are angry, socially alienated, and appear psychopathic by history and by thinking. They see physical violence as a legitimate means for gaining sexual gratification. They may not use violence to cause physical harm, but they aren't troubled when they do. These men are so cognitively distorted and emotionally defended that none of their actions bother them. These individuals have seldom practiced restraint or turned away from an opportunity to abuse others. These men are most often violent rapists, stalking, striking, and restraining their victims for longer than necessary to complete a rape.

These men are never appropriate for outpatient treatment. They demonstrate high levels of antisocial thinking and behaving. They require secure inpatient treatment. It can be expected that their antisocial beliefs and processing will be highly resistant to any treatment. These men will most likely have criminal sexual histories sufficient for consideration for civil commitment as sexually violent predators.

Very high violence risk/high recidivism rate (psychopathic personality) individuals hurt others because they enjoy it. They easily justify their actions as the result of others provocation's. They perceive others as needing to be punished and themselves as the instrument to punish. They will use physical violence for entertainment. They enjoy the pain they cause. These men must be considered lethal. It is highly unlikely that any treatment will change their lives. These men do best in long-term confined treatment settings. These individuals will have most likely had criminal sexual histories sufficient for consideration for civil commitment as sexually violent predators.

Finding Three. The treatment responsiveness of sex offenders is infinitely variable; some are highly motivated to change while others will remain intransigent despite the negative consequences that attend their offending and resistance to treatment. The key to reducing recidivism seems to be accurately matching sex offenders with the type of intervention most appropriate to their needs and to the level of restriction necessary to adequately protect the community. As used here, triage is the process of separating sex offenders into logical groups based on their level of risk for recidivism and their potential treatability. The key to this triage is conducting high quality, state-of-the-art screening and assessment of sexual offenders; using the most valid and reliable instruments, approaches, and protocols to examine the nature and history of their sexual offending to identify and stipulate their treatment and containment needs.

Finding Four. The treatment resources for sex offenders in Virginia are limited. The Department of Corrections currently provides specialized sex offender treatment for approximately 300 individuals. An additional 47 treatment beds will be added when the Department's new sex offender therapeutic community opens. The Department of Juvenile Justice provides specialized sex offender services for approximately 120 to 150 youth. In addition to these resources, the Department of Health Professionals reports that there are currently

336 certified Sex Offender Treatment Providers (SOTP) licensed in the Commonwealth. It is r known how many of these providers are actually practicing or many individual sex offenders they are serving. Neither the Medical Society, that licenses Psychiatrists, nor the Department of Health Professions, that licenses Clinical Psychologists, know how many licensed psychologists or psychiatrists are also SOTP.

DMHMRSAS currently has no personnel assets available to provide the services required by the Center.

The Department of Corrections, Public Safety, and DMHMRSAS are currently examining the availability of physical plant resources within DOC and DMHMRSAS to house the sexually violent predator program for those sex offenders civilly committed under the new law.

Survey of other states sex offender services

Finding Five. During the course of this study a survey was conducted of sexually violent predator civil commitment programs in other states. Seven states were surveyed and two Work Group members completed site visits of three of these programs. In addition, the Work Group acquired data from previous surveys of all fifty states relating to sexually violent predators. Data from the site visits survey is summarized in Appendices B.1 and B.2.

Finding Six. Two standards for screening and assessment are involved in work with sexually deviant disorders. The higher standard is applied when the case is part of a civil commitment proceeding. Screening and assessing for non-civil commitment cases is generally seen as a mor relaxed procedure, although the summary findings and recommendations still must meet the standard of proof established by the court.

Finding Seven. As part of this study, Work Group members attended a national conference, sponsored by the American Prosecutors Research Institute and the National Center for the Prosecution of Child Abuse, on the civil commitment of sexually violent predators. This conference focused on the experiences of states with currently active civil commitment of sexually violent predator laws and treatment programs. These states, in writing their civil commitment laws and developing their commitment programs have closely followed the *Hendricks v. Kansas* Supreme Court decision on civil commitment of sex offenders. In turn, the Kansas law was strongly influenced by its immediate predecessor, the state of Washington sexual predator law.

Legal considerations

Finding Eight. The primary legal consideration, in the creation of an assessment center (excluding the larger issues of civil commitment spoken to in the *Hendricks v. Kansas* Supreme Court decision) are related to inmate's/patient's right to remain silent and what limits on screening and assessment would arise from that a subject's exercising this right. It is assumed that an inmate or patient can always choose to remain silent by lying, by giving limited answers,

or by otherwise refusing to cooperate. The Work Group's opinion is that, even when a subject chooses to remain silent, the Center could probably proceed at least with screening and make recommendations to the CRC/OAG as to whether the person seems to meet the criteria for Sexually Violent Predator or seems to present a risk for reoffense. Other states report that, depending on the wording of their laws, they have successfully civilly committed individuals, lacking the inmate/patient's cooperation, using evidence gained from actuarial screening/record review protocols.

Finding Nine. The Work Group discussed the efficacy of videotaping clinical interviews for the purpose of internal review and consultation or to establish a procedural record and determined that these decisions might need to be made on a case by case basis.

Finding Ten. The Work Group concluded that the penile plethysmograph and polygraph instruments for assessing sexual offenders should be used wherever use of these instruments is a standard and accepted protocol of the field.

Screening

Finding Eleven. Actuarial screening (prediction of recidivism) of sex offenders is a growing trend in North America and the United Kingdom (Quinsey, Harris & Rice, 1998). From the surveys reviewed, states having civil commitment programs for sexually violent predators employ some form of actuarial consideration of recidivism risk as part of their screening and assessment of convicted and incarcerated sex offenders prior to discharge. These states assert that plethysmography is a critical piece of assessing treatment progress.

Prediction of sexual recidivism is predicated on two caveats; that recidivism is nearly impossible to measure with any accuracy, and therefore nearly always underreports the actual rate of reoffense, and that recidivism prediction rates are meaningful only when compared with offending "base rates." [A base rate is the rate, during specified periods of observation, at which untreated sex offenders of the same offense type reoffend upon release from confinement or supervision].

Historically, official recidivism rates have been based on criminal convictions only. This conviction rate seriously underreports the actual rate of sexual offending. Furby, et. al, (1989), for example, found only 15 convictions for 315 reported rapes in a target year in one city. Calculating recidivism from these 15 convictions would seriously misrepresent the actual rate of offending. Further, it is also likely that many of the remaining 315 rape cases were cleared with pleas to non-sexual crimes or by conviction for non-sexual assaults. To be useful, recidivism rates must be refined through extensive records reviews; examining case files for all complaints, arrests, and convictions, looking for evidence of sexual focus, content, or intent in the criminal behavior.

Base rates represent the frequency with which individuals, in a given class of sex offenders w repeat their pattern of sexual offending. Problems arise when base rates for disparate classes o. offenders are aggregated. For example, actuarial prediction instruments are intended for use almost exclusively with high-risk offenders. To construct a base rate for predicting recidivism that includes sexual offenses having very low recidivism-conviction rates reduces the overall base rate. Such a base rate will always under-predict the likelihood of reoffense. The instruments considered in this study carefully specified the boundaries of their recidivism net and controlled for variations in offending base rates.

Three instruments are in common usage; the Minnesota Sex Offender Screening Tool – Revised (MnSOST-R) assessing the probability of sexual recidivism; the Sex Offender Risk Appraisal Guide (SORAG) for the same purpose; and the Violence Risk Appraisal Guide (VRAG) assessing the probability of general violence. These instruments represent the new science of predicting violence. They are constructed on sound methodological foundations and use contemporary, robust models of statistical analysis. Each was constructed using statistical comparisons of sexual and other violent offenders seen in institutions, samples that match closely those with which the instruments will be used. By analyzing pre-confinement behavior and post-institutional actions, actuarial profiles were constructed. Additional samples were selected with which to test the overall efficacy of the instruments. Replication of these instruments by other researchers is continuing. An advantage this research enjoys is the ability to test predictions with retrospective data. Because of this, follow-up studies of recidivism are as long as 25 years (Prentky, Lee, Knight, & Cerce, (in press). In this manner, the instruments are being continually refined and their overall efficiency at predicting recidivism is increasing.

But what does it mean to predict recidivism? In this case, a score on one of these instruments means that, all things being equal, the subject scoring "X" on one instrument will behave in a manner similar to persons from a similar offense class having a similar score on that instrument in the past. This means also, that the prediction will be wrong at the same ratio and in the same direction for the present subject as it was for those in the past. For example, a prediction of 80% probability of reoffending means that the prediction will be wrong *at least* 20% of the time. At the present time, actuarial instruments demonstrate predictive reliability approximately between 50% and 80%; it is likely that they will be correct more often than not, but sometimes not by much.

However poor these rates of predictive accuracy may seem, their predictive reliability is now demonstrably better than clinical judgment. During the last decade, several studies have compared clinical judgment – predictions of dangerousness made by mental health professionals – with actuarial-based models. In all cases, the actuarial approaches were superior to clinical judgment (Lidz, Mulvey, and Gardner, 1993; Wormith & Goldstone, 1984).

In application, actuarial instruments require a technician trained in their use to review official records, offense reports, victims statements, and other documents to describe the offender's history of sexual offense convictions (MnSOST-R), the length of the offender's sexual offending "career" (MnSOST-R), use of force, age range and gender of victims (MnSOST-T and SORAG), relationship to victim (MnSOST-T and SORAG), the presence of psychopathy (SORAG), school

adjustment (SORAG), history of chemical abuse (MnSOST-R and SORAG), criminal history (SORAG), and phallometric profile (SORAG). Since all of the listed instruments integrate a DSM-IV diagnosis, it must be recognized that they are used as part of a larger protocol of screening and assessment.

Finding Twelve. The courts in other states have generally allowed reports of actuarial screening into evidence. Clearly, the likelihood of having actuarial data accepted into court is highly dependent upon the quality of the "expert's" testimony in its support. However, the experience of other jurisdictions using these instruments in civil commitment proceedings predicts that they will be strongly challenged by the subject's attorney using *Daubert v. Merrell Dow Pharmaceuticals, Inc.* Using *Daubert*, conclusions such as those reached using the actuarial risk prediction instruments must proceed from scientifically valid principles and methodologies. Further, the methodology of, in this case, actuarial risk prediction, must "fit" the purposes to which it is put. The scientific principles and methodologies upon which these instruments are based have been found to be scientifically sound by various courts. It follows that experts, in their testimony about risk prediction, must know and be able to describe these principles and methodologies.

Assessment

Finding Thirteen. As noted above, the accuracy of clinical judgment in predicting future dangerousness is clearly limited. More properly, clinical assessment is most appropriately used to diagnose disorders using the protocols standardized by the DSM IV (Diagnostic and Statistical Manual IV), to describe the sex offender's pattern of selection, engagement, abuse, and control of his victims, and to organize the data collected from various sources into a cogent and useful diagnostic/descriptive report.

Further, clinicians completing diagnostic and descriptive reports on sexual offenders must be cognizant of the language and mores of the court system. Reports must be clear, assert no findings that cannot be supported in the data available to the clinician, and limit their recommendations to diagnosis and description. Prevailing opinion expressed at the National Conference on Civil Commitment of Sexually Violent Predators in May of 1999 was that diagnostic and descriptive reports should give information and make logical arguments sufficient for the court to reach its own conclusions and findings.

Finding Fourteen. Two important components of risk prediction and assessment are the penile plethysmograph and the clinical use of the polygraph (lie detector) (See Appendix D). Both the polygraph and the plethysmograph, when used as clinical tools, and as part of a larger protocol for screening or assessment, are held in many jurisdictions to be legitimate and acceptable tools for assessing sexually deviant disorders. They should never be used alone as the single piece of data upon which decisions or recommendations are made.

All states having SVP programs conduct some measurement of sexual attraction to devi themes. In Minnesota, all sexual offender prisoners being considered for civil commitme complete plethysmograph assessments conducted by the Department of Corrections. Once in the SVP program, they complete the Abel Screen of sexual interest in deviant themes. In Kansas, subjects do not undergo plethysmography during the assessment period, but complete multiple plethysmograph assessments during treatment. California uses the plethysmograph as a regular part of treatment to measure progress.

Although the plethysmograph is a very reliable measure of changes in penile tumescence (as an expression of sexual arousal), it is vulnerable to "faking good" wherein the subject refuses to look at the images shown, to listen to the audio presentation, or otherwise distracts himself from attending to the presented stimuli. The result is an inaccurate profiling of the individual pattern of sexual preferences.

One highly successful method for measuring cooperation in the plethysmograph assessment consists of polygraphing the subject on questions of cheating immediately after the plethysmograph assessment. The plethysmograph has been accepted in court as a valid and reliable tool for assessing sexual arousal to deviant themes. It is not accepted, and should not be used as a "penile lie detector." This is clearly outside appropriate use of this instrumentation.

A relatively recent alternative to the plethysmograph is the Abel Screen. This protocol presents sexual stimuli as a set of slides shown on a computer screen and does not involve any direct interaction with the subject's penis. The subject is required to press a specific computer key in response to the images presented. The computer program measures response as temporal latency the time differential between image presentation and key-press. In side by side comparisons with the plethysmograph, the Abel Screen seems to demonstrate equivalency with the plethysmograph. It is now considered a usual and accepted alternative to plethysmograph. However, the actual validity and reliability of this instrument has not been established through peer review.

The Abel Screen is an expensive instrument. It comes as a laptop computer specially configured for the assessment and requires the operator to complete a training course with the Screen's designer, Dr. Abel. The price for the basic instrument, licensing, training, and materials is approximately $5,750. Completed assessments are returned to, evaluated by, and reported on by Dr. Abel's team in Atlanta. These mandatory services cost between $37.50 and $75.00 for each assessment depending on volume of assessments referred for interpretation. Additional information can be reviewed at Dr. Abel's business Website at "www.abelscreen.com."

Treatment

Finding Fifteen. Research on the efficacy of treating sex offenders is not encouraging. Meta-analysis suggests that treatment has little or no effect on reducing recidivism (Hall, 1995). However, meta-analyses suffer from the methodological limitation of comparing studies without controlling for differences in treatment models and treatment integrity. With this in mind, a

review of more recent and methodologically robust studies suggest two conclusions: that in terms of reducing sexual recidivism, certain types of treatment can be expected to be more effective and certain types of sex offenders can be expected to be more responsive.

With regard to the types of treatment, the treatment approaches that identify, weaken, and alter the patterns of antisocial thinking that support and condone sexual abuse (cognitive-behavioral therapy) combined with approaches that identify, weaken, and alter the sex offender's sexual preference for abusive themes and targets (behavioral and hormonal therapies) seem to be effective at reducing sexual recidivism with all but antisocial and psychopathic offenders (Fedoroff, Wisner-Carlson, Dean & Berlin, 1992; Marshall & Barbaree, 1988; Hildbran & Pithers, 1992). Second, the effectiveness of these combined cognitive, behavioral, and hormonal approaches – often called "relapse prevention models" because of their focus on intervening in the offender's abusive pattern before he offends – are enhanced when combined with registration, notification and long-term community monitoring strategies; the so-called community containment model (Schram & Milloy, 1995; Gendreau, Cullen & Bonta, 1994). At the very least, registration, notification, and community containment are associated with much earlier discovery and arrest for sexual recidivism. And, since sexual recidivism is most often represents multiple sexual abuse incidents, earlier discovery and arrest will reduce the overall number of abuse incidents, and may also reduce the number of sexual abuse victims.

Regarding types of offenders, some sex offenders benefit more from treatment -- even weak treatment -- than others (Quinsey, et al. 1998). Sex offenders who have fewer victims, non-psychopathic personalities, who have non-criminal ties to their family and community, and who can on some level genuinely recognize the harm their actions cause, seem to benefit most from treatment. It is not surprising that these offenders also have higher rates of treatment completion and lower rates of sexual and other types of criminal recidivism.

Conversely, those sex offenders who seem to benefit least from treatment are those with psychopathic tendencies, which have limited or weak non-criminal ties to family and community, and can not, or will not, acknowledge their culpability in sexually abusing others. These offenders regularly have the lowest rates of treatment completion and the highest rates of sexual recidivism (Rice, et al., 1992; Quinsey, et al. 1998). Even worse, the Rice data suggest that treating psychopathic offenders may actually increase their violent recidivism.

From this it can be reasonably inferred that effective treatment, and therefore lower recidivism, stipulates a combination of (1) effective screening, (2) comprehensive assessment, (3) sex offender-specific treatment including hormonal control of sexual arousal, and (4) intensive, long-term monitoring. By extension, the most efficacious and pragmatic approach, with regard to cost and decreasing sexual recidivism (short of sentencing all adjudicated sex offenders to life in prison) can best be achieved through a kind of triage; i.e., sorting sex offenders into the type and intensity of treatment appropriate to their needs, placing them in the level of security adequate to maintaining the greatest public safety, and continuing to monitor them closely for the remainder of their lives.

University affiliation

Finding Sixteen. Two universities participated in the SJR 334 Work Group, Virginia Commonwealth University, and the University of Virginia. Both Universities expressed concern about participating in a cooperative research or clinical effort under the three proposed alternatives. The universities' concerns centered on two issues: (1) the ethics of using psychiatrists or psychologists to conduct civil commitment assessments of sexually violent predators. This position is consistent with that formally expressed by the American Psychiatric Association; (2) the universities could not commit personnel to conduct assessments until it was clear where the Center will be located. The issue here is distance traveled. The universities are very concerned also about issues of liability. They see high risk in conducting civil commitment assessments of what will most likely be a highly litigious group. Finally, both universities are very interested in pursuing research possibilities but would like to wait until a Center takes form before committing to any joint venture.

Projected assessments

Finding Seventeen. Working with representatives of DOC, DJJ, DMHMRSAS and the Crime Commission, the Work Group developed projections for the number of sex offenders likely to need assessment and treatment resources in the next five years. These data were difficult to acquire because, in most cases, it was not systematically collected or stored. In sum, these figures are clearly estimates. Some of the data were generated by conducting computer runs keyed to DOC release dates of inmates convicted of sexual offenses. Other data was developed based on knowledge of assessment rates averaged for the last two years. In all cases, in the opinion of the Work Group, these numbers probably undercount the number of assessments required.

Mindful of the above, the number of possible sexually deviant disorder assessments to be completed by the Center is quite large. When all assessments required pursuant to §19.2-300, §37.1-70.5B, §37.1-70.11B, and 37.1-70.12, are totaled, it is possible that the Center could be required to assess:

- 902 sex offenders during 2001,
- 967 sex offenders during 2002,
- 1006 sex offenders during 2003, and
- 1049 sex offenders during 2004.

These figures do not include annual reassessments of sex offenders civilly committed as sexually violent predators, which could require an additional 20 to 60 assessments (Note: It is impossible to predict how many individuals will be civilly committed to the sexually violent predator program each year). Considering the complexity of screening, assessing and treating sex offenders, conducting this volume of assessments would involve the commitment of significant resources and funds.

Chapter 4: Recommendations

Discussion

In Chapter 2 of this study, the Work Group posed three fundamental questions. This chapter answers these questions and proposes three alternatives for serving Virginia's sexually deviant disordered population.

Question 1. Should the Commonwealth conduct state-of-the-art assessments of sex offenders? In the opinion of the Work Group, based on the data at hand, the answer is yes. The principle focus of this study is sexual recidivism, i.e., the repeated sexual abuse of large numbers of Virginians by a relatively small number of sexual perpetrators. The literature suggests that the key to reducing recidivism is sorting sex offenders into treatment that is appropriate to their individual needs and locating them at the level of containment sufficient to protect the community from further sexual abuse. This approach is called "triage."

Triage, as used here, means the process of separating sex offenders into logical groups based on their risk for violence, their risk for recidivism, and their potential treatability. Successful triage requires three things: (1) resources necessary for conducting highest quality, state-of-the-art screening and assessment of sexual offenders, using the most valid and reliable instruments, approaches, and protocols available; (2) assessment protocols sufficient to identify the nature and history of their sexual offending; and (3) treatment resources appropriate to meeting their clinical needs while providing the necessary level of containment.

Question 2. Is a specialized sex offender assessment Center necessary for conducting these assessments and performing triage? Yes, a specialized Center is required. Although it is possible to screen and assess sex offenders well without a Center, a Center would do this best. It is able to bring together assets specific to the task at hand, to train and support staff in the appropriate protocols, and to closely monitor service quality. It is able to respond quickly to changes in the field and apply improvements in screening and assessment technology as they emerge. A Center is able to provide all of these services on a relatively large scale while maintaining clinical and programmatic integrity. Such a Center can provide additional benefits beyond simply conducting assessments or delivering treatment to individuals. A Center could also function as a provider of training and consultation to mental health providers; as a research entity; and as a contributor in the standardization of assessment and treatment protocols within the Commonwealth.

Question 3. If such a Center is necessary for these assessments, how should it be organized and function? Creating such a center is relatively easy, when cost is not a concern. However, cost is a natural and logical constraint. Cost and service delivery are linked, i.e., the greater the number and intensity of services offered, the greater the cost. The Work Group identified eight sources of referral for its assessment function and additional three adjunctive functions. These are described below.

Sources of referrals and other functions

The first step in designing a Center model was to develop an estimate of the maximum number of assessments that such a Center could be expected to complete in its first year. The Work Group started by identifying all the Virginia statutes under which sex offenders could be referred to a Center for assessment. From this, the Work Group developed an estimate of the number of individuals that might be seen during the year 2001 in each of these statutory assessment categories.

It became immediately clear that developing an accurate estimate was impossible. These figures are compromised by several factors. First, it is impossible to predict at this time how many cases will be screened or how many hours screening these cases will require. This is due to the nature of sentencing. Some sex offenders, as a result of plea-bargaining and other alterations to their original charges, are convicted of, and incarcerated for, non-sexual crimes. At least some of these individuals will complete their sentences and be released without being identified as sex offenders, screened, or assessed.

Second, it is impossible to know how many cases will require staff to prepare for and participate in depositions or provide testimony in court. The experience of other states having SVP legislation varies considerably with between 10 and 30 percent of cases assessed proceeding to civil commitment. Some states also report spending large numbers of hours responding to lawsuits brought by those civilly committed.

Third, these calculations do not include hours for conducting training, research, or other duties as the Work Group anticipated that most of these functions would begin during the second year of Center operation.

These numbers, where we believe our estimates are reasonably accurate, appear in parentheses after each.

1. Conducting sex offender assessments pursuant to any of the following legislation for civil commitment of sexually violent predators during 2000: (325 cases estimated)
   - §37.1-70.5B
   - §37.1-70.11B
   - §37.1-70.12
2. §19.2-300 assessments (100 cases estimated)
3. Consultative assessments of Dept. of Corrections inmates for treatment planning. (10 cases estimated)
4. Consultative assessments of individuals in the custody of DMHMRSAS for treatment planning. (10 cases estimated)
5. Consultative assessments of Dept. of Juvenile Justice inmates for treatment planning. (50 cases estimated)
6. Consultative assessments of individuals for probation. (300 cases estimated)
7. Consultative assessments for community mental health (SOTP) providers. (25 cases estimated)

8. Conducting screening of sex offenders about to be released from prison. (Unknown. This figure is very difficult to establish as some incarcerated sex offenders, as a result of plea-bargaining and other reasons were convicted of non-sexual crimes).

In addition to an assessment function, such a Center could be expected to share its expertise with the community. These functions would include:

9. Conducting treatment of sex offenders.[1]
10. Conducting training for clinicians (public and private).
11. Conducting research.

Estimated total possible assessments conducted during 2001	852
Total estimated hours required for each assessment	36[2]
Total hours required for 852 assessments	30,672
Total assessment FTEs (@ 1800 hours ea.)	17
Center Director FTEs (@ 1800 hours)	1
Office Manager FTEs (@ 1800 hours)	1
Support personnel FTEs (@ 1800 hours each)	(varies with alternative)

Earlier in this discussion, in order to pursue a best practice approach to configuring an assessment Center, the Work Group set aside cost as a design constraint. Clearly, however, the number of personnel, the amount of physical plant space necessary for accomplishing all of these services, and the amount of time invested in each assessment, is significant. Faced with this, the Work Group considered various options for limiting services without compromising the original mission of the Center. With this in mind, the Work Group constructed two alternatives based on what it believed to be the maximum and minimum level of services to be offered and an additional, third alternative approximately mid-way between these two.

Center configuration

The process of configuring service delivery began by differentiating services that could best be delivered by a Center from those that could be provided easily and well by persons or agencies other than the Center. This process continued through three initial iterations. In the first iteration, the Work Group reviewed the actuarial screening instruments in current usage and found that it would be ethical and proper for much of the work of screening – records review, etc. -- to be conducted by non-mental health professionals. The Work Group concluded that DOC personnel or probation officers could screen those sex offenders confined in their institutions or with whom they were most familiar. This eliminated approximately four service hours from each case (4 x 852 possible cases = 3408 hours) or slightly less than 2 FTEs.

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[1] The Work Group estimated that the service 8, 9, and 10 would be allowed to consume no more than 25% of the Center's available time.

[2] The assessment components, and hours required for each, are described below under each Center alternative.

The second iteration addressed the provision of sex offender treatment. After considering t' complexity of housing and providing personnel to conduct treatment, the Work Group concluded that treatment would increase the cost of a Center geometrically and would require the creation of a separate treatment, care, and security staff. Providing treatment would also require creating a physical plant sufficient to housing, providing security for, and caring for those civilly committed. The SJR 334 Work Group did not have the resources or funds necessary to complete an architectural analysis of these needs. As importantly, the Work Group was concerned that conducting assessments and providing treatment inside the same organization would create an appearance of conflict of interest or bias. Such an appearance of bias would be used to argue that assessors would be prejudiced in the direction of referring clients to their own treatment program to ensure full census. For these reasons, the Work Group concluded that providing treatment was incompatible with, and should not be part of, the Center's mission.

In the third iteration, the Work Group considered where and under what conditions the Center would be most appropriately located. Recognizing the need to provide quality services to the more rural and geographically isolated Virginia communities, the Work Group initially discussed having the Center's assessors travel to conduct assessments. This poses the obvious logistical problems of transportation, lodging, and security. With respect to plethysmography and polygraphy, travel to distant communities would require sending at least two Center personnel, i.e., a clinician and a psychophysiological assessment technician(s) and his or her equipment.

A more practical option is to locate the Center in a central community and to require that non-incarcerated individuals travel to the Center at their own expense, or at the expense and under the supervision of the local jurisdiction. Center personnel would still travel to prisons to conduc assessments. It would also be practical and useful to establish satellite offices in the prisons with resources for testing and psychophysiological assessment. In this way, the necessary equipment, office, computer, phone, interview space, and security would be readily available on-site.

With the above considerations in mind, the Work Group developed three alternatives. Together, these alternatives represent a rough continuum of services. Each of these alternatives is built on the same organizational chart – shown on the following page as Figure 1 -- and staffing pattern, although the number of FTEs differs in response to the level of services provided.

Assessment core services. For each of the three Center alternatives, the Work Group recommends that the following core services be delivered during each assessment.

1. Screening (To be completed by personnel outside of the Center) including at least:
   - Records review
   - Contact prior jurisdictions to acquire additional records
   - Collateral contacts and interviews
   - Completing actuarial risk assessment screening instrument
2. Clinical assessment (depending on the characteristics of the case, clinical assessment may include both psychological and psychiatric interviews, record reviews, and clinical consultation) including at least:
   - Records review (and review of the previously completed screening materials)

- Clinical interview (psychological at least with a psychiatric interview as needed)
- Test and screening instrument interpretation
- Administering and scoring PCL-R
- Collateral interviews and contacts
- Case consultation
- Report writing and revision

3. Testing, including at least the following:
   - Administering psychological tests
   - Administering penile plethysmograph
   - Administering Abel Screen
   - Administering polygraph

In addition to these core services, the Work Group recommends that the Center conduct some consultation, training, and research, such as the development of statewide assessment protocols and standards of care.

In the final iteration, the Work Group returned to the statutory instructions, described in the *Code of Virginia*, whereby persons who have committed sexually violent offenses will be examined for the purposes of civil commitment as sexually violent predators (§37.1-70.6, §37.01-70.3, B, and §37.1-70.5, B). The Work Group understands these Code Sections to give the Commissioner of DMHMRSAS the option of designating any qualified psychologist or psychiatrist, not just those working for a Center, to complete these sexually violent predator assessments. By extension, the Work Group concluded that the Commissioner could choose to develop a Center to conduct only sexually violent predator assessments or could elect to have these SVP assessments conducted by designated mental health professionals outside of the Center. Considering this, the Work Group identified three naturally occurring alternative service configurations for an assessment Center:

1. To conduct assessments of all persons with sexually deviant disorders except those being considered for civil commitment as sexually violent predators (who would be assessed by mental health professionals designated by the Commissioner of DMHMRSAS);

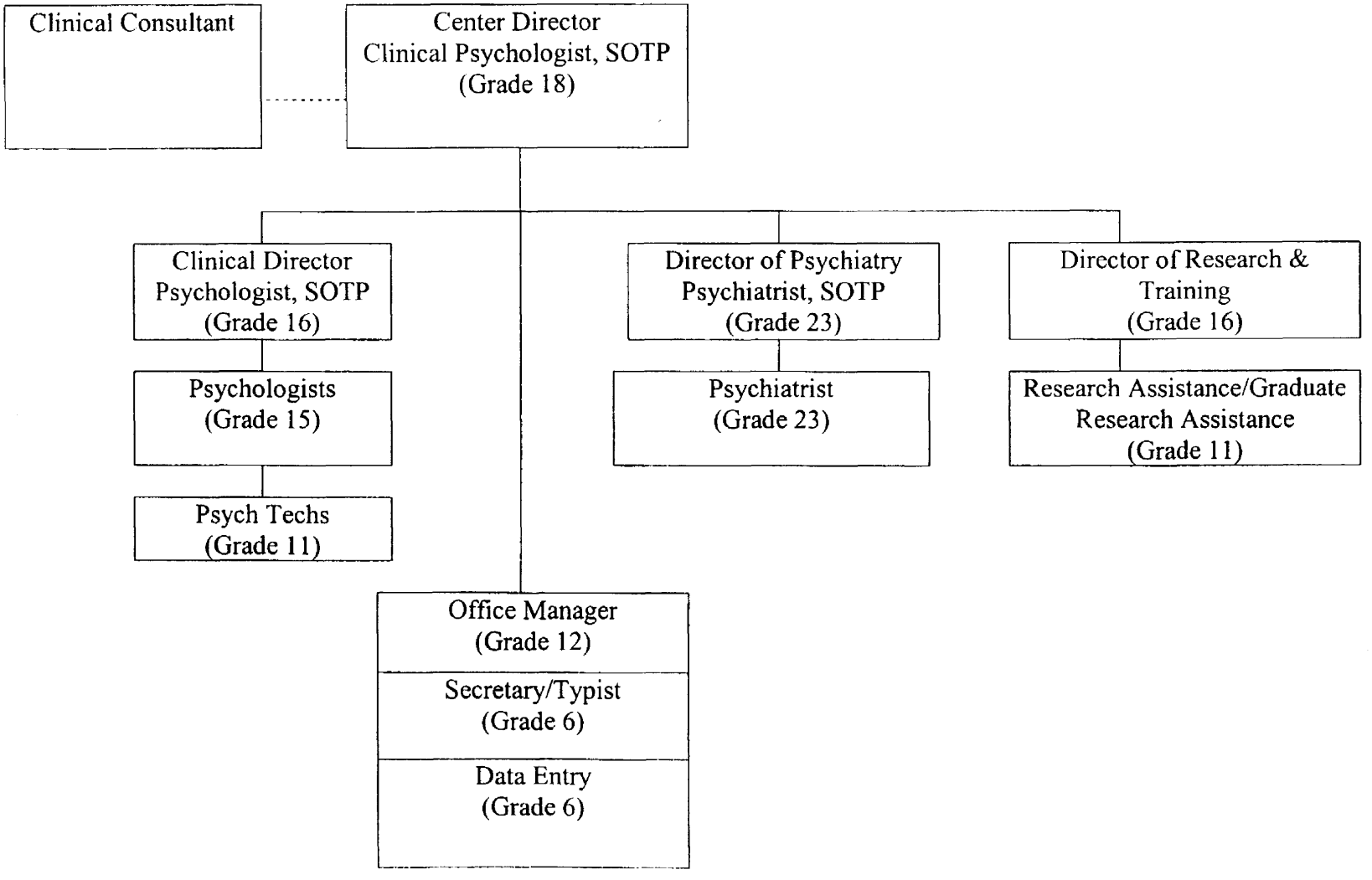
2. To conduct assessments of all persons with sexually deviant disorders including those being considered for civil commitment as sexually violent predators;

3. To conduct assessments of only those persons being considered for civil commitment as sexually violent predators.

Clearly, any of these alternatives can stand alone or be easily modified to better meet the needs of the Commonwealth. These alternatives are described in the following sections.

ATTACHMENT No. 1 Organization Chart

Organization Chart: SJR 334. Center for the Assessment of Sexually Deviant Disorders



Alternative one. Completing 545 assessments during year one. Cost; $1,765,924.

This Center conducts assessments of all persons with sexually deviant disorders except those being considered for civil commitment as sexually violent predators (who would be assessed by professionals designated by the Commissioner of DMHMRSAS). In this alternative, the Center's mission has two parts. The first would be to conduct assessments of adults and juveniles with sexually deviant disorders. Second, the Center would provide consultation, training, and conduct research.

Having defined minimum content standards for conducting highest-quality assessments of sex offenders (the core services above), it was the Work Group's belief that sex offender assessments require the best-trained and skilled evaluators possible. Assessments conducted by the Center under Alternative One would be comprehensive and would be completed by a clinical psychologist, a psychiatrist as needed, and psychology technicians. In this alternative, the Center would conduct research and training and would have a three-person clerical and support staff.

Table 1.[3] Functional Outline for Alternative One.

	Alternative One
Location	Operates out of one central site with multiple satellite offices
Mission	1. Excludes assessments of Sexually Violent Predators. 2. Provides assessments for adult and juveniles with sexually deviant disorders. 3. Perform consultation, training, and research.
Management	Administered and operated by Virginia DMHMRSAS as per §37.1-70.10
Customer Base	Department of Corrections Department of Juvenile Justice Department of Mental Health Community Corrections Community Assessments
Statutory Authority	Adults: 1. §19.2-300 pre-sentence assessments. N = 100 2. Assessments of sex offenders to provide recommendations for treatment and supervision to probation services. N = 300 3. Assessments of sex offenders in DOC custody to provide recommendations for treatment. N = 10 4. Assessments of sex offenders in DMHMRSAS custody to provide recommendations for treatment. N = 10 5. Consultation assessments of sex offenders to provide recommendations for treatment and supervision to private mental health practitioners. N = 25 Juveniles 1. 19.2-300 pre-sentence assessments. N = 0 2. Assessments of juvenile sex offenders to provide recommendations for treatment and supervision to probation. N = 50

[3] Attachment 1 presents this table for each alternative in a side-by-side format.

	3. Assessments of juvenile sex offenders in custody of DJJ to provide recommendations for treatment. N = 10 4. Evaluation of juvenile sex offenders in custody of DMHMRSAS to provide recommendations for treatment and supervision. N = 15 5. Consultative assessments of juvenile sex offenders to provide recommendations for treatment and supervision to private mental health practitioners. N = 25
Treatment	None.
Other services	1. Provide consultation, training, and conduct research. Cooperate with universities in developing training and research assets. 2. Establish standards of care for screening, assessing, and treating adult and juvenile sex offenders. 3. Sponsors, or co-sponsors annual conference on the sate-of-the-art of screening, assessing, and treating adult and juvenile sex offenders.

Figure 2. Base services required to conduct one sex offender (non-SVP) assessment.

19 hours of psychologist time

- (2 hours) Records review
- (4 hours) Clinical interview
- (2 hours) Test interpretation
- (2 hours) To administer and score the PCL-R
- (2 hours) Collateral interviews and contacts
- (1 hour) Case consultation
- (6 hours) Report writing and revision

2.5 hours of psychiatrist time

- (.5 hours) Records review
- (1 hour) Clinical interview
- (.25 hours) Case consultation
- (3 hours) Report writing and consultation

11 Hours of Psych Tech time

- (4 hours) Plethysmograph testing
- (4 hours) Test administration (Battery to be determined later)
- (2 hours) Administer Abel Screen
- (1 hour) Administer actuarial screening instruments

Figure 3. FTEs formula for 545 non-SVP evals conducted by Alternative One in year one.

(40 hours)(52 weeks) – (vacation days + sick days + holidays) = time available for assessments

Example: 1 FTE = $\frac{\text{(Total hours by psychologist)(Total assessments)}}{\text{(Total hours available per assessor)}}$ - or - $\frac{(19)(545)}{1800}$ - or - $\frac{10,355}{1800}$ = = 6.0 FTE

Figure 4. FTE base values for Alternative One: 545 assessments total for year one.

None of these cases are SVP so few should generate any court time for the clinical staff. Thus.

545 cases will require 19 hours of psychologist time = 10,355 hours
545 cases will require 2.5 hours of psychiatrist time = 1,363 hours
545 cases will require 11 hours of psych tech time = 5,995 hours

Table 2. FTEs calculated for 545 non-SVP assessments completed by Alternative One during year one

	Total hours for 545 evals	Divided by available work hours per person, per year	Equals total FTEs required for 545 evals (rounded up)
Psychologists	10,355	1800	6.0
Psychiatrists	1,363	1800	1.0
Psych Techs	5,995	1800	4.0

Table 3. STAFF COSTS FOR ALTERNATIVE ONE.

POSITION	GRADE	SALARY	FRINGE	HEALTH	TOTAL SALARY	FTEs	TOTAL COST
PSYCHIATRIST	23	110,675	23,142	4,356	138,173	1	138,173
CENTER DIRECTOR	18	70,889	14,823	4,356	90,068	1	90,068
CLINICAL DIRECTOR	16	59319	12,404	4,356	76,079	1	76,079
DIRECTOR OF RESEARCH	16	59319	12,404	4,356	76,079	1	76,079
PSYCHIATRIST	23	110,675	23,142	4,356	138,173	1	138,173
PSYCHOLOGIST	15	54,262	11,346	4,356	69,964	6	419,784
PSYCH TECHS	11	37,995	7,945	4,356	50,296	4	201,184
RESEARCH ASSISTANT	11	37,995	7,945	4,356	50,296	4	201,184
OFFICE MANAGER	12	41,535	8,685	4,356	54,576	1	54,576
SECRETERY	6	24,337	5,089	4,356	33,782	1	33,782
DATA ENTRY	6	24,337	5,089	4,356	33,782	1	33,782
TOTAL						21	1,462,864

Note: All positions are budgeted at step 12 in the salary range.

Alternative Two. Completing 870 assessments during year one. Cost; $2,939,584.

Here, the Center's mission has three components. First, to conduct assessments of individuals being considered for civil commitment as sexually violent predators pursuant to §37.1-70.5B, and persons civilly committed as sexually violent predators needing annual review assessments pursuant to §37.1-7-.11B and §37.1-70.12. Second, to conduct assessments of adults and juveniles with sexually deviant disorders needing assessments pursuant to §19.2-300. Third, to provide consultation, training, and conduct research.

Assessments conducted by the Center under this proposed alternative would be comprehensive and include the same types of provider personnel as under Alternative One.

Table 4. Functional Outline for Alternative Two.

	Alternative Two
Location	Operates out of one central site with multiple satellite offices
Mission	1. Provides assessments to persons being considered for civil commitment as sexually violent predators under §37.1-70.5B 2. Provides assessments to persons civilly committed as sexually violent predators needing annual re-evaluation under §37.1-70.11B. 3. Provides assessments for adults and juveniles with sexually deviant disorders 4. Provides consultation, training, and conducts research.
Management	Administered and operated by Virginia DMHMRSAS as per §37.1-70.10
Customer Base	Department of Corrections Department of Juvenile Justice Department of Mental Health Community Corrections Community Assessments
Statutory Authority	Sexually violent predator assessments, by year (estimated) under: 1. §37.1-7-.5B 2. §37.1-7-.11B 3. §37.1-7-.12 FY2000 = 325 FY2001 = 357 FY2002 = 392 FY2003 = 431 FY2004 = 474 Adults: 1. §19.2-300 pre-sentence assessments. N = 100 2. Assessments of sex offenders to provide recommendations for treatment and supervision to probation. N = 300 3. Assessments of sex offenders in custody of DOC to provide recommendations for treatment. N = 10

	4. Assessments of sex offenders in DMHMRSAS custody to provide recommendations for treatment. N = 10 5. Consultative assessments of sex offenders to provide recommendations to private mental health providers. N = 25 Juveniles 1. 19.2-300 pre-sentence assessments. N = 0 2. Assessments of juvenile sex offenders to provide recommendations for treatment and supervision to probation. N = 50 3. Assessments of juvenile sex offenders in custody of DJJ to provide recommendations for treatment. N = 10 4. Evaluation of juvenile sex offenders in custody of DMHMRSAS to provide recommendations for treatment and supervision. N = 15 5. Consultative assessments of juvenile sex offenders to provide recommendations for treatment and supervision to private mental health practitioners. N = 25
Treatment	None
Other Services	1. Provide consultation, training, and conduct research. Cooperate with universities in developing training and research assets. 2. Establish standards of care for screening, assessing, and treating adult and juvenile sex offenders. 3. Sponsors, or co-sponsors annual conference on the sate-of-the-art of screening, assessing, and treating adult and juvenile sex offenders.

Figure 5. Base services required for conducting one specialized sex offender (SVP) assessment in Alternative Two.

Note: Alternative Two divides staff time between assessments of sexually violent predators (75%) and other sex offenders (25%). This is taken into account for the calculation of FTEs.

DOC reports that it expects to discharge approximately 325 persons in 2000 who have been convicted of a predicate offense for civil commitment as a sexually violent predator. The current legislation requires that each of these individuals receive an assessment including a mental health examination, including a personal interview, of the prisoner by a licensed psychiatrist or a licensed clinical psychologist, designated by the Commissioner of the Department of Mental Health, Mental Retardation, and Substance Abuse Services, who is skilled in the diagnosis and treatment of mental abnormalities and disorders associate with violent sex offenders, and who is not a member of the CRC. Therefore, it is projected that the Commissioner, and therefore the Center, would have to conduct 325 assessments the first year. Each of these individual assessments will consume:

19 hours to of psychologist time

- (2 hours) Records review
- (4 hours) Clinical interview

- (2 hours) Test interpretation
- (2 hours) To administer and score the PCL-R
- (2 hours) Collateral interviews and contacts
- (1 hour) Case consultation
- (6 hours) Report writing and revision

10 hours of psychiatrist time (for SVP assessments)

- (2 hours) Records review
- (4 hours) Clinical interview
- (1 hours) Case consultation
- (3 hours) Report writing and consultation

2.5 hours of psychiatrist time (for non-SVP assessments)

- (.5 hours) Records review
- (1 hour) Clinical interview
- (.25 hours) Case consultation
- (3 hours) Report writing and consultation

11 Hours of Psych Tech time

- (4 hours) Plethysmograph testing
- (4 hours) Test administration (Battery to be determined later)
- (2 hours) Administer Abel Screen
- (1 hour) Administer actuarial screening instruments

In addition to these clinical hours for the 325 individual assessments, Center staff will provide time to prepare for and appear in legal proceedings leading up to civil commitment of some individuals. The experience of other states with similar civil commitment legislation for sexually violent predators is that approximately 30% of all cases assessed appear to meet the statutory definition of Sexually Violent Predator and are taken forward by the Office of the Attorney General to probable cause hearing and trial for civil commitment as a sexually violent predator. In these cases, the evaluation team and its associates will spend some time preparing for civil discovery and testifying in these hearings. Based on the experiences of other states and practitioners in Virginia, these are estimated to be:

- (three days or 24 hours) **Psychologist time**
- (three days or 24 hours) **Psychiatrist time**
- (1.5 days or 12 hours) **Psych Tech time**

Figure 6. Formula for calculating FTEs for 325 SVP evals conducted by Alternative Two in year one.

Total individual available hours per year dedicated to SVP assessments

$$\frac{(40 \text{ hours})(52 \text{ weeks}) - (\text{vacation days} + \text{sick days} + \text{holidays})}{.75} = \text{time available for SVP assessments}$$

Total individual available hours per year dedicated to other services (research, training, etc.)

$$\frac{(40 \text{ hours})(52 \text{ weeks}) - (\text{vacation days} + \text{sick days} + \text{holidays})}{.25} = 1.0 \text{ FTE}$$

Figure 7. FTE base values for Alternative Two:

Alternative Two assumes that the Center will assess a total of 870 cases during its first year; 545 sexually deviant disorders and 325 sexually violent predators. Of the 325 sexually violent predator assessments, approximately 30% will require additional court time for each of the evaluation team members. For this 30%, staff time is increased by the amount above (e.g., 24 hours for psychologists). Thus, 19 regular psychologists' assessment hours are increased by 24 additional court hours for a total of 43 assessment hours.

Alternative Two includes conducting annual re-assessments of civilly committed sexually violent predators and conducting assessments of other, non-SVP adults and juveniles for sexually deviant disorders. During year one of the Center, anticipating that it will open before or concurrent to any SVP civil commitment program, there will be no re-assessments of SVPs. In addition to these 325 SVPs, 525 other sex offenders are estimated to need assessments during year one. The times and FTEs required to complete these assessments are described below.

SVP assessments. 325 evals total. Less 30% of cases requiring increased assessment time for court (97.5 rounded up to 98 evals) = 227. Therefore,

- 227 evals will require 19 hours of psychologist time each = 4,313 hours total
- 98 evals will require 43 hours of psychologist time each = 4,214 hours total
- Total hours of psychologists time for 325 evals (227 + 98) = 8,527 hours total

- 227 evals will require 10 hours of psychiatrist time each = 2,270 hours total
- 98 evals will require 34 hours of psychiatrist time each = 3,332 hours total
- Total hours of psychiatrist time for 325 evals = 5,602 hours total

- 227 evals will require 11 hours of psych tech time each = 2,497 hours total
- 98 evals will require 23 hours of psych tech time each = 2,254 hours total
- Total hours of psych tech time for 325 evals = 4,751 hours total

Table 5.a FTEs calculated for 325 SVP evals when 30% (98 cases) go to civil commitment

	1 year available work hours per persons @ 75% time for evals only	Total hours to complete 325 SVP evals	Total FTEs SVP evals only
Psychologists	1350	8527	6.0
Psychiatrists	1350	5602	4.0
Psych Techs	1350	4751	4.0

Table 5.b FTEs calculated for 545 non-SVP evals

	Total hours for 545 evals	1 year available work hours per persons @ 75% time for evals only	Equals total FTEs required for 545 evals (rounded up)
Psychologists	10,355	1350	7.7
Psychiatrists	1,363	1350	1.0
Psych Techs	5,995	1350	4.5

Table 5.c Combined FTEs calculated for 325 SVP and 545 non-SVP sex offender assessments

	Total FTEs for assessing 325 SVPs	Total FTEs for assessing 545 non-SVPs	Total combined FTEs
Psychologists	6.0	7.7	13.7
Psychiatrist	4.0	1.0	5.0
Psych Techs	4.0	4.5	8.5

Table 6 STAFF COSTS FOR ALTERNATIVE TWO.

POSITION	**GRADE**	**SALARY**	**FRINGE**	**HEALTH**	**TOTAL SALARY**	**FTEs**	**TOTAL COST**
DIRECTOR OF PSYCHIATRY	23	110,675	23,142	4,356	138,173	1	138,173
CENTER DIRECTOR	18	70,889	14,823	4,356	90,068	1	90,068
CLINICAL DIRECTOR	16	59319	12,404	4,356	76,079	1	76,079
DIRECTOR OF RESEARCH	16	59319	12,404	4,356	76,079	1	76,079
PSYCHIATRIST	23	110,675	23,142	4,356	138,173	5	690,865
PSYCHOLOGIST	15	54,262	11,346	4,356	69,964	12	839,568
PSYCH TECHS	11	37,995	7,945	4,356	50,296	8	402,368
RESEARCH ASSISTANT	11	37,995	7,945	4,356	50,296	4	201,184
OFFICE MANAGER	12	41,535	8,685	4,356	54,576	1	54,576
SECRETERY	6	24,337	5,089	4,356	33,782	1	33,782
DATA ENTRY	6	24,337	5,089	4,356	33,782	1	33,782
TOTAL							2,636,524

Note: All positions are budgeted at step 12 in the salary range.

Alternative Three. Completing 325 assessments during year one. Cost; $2,629,100.

This alternative presumes that the Center's mission is to conduct assessments of sexually violent predators being considered for civil commitment or presently civilly committed. At least seventy-five percent of the Center's time is devoted to conducting assessments of persons being considered for civil commitment as sexually violent predators pursuant to §37.1-70.5B and conducting annual review assessments to persons already civilly committed as sexually violent predators pursuant to §37.1-70.11B and §37.1-70.12. As resources permit, up to twenty-five percent of the Center's time is dedicated to conducting assessments of adults and juveniles with sexually deviant disorders, to providing consultation, training and conducting research.

Assessments conducted by the Center under this alternative would be comprehensive and include the same types of provider personnel as Alternative One and Two. The FTEs and budget for this proposal are described in Attachment 3.3.

Table 7. Functional Outline for Alternative three.

	Alternative Three
Location	Operates out of one central site with multiple satellite offices
Mission	1. Provides assessments to persons being considered for civil commitment as sexually violent predators under §37.1-70.5B 2. Provides assessments to persons civilly committed as sexually violent predators needing annual re-evaluation under §37.1-70.11B. 3. Provides consultation, training, and conducts research. 4. Provides assessments for adults and juveniles with sexually deviant disorders as resources and time permit.
Management	Administered and operated by Virginia DMHMRSAS as per §37.1-70.10
Customer Base	Primarily sexually violent predators in the custody of DOC and DMHMRSAS.
Statutory Authority	Sexually violent predator assessments, by year (estimated) under: 1. §37.1-70.5B 2. §37.1-70.11B 3. §37.1-70.12 FY2000 = 325 FY2001 = 357 FY2002 = 392 FY2003 = 431 FY2004 = 474 3. Annual reassessments of civilly committed sexually violent predators.
Treatment	None
Other Services	4. Provide consultation, training, and conduct research as resources and time permit.

Figure 8. Base services required for conducting one specialized sex offender (SVP) assessment in Alternative Three. The Department of Corrections (DOC) reports that it expects to discharge approximately 325 during 2000 who have been convicted of a predicate offense for civil commitment as a sexually violent predator. The current legislation requires that each of these individuals receive an assessment including a mental health examination, including a personal interview, of the prisoner by a licensed psychiatrist or a licensed clinical psychologist, designated by the Commissioner of the Department of Mental Health, Mental Retardation, and Substance Abuse Services, who is skilled in the diagnosis and treatment of mental abnormalities and disorders associate with violent sex offenders, and who is not a member of the CRC. It is projected that the Commissioner, and therefore the Center, will have to conduct 325 assessments of sexually violent predators the first year. Each of these individual assessments will consume:

19 hours to of psychologist time

- (2 hours) Records review
- (4 hours) Clinical interview
- (2 hours) Test interpretation
- (2 hours) To administer and score the PCL-R
- (2 hours) Collateral interviews and contacts
- (1 hour) Case consultation
- (6 hours) Report writing and revision

10 hours of psychiatrist time (SVP evals)

- (.2 hours) Records review
- (4 hours) Clinical interview
- (1 hour) Case consultation
- (3 hours) Report writing and consultation

2.5 hours of psychiatrist time (non-SVP evals)

- (.5 hours) Records review
- (1 hour) Clinical interview
- (.25 hours) Case consultation
- (3 hours) Report writing and consultation

11 Hours of Psych Tech time

- (4 hours) Plethysmograph testing
- (4 hours) Test administration (Battery to be determined later)
- (2 hours) Administer Abel Screen
- (1 hour) Administer actuarial screening instruments

Figure 9. Formula for calculating FTEs for 325 SVP evals conducted by Alternative Three in year one when 75% of each staff's time is dedicated to conducting assessments. 25% of each staff's time is dedicated to other functions.

Total individual available hours per year dedicated to assessments

$$\frac{(40 \text{ hours})(52 \text{ weeks}) - (\text{vacation days} + \text{sick days} + \text{holidays})}{.75} = \text{time available for assessments}$$

Total individual available hours per year dedicated to other services

$$\frac{(40 \text{ hours})(52 \text{ weeks}) - (\text{vacation days} + \text{sick days} + \text{holidays})}{.25} = \text{time available for other services}$$

1 FTE = Time for assessments (at 75%) + Time for other services (at 25%)

Figure 10. FTE base values for Alternative Three, SVP evals: 325 assessments total for year one. In addition to the clinical hours necessary to complete 325 individual assessments, Center staff will also provide time to prepare for and appear in legal proceedings leading up to the civil commitment of some individuals. The experience of other states with similar civil commitment legislation for sexually violent predators is that approximately 30% of all cases assessed appear to meet the statutory definition of Sexually Violent Predator and are taken forward by the Office of the Attorney General to probable cause hearing and trial for civil commitment as a sexually violent predator. In these cases, the evaluation team and its associates will spend additional time preparing for civil discovery and testifying in these hearings. Based on the experiences of other states and our own clinical and legal staff, these will include:

- (three days or 24 hours) **Psychologist time**
- (three days or 24 hours) **Psychiatrist time**
- (1.5 days or 12 hours) **Psych Tech time**

Thus, for 98 cases (30% of 325 cases) the clinical team will be required to prepare for and appear in court for probable cause hearings and trial. For each case prosecuted by the Office of the Attorney General, it is estimated that staff time devoted to court related activities would be as follows:

325 evals total. Less 30% (97.5 rounded up to 98 evals) = 227. Therefore,

- 227 evals will require 19 hours of psychologist time each = 4,313 hours total
- 98 evals will require 43 hours of psychologist time each = 4,214 hours total
- Total hours of psychologists time for 325 evals = 8,527 hours total

- 227 evals will require 10 hours of psychiatrist time each = 2,270 hours total
- 98 evals will require 34 hours of psychiatrist time each = 3,332 hours total
- Total hours of psychiatrist time for 325 evals = 5,602 hours total

- 227 evals will require 11 hours of psych tech time each = 2,497 hours total
- 98 evals will require 23 hours of psych tech time each = 2,254 hours total
- Total hours of psych tech time for 325 evals = 4,751 hours total

FTE base values for Alternative Three, non-SVP evals: 82 assessments total for year one. Of these, none will require additional court time from each of the evaluation team. Thus,

For 82 assessments,

- 81 evals will require 19 hours of psychologist time each = 1539 hours total
- 81 evals will require 2.5 hours of psychiatrist time each = 203 hours total
- 81 evals will require 11 hours of psych tech time each = 891 hours total

Table 8.a. FTEs calculated for 325 SVP evals when 30% go to civil commitment and percent of staff time equals 75%

	1 year available work hours per persons @ 75% time for SVP evals only	Total weighted[4] hours for 325 evals	Total FTEs if weighted hours for 325 evals and 75% time for SVP only
Psychologists	1350	8527	6.0
Psychiatrists	1350	5602	4.0
Psych Techs	1350	4751	4.0

Table 8.b. FTEs calculated for non-SVP assessments and other activities when staff time equals 25%

	1 year available work hours per person @ 25% time	Total FTEs @ 25% time
Psychologists	450	0.25
Psychiatrists	450	0.25
Psych Techs	450	0.25

[4] Weighted value: 325 SVP cases, less 30% court involved. (325) – (98) = 227.
FTE = 227 cases at (X hours) plus 98 cases at (X hours)
.75 (or.25)

Table 9. STAFF COSTS FOR ALTERNATIVE THREE.

POSITION	GRADE	SALARY	FRINGE	HEALTH	TOTAL SALARY	FTEs	TOTAL COST
PSYCHIATRIST	23	110,675	23,142	4,356	138,173	1	138,173
CENTER DIRECTOR	18	70,889	14,823	4,356	90,068	1	90,068
CLINICAL DIRECTOR	16	59319	12,404	4,356	76,079	1	76,079
DIRECTOR OF RESEARCH	16	59319	12,404	4,356	76,079	1	76,079
PSYCHIATRIST	23	110,675	23,142	4,356	138,173	5	690,865
PSYCHOLOGIST	15	54,262	11,346	4,356	69,964	9	629,676
PSYCH TECHS	11	37,995	7,945	4,356	50,296	6	301,776
RESEARCH ASSISTANT	11	37,995	7,945	4,356	50,296	4	201,184
OFFICE MANAGER	12	41,535	8,685	4,356	54,576	1	54,576
SECRETERY	6	24,337	5,089	4,356	33,782	1	33,782
DATA ENTRY	6	24,337	5,089	4,356	33,782	1	33,782
TOTAL						21	2,326,040

Note: All positions are budgeted at step 12 in the salary range.

Consultation and Start-up

Other states already having civil commitment programs and systems of assessing individuals with sexually deviant disorders recommend having a nationally accepted and respected expert to consult and otherwise assist during the start-up and train-up phase of the civil commitment process. The problem is that few people in the world, fewer still in the United States, and to our knowledge, no one in Virginia, have the requisite expertise in the assessment of sexually violent predators. Because the Center will be assessing SVPs as part of its mission to assess sexually deviant disorders, having the assistance and guidance of such an expert is critical. Clearly, it is imperative that Virginia contracts with an expert to assist Center administrators with designing and implementing this program and with conducting initial and ongoing training with the evaluators and technical staff. We anticipate that the Center will use this Consultant most intensively during year one of the Center's operation. The Center should continue to use the Consultant for two additional years to insure philosophical and theoretical continuity and clinical integrity and consistency. Time and scheduling for this consultation are described below.

Cost Summary, consultation during start-up and year one, two, and three.

Year one. Consultation 4 days per month (2days, twice per month) during the first year or 48 days.
Year two and three. Consultation for one, 2-days period each month during the second and third year or 48 days.

Total consultation time = 96 days
Cost = $2,000.00 per day.

Year one =	$96,000.00
Year two =	$48,000.00
Year Three =	$48,000.00
	$192,000.00

Expenses per each of 48 trips during the three years (at $300.00 each) = $14,400.00.

Total for consultation and travel expenses for three years = $206,400.00.

Cost Summary: Operations

Because each of the three proposed Center's uses a common organizational structure, the Work Group anticipates that their operational cost will be comparable. The following figures project the costs of opening and operating an assessment Center for one year.

Total personnel service costs, Alternative 1	$1,462,864
Alternative 2	2,636,524
Alternative 3	2,326,040
Rent	28,000
Travel and Office supplies, etc.	42,000
Training and education, continuing	20,000
Consultant, three years	192,000
Telephone service	13,260
Pagers	1,500
Cell phones	6,300
Total operational costs	$303,060
Total start-up consultation costs (for three years)	$206,400

Cost summary: All costs

The following figures show the total estimated costs (personnel, operations, and consultation and training) for opening and running an assessment Center during year one:

Alternative One	$1,869,124
Alternative Two	$2,991,184
Alternative Three	$2,680,700

ATTACHMENT

SERVICE MATRIX FOR THREE CENTER ALTERNATIVES

ATTACHMENT No. 1 **Service Matrix for three Center Alternatives.**

	Alternative 1	Alternative 2	Alternative 3
Location	Number of sites undetermined	Number of sites undetermined	Number of sites undetermined
Assessments completed during year one	545 assessments	870 assessments	325 assessments
Budget projections Personnel: Operations: Start-up Consult, (three years): **Total:**	 $1,765,924 $303,060 $206,400 **$2,275,384**	 $2,939,584 $303,060 $206,400 **$3,449,044**	 $2,629,100 $303,060 $206,400 **$3,138,560**
Purpose	1. Exclude SVP population 2. Provide assessments for adults and juveniles with sexually deviant disorders 3. To perform research, training, and consultation.	A. To conduct evaluations of: 1. Persons being considered for civil commitment as SVP 2. SVPs committed to custody of the Commissioner – annual review evaluations B. Provide assessments for adults and juveniles with sexually deviant disorders B. To perform research, training, and consultation.	A. To conduct evaluations of: 1. Persons being considered for civil commitment as SVP 2. SVPs committed to custody of the Commissioner - annual review evaluations C. To perform research, training, and consultation. C. To conduct a limited of assessments for adults and juveniles with sexually deviant disorders (as resources permit).
Management	Administered and operated by Virginia DMHMRSAS as per §37.1-70.10		
Customer Base	DOC, DJJ, DMH, Community Corrections and Community evaluations.	A. SVPs B. DOC, DJJ, DMH, Community Corrections, Community evaluations	Primarily SVPs in the custody of DOC or DMHMRSAS.

ATTACHMENT No. 1 **Service Matrix for three Center Alternatives.**

A. Populations B. Statutory authority C. projected numbers of assessments	A. Evaluations of adults B & C. 1. 19.2-300 pre-sentence evals. N = 100 2. Evaluations of sex offenders to provide recommendations for treatment and supervision to probation and parole officers. N = 300 3. Evaluations of sex offenders in DOC custody to provide recommendations for treatment to DOC N = 10 4. Evaluations of sex offenders in DMHMRSAS custody to provide recommendations for treatment to DMHMRSAS. N = 10 5. Consultative assessments of sex offenders to provide recommendations for treatment and supervision to community MH practitioners. N = 25 B. Evaluations of juveniles	A. SVP assessments primarily FY2000 = 325 FY2001 = 357 FY2002 = 392 FY2003 = 431 FY2004 = 474 B. 37.1-70.5B 37.1-7-.11B 37.1-70.12 C. Evaluations of adults 1. 19.2-300 pre-sentence evals N = 100 2. Evaluations of sex offenders to provide recommendations for treatment and supervision to probation and parole officers. N = 300 3. Evaluations of sex offenders in DOC custody to provide recommendations for treatment to DOC N = 10 4. Evaluations of sex offenders in DMHMRSAS custody to provide recommendations for treatment to DMHMRSAS. N = 10 5. Consultative assessments of sex offenders to provide recommendations for treatment and supervision to	A. SVP assessments primarily FY2000 = 325 FY2001 = 357 FY2002 = 392 FY2003 = 431 FY2004 = 474 B. 37.1-70.5B 37.1-7-.11B 37.1-70.12 C. 325 in Year One.

ATTACHMENT No. 1 **Service Matrix for three Center Alternatives.**

	1. 19.2-300 pre-sentence evals N = 0 2. Evaluations of sex offenders to provide recommendations for treatment and supervision to probation and parole officers. N = 50 3. Evaluations of sex offenders in DJJ custody to provide recommendations for treatment to DJJ N = 10 4. Evaluations of sex offenders in DMHMRSAS custody to provide recommendations for treatment to DMHMRSAS. N = 15 5. Consultative assessments of sex offenders to provide recommendations for treatment and supervision to community MH practitioners.	community MH practitioners. N = 25 D. Evaluations of juveniles 1. 19.2-300 pre-sentence evals N = 0 2. Evaluations of sex offenders to provide recommendations for treatment and supervision to probation and parole officers. N = 50 3. Evaluations of sex offenders in DJJ custody to provide recommendations for treatment to DJJ N = 10 4. Evaluations of sex offenders in DMHMRSAS custody to provide recommendations for treatment to DMHMRSAS. N = 15 5. Consultative assessments of sex offenders to provide recommendations for treatment and supervision to community MH practitioners. N = 25	

ATTACHMENT No. 1 **Service Matrix for three Center Alternatives.**

	N = 25		
Treatment[1]	None	None	None
Fiscal	State General Funds	State General Funds	State General Funds
Other Services	1. Provides consultation, research, and training in conjunction with Universities. Develops and establishes standards of care for providers of sex offender assessment and treatment 2. Sponsors and provides an annual conference on the state of the art of assessment and treatment of sex offenders.	1) Provides a range of consultation, training, and supervision/mentoring services. 2) Participates in developing community sex offender resources 3) Facilitate policy development 4) Develops and establishes standards of care for providers of sex offender assessment and treatment 5) Sponsors and provides an annual conference on the state of the art of assessment and treatment of sex offenders.	Provides consultation, research, and training as secondary activities as resources permit.
Consideration of victim impact	Victim impact will be considered and clearly addressed in the assessment and treatment protocols considered by the Center	Victim impact will be considered and clearly addressed in the assessment and treatment protocols considered by the Center	Victim impact will be considered and clearly addressed in the assessment and treatment protocols considered by the Center

[1] The work group recommends that the Center not provide treatment. It is the opinion of the work group that treatment of sex offenders is most effective in close collaboration within a community containment model that is part of a local network of care to increase the ability to supervise and increase the range of services.

APPENDICIES

APPENDIX A

SENATE JOINT RESOLUTION 334

SENATE JOINT RESOLUTION No. 334

Requesting the Department of Mental Health, Mental Retardation, and Substance Abuse Services, in collaboration with the Department of Corrections, the Department of Juvenile Justice, Norfolk State University, the University of Virginia, and Virginia Commonwealth University, to conduct a study on the development of the Center for Assessment and Treatment of Sexually Deviant Disorders.

Agreed to by the Senate, January 29, 1999
Agreed to by the House of Delegates, February 18, 1999

WHEREAS, research indicates that certain sex offenders benefit from treatment interventions; and

WHEREAS, the Department of Corrections currently does not have assessment or clinical treatment services for sex offenders available within Virginia's prison system; and

WHEREAS, the Virginia State Crime Commission recommends that sex offenders undergo a formal assessment and treatment, if indicated, at some time during their incarceration or community supervision; and

WHEREAS, the Commission further recommends the provision of clinical sex offender treatment services within the Department of Corrections; and

WHEREAS, the Commission found that research and development of standardized assessment instruments and treatment protocols are needed throughout the Commonwealth; now, therefore, be

RESOLVED by the Senate, the House of Delegates concurring, That the Department of Mental Health, Mental Retardation, and Substance Abuse Services, in collaboration with the Department of Corrections, the Department of Juvenile Justice, Norfolk State University, the University of Virginia, and Virginia Commonwealth University, be requested to conduct a study on the development of the Center for Assessment and Treatment of Sexually Deviant Disorders. The study shall include (I) a review of the availability of facilities and professional staff, (ii) review of the legal issues pertinent to this type of treatment center, including informed consent, liability, inmate/patient security requirements, (iii) consultation with other states, state agencies, and academic institutions regarding multi-agency utilization of a center, and (iv) the associated costs of establishing a center of this type.

All agencies of the Commonwealth shall provide assistance to the Department for this study, upon request.

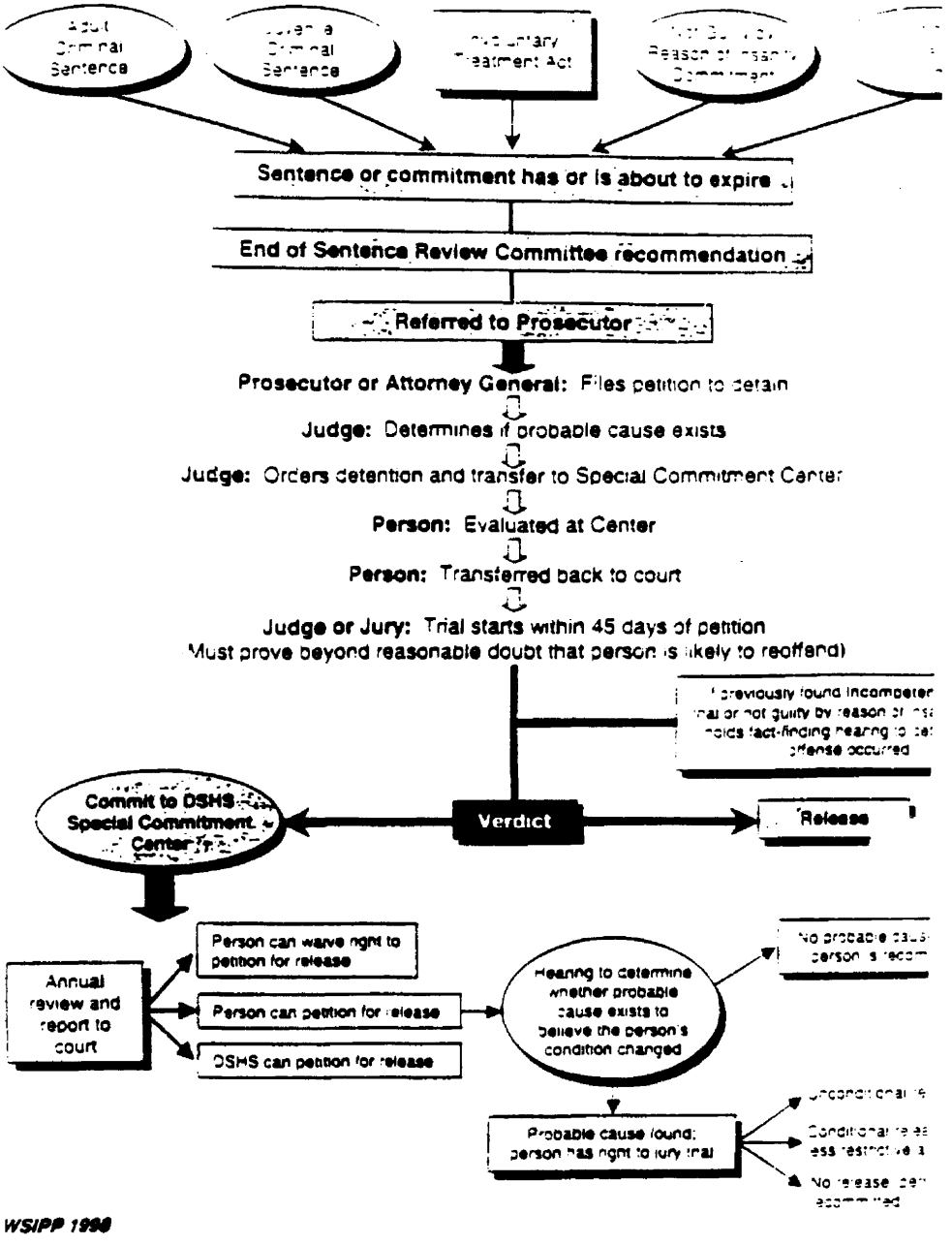
An estimated $50,000 is allocated for conducting this study. Such expenses shall be funded by a separate appropriation by the General Assembly.

The Department shall complete its work in time to submit its findings and recommendations to the Governor and the 2000 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the Processing of legislative documents.

APPENDIX B

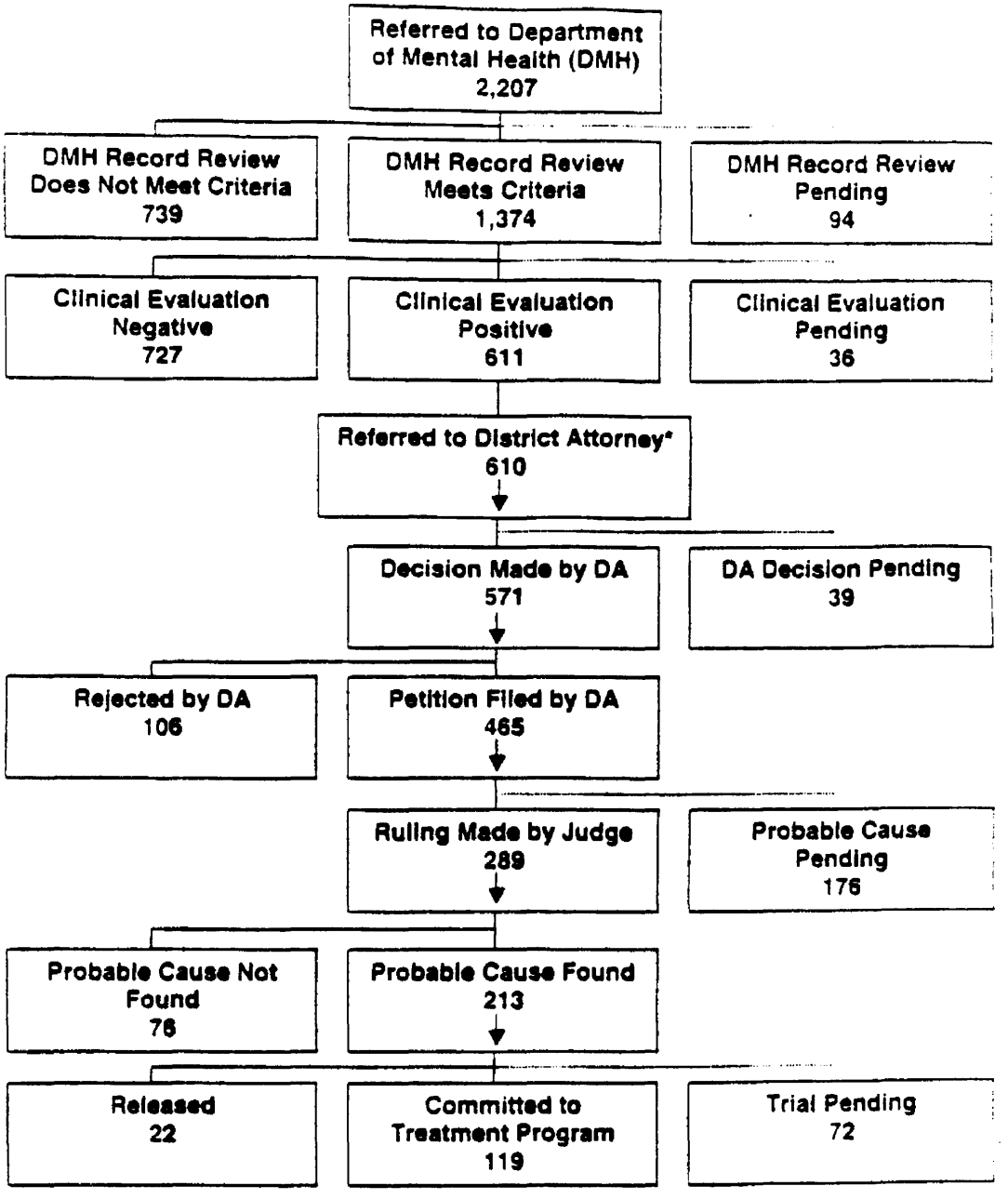
EXAMPLE OF SCREENING, ASSESSMENT, AND CIVIL COMMITMENT PROTOCOLS

FIGURE 1: CIVIL COMMITMENT OF SEXUALLY VIOLENT PREDATORS IN WASHINGTON STATE: DECISION STEPS



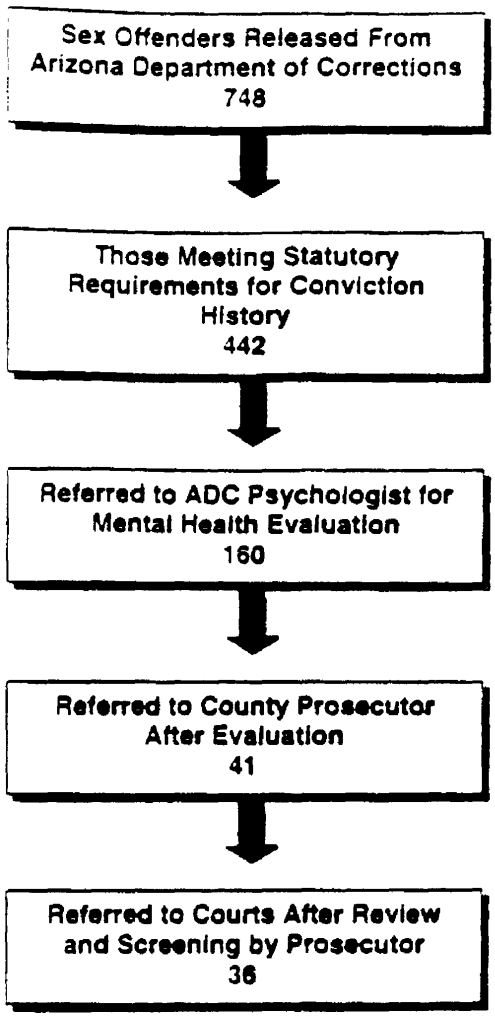
WSIPP 1998

FIGURE 3: CALIFORNIA SEX OFFENDER COMMITMENT PROGRAM (SOCP) ALL CASES AS OF AUGUST 31, 1998



Source: California's Department of Mental Health.
*One case with a positive clinical evaluation was not referred to the District Attorney.

FIGURE 2: ARIZONA SEXUALLY VIOLENT PERSON ACT: CASE DECISIONS, AUGUST 1997 – MAY 1998



Source: Arizona Department of Health Services.

APPENDIX C

STATEMENT OF POLICIES ON THE TREATMENT OF SEXUALLY VIOLENT PERPETRATORS

BY THE

ASSOCIATION FOR THE TREATMENT OF SEX ABUSERS

REDUCING SEXUAL ABUSE THROUGH TREATMENT AND INTERVENTION WITH ABUSERS

Adopted by the ATSA Executive Board on November 6, 1996

The serious harm caused by sex offenders underscores the significant need to develop methods of reducing the risks those offenders pose to society. The membership of the Association for the Treatment of Sexual Abusers (ATSA) is committed to developing strategies to eradicate sexual abuse while increasing the protection of the public. The following statement defines the role of treatment in society's management of sex offenders.

Who is included in the category of sex offenders?

It is important to understand that sex offenders are not all the same and, in fact, this heterogeneous group of individuals includes a tremendous variety in age, psychological profile, and history of offending. The vast majority of offenders are male. Studies indicate approximately eighty percent of sex offenses against children are committed by males and approximately twenty percent are committed by females.

Many people's awareness of sex offenders has been formed by media descriptions of the most serious offenders, frequently offenders who also murdered their victims. Certainly these offenders have committed very heinous acts and merit society's attention and censure; however, it is important to realize that this type of offender does not represent the typical sex offender.

Based on surveys from the general population, the offender is known to the victim or famil eighty to ninety-five percent of the cases. The offenders are family members I less than fifty percent of all occurrences and are identified as acquaintances (neighbors, coaches, teachers, religious leaders) in the remaining cases. Adults are the identified abusers in two-thirds of the assaults, the remaining one-third of abusers are under the age of eighteen years.

Sex offenders differ greatly in terms of their level of impulsiveness, persistence, and the risks they pose to the pubic and their desire to change their behavior. Most people recognize the significant differences between a violent rapist with four identified victims and a teenager who has sexually abused a neighborhood child. Effective public policy needs to be cognizant of the differences among offenders rather than applying a "one size fits all" approach.

How frequently do sex offenders re-offend?

Many people ask this question with the expectation that there is a typical re-offense rate for sex offenders and, based on many media reports, expect the answer to be somewhere between eighty and ninety percent. Because sex offenders are not a homogeneous group, generalizing a single re-offense rate is misleading and inaccurate. Rather, it is more accurate to examine re-offense patterns for the different categories of sex offenders. At present, the research literature indicates that re-offense rates for untreated sex offenders, who choose victims from within the family unit, range from between four and ten percent. Re-offense rates for untreated sex offenders, who

primarily target children, range from ten to forty percent and rates for untreated sex offenders who target adult women range from seven to thirty-five percent.

What role does treatment play in the management of sex offenders?

Often, the anger and hostility the public feels about sex offenders decreases the possibility of supporting treatment for sex offenders. Most often sex offender treatment is viewed as a "soft" response that minimizes the harm the offender has caused.

The Association for the Treatment of Sexual Abusers supports the position that treatment of sex offenders does not replace a criminal justice response, but rather is one of several tools society can use in designing effective sentences for offenders. Treatment can be combined with other criminal justice responses such as probation, jail, incarceration, as well as community monitoring and supervision. The purpose of treatment and the manner in which treatments instituted can vary. When treatment is an option, prosecutors have more alternatives when convictions may be difficult to obtain.

Treatment is a powerful component in the prevention of future sex offenses. Prevention can be better addressed as offenders identify the means of accessing victims and the behaviors antecedent to their sexual acting out. As this information is provided to the treatment personnel, the offender's risk level to potentially re-offend can be closely monitored. Also, treatment providers garner a growing body of knowledge regarding the cognitive and behavior patterns exhibited by sex offenders, which can then be incorporated into education and prevention programs.

What kind of treatment is effective with sex offenders?

Treatment for sex offending is still a developing field. Because sex offenses were kept hidden for so many years, the topic did not receive priority attention for funding. However, sufficient progress has been made allowing for the identification of strong indicators about the treatment approaches most likely to be successful.

The core approach used in many programs is cognitive-behavioral, which utilizes a relapse prevention model. The goal of this approach is to enable the offender to understand their behavior, take responsibility for the behavior, increase motivation to change their harmful behavior and learn the skills necessary to control their deviancy. With training in relapse prevention techniques, offenders learn to identify the chain of thoughts and behaviors that, if uninterrupted, could culminate in the commission of a sex offense. In addition to learning to identify the chain, the offender masters alternative non-harmful techniques to intervene and stop the progression of behaviors.

Where should treatment occur?

Treatment can occur in a variety of settings and at various stages in the criminal justice system. Some states have sentencing options combining a probation sentence, which may or may not include confinement, with community based outpatient treatment. The offender is supervised by

corrections' personnel during the mandated treatment and if the offender does not satisfactory progress, or is not adhering to the treatment plan, the case may be returned to court, reviewed by the Judge and a prison sentence imposed. Thus, treatment is offered to the offender and if sufficient progress is not attained, incarceration remains an option. In some states, treatment programs are offered to prison inmates. Following the prison term, a correctional officer supervises and monitors the individual in the community. This post-prison monitoring is an important part of the total treatment program.

What are the costs of treatment?

Treatment costs vary greatly depending on the treatment setting, intensity, and duration. In most cases, the offender is required to cover the cost of the court mandated treatment program, but the government pays for correctional supervision and court time. The costs of prison sentences, even though they include a treatment program, are covered by the state. One study estimated that providing treatment to incarcerated sex offenders increased the cost of the sentence by twenty percent. To the extent that treatment can reduce recidivism and prevent new offenses, this is a wise investment of public resources – especially when considering the tremendous price paid by each victim of sexual abuse.

Is treatment sufficient to reduce a sex offender's risk to the community?

Because offenders represent a heterogeneous group, some offenders will respond well to treatment interventions and other will not take advantage of the treatment concepts presented. A formal risk assessment conducted by a qualified professional offer the best method of estima the risk posed by a particular sex offender. An appropriate assessment incorporates a review the offender's history, clinical impressions, as well as risk prediction testing utilizing test that have research validity.

Risk reduction can be objectively measured by conducting longitudinal studies of offenders and identifying their rates of re-offending. An effective treatment program should be able to reduce the recidivism of its participants, compared to similar offenders who did not receive treatment. One review of studies published primarily before the 1980's raised questions about the effectiveness of treatment. Studies conducted since that time have examined programs using more "state-of-the-art" treatment techniques and results are indicative of some reduction in recidivism for the groups of offenders receiving treatment.

Where do we go from here?

The Association for the Treatment of Sexual Abusers is committed to decreasing sexual abuse and increasing public safety. Sex offender treatment is seen as a valuable tool to use in addressing that commitment. Our knowledge about sex offender, as well as how to best decrease the occurrence of sexual offending has progressed greatly in recent years. Unfortunately the definitive answers are still out of reach. It is only through continued research and treatment of sex offenders that we can understand the etiology of sexual offending and eliminate sexual abuse of children and adults.

CIVIL COMMITMENT OF SEXUALLY VIOLENT OFFENDERS

Adopted by the ATSA Executive Board on November 6, 1997

Beginning in 1990 some states enacted legislation which established procedures for the civil commitment of persons who, due to a mental abnormality or a personality disorder, are likely to engage in predatory acts of sexual violence. Considerable disagreement, both clinically and legally, resulted, due to the fact that these commitments typically were initiated at the end of an offender's prison term. Ultimately, after several lower court rulings, the U.S. Supreme court heard *Hendricks v. Kansas* petition in December 1966. In a majority decision on June 23, 1997, the Court upheld the Kansas statute.

The Kansas case is a landmark decision in that its statue is similar to the statues developed in other states. While this decision may not answer all the issues raised regarding the civil commitment of sexually violent offenders, for the present, the Court's decision has allowed states with such statutes to continue to use them. Further, it is highly likely that other states will consider similar legislation in the future.

Given the recent Supreme Court decision to uphold the statues, we believe there are a number of key policy issues that State legislators will face once a decision is made to pursue a civil commitment law. The Association for the Treatment of Sexual Abusers does not take a position either in support of, or in opposition to, such laws but dies have strong recommendations regarding their effective implementation.

First, the criteria for determining who is a "sexually violent offender" should be based on the best available scientific knowledge, including the use of validated risk assessments. Second, those professionals performing the evaluations and making the determinations should be highly qualified and experienced in the evaluation and treatment of sex offenders and follow established ethical guidelines.[1]

Third, the State must commit itself to fully funding the law. The program should be housed in a treatment-oriented facility that is similar to other settings for persons who are civilly committed in the state. Because these laws have arisen out of a genuine concern of the public for the safety of future victims and the community, programs should be developed and located where they can provide the greatest degree of security while the offender is being treated. Staff in the commitment facility should be qualified and appropriately licensed. Oversight should be provided by both an internal review process and external body either through a licensing organization or another entity.

The treatment program should be consistent with current institutional standards for the treatment of sexual offenders and include all the components recognized as necessary for maximum treatment potential. Individualized treatment plans are critical and should provide

[1] Specific information regarding current guidelines for professionals in the field of sexual offending and additional resources can be obtained from the Association for the Treatment of Sexual Abusers.

for systematic measurements of the individual's progress. The program should be structu with identifiable phas3es so individuals can mark their progress in treatment.

Those who successfully complete the inpatient phase of treatment and whose risk is considered manageable in the community should be moved into a conditional release program that includes monitoring and supervision, as well as continued community-based treatment.

Finally, it should be recognized that laws allowing the commitment of sexually violent offenders need to be utilized judiciously. That is, they were designed to address problems related to a very specific group of the most serious, chronic sex offenders whose risk to other has not been reduced by prior treatment or other mitigating factors.

ANTI-ANDROGEN THERAPY AND SURGICAL CASTRATION

Adopted by the ATSA Executive Board on February 7, 1997

Utilizing hormonal agents, anti-androgens and surgical castration in the management of sexual abusers continues to be an area of concern and attention for many including researchers, clinicians, program administrators, legislators, and sexual abusers, victims of sexual abuse, as well as the general public. The Association for the Treatment of Sexual Abusers holds that:

1. Organic treatments have been used to reduce the sexual drive of some sexually aggressive males and other paraphiliacs whose inability to control their behavior leads to repeated occurrences of sexually deviant behavior.

2. The role of sexual motivation varies among abusers; therefore, the reduction of sexual drive would be of limited usefulness for some abusers.

3. Anti-androgen therapy should be prescribed by a physician only after an extensive offense specific evaluation has been completed.

4. Not all abusers are the same and anti-androgen therapy is not appropriate for use with all sexual abusers. It is important to develop ordered and reasonable criteria based on diagnosis, history, motivation, and risk when prescribing this medical intervention.

5. Anti-androgen medications carry some medical risk; therefore, the treatment should only be administered under ongoing medical supervision.

6. Anti-androgen treatment should be coupled with appropriate monitoring and counseling within a comprehensive treatment plan. An abuser should be involved in concurrent cognitive-behavioral treatment designed to address other aspects of the deviant behavior in

addition to sexual interests. These medications should never be used as a sole method of treatment.

7. As win any treatment intervention, appropriate informed consent must be obtained when anti-androgen therapy is implemented.

8. The effect of surgical castration is to reduce the availability of androgen by removing the testes where approximately 95% of testosterone are produced. Altho8gh it seems reasonable and has, in fact, been shown that surgical castration may reduce paraphiliac fantasies and behaviors, there are alternative and less invasive treatments available.

9. ATSA is opposed to surgical castration procedures based on the availability of anti-androgen medications, which can achieve the same, if not better, results.

10. A substantial percentage of surgical castrates retain sexual functioning. Even if an abuser's capacity to have an erection or ejaculate is permanently inhibited, the act of sexual aggression many times involves more than the use of the penis and those behaviors would not be affected.

11. Replacement androgens can be obtained after the surgical castration procedure, taken as a supplement to restore testosterone to pre-castration levels, thus nullifying the effects of the surgical castration.

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