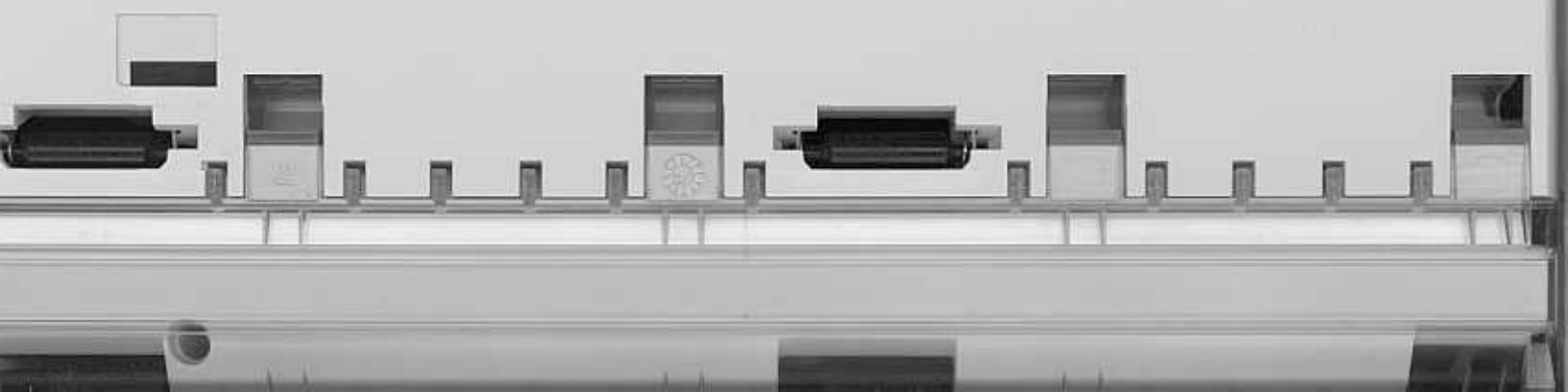


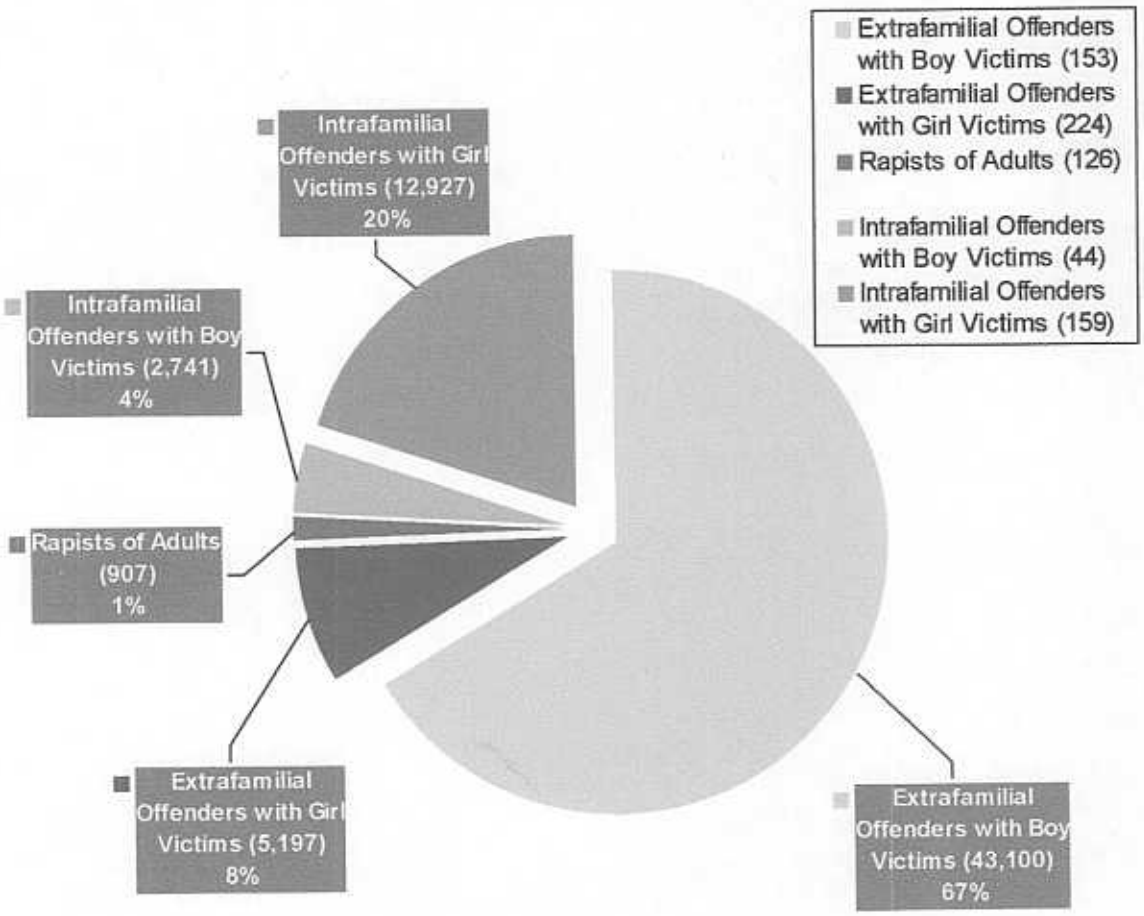
SEXUALLY VIOLENT PREDATOR ACT
REVIEW COMMITTEE

EXECUTIVE SUMMARY

Your committee reviewing the Sexually Violent Predator (SVP) Act concludes that now more than ever the State of South Carolina must continue its efforts to prevent sexually violent individuals from re-offending following their release from prison.

The risk of re-offense which sex offenders pose is well researched. The magnitude of the risk is dramatically illustrated by the following chart showing the results of a study of 561 incarcerated sex offenders.

561 Sex Offenders
64,872 Victims



Abel, et al. (1987) By the offenders own admission, they had a combined total of 64,872 victims, or an average of 115 victims each, though most had only two (2) or three (3) criminal convictions. Other researchers have reported similar results.

The dedicated efforts of staff of the Department of Mental Health and the Department of Corrections, in the face of extreme adversity and ever declining fiscal support, have brought about the development of an adequate and secure treatment program for committed sexually violent predators, but these agencies are rightfully concerned about future needs for program space and staff. The committee believes that funding for increased program space and staff should be identified.

The committee also believes that, to ensure public safety, the current civil commitment law should be utilized for those perpetrators who are, in fact, mentally ill and still present a propensity to re-offend, perhaps not at the level of concern as those currently committed Sexually Violent Predators (SVPs). These individuals are considered by forensic psychiatrists to be a mid-level risk while the other incarcerated SVPs, often referred to as "the worst of the worst," present the greatest threat.

This mid-level group is thought to be mentally ill, and may be at risk to harm themselves or others. This is in the basic criteria for persons processed through the probate court. Your committee actively pursued this avenue, which may also relieve some of the requirement for those incarcerated who may be of borderline concern, but may be helped through intensive out-patient treatment and careful monitoring. This would offer certain economies of scale during these fiscally sparse times. However, the Committee also understands that treatment is not successful in all cases and research indicates that even among offenders who receive treatment a significant number do re-offend.

Support of personnel in Senate finance, judiciary, and Attorney General's office and the SC Victims Assistance Program has been vital and outstanding during the review process.

The recommendations of the Committee include continued implementation of the current law, adding the offense of ABHAN to the list of sexually violent offenses when the assault is sexual in nature, continuing to appropriate the necessary funding for providing the committed persons constitutionally adequate treatment, appropriating the necessary funding for expanding the current treatment facility before it exceeds its capacity (considered to be well within the grasp of the General Assembly), and to begin to utilize the existing civil commitment statutes to address the group of offenders being released who are mentally ill and who pose some risk of re-offense. This latter approach would contribute to preventing an untold number of sexual assaults, particularly child molestation.

Introduction

The committee was created to review the Sexually Violent Predator Act pursuant to Proviso-72.96, GP: Sexual Predator Treatment Program. (**Appendix A**). The Committee was to review the status of the Sexually Violent Predator (SVP) law, evaluate its effectiveness and determine short and long range plans to implement its aspects and in all actuality to ensure the best possible way to protect the public with attendant costs. This study was extremely comprehensive encompassing principal issues, i.e., threats to the public, constitutionality, treatment, and housing (both location and cost). Areas that may require legislative and policy changes for the sake of community safety were identified.

The committee, 10 members (**Appendix B**), met four (4) times during which experts in the legal and medical fields offered insights to the most complex issues. (**Appendices D, E, F, I, J**) Matters regarding public safety, civil commitment, treatment, and housing were explored in great detail. (**Appendices G, H, K, L, M, N**) Support must be acknowledged specifically to the SCVAN personnel and forensic psychiatrists/psychologists who enabled your committee to identify the far reaching detrimental effects sexual predators have had and may continue to have on the community – particularly with respect to children.

Findings

It is not unusual for a perpetrator, while not convicted of more than one or two sexual crimes, to have sexually assaulted over 100 or more children. Such persons may be expected, if not treated, to sexually assault a like number upon release. Some psychiatrists estimate that one perpetrator may have sexually assaulted 250 or more children. This is a staggering number which in itself dictates the need for the continuation of the SVP Act, its expansion and necessary funding support. Funds are required for treatment and the establishment of a larger facility to house SVPs for the long term. It should be noted that DMH and DOC have defied the national average with each committed SVP costing $46,000 annually while other SVP involved states (16) list expenses for SVPs anywhere from $55,000 to $120,000 per year. (**Appendices G, J**)

Changes to the Law

It was revealed that the SVP law concentrates on "the worst of the worst" or the top tier of those with mental abnormalities likely to re-offend. However, according to psychiatrists, a second tier of convicted sex offenders with mental illnesses exists who, upon release, may still be at significant risk to re-offend. These individuals do not meet the law's criteria of "likely to re-offend" and so are not being monitored/treated. This group, many of whom have sexually assaulted multiple victims, clearly require review and control and would be appropriate for the civil commitment procedures available through the probate court. This may be accomplished under existing laws, with involvement by the probate court. The availability of civil outpatient treatment for mid-level perpetrators would enable psychiatrists to refer these moderate risk individuals into such programs.

Similarly, it would appear that sentencing judges, while determining periods of incarceration of sexual perpetrators, need to also routinely address probation and treatment after release. Such an approach would cause a decline in recidivism and therefore give added protection for the public. Proper transition back into the community is vital and affords a measure of prevention not heretofore fully considered. Judges

should be requested to flag appropriate Assault and Battery of a High and Aggravated Nature (ABHAN) convictions to require SVPA review prior to release.

When introduced in the context of a sex crime ABHAN should be made a part of the list of crimes set forth in the SVP law. (**Appendix C**) The courts should also have an option to impose a sentence in excess of 20 years for any sex crime against children under the age of 12, including sexual exploitation of a child.

The law should increase the period of probation for those convicted of crimes against children and require their mandatory treatment as a condition of probation.

Treatment Issues

The actual result of appropriate treatment of sex offenders is somewhat difficult to study, but research suggests it is effective for some offenders. (**Appendix E**) The actual rate of re-offense of sex offenders will never be truly known due to the difficulty of discovering sex crimes. Most studies utilize arrest or conviction data, and when comparing treated and un-treated sex offenders, research indicates offenders who have received treatment consistently have less recidivism than those offenders who did not. Psychosocial treatment alone shows a 25% reduction in recidivism over a 5 year period. Combined medication and psychosocial treatment reduces recidivism between 30% - 60% below untreated sex offenders.

Treatment Recommendations

1. Allocate funding to provide presentencing forensic psychiatric evaluation for all sex offenders.
2. Provide treatment for sex offenders while in prison.
3. Require providers to be certified as knowledgeable in the field of sex offender treatment, as well as being either licensed physicians or mental health professionals. The certification process should be developed with oversight by the DMH.

Just before the Committee's final meeting, the importance of South Carolina continuing its efforts to prevent sexually violent offenders from re-offending was highlighted by the release of a new study. (**Appendix N**) According to forensic psychiatrists/psychologists, the new research findings from Canada convincingly show that convicted sex offenders will almost all eventually re-offend after release from prison unless they participate in sex offender treatment.

The Committee's full set of recommendations are attached as **Appendix O**.

Respectfully submitted,

January 12th, 2005

Honorable Jack I. Guedalia, Chair

Attachments

APPENDICES

Sexually Violent Review Act Committee Final Report

A. Authorizing Legislation

B. Membership List

C. Proposed SVPA amendments

D. Presentation by Dr. Pam Crawford, M.D., DMH

E. Presentation by Dr. Margaret Melikian, D.O., Forensic Psychiatry, Medical University of South Carolina (MUSC)

F. Presentation by Dr. William Burke, Ph.D., practitioner in treatment of sex offenders

G. Presentation by Brenda Hartt, SC Senate Finance Committee

H. Presentation by SCVAN re: all states

I. Presentation by Debbie Shupe, Esquire, Assistant Attorney General, SC Attorney General's Office re: sex offenders, numbers, screened, processed, civilly incarcerated

J. Presentation by Mark Binkley, Esquire, General Counsel, SC Department of Mental Health

K. Department of Mental Health facility construction cost projections for future space requirements

L. Department of Mental Health staffing cost projections for future staffing requirements

M. Miscellaneous Informative Issues, including self reported contact sexual offenses by participants in the Federal Bureau of Prisons

N. New study on re-offense rates of untreated sex offenders

O. Recommendations for the General Assembly

APPENDIX A

Authorizing Legislation

72.96. (GP: Sexual Predator Treatment Program) From the funds appropriated for the Sexual Predator Treatment Program to the Department of Mental Health a committee is established to review the Sexually Violent Predator Act and make a report and recommendations to the General Assembly. The committee shall review the experience to date under the act, including the referral, review, and commitment process, the treatment program and its location and the costs associated with the act, including the cost of treatment for committed persons. The committee also shall study the future operating costs and capital needs of the treatment program. The committee shall make recommendations for improvements, including recommendations which address the budgetary and capital needs of the treatment program for the committed persons. The committee must be comprised of: the Governor or his designee, the Director of the Department of Mental Health or his designee, the Director of the Department of Corrections or his designee, the Attorney General or his designee, three members appointed by the Speaker of the House of Representatives and three members appointed by the President Pro Tempore of the Senate. The committee must be chaired by the Governor, or his designee. The committee shall submit its report to the Senate Judiciary Committee and the House Judiciary Committee before January 16, 2005.

APPENDIX B

Membership List

Committee to Review the Sexually Violent Predators Act (SVPA)
Proviso List of Members

1. Governor's designee:
   Hon. Jack I. Guedalia, Associate Judge of Probate, Chairman

2. The Hon. Mike Fair, Senator, Greenville

3. The Hon. Jim Ritchie, Senator, Spartanburg

4. The Hon. Yancy McGill, Senator, Kingstree

5. The Hon. Becky Martin, Representative, Anderson

6. The Hon. Seth Whipper, Representative, North Charleston

7. The Hon. Gloria Haskins, Representative, Greenville

8. George Gintoli, State Director
   SC Department of Mental Health
   alt: Mark W. Binkley, General Counsel

9. Henry McMaster, Attorney General
   alt: Deborah R. J. Shupe
   Assistant Attorney General

10.. Jon Ozmint, Director
   South Carolina Department of Corrections
   alt: David Tatarsky, General Counsel

APPENDIX C

Proposed SVPA Amendments

A BILL

TO AMEND THE CODE OF LAWS OF SOUTH CAROLINA, 1976, BY AMENDING SECTION 44-48-30, AS AMENDED, TO ADD ASSAULT AND BATTERY OF A HIGH AND AGGRAVATED NATURE TO THE LIST OF SEXUALLY VIOENT OFFENSES WHEN THE ASSAULT IS SEXUAL IN NATURE.

Be it enacted by the General Assembly of the State of South Carolina:

SECTION 1. Chapter 48 of Title 44 of the 1976 Code is amended to read:

SECTION 44-48-30. Definitions.

For purposes of this chapter:

(1) "Sexually violent predator" means a person who:

(a) has been convicted of a sexually violent offense; and

(b) suffers from a mental abnormality or personality disorder that makes the person likely to engage in acts of sexual violence if not confined in a secure facility for long-term control, care, and treatment.

(2) "Sexually violent offense" means:

(a) criminal sexual conduct in the first degree, as provided in Section 16-3-652;

(b) criminal sexual conduct in the second degree, as provided in Section 16-3-653;

(c) criminal sexual conduct in the third degree, as provided in Section 16-3-654;

(d) criminal sexual conduct with minors in the first degree, as provided in Section 16-3-655(1);

(e) criminal sexual conduct with minors in the second degree, as provided in Section 16-3-655(2) and (3);

(f) engaging a child for a sexual performance, as provided in Section 16-3-810;

(g) producing, directing, or promoting sexual performance by a child, as provided in Section 16-3-820;

(h) assault with intent to commit criminal sexual conduct, as provided in Section 16-3-656;

(i) incest, as provided in Section 16-15-20;

(j) buggery, as provided in Section 16-15-120;

(k) committing or attempting lewd act upon child under sixteen, as provided in Section 16-15-140;

(l) violations of Article 3, Chapter 15 of Title 16 involving a minor when the violations are felonies;

(m) accessory before the fact to commit an offense enumerated in this item and as provided for in Section 16-1-40;

(n) assault and battery of a high and aggravated nature if, based on the circumstances of the case, the assault was a sexual offense;

(~~n~~o) attempt to commit an offense enumerated in this item as provided by Section 16-1-80; ~~or~~

(~~o~~p) any offense for which the judge makes a specific finding on the record that based on the circumstances of the case, the person's offense should be considered a sexually violent offense~~.~~ ; or

(~~p~~q) criminal solicitation of a minor, as provided in Section 16-15-342, if the purpose or intent of the solicitation or attempted solicitation was to:

(i) persuade, induce, entice, or coerce the person solicited to engage or participate in sexual activity as defined in Section 16-15-375(5); or

(ii) perform a sexual activity in the presence of the person solicited.

(3) "Mental abnormality" means a mental condition affecting a person's emotional or volitional capacity that predisposes the person to commit sexually violent offenses.

(4) "Sexually motivated" means that one of the purposes for which the person committed the crime was for the purpose of the person's sexual gratification.

(5) "Agency with jurisdiction" means that agency which, upon lawful order or authority, releases a person serving a sentence or term of confinement and includes the South Carolina Department

of Corrections, the South Carolina Department of Probation, Parole and Pardon Services, the Board of Probation, Parole and Pardon Services, the Department of Juvenile Justice, the Juvenile Parole Board, and the Department of Mental Health.

(6) "Convicted of a sexually violent offense" means a person has:

(a) pled guilty to, pled nolo contendere to, or been convicted of a sexually violent offense;

(b) been adjudicated delinquent as a result of the commission of a sexually violent offense;

(c) been charged but determined to be incompetent to stand trial for a sexually violent offense;

(d) been found not guilty by reason of insanity of a sexually violent offense; or

(e) been found guilty but mentally ill of a sexually violent offense.

(7) "Court" means the court of common pleas.

(8) "Total confinement" means incarceration in a secure state or local correctional facility and does not mean any type of community supervision.

(9) "Likely to engage in acts of sexual violence" means the person's propensity to commit acts of sexual violence is of such a degree as to pose a menace to the health and safety of others.

(10) "Person" means an individual who is a potential or actual subject of proceedings under this act and includes a child under seventeen years of age.

(11) "Victim" means an individual registered with the agency of jurisdiction as a victim or as an intervenor.

(12) "Intervenor" means an individual, other than a law enforcement officer performing his ordinary duties, who provides aid to another individual who is not acting recklessly, in order to prevent the commission of a crime or to lawfully apprehend an individual reasonably suspected of having committed a crime.

APPENDIX D

Presentation by Dr. Pam Crawford, M.D.
SC Department of Mental Health

APPENDIX D

Summary of Testimony of Pamela Crawford, M.D.

I work for the Department of Mental Health. I am a forensic psychiatrist, and for the past two and one-half years, I have been assigned by the Department to conduct the pre-commitment evaluations pursuant to §44-48-80(D), of the Act.

OUTPATIENT COMMITMENT TREATMENT OPTION FOR SEX OFFENDERS:

As a result of my experience, I have found the individuals who I evaluate following the probable cause stage of the commitment process fall into three general groups.

There is one group that clearly meets the standard for commitment as outlined by the Act. These are people who, in the opinion of this evaluator, have a mental abnormality and/or a personality disorder to such a degree that their disorder makes them likely to re-offend if not confined to the Behavioral Disorders Treatment Program of the South Carolina Department of Mental for treatment.

The second group of individuals evaluated clearly does not, in the opinion of this evaluator, have a mental disorder and/or personality disorder that make it likely that they will reoffend. This group of individuals is not referred for commitment.

The third group of offenders presents considerable difficulty from a clinical standpoint. This group has evidence of a significant mental disorder and/or personality disorder but I can not determine with a reasonable degree of medical certainty that they are likely to re-offend if not committed to a secure facility, pursuant to the SVP Act. Often, these offenders are in need of treatment and do in fact present some risk of reoffending without this treatment. They, however, cannot be said to be "likely" to reoffend. There is no provision in the Act for the mandatory treatment of these individuals either on an inpatient or outpatient basis.

Many of the individuals who fall in the third group could conceivably be ordered into psychiatric treatment by the Probate Court using the existing South Carolina civil commitment statutes. People with mental illnesses (specifically, paraphilias) that predispose them to offending sexually have traditionally not been viewed by most mental health professionals as appropriate for commitment, and are therefore generally not committed by the probate court for treatment in a mental health facility of the South Carolina Department of Mental Health. In large part this is because there is no outpatient sex offender treatment program or inpatient sex offender treatment program (other than the Behavioral Disorders Treatment Program) available through DMH.

While developing public sex offender treatment programs may be a costly endeavor, it is important to consider establishing them, both for the benefit of the individuals

who suffer with these disorders and for the potential victims of these people who, if left untreated and unmonitored, present some ongoing risk of re-offending.

TREATMENT FOR SEX OFFENDERS IN THE SOUTH CAROLINA DEPARTMENT OF CORRECTIONS:

Treatment for sex offenders has been virtually eliminated in the Department of Corrections. Up until January of 2004, the Department of Corrections had in place a very small but effective treatment program for sex offenders. This program could only serve a fraction of those inmates in need of treatment, however, those it did serve benefited greatly. In addition to providing needed treatment, this treatment program provided vital information regarding inmates who had participated in the program for me and the other individuals who under the Act participate in the evaluation of sex offenders being released from the Department of Corrections.

This former DoC program was rigorous and only those inmates who were actively participating in treatment and showing substantial progress could complete the program. For those that did not complete the program, there was detailed information available to the psychiatrists performing SVP evaluations as to diagnosis, motivation for treatment and potential risks if not committed for long-term treatment. This information was essential in a number of cases to making a determination of whether someone is likely to re-offend. In some cases, the inmate's records from this treatment program were the most significant factor in whether or not the person was recommended for commitment. Information from this treatment program was used routinely in Sexually Violent Predator Act commitment proceedings.

When the evaluating psychiatrist does not have this kind of information, decisions are very difficult to make. Often, there are offenders referred for evaluation that have served 15 to 20 years in prison for serious sex offenses including child molestation and serial rape and have never received or, in some cases, never even been offered sex offender treatment. This gives the psychiatrist conducting these evaluations very little recent relevant data to go on in forming an opinion regarding risk. In the majority of cases, the psychiatrist is forced to render an opinion without the benefit of this information.

When the psychiatrist recommends an offender for commitment, the psychiatrist must then testify to a jury about their opinion and must testify about the basis for their opinion. The credibility of the psychiatrist's opinion is uniformly called into question when the psychiatrist does not have any data regarding issues that deal with sexual deviance while incarcerated.

For example, in recent SVP trials, juries were presented with the argument by attorneys for the offenders that the State of South Carolina had years to evaluate and treat the offender but elected not to until after they had finished their prison sentences. In the face of such arguments, and without evidence of attempts at treatment during incarceration, Courts and juries may conclude that the State has not

met its high burden of proving the person is likely to re-offend. This ultimately presents serious safety issues.

APPENDIX E

Presentation by Dr. Margaret Melikian, D.O.
MUSC


Sexually Violent Predators

Richard L. Frierson, M.D.
Associate Professor of Clinical Neuropsychiatry
Director, Forensic Psychiatry Fellowship
University of South Carolina

Sexual Abuse of Children in the United States

- 75% of committed sex offenders in the U.S. victimized children
- 17% of girls < 18 years and 6% of boys are estimated to be victims of sexual abuse (self report); a major public health problem
- Number of sexually abused children rose 125% from 1986-1993
- Offenders are parents (25%), acquaintances (50%), family members (12%) and strangers (13%)

SVP Landmark Cases

- *Kansas v. Hendricks* (1997): U.S. Supreme Court declares SVP law constitutional, focuses on civil commitment, not incarceration
- *Kansas v. Crane* (2002): U.S. Supreme Court requires proof of serious difficulty in controlling behavior

South Carolina's Sexually Violent Predator Act

- Act defines Sexually Violent Predator as :

1) convicted of sexually violent offense
2) mental abnormality or personality disorder that makes a person likely to engage in acts of sexual violence if not confined to a secure facility for long-term control, care, and treatment

SVP law (cont'd)

- Sexually violent offense = CSC 1, 2, 3, CSC with minor 1, 2, engaging a child in sexual performance, producing or promoting performance by a child, assault with intent to commit CSC, incest, buggary, lewd act on a child, any offense which judge declares a sexually violent offense

"Convicted" Means:

- Pled *guilty* or *no contest*
- Found guilty at jury trial
- Adjudicated delinquent
- Charged but determined incompetent to stand trial
- Found Not Guilty by Reason of Insanity
- Found Guilty but Mentally Ill

SVP Step 1

- Multidisciplinary team: DOC; Probation, Pardon, and Parole; DMH; retired judge; Chief Attorney from office of Appellate Defense
- Reviews records
- Decides if person is a Sexually Violent Predator

SVP Step 2

- Prosecutor's Review Committee
- Determines if probable cause exists
- Schedules hearing regarding probable cause
- After hearing, person may be taken into custody

SVP Step 3

- Evaluation by Court Expert: appointed by DMH
- Person may request jury trial
- Person may request defense expert
- Beyond a reasonable doubt standard used at hearing
- If Incompetent to Stand Trial, fact finding hearing must be held first to see if sexual offense committed

Release of SVP

- May request hearing yearly
- Court of Common Pleas retains jurisdiction
- If released, must register yearly
- Constitutional requirement for care and treatment while hospitalized

SVP in South Carolina

- A diverse group (persons with paraphilias, schizophrenia, mental retardation, antisocial personality disorder); presents unique problems to treatment given variety of treatments needed
- Many are treatable, some are probably not

Paraphilia

- A disorder characterized by recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving:
  1) nonhuman objects
  2) the suffering or humiliation of oneself or one's partner
  3) children or non-consenting persons

  May be exclusive or nonexclusive

Paraphilias

- Exhibitionism
- Fetishism
- Pedophilia
- Sexual Masochism
- Sexual Sadism
- Transvestic Fetishism
- Voyeurism
- NOS

Crossover exists in these disorders

Pedophilia

- For at least 6 months, recurrent sexually arousing fantasies, sexual urges, or behaviors involving sexual activity with a prepubescent child (generally 13 years of age or younger)
- Person has acted on urges, or they cause marked distress or interpersonal difficulty
- Person is at least 16 years and at least 5 years older than victim
- Not all child molesters are pedophiles, not all pedophiles are child molesters

Risk Factors and Associated Findings

- Victim of sexual abuse as a child
- Elevated plasma epinephrine and norepinephrine levels, reduced brain serotonin activity
- Pituitary (endocrine) abnormalities
- Depression and anxiety disorders, especially obsessive compulsive disorder (OCD), and Tourette's Disorder

Assessment

- Complete medical, psychiatric, family, social, and psychosexual history as well as mental status examination
- Review of police reports, victim statements
- Labs: Sex hormone profile
- Penile plethysmography (PPG)
- Abel Screening Examination

Treatment principles

- Although a person with pedophilia is not at fault for having this psychiatric disorder, he or she has the social and moral responsibility for controlling its expression
- Treatment is aimed at controlling behaviors rather than reconditioning the sexual drive
- Goal of treatment: stop the sexual abuse of children
- Like schizophrenia, treatment must be life long

Biological Treatment

- SSRI's: sertraline (Zoloft®), fluoxetine (Prozac®), and fluvoxamine (Luvox®), have reduced paraphilic symptoms (response rate 50%)
- Hormonal Agents: medroxyprogesterone acetate (Provera®), leuprolide (Lupron®) reduce sexual arousal and behavior (additional 18%)
- Surgical Castration: Texas (involuntary); California, Florida, Iowa, Louisiana (voluntary), unconstitutional in S.C.

Hormonal Therapy Side Effects

- Depression
- Feminization
- Hypertension
- Diabetes
- Weight gain
- Osteoporosis

Psychosocial Treatment

- Group therapy: confrontation techniques with similar offenders targeting denial
- Cognitive behavioral therapy targeting distorted beliefs (i.e. way to teach children about sexuality, etc.)
- Social skills training to promote healthy adult relationships

Untreated Pedophilia Recidivism

- Biological children as victim: 19%
- Extended family as victim: 40%
- Acquaintance was victim: 36%
- Stranger was victim: 45%

- Overall rate about 30-36%

Results of Treatment

- Actual recidivism rates unknown due to non-reporting of these crimes
- Psychosocial treatment alone: 25% reduction in recidivism over 5 year period
- Most studies suggest combined biological/psychosocial treatment reduces long term recidivism by at least 30%-60% (down to 14%)
- Castration reduces 20 year recidivism to 2.3% compared to 80%
- Similar study results of the antiandrogen cyproterone acetate in Canada (not available in US)

Cost Effectiveness

- Only study is from Australia (1998), program is cost effective after 6% reduction in recidivism rate
- Study showed that if recidivism rate could be reduced by 8%, then government would have a net benefit of $2580 (Australian) per offender. If rate could be reduced by 14%, government would have a net benefit of almost $40,000 per offender

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APPENDIX F

Presentation by Dr. William Burke, Ph.D.

The SVP Law:
Overview & Proposal

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Four Points

- The SVP Law: Issues to be addressed
- Assessment Standardization
- Treatment Standardization
- A new proposal

The SVP Law

- "***All or nothing***": Those who don't quite meet the criteria are still dangerous. There is only the dichotomy of choice.
- "***Absence of Motivation***": Those in the SVP facility believe they probably will never be released. Why comply with treatment?
- "***Absence of Follow-up***": The few that have been released are not required to participate in any type of outpatient care.

SVP Law Continued:

- "***Emotional Reactivity***": Juries and Judges have reacted emotionally to the testimony of offenders. They make decisions based on how old the offender looks and statements by the offender that he has been "healed by God."
- "***Critical Dependence on Initial Conditions***": Decisions are made based on expert testimony that is flawed and is some cases unethically presented.

SVP Law Continued:

- A need to recognize the dangerousness associated with non-contact sex offenses.
- A need to recognize that CSC charges pled down to ABHAN charges--in the current form--actually increases recidivism.
- A need to have ABHAN pleas counted toward the SVP Law's recognition of "the number of victims" or offenses.

Assessment Standardization

- Utilize the methodologies that valid research has determined to be the most accurate.
- Actuarial Scales and Physiologic Testing.
- A need for the standardization of assessments to be part of the SVP law.
- A need to certification of evaluators and treatment providers.

Treatment Standardization

- A need for Sex Offender Specific Probation & Parole Officers.
- A need for treatment standardization that includes the use of medication management, close community supervision, chaperone training, and polygraphy.
- The standardized treatment would be provided by certified clinicians.

A New Proposal

- Incorporate level of risk categories that correspond to level of intervention (addresses ***the all or nothing*** issue).
- Those deemed to be SVPs necessitating inpatient treatment will have a two year program that requires the completion of specific "treatment modules" in order to be released into the community.
- Failure to complete the treatment modules results in lifetime imprisonment without treatment (addresses ***motivation*** issue).

A New Proposal Continued:

- For those completing the inpatient treatment modules or those deemed in need of outpatient treatment, the utilization of a standardized treatment protocol provided by certified clinicians.
- The treatment protocal should include the use of medication management, Sex Offender Specific PPP agents, chaperone training, and polygraphy.

A New Proposal Continued:

- The offender should pay all or the majority of the cost of outpatient treatment.
- It may be prudent for the State to pay for the mediation and medication management.
- Outpatient treatment should include decision making criteria for determining the frequency of treatment attendance.
- A committee to address developing issues.

Cross Diagnosis by Paraphilia

Secondary Diagnosis

Primary Dx		Female nonincest pedophilia	Male nonincest pedophilia	Female incest pedophilia	Male incest pedophilia	Rape	Exhibitionism	Voyeurism	Frottage	Transvestism	Fetishism	Sadism	Masochism	Obscene phone calling	Public masturbation	Bestiality
Female nonincest pedophilia	%	100	22	30	7	10	18	14	7	2	5	1	2	5	2	7
Male nonincest pedophilia	%	37	100	5	13	3	12	10	5	4	2	5	3	0	1	3
Female incest pedophilia	%	19	5	100	6	10	10	7	3	5	3	3	1	1	1	4
Male incest pedophilia	%	27	32	32	100	18	8	18	9	3	12	3	0	3	3	9
Rape	%	17	2	5	0	100	11	14	6	2	1	9	0	5	4	4
Exhibitionism	%	13	8	12	3	14	100	27	17	5	4	3	3	3	10	4
Voyeurism	%	15	0	4	0	33	28	100	11	7	15	0	4	7	7	11
Frottage	%	14	0	1	0	14	17	14	100	0	11	8	0	6	0	6
Transvestism	%	5	5	0	0	0	5	15	0	100	20	0	1	5	5	10
Fetishism	%	17	8	8	8	8	8	8	8	33	100	17	33	0	17	0
Sadism	%	36	18	18	0	48	9	36	9	9	0	100	9	0	0	0
Masochism	%	8	0	0	0	15	15	23	8	15	8	23	100	0	0	23
Obscene phone calling	%	0	0	13	0	13	13	25	0	25	25	0	13	100	13	25
Public masturbation	%	18	6	12	0	12	28	41	12	6	18	12	0	6	100	12
Bestiality	%	33	17	17	17	0	0	50	0	33	33	0	33	33	0	100

From NIMH Research Grant. The Evaluation of Child Molesters 1981-85. Principal Investigator: Gene G. Abel, M.D.

ABEL SCREENING

Sex Offender Treatment Proposal for South Carolina

William Burke, Ph.D.
Southeastern Assessments
709 Trolley Road
Summerville, SC 29485
843-821-2480

Outline of Proposal

- What is needed regarding assessment.
- What is needed regarding treatment.
- Issues regarding treatment providers.
- Proposed resolution regarding treatment providers.
- Intensive Outpatient Programs VS Inpatient Programs.
- Formulation of Committee to Recommend Sanctions
- Who Pays?

Assessment Needs

- All should undergo:
- 1) Historical Polygraph
- 2) Penile Plethysmograph Study
- 3) Static 99
- 4) Abel Assessment
- 5) Hare Psychopathy Checklist-Revised
- 6) Structured Interview
- 7) More...

Outpatient Proposal *SEA* Can Provide:

- Standardization of Treatment State Wide
- Certification of Treatment Providers
- Continued Oversight of Treatment
- Polygraph Exams for All Offenders
- Specialized Training for PPP Agents & DSS Social Workers.

Standardization of Treatment

- Relapse Prevention
- Covert Sensitization
- Ammonia Aversion
- Masturbatory Satiation
- Chaperone Training
- Medication Management (*SEA* will contract with Gene Abel, M.D. to provide med. mgt. training to physicians).

Issues Regarding Treatment Providers

- It would take at least 12 to18 months of training to have a viable treatment force.
- There are currently many treatment providers in the state working with S/Os.
- The vast majority (more than 95%) are not providing treatment that meets the ATSA standards of care.
- You don't want to exclude the existing treatment providers.

Proposal to Effect Change in Sex Offender Treatment

- ***SEA*** would train existing providers and certify them to provide Relapse Prevention, Cognitive Behavioral, & Chaperone Treatment in a 48 hour course.
- ***SEA*** would provide oversight for compliance with the standards of care.
- Existing providers can continue to do what they have been doing in the past.

Effects of Outpatient Proposal

- All offenders will have an evaluation that meets the standards of care.
- All offenders will receive treatment that meets the standards of care.
- Existing treatment providers can continue to work with ***SEA*** augmented oversight.
- ***SEA*** provides medication management and ongoing polygraph services.

Formulation of a Committee

- Representatives of Victim Advocacy Groups
- Representative from Depart. of Mental Health.
- Representative and Liaison from Probation, Parole, & Pardon Services.
- Representatives from Area Outpatient Treatment Providers.
- Representative and Liaison from the Department of Social Services.
- Representatives from the Media.

Functions of the Committee

- To exchange ideas about improving community safety.
- To meet, discuss, & vote on the disposition of offenders that have been terminated from outpatient treatment.
- Address & Confront Treatment Providers Who Endanger the Community.
- Offender information would exclude offender name during discussion.

A Multi-systemic Approach

Systemic Needs:

- Each Local County Probation, Parole, & Pardon Service should have a sex offender specific agent to handle that case load.
- A supervising sex offender specific agent is needed to provide oversight and compliance for the entire state.
- The same type of arrangement is needed for the Department of Social Services.
- *SEA* can provide the training necessary to augment PPP agents existing skills.

Projected Costs

- Standardization of care to include all previously mentioned training, materials, continued oversight of all outpatient care, and for the first time, accurate & comprehensive statistical analysis of SC sex offender population and recidivism rates to be published 14 months from the start of the program: $ 470,000.00 per year.
- *SEA* has two certified polygraphers that will provide on going exams for $150.00 each.

Costs Continued:

- Proper assessment (meets ATSA standards) to include historical polygraph, penile plethysmograph, Abel Assessment, MMPI2, Hare PCL-R, Static 99, etc. This excludes IQ testing which should be readily available from other historical sources: $1600.00 per offender. (Includes psychiatric component).
- **This price is 50% lower (or better) than usual fees in SC and other states.**
- Will produce 20+ page report within 5 to 10 working days.

Inpatient Treatment

- For those deemed not appropriate for the SVP Program but are still an elevated risk to the community we suggest a 28 day inpatient treatment program.
- At the end of the 28 day period the offender will have completed an assessment (including a polygraph), completed a Relapse Prevention Plan, undergone Covert, Aversion, & Satiation treatment modules.
- *SEA* is presently performing a cost analysis of constructing & maintaining such a facility.

28 Day Program Continued:

- A referral to a treatment provider in his home area with a complete outpatient treatment plan.
- Coordination with Probation, Parole, & Pardon Services Agent to monitor in the community.
- Continued follow up by ***SEA***.

Who Pays?

- Offenders would continue to pay for their group and individual therapies as they presently do.
- The high cost associated with proper outpatient offender care is with the psychiatric/medication management, assessments, and ongoing polygraphs. We therefore suggest the state contracts out for these services.

2004 PPP Numbers in SC

- 26 Sex Offenders Released on Parole
- 377 Sex Offenders Released on Probation

- With our proposal:
- 400 X $ 1600.00 = $ 640,00.00

Costs & Recommendations

- SEA Training & Oversight: $ 470,000.00
- SEA Evaluations: 640,000.00
  - »Total: $1,110,00.00

3 Full Time Psychiatrists Contracted With the State to Cover The Medication Management of All Outpatient Offenders.

A Sex Offender Specific Agent in Every County With a Sex Offender Specific Statewide Supervising Agent.

APPENDIX G

Presentation by Brenda Hartt
SC Senate Finance Committee

Department of Mental Health Appropriation History with History for Sexual Predator Program

Agency-Wide

Year	Total*	State	Federal	Other	Supplemental
FY 1999-2000	337,510,716	182,469,922	5,397,292	149,643,502	15,360,461
FY 2000-2001	351,880,492	189,770,406	6,315,636	155,794,450	
FY 2001-02	358,177,193	185,269,619	9,838,570	163,069,004	
FY 2002-03	344,935,818	178,412,977	9,361,317	157,161,524	4,000,000
FY 2003-04	340,490,366	169,438,293	9,439,724	161,612,349	4,875,000
FY 2004-05	332,003,875	158,899,719	10,891,807	162,212,349	10,482,452

**Excludes Supplemental*

Sexual Predator Program

Year	Total*	State	Federal	Other	Supplemental
FY 1999-2000	114,500	114,500			4,017,161
FY 2000-2001	115,683	115,683			1,375,336
FY 2001-02	1,224,246	1,212,346		11,900	
FY 2002-03	1,224,246	1,212,346		11,900	
FY 2003-04	1,229,930	1,212,346		17,584	750,000
FY 2004-05	1,913,638	1,891,188		22,450	1,000,000

**Excludes Supplemental*

Comparison of Appropriations to Actual Expenditures

Year	Actual Expenditures	Recurring Appropriations	Difference Recurring	Total Appropriations	Difference Total
FY 1999-2000	1,792,860	114,500	(1,678,360)	4,131,661	2,338,801
FY 2000-2001	2,154,448	115,683	(2,038,765)	1,491,019	(663,429)
FY 2001-02	2,239,941	1,224,246	(1,015,695)	1,224,246	(1,015,695)
FY 2002-03	2,404,959	1,224,246	(1,180,713)	1,224,246	(1,180,713)
FY 2003-04	1,662,010	1,229,930	(432,080)	1,979,930	317,920
FY 2004-05**	3,354,316	1,913,638	(1,440,678)	2,913,638	(440,678)

***The expenditure figure includes all costs associated with the Sexual Predator Program with 73 residents.*

FY 2005-06
Possible Non-Recurring Revenue Sources

FY 2004-05 Projected Surplus	$	108,961,497
Capital Reserve Fund	$	99,356,026
Lapsed Debt Service Funding	$	1,529,390
Property Tax Relief Fund Carry-Forward	$	7,589,618
	$	217,436,531

FY 2001-02 Costs for State Sexually Violent Predators Facilities

	Expenditures	Avg Populations	Avg Expenditure/ Resident
Arizona	9,500,000	135	70,370.37
Florida	19,800,000	378	52,380.95
Illinois	16,000,000	174	91,954.02
Iowa	1,310,000	27	48,518.52
Kansas*	2,500,000	59	42,372.88
Minnesota	14,006,677	178	78,689.20
Washington	16,400,000	150	109,333.33

FY 1999-2000 Data

California	107,000.00
Wisconsin	87,500.00

*Calendar 2002 projection

Source: Greg Venz, State of Florida, November 9, 2004

South Carolina Department of Corrections
Division of Budget and Finance

Purpose: Comparison of Sexual Prediator Costs vs Regular Inmate Costs

Services	Total Fac.	Sexual Pred.
# of Inmates as of 6/30/04	1359	77
Personal Services	17.76	6.04
Inmate Pay	0.11	0
Employer Contributions	1.83	0.62
Other Contracts	0.07	0.07
Water	0.70	0.70
Telephones	0.03	0.03
Supplies	0.78	0.78
Food Charges	1.38	1.38
Fixed Charges	0.03	0.03
Travel	0	0
Heat/Power/Lights	1.42	1.42
Transportation	0	0
Total Direct Costs	24.11	11.07
Medical Allocations	6.58	0
Total per Day per Inmate	30.69	11.07
Total Per Year Per Inmate	11,201.85	4,040.55

Sexual Predator Program History
FY1999 - FY2005

Year	Expenditures*	Recurring Appropriations**	Nonrecurring Appropriations	Appropriations - Expenditures	Year-End Population
FY1999	$ 1,051,674	$ 140,865	$ -	$ (910,809)	13
FY2000	$ 1,988,989	$ 140,865	$ 4,017,161	$ 2,169,037	26
FY2001	$ 2,710,103	$ 140,865	$ 1,375,336	$ (1,193,902)	43
FY2002	$ 2,711,915	$ 1,515,865	$ -	$ (1,196,050)	51
FY2003	$ 3,037,491	$ 1,515,865	$ -	$ (1,521,626)	64
FY2004	$ 3,045,132	$ 1,515,865	$ 750,000	$ (779,267)	71
	Budget*				
FY2005	$ 3,435,091	$ 2,265,865	$ 1,000,000		

*All sources of funds and includes fringe benefits

**Cumulative total of recurring dollars appropriated by the General Assembly; does not reflect additional funding that DMH allocated to the program each year

SEXUAL PREDATOR PROGRAM
ANNUALIZED COST ANALYSIS - 73 BEDS

DMH @ EDISTO

	FTE'S	SALARIES	PER DAY
DIRECT STAFF			
Clerical Spec B	1.00	22,562	0.85
Admin. Asst	1.00	32,265	1.21
Exec. Asst for Program Mngmnt	1.00	67,375	2.53
LPN II	3.00	96,953	3.64
Nurse	6.00	289,402	10.86
Social Wrkr	4.00	149,974	5.63
Clinical Security Spec	5.00	106,802	4.01
MHS	9.00	212,997	7.99
Activity Thrpy/Suprvsr	2.00	55,670	2.09
Psychologist	1.00	68,245	2.56
Program Mngr	1.00	50,418	1.89
Human Svs Coordinator	1.00	35,535	1.33
Lab Tech	1.00	33,287	1.25
Security	14.00	383,759	14.40
Psychiatrist	1.00	146,085	5.48
Total Direct	51.00	1,751,329	65.73
INDIRECT STAFF (CBHS)			
Admin/Support	3.70	119,874	5.05
Psychiatrist	0.05	7,641	0.29
Physician			0.00
Voc. Ed. Spec			0.00
Chaplain			0.00
Pharmacy staff	1.15	66,352	2.49
Nurse	0.65	31,204	1.17
Total Indirect	5.55	225,070	8.45
Total Salaries	57	1,976,399	74.18
Terminal Leave Pay		9,000	0.34
Client Earnings		25,000	0.94
Temporary Svs (nurse pool)		89,493	3.36
Overtime/Shift Diff/On Call		119,367	4.48
TOTAL PERSONAL SVS.	57	2,219,259	83.29
FRINGE		687,771	25.81
OPERATING			
Building/Property Services		3,997	0.15
Medical/Health Svs		95,911	3.60
Telephone/Telecmmnctn		15,464	0.58
Vehicle Repair/Supplies			0.00
Medications/Lab Supplies		173,767	6.52
Food		13,917	0.52
General/Admin/Office		27,675	1.04
Clothing		5,609	0.21
Insurance/Training/Credntlng		8,336	0.31
Travel		2,480	0.09
Legal Fees		5,000	0.19
TOTAL OPERATING		352,156	13.22
EVALUATIONS		47,460	1.78
GENERAL & ADMIN. EXP.		47,669	1.79
GRAND TOTAL		3,354,316	125.89

APPENDIX H

Presentation by SCVAN

NOVEMBER 2004 STATE PROGRAM COMPARISON OF THE INVOLUNTARY COMMITMENT OF SEXUALLY VIOLENT PREDATORS

	Treatment offered during incarceration	Housed where?	Separated from general population?	How many in program?	How many officially released in last 6 yrs?	Recidivism rate?
Arizona	No	Arizona State Hospital in a separate facility	Separate	105	14	N/A
California	No	State facility under DMH & DOC	Separate	As of 01/28/04 - 535		
Florida	Yes DOC offers voluntary 20 week sex offender treatment program	Florida Civil Commitment Center in Archadia, Florida	Separate	as of 10/30/04 454	11	1 out of 11 rearrested for a sexual offense
Illinois	No Post incarceration only	A treatment and detention facility in Joliet, Illinois	Separate	224	16	N/A
Iowa	No	A Mental Health Facility in Cherokee, Iowa under the Department of Human Services	Separate	47	1	N/A
Kansas	No	A treatment facility under the jurisdiction of the Department of Social Services	Separate	175	1	N/A
Massachusetts	Yes	The Massachusetts Treatment Center	the offenders are housed separately but have access to inmates	12	None	N/A
Minnesota	Yes Approx. 1400 sex offenders and 250 treatment beds	Housed in separate fac through DHS. Currently have two facilities	Separate	As of 10/02/04 - 252	None	N/A
Missouri	Yes, 2-phase program	Housed in separate facility through DMH	Separate	94	None	N/A
New Jersey	Yes NJ Sex Offender Act	2 temporary sites DOC responsible	Separate	As of 11/08/04 - 311	12 on conditional discharge	2 on technical viol
North Dakota	Yes waiting list for treatment	State Hospital	Separate	18 committed 5 in evaluation	1 currently being discussed	N/A
South Carolina	Yes 2-phase program (Educ. & residential intensive)	Behavior Disorder Treatment Program at Broad River Correctional Institute	Separate	69 2 pending	6 completed prog. 8 on re-evaluation	N/A
Texas	Yes, but not to all. Highest risk offenders are placed in treatment. Treat 11% to 12% of whole population	Outpatient treatment private halfway houses or in own residence	N/A	41	None	N/A
Virginia	Yes	Facility under Dept. of Mental Health	Separate	10	None	N/A
Washington	Yes, 2-phase program: confinement phase and community phase	Total confinement facility	Separate	As of 11/01/04: 205	None	N/A
Wisconsin	Yes	2 facilities separate from general population	Separate	1st fac - 222 2nd fac - 43	Yes supervised & non-supervised released	N/A

Information compiled by Shannon Geary and Carrie Harviel

Problems?	Security level	Cost per year/ per client	How are SVP's tracked once released	Contact person(s)
NO	3 levels of security dependent upon point in program	$80,300	GPS after they are completely released have to register as a sex offender	Micheal Gains Program Coordinator (602) 220-6287
"	Secure facility controlled by DOC	refer to Texas chart	"	Information obtained from website(printed) Person(s) initially contacted not helpful
Yes, Financial and treatment problems	Perimeter has a maximum security level the facility has Medium Security Level	$50,000	If the offender is not on probation then the offender is not tracked	Gregg Venz Department of Children and Families (850) 921- 4490
Yes, the program has grown over the last seven years, need for a larger facility	Maximum Security secure perimeter	$85,000	A Conditional Release Program Use a containment model including a global positioning satellite	Tim Budz Department of Human Services (815) 740-8781 * 207
Yes, they are going to ask for a supplemental from the Legislature this year	Medium Security Level	$67,000	A sub-contracted community residential facility, where they receive treatment	Department of Human Services (712) 225-2594
Lacking in Sufficient Funds	Medium Security Level secure perimeter	45,000	A Step Down Program transitional housing next to the Out Patient Housing	John House Mental Health (785) 296-7272
The inmates frequently sue the staff	"	refer to Texas chart	They are tracked by the Sex Offender Registry Board in Salem, Mass.	Allison Hallet Department of Mental Health (508) 850-7772
No problems; program growing due to increase in referrals	Perimeter: Maximum Security	Approx. $100,000	None released	Steve Huot, Director of Sex Offender Services (651) 582-1885
Yes, growth rate is approx. 17 per year, need new facility, renovations, more staff.	Different security levels for SVP's in facility	Approx. $55,000	None released	Sheila, Sex Offender Treatment Program (573) 218-6015
Struggles w/ space issues nearing capacity w/ temp sites	Perimeter: Maximum	Approx. $47,000	Community supervision through parole office	Contact Shannon Geary, SCVAN (803) 750-1200
No problems currently, just doubled the amount of beds.	Very secure lock down most hours	Approx. $90,000 to $100,000	There will be a high level of tracking inv. contemplating amend. allowing comm. confinement (tracking w/ list of rules)	Jon Byers, Assistant Attorney General (701) 328-4183
Space limitations causing treatment issues	DMH controls internal security; SCDC controls perimeter security		Required to register as SVP on sex offender registry	Debbie Shupe, Attorney General's Office (803) 734-3970
No specific problems	Outpatient, monitored by global positioning devices 24/7	$30,000.00	No one discharged at this point	Lisa Worry, Council on Sex Offender Treatment (512) 834-4530 Judy Johnson, Sex Offender Treatment Prog. In DOC (936) 437-2848
Expenses greater than predicted lost 20% of funding 1st year high staff & residence health care cost	Perimeter: Maximum	Approx. $80,000	No one discharged at this point	Robin Hulbert, Mental Health Program Director (804) 674-3000 Dr. Dennis, Clinical Director (804) 524-4685
No problems, very expensive program but there is a willingness to fund.	Comparable to prison	$70,000-$100,000	Special Commitment Center and an official tracker through community corrections office	Dianne Ashlock, DOC (360) 753-6789 Steve Williams DSHS Communications Division (360) 902-7569
No problems	Perimeter: Maximum Security	Approx. $100,000 both facilities	No way to track legally, except through sex offender registry	Deb McCulloch (608) 847-1737

2003 Data (Texas Dept. of State Health Services)

STATE BY STATE COMPARISON OF THE INVOLUNTARY CIVIL COMMITMENT OF SEXUALLY VIOLENT PREDATORS

STATE/CODE	TREATMENT FOLLOWING COMMITMENT	NUMBER COMMITTED	EST. COST PER YEAR PER CLIENT	COST PER DAY PER CLIENT	PROJECTED ANNUAL COST	DISCH. OR RELEASED
TEXAS Health & Safety Code 841.001 et seq. (1999)	**Outpatient containment model that incorporates intensive treatment, comprehensive case management, and tracking by global positioning satellites. Failure to comply results in a 3rd degree felony. The Council on Sex Offender Treatment administers program. Average of 15 commitments per year.**	**38**	**$30,000.00**	**$82.19**	**$1,140,000.00**	**0**
Arizona 36-3701 et seq. (1996)	Placed in custody of Dept. of Health Services. If appropriate, a judge may grant conditional release to a less restrictive alternative.	121	$75,920.00	208.00	$9,186,320.00	14
California W&I. 6600 et seq. (1996)	Confinement in a secure facility up to two years. SVP can petition for a conditional release or discharge; hearing may be held after one year.	428	$107,000.00 TO $125,000.00	$293.00 TO $347.00	$45,796,000.00 TO $53,500,000.00	N/A
Florida (1998) 394.910 et seq.	Detained in a secure facility until disorder has changed so that is safe for the SVP to be at large.	117	$97,000.00	$266.00	$11,349,000.00	8
Illinois 725 ILCS 207/1 et seq. (1938)	Least restrictive manner appropriate. Judge has discretion to order institutional care or conditional release with necessary treatment and services	138	$87,000.00	$238.00	$12,006,000.00	1
Iowa (1998) 229.A1 et seq.	Committed to the custody of Dept. of Human Services for placement as inpatient. Right to petition for discharge or transitional release at annual review.	34	$80,000.00	$219.00	$2,240,000.00	1
Kansas 59-29a01 et seq. (1994)	Committed to the custody of the Secretary of Social and Rehab. Services for placement in a secure facility. Right to petition for discharge at annual review.	111	$80,000.00	$219.00	$8,880,000.00	3
Massachusetts Part I Title XVII Chap. 123A 1 et seq.	Committed to a treatment center. May apply for community access program, but still requires residence at the treatment center until discharge.	12*	N/A	N/A	N/A	0
Minnesota 253B.01 et seq. (1994) 253B.185 (1939)	Least restrictive treatment program that can meet the SVPs and society's needs.	190	$110,000.00	$301.00	$22,220,000.00	0

CSOT 6/04

STATE BY STATE COMPARISON OF THE INVOLUNTARY CIVIL COMMITMENT OF SEXUALLY VIOLENT PREDATORS

STATE/CODE	TREATMENT FOLLOWING COMMITMENT	NUMBER COMMITTED	COST PER YEAR PER CLIENT	COST PER DAY PER CLIENT	PROJECTED ANNUAL COST	DISCH OR RELEA SED
Missouri 632.480 et seq. (1998)	Committed to the custody in a secure facility until the SVP is safe to be at large. Right to petition for release at annual review. Average 17 commitments per year.	40 (Plus 30 detainees)	$54,266.00	$149.00	$2,170,640	0
New Jersey 30:4-27.24 et seq. (1994)	Involuntary commitment to a designated facility. Dept. of Human Services can recommend conditional discharge if likely to comply with treatment plan, but the order is at the discretion of the court.	279 (plus 30 temporary commitment)	$57,000.00	$156.00	$15,903,000.00	30
North Dakota 25-03.3-01 et seq. (1997)	Committed to the custody of the Executive Director from the Dept. of Human Services. Director assigns the least restrictive treatment facility or program necessary.	10	$100,000.00	$274.00	$1,000,000.00	0*
South Carolina 44-48-10 et seq. (1998)	Committed to the custody of the Dept. of Mental Health as an inpatient in a secure facility. Right to petition for release at annual review.	71	$46,500.00	$127.00	$3,301,500.00	2
Virginia 37.1-70 et seq. Effective 1-1-04	Inpatient confinement in secure facility, unless less restrictive conditional release is appropriate.	None	Program start date 1/04			
Washington 71.09.010 et seq. (1990)	Committed to the custody of the Dept. of Social and Health Services for placement in a secure facility. Court can order less restrictive alternative placement only after a hearing following the initial commitment.	177 (Detainees and committed)	$70,000 TO $100,000	$191.00 TO $365.00	$12,390,000.00 TO $17,700,000.00	10 (less restrictive
Wisconsin 980.01 et seq. (1994)	Institutional care at a secure mental health facility. Person may petition for supervised release 18 months after initial commitment	255	$84,000.00	$230.00	$21,420,000.00	10 (33 on supervis release)
Canada R.S., c. C-34, s. 688 (1977) Chapter 17 (1997)Dangerous Offenders Provision	An offender must have committed a "serious personal injury offense. Murder is not included since it results in an automatic life sentence. Evidence must show that the offender constitutes a risk to others and one of the following: a pattern of repetitive and persistent behavior that is likely to lead to injury or death; the likelihood of injury through a failure to control sexual impulses; or a crime so brutal that it	276 (2% of the Federal Offender Population 2000)	N/A	N/A	N/A	N/A

	is unlikely the person can inhibit their behavior in the future.					

*** Denotes state statistics as of 1-1-02**

U.S. Civil Commitment Totals=2073(Includes detainees)
U.S. Discharged or Released from Commitment=69 (Does not include supervised or less restricted)

Texas Commitment

Behavioral abnormality means a congenital or acquired condition that, by affecting a person's emotional or volitional capacity, predisposes the person to commit a sexually violent offense, to the extent that the person becomes a menace to the health and safety of another person.

Predatory Act means an act that is committed for the purpose of victimization and that is directed toward a stranger, a person of casual acquaintance with whom no substantial relationship exists, or a person with whom a relationship has been established or promoted for the purpose of victimization.

Sexually violent Predator is a person who is a repeat sexually violent offender and suffers form a behavioral abnormality that makes the person likely to engage in a predatory act of sexual violence.

***Information provided by the Texas Council on Sex Offender Treatment and the National Center for Prosecution of Child Abuse.**

APPENDIX I

Presentation by Debbie Shupe, Esquire
SC Attorney General's Office

South Carolina Sexually Violent Predator Act

Jimmy Sligh
Div. Dir., Classification & Inmate Records
South Carolina Department of Corrections
Debbie Shupe
Assistant Attorney General
South Carolina Attorney General's Office

The "Act"

S.C. Code 44-48-10 through -170

The Statute

A. Purpose

1. Mentally abnormal & extremely dangerous
2. Require involuntary civil commitment
3. Likelihood of repeat acts of sexual violence without treatment is significant

B. Criteria

1. Convicted of a sexually violent offense
   a. CSC 1st degree
   b. CSC 2nd degree
   c. CSC 3rd degree
   d. CSC 1st degree with minors
   e. CSC 2nd degree with minors
   f. Engaging child for sexual performance
   g. Producing, directing or promoting sexual performance by a child
   h. Attack with intent to commit CSC
   i. Incest
   j. Buggery
   k. Committing or attempting lewd act on a child under 16
   l. Offenses against morality & decency involving minors when the violations are felonies
   m. Accessory before fact of any enumerated offenses
   n. Criminal Solicitation of a Minor
   o. Attempt to commit any enumerated offenses
   p. Any offense for which the judge makes a specific finding on the record that based on circumstances of the case, offense should be considered a sexually violent offense

B. Criteria (continued)

1. Suffers from a mental abnormality or personality disorder that makes the person likely to engage in acts of sexual violence if not confined for long term control, care and treatment

   a. Mental abnormality is a "mental condition affecting a person's emotional or volitional capacity that predisposes the person to commit sexually violent offenses"

   b. "Likely to engage in acts of sexual violence" means the person's propensity to commit acts of sexual violence is of such a degree as to pose a menace to the health and safety of others.

The Process

A. Multi-Disciplinary Team (MDT)

1. Representatives of SCDC (Chair), DPPS, DMH, retired judge, and criminal defense attorney (appointed by the Chief Justice for one-year term)
2. MDT, Registered Victims, and Attorney General Receive Notice 180 days before:
   a. Person convicted of sexually violent offense is to be released from total confinement
      1. Revocation of community supervision program – notice as soon as possible after readmission to prison
   b. Hearing on fitness to stand trial if previously found unfit to stand trial
   c. Anticipated hearing re: release of person found NGBI
   d. Release of person found guilty of a sexually violent offense but mentally ill
   e. Person convicted of a sexually violent offense is to be paroled or conditionally released
3. MDT reviews records and determines whether person satisfies definition of a sexually violent predator
   a. If not, no further action
   b. If so, refer for further action

B. Prosecution Review Committee (PRC)

1. Appointed by Attorney General
   a. Attorney General or his designee (Chair)
   b. Elected circuit solicitor
   c. Victim's representative
2. Within 30 days of receiving referral from MDT, PRC reviews records from MDT and information from prosecuting solicitor
3. Determines whether there is probable cause to believe person is a sexually violent predator

C. Petition

1. If PRC determines there is probable cause, Attorney General must file petition within 30 days with the court in the jurisdiction where qualifying offense committed
2. Petition shall request a probable cause determination as whether person is a sexually violent predator
   a. Attorney General's Office must notify registered victim(s) of the time, date and location of probable cause hearing
3. If court finds probable cause, person must be taken into custody if not already confined in a secure facility

C. Petition (continued)

4. Within 72 hours of detainment, person is entitled to probable cause hearing
   a. Verify identity
   b. Receive evidence and hear arguments from Attorney General and person
   c. Determine whether probable cause exists
5. At probable cause hearing, person has right
   a. To be represented by counsel (appointed if indigent)
   b. To present evidence
   c. To examine witnesses
   d. To view and copy all petitions and reports in the court's file
6. If court finds probable cause, court shall direct transfer to a secure facility for an evaluation to be conducted by approved qualified expert

D. Trial

1. Held within 60 days of completion of probable cause hearing
2. Attorney General and person may request jury trial
3. Trial to be in jurisdiction where qualifying offense committed
4. Trial may be continued for good cause if the person will not be substantially prejudiced
5. Attorney General's Office must notify registered victim(s) of the time, date and location of the trial
6. Determination of sexually violent predator status must be beyond a reasonable doubt

E. Commitment

1. Custody of DMH for control, care and treatment
   a. Housed & managed separately from inmates
2. Currently Behavior Disorders Treatment Program
   a. Edisto Unit at BRCI

F. Annual Review

1. Must be examined once a year
2. May retain or request qualified expert
3. Report provided to the court, the Attorney General, the prosecuting solicitor and the MDT
4. Court shall conduct annual review hearing
   a. Person may petition for release at hearing
   b. Entitled to be represented by counsel, but not to be present at the hearing
   c. Person has burden to show probable cause to believe mental status has so changed; he is safe to be at large
   d. Attorney General's Office must notify registered victim(s) of all proceedings
5. If court determines probable cause exists to believe mental status has so changed that person is safe to be at large, shall schedule a trial
   a. Person entitled to be present at trial
   b. Person has all constitutional guarantees afforded at initial commitment proceeding
   c. Attorney General or person may request jury trial.
   d. State has burden to prove beyond a reasonable doubt that person's mental status remains such that he is not safe to be at large

G. Release

1. If mental status so changes person is safe to be at large, Director of DMS shall authorize person to petition for release
   a. Petition served on court and Attorney General
   b. Hearing held within 30 days
   c. Attorney General represents the State of S.C.
      i. His right to have person examined by other experts
   d. Either party has right to a jury trial
   e. State has burden of proof
2. Denial of petition of release
   a. If previous petition(s) were filed without authorization of DMH Director and court denied as frivolous or person not safe to be at large
   b. Court shall, when possible, review petition & deny without a hearing if based on frivolous grounds

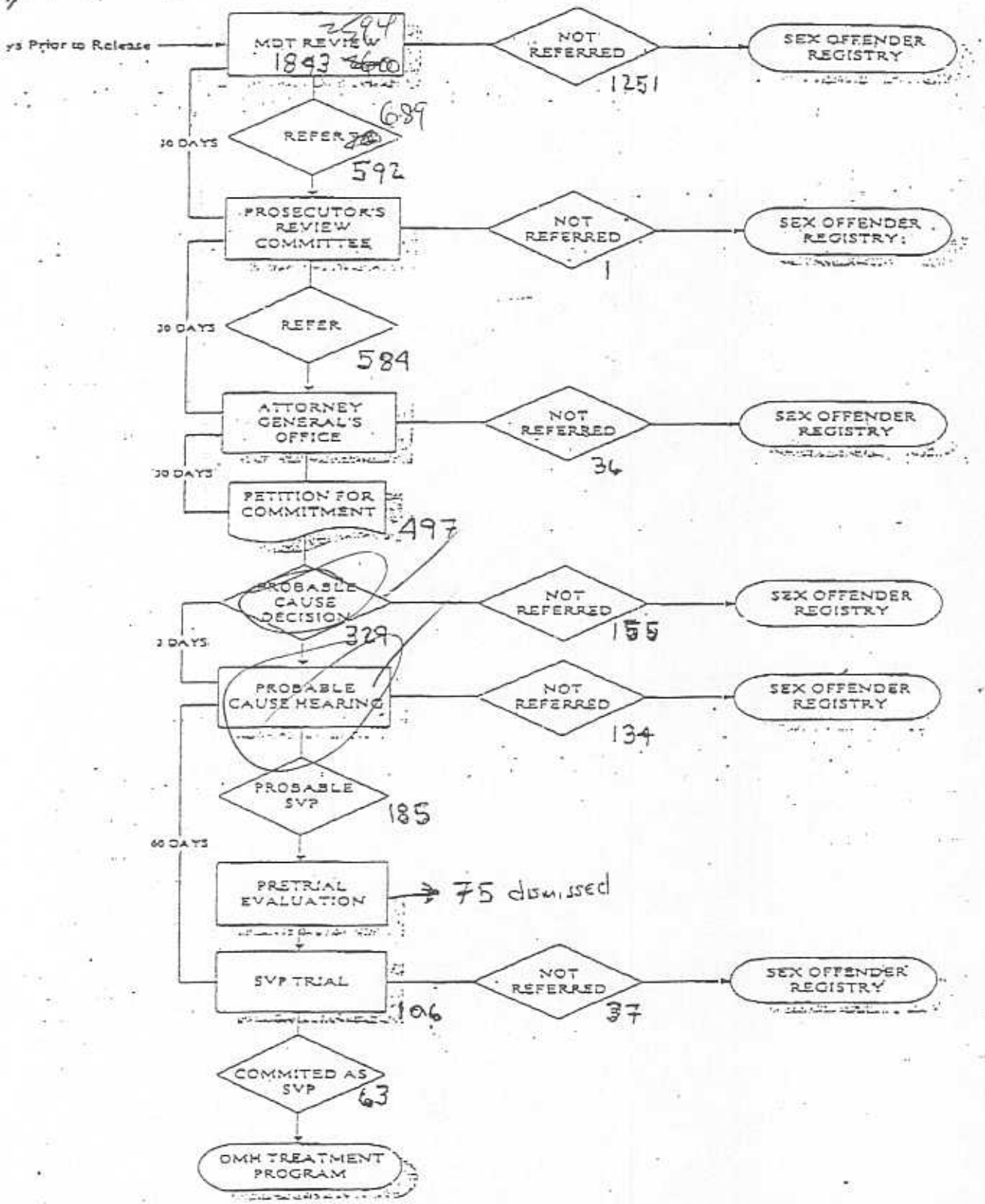
H. Records

1. Psychological reports, drug & alcohol reports, treatment records, medical records and victim impact statements are part of the record but must be sealed

I. Sex Offender Registry

1. Person released from commitment must register as a sex offender
2. Must be designated as a sexually violent predator
3. Must verify registration and be photographed every 90 days

South Carolina Sexually Violent Predator Commitment Process



APPENDIX J

Presentation by Mark Binkley, Esquire
SC Department of Mental Health

SOUTH CAROLINA DEPARTMENT OF MENTAL HEALTH
OFFICE OF GENERAL COUNSEL
Columbia, South Carolina

MEMORANDUM

TO: SVPA Study Committee

FROM: Mark W. Binkley, General Counsel MWB

DATE: October 20, 2004

SUBJECT: Litigation filed by BDTP residents

Attached is a synopsis of pending lawsuits filed by residents of the Behavioral Disorders Treatment Program (BDTP) against the Department of Mental Health or its staff. This does not include appeals which the residents may have filed concerning their commitments. Those appeals are handled by the Attorney General's office.

The number of cases is noteworthy. There are approximately 70 residents in the program, and the number of pending cases is 62, and at times has been higher. By comparison, the Department of Mental Health treats approximately 90,000 persons each year in its hospitals, nursing homes and community mental health centers. The number of pending cases arising from the treatment of those persons is 19.

The fact that all of the cases are "pro se," meaning that the plaintiffs do not have legal counsel, is also noteworthy.

Finally, it is also noteworthy that, to date, none of the actions brought by a BDTP resident has resulted in a settlement or verdict in which the Department or its employees have been found negligent or responsible for any improper conduct.

Active Litigation filed by
Residents of the Behavioral Disorders Treatment Program
As of October 20, 2004

Habeas Corpus Petitions (Most recently dismissed, 3 still awaiting hearings)

Francis, Kennedy & Williams scheduled for 11/2/04

Tort and Medical Malpractice Litigation (59)

Jonathan **Francis;** C/A 8:04-1131-22BI BDTP resident alleges double jeopardy, ineffective asst of counsel & denial of access to courts

Danny G. **Williams** vs.Gintoli, et al.; C/A 9:03-1624-24BG BDTP resident alleges the defendants violated his civil and constitutional rights by failing to provide him with recommended treatment for Hepatitis C.

Clifford **Thompson** vs. Gintoli, et al.; C/A 9:03-3645-24BG BDTP resident alleges the defendants violated his civil and constitutional rights by failing to provide him with recommended treatment for Hepatitis C.

John **Corley** v. SCDMH, et al.; C/A 03-CP-40-0965 Resident of BDTP alleges exploitation/negligence in connection with improper relationship with staff.

Smith, et al. v. SCDMH; C/A 01-CP-40-2975 BDTP residents allege violations of constitutional rights by improperly imposing prison rules, regulations and policies.

Smith v. Gintoli; C/A 2:04-0048-10AJ BDTP resident alleges violations of due process, etc and requests $250K in compensatory damages.

James **Price** v. DMH Staff; C/A 03-CP-40-5470 BDTP resident alleges punitive refusal to transport, isolation and visitation restrictions and acquiescence and deliberate indifference.

Earnest **Larch** v. Stanley; C/A 3:04-2296-17BC BDTP resident alleges physical violence violated his constitutional rights.

John **Kennedy and Others (11);** C/A 8:04-1776...22BG Multiple suits originally filed as one, but separated by Fed Ct. 42 USC §1985, Primary complaint: lack of access to law library

Kris **Kollyns** vs. SCDMH; C/A No. 04-CP-40-1158 BDTP resident alleges violation of rights of speech and religion based upon not having access to "Dungeons and Dragons"

Kris **Kollyns** vs. SCDMH; C/A No. 3:04-1599-17BC 42 USC §1983 alleging willful denial of access to courts violating 8th & 14th Amendments

Kris S. **Kollyns** vs. SCDMH; C/A No. 04-CP-40-2589 BDTP alleges medical malpractice. "Pseudoseizures," Hepatitis C, vomiting, glaucoma, cataracts and failure to respond to his medical problems. Kollyns is seeking treatment and $500K

Kris **Kollyns & Others (27);** C/A 3:04-1941...-17BC 42 USC §1983 alleging violations of 5th, 9th, 10th & 14th Amendments because "never released from DoC"

Timothy **Farmer** v. SCDMH; C/A 9:04-2550-20BG Same as above, but filed in different Division of the District.

Ms. Kris **Kollyns** vs. SCDMH; C/A No. 3:04-2552-17BC Kollyns alleges that (s)he suffers from "Gender Identity Disorder" and that (s)he has unsuccessfully sought testing and treatment by SCDMH for this condition.

Kris **Kollyns** vs. SCDMH Kollyns basically alleges in state court the same GID allegations as in C/A No. 04-CP-40-4218, his fed case listed above. He adds gross negligence, abuse and endangerment of health.

Herbert **McCoy** vs. SCDMH; C/A No. 04-CP-40-3245 McCoy alleges gross negligence and criminal action and seeks $25K. He alleges that a DMH employee slapped him in the face with her hand.

Terry **Manus**; Manus made a Motion alleging lack of access to law library in an existing 2001 DOC case in which DMH is not a party;

Leonard Smith "Appeals"* (*time to appeal is well past)
Smith v. Mitchell, No. 04-7321; C/A 2:00-1245-10AJ
Dismissed 11/16/00

Smith v. Spell, No. 04-7324; C/A 2:00-914-10AJ
Dismissed 4/12/00

Smith v. Montgomery, No. 04-7323; C/A 2:00-400-10AJ
Dismissed 4/12/02

Civil Commitment of Sex Offenders: A Brief History

Mark Binkley
General Counsel
SCDMH

Civil Commitment of Sex Offenders

- First Generation Statutes: 1937 – 1990
- Sexual Psychopath Commitment Laws
- Eventually over half the States passed such laws

Civil Commitment of Sex Offenders

- Most required conviction of a crime—usually a sex crime
- Some permitted commitment based on charge of sex offense
- In five states, no criminal offense was needed

Civil Commitment of Sex Offenders

- If offender's commitment was triggered by conviction:
  - In some, commitment was in lieu of sentence,
  - in some, sentencing held in abeyance with return to court following release

Civil Commitment of Sex Offenders

- Assumed:
  - There is a specific mental disability called sexual psychopathy
  - Persons suffering this disability are more likely to commit serious sex crimes than "normal" criminals
  - Such persons can be identified by mental health professionals

Civil Commitment of Sex Offenders

- Assumptions, continued:
  - The dangerousness of these offenders can be predicted by mental health professionals
  - Treatment is available for this condition
  - Treatment will cure many of those with this condition

Civil Commitment of Sex Offenders

- During 70's & 80's laws were widely criticized as failures
- Many repealed; some fell into disuse

Civil Commitment of Sex Offenders

- GAP, 1977: Psychiatrists can't accurately identify which offenders are more dangerous
- Minimal treatment; "Warehousing operation for social misfits"
- Two kinds of horror stories:
  - Civil Rights: Minor or Non offenders
  - Public Safety: Ziglinski case

Civil Commitment of Sex Offenders

- High of 28 in 1960 to
- 12 by 1990
  - Of which only 6 were actively using their law

Civil Commitment of Sex Offenders

- Second Generation: 1990 to Present
- Sexually Violent Predator or Sexually Dangerous Persons commitment laws
- At least 16 States since 1990

Civil Commitment of Sex Offenders

- 1987: Earl Shriner maxes out
- Released despite extraordinary efforts to keep him confined
- 1989: Rapes and mutilates a 7 year old boy
- Outrage; Task Force; Legislation: The Washington Community Protection Act

Civil Commitment of Sex Offenders

- Task Force concluded that most appropriate place for dangerous sex offenders is prison
- Community Protection Act of 1990 increased sentences for sex offenses by an average of 50% and extended post-release supervision for certain offenders

Civil Commitment of Sex Offenders

- Contained a sex offender registration requirement
- Enacted a civil commitment process for "Sexually Violent Predators"

Civil Commitment of Sex Offenders

- Sexually Violent Predator (SVP) laws are not predicated on faith in psychiatry or faith in sex offender treatment;
- In fact, the law emphasizes protection of society by confinement of the person over reduction of the risk through treatment

Civil Commitment of Sex Offenders

- SVP commitment is not intended to be in lieu of punishment;
- It follows, and is in addition to punishment
- The primary component of the Community Protection Act was increasing sentences for certain sex offenses;
- SVP commitment was an adjunct to that effort

Civil Commitment of Sex Offenders

- All SVP treatment programs are burdened by this dichotomy:
  - The programs are required to offer treatment to persons who the law declares may not be treatable
  - Yet the law's constitutionality depends in large part on the adequacy of the treatment programs

Council on Sex Offender Treatment

TEXAS CIVIL COMMITMENT OF THE SEXUALLY VIOLENT PREDATOR (Art. 4, Title 11, Chapter 841)

Civil Commitment statute is civil law. The State has the burden to prove beyond a reasonable doubt that the person is a sexually violent predator with a behavioral abnormality (Sec. 841.062). This language is used to narrowly confine the class of sexually violent predators being committed. Typically, civil law only requires preponderance of the evidence. Sex offenders are not convicted of being a sexually violent predator. These offenders are committed. Civil commitment is different than a criminal charge in that a criminal sentence has a definitive timeframe. Civil commitment continues until it is determined that the person's behavioral abnormality has changed to the extent that the person is no longer likely to engage in a predatory act of sexual violence. The civil commitment program of the sexually violent predator is not a criminal charge or punitive. The intent of the law is to provide intensive outpatient rehabilitation and treatment to the sexually violent predator.

The Kansas **Sexually Violent Predator Act (1994)** has withstood the constitutional challenges and has validated identical laws in numerous other states (Kan. Stat. Ann 59-29a01 et seq., 1994). The U.S. Supreme Court in the Hendrick's case ruled that as long a State's ancillary purpose is to treat the sex offender and his due process rights were protected, the State may commit the sex offender for an indefinite period as far as the United States Constitution is concerned.

Texas civil commitment statute requires a "**behavior abnormality**" which means a congenital or acquired condition that, by affecting a person's emotional or volitional capacity, predisposes the person to commit a sexually violent offense, to the extent that the person becomes a menace to the health and safety of another person (Sec. 841.002). The 9th Circuit Court of Appeals noted "by definition, a menace is a threat or imminent danger, and the menace described in the Act is substantial and satisfies any proof requirement of a threat or risk of future harm".

Commitment Eligibility- The sex offender must be a repeat sexually violent offender serving a determinate sentence.

Sexually Violent Predator is defined as:

A) A person is a sexually violent predator if the person:

1. is a repeat sexually violent offender

2. suffers from a behavioral abnormality that makes the person likely to engage in a predatory act of sexual violence

B) A person is a repeat sexually violent offender if the person is convicted of more than one sexually violent offense and a sentence is imposed for at least one of those offenses or if:

1. the person:
    a. is convicted of a sexually violent offense regardless of whether the sentence for the offense was ever imposed or whether the sentence was probated and the person was subsequently discharged from community supervision
    b. enters a plea of guilty or nolo contendere for a sexually violent offense in return for a grant of deferred adjudication
    c. is adjudged not guilty by reason of insanity of a sexually violent offense or
    d. is adjudicated by a juvenile court as having engaged in delinquent conduct constituting a sexually violent offense and is committed to the Texas Youth Commission under Section 54.04(d)(3) or (m), Family Code
3. After the date the person is convicted, receives a grant of deferred adjudication, is adjudged not guilty by reason of insanity, or is adjudicated by a juvenile court as having engaged in delinquent conduct, the person commits a sexually violent offense for which the person is:
    a. convicted, but only if the sentence for the offense is imposed
    b. or is adjudged not guilty by reason of insanity

Sexually Violent Offense are defined as:

1. Indecency with a Child by Contact
2. Compelling Prostitution of a Minor
3. Sexual Assault regardless of the age of the victim
4. Aggravated Sexual Assault regardless of the age of the victim
5. Prohibited Sexual Contact
6. Sexual Performance by a Child
7. Possession or Promotion of Child Pornography
8. Aggravated Kidnapping with the Intent
9. Burglary of a Habitation with the Intent

Predatory Act means an act that is committed for the purpose of victimization and that is directed toward:

1. a stranger
2. a person of casual acquaintance with whom no substantial relationship exits
3. a person with whom a relationship has been established or promoted for the purpose of victimization

Standard of Dangerousness-The sex offender must have a behavioral abnormality that makes the person likely to engage in a predatory act of sexual violence. The 9th Court of Appeals defined "likely" as probable. "Something that is probable is beyond a mere possibility or potential for harm." "The beyond a reasonable doubt burden is not inconsistent with the element that must be proven—that the person suffers from a behavioral abnormality that makes the person likely to engage in a predatory act of sexual violence."

A **Multidisciplinary Team** (MDT) consisting of members from the Council on Sex Offender Treatment, Texas Department of Criminal Justice, Texas Department of Criminal Justice-Victim Services, Texas Department of Mental Health/Mental Retardation, and Texas Department of Public Safety review records and refer sex offenders who meet the eligibility criteria for a behavioral abnormality assessment. The MDT reviews the following criteria, but is not limited to just the following (Sec.841.021):

- Past and present criminal history including the nature of the offense
- The offender's relationship to the victim(s)
- The offender's institutional adjustment
- Medical and psychological reports if relevant
- If the offender has participated in any sex offender treatment and the results of the treatment
- Proposed release plans
- The proximity of discharge from supervision
- Past supervision history completed or failed
- Level of assessed risk for the probability that the offender will commit another sexually violent offense

If the person meets the eligibility criteria the case is referred for a behavioral abnormality assessment.

TDCJ contracts an **expert** to conduct the initial assessment which includes a clinical interview, psychological testing, review of the risk assessments, institutional records, and all relevant medical and psychological records and reports.

If a behavioral abnormality is found, the case is then referred to the Special Prosecution Unit to determine if a petition will be filed.

The **Special Prosecution Unit**, a division separate from prosecuting criminal cases, is responsible for initiating and pursuing a civil commitment proceeding.

If the Special Prosecution Unit files a petition alleging a predator status the **Office of State Counsel for Offenders** is notified and is responsible for representing an indigent person subject to a civil commitment proceeding. If for any reason the Office of State Counsel is unable to represent an indigent person

the court shall appoint other counsel to represent the person (Health & Safety Code 841.005).

Both the prosecution and defense each retain **an expert** who conducts another assessment which includes a clinical interview, psychological testing, and reviews the risk assessments, institutional records, and all relevant medical and psychological records and reports (Sec. 841.061).

All Civil Commitment Trials are held in Montgomery County, Texas. The State is responsible for the costs of the initial Civil Commitment proceedings in an amount not to exceed $2,500.00 per case as well as other commitment proceedings.

A judge or twelve person jury must unanimously agree **beyond a reasonable doubt** to the following questions about the sex offender (Sec. 841.062):

1. Is the person a repeat sexually violent offender?
2. Does the person suffer from a behavioral abnormality that makes them likely to engage in a predatory act of sexual violence?

The Judge or jury is not asked to predict "**future**" behavior. Jurors are also not privy to information regarding the civil commitment program because under state law, the jury is not supposed to know the effect of their answers to the questions they are asked in the jury charge. They are asked if the sex offender has those two elements present at the current time of the trial. If the Judge or jury unanimously responds, "yes" to both questions, then the person will be ordered into the outpatient sexually violent predator treatment program.

Court Ordered Requirements Imposed on a Sexually Violent Predator (Sec. 841.082)

1. Requiring the person to reside in a particular location
2. Prohibiting the person's contact with the victim or potential victim of the person
3. Prohibiting the person's possession or use of alcohol, inhalants, or a controlled substance
4. Requiring the person's participation in and compliance with a specific course of treatment
5. Requiring the person to:
    A. Submit to tracking under a particular type of tracking service and to any other appropriate supervision; and
    B. Refrain from tampering with, altering, modifying, obstructing, or manipulating the tracking equipment
6. Prohibiting the person from changing the person's residence without prior authorization from the judge and from leaving the state without that prior authorization

7. If determined appropriate by the judge, establishing a child safety zone in the same manner as a child safety zone is established by a Judge under Section 13B, Article 42.12 Code of Criminal Procedures, and requiring the person to comply with requirements related to the safety zone
8. Requiring the person to notify the case manager immediately but in any event within 24 hours of any change in the person's status that affects proper treatment and supervision, including a change in the person's health or job status and including any incarceration of the person; and
9. Any other requirements determined necessary by the Judge

The **outpatient treatment and supervision program** begins upon the person's release from the Texas Department of Criminal Justice-Institutional Division, discharge from a state hospital, or upon conclusion of the trial. The person will remain on civil commitment until the person's behavioral abnormality has changed to the extent that the person is no longer likely to engage in a predatory act of sexual violence. The Council on Sex Offender Treatment is the administrator of this program (Sec. 841.081).

Either the state or the client is entitled to **appeal** the determination (verdict).

Outpatient civil commitment incorporates intensive outpatient sex offender treatment, monitoring with high-technology global positioning satellite tracking, comprehensive case management, and Department of Public Safety surveillance. The Council as administrator of the Civil Commitment Program is responsible for the reimbursement of the following but not limited to:

- Case Management System
- Residential housing requirements (if applicable)
- Sex offender treatment (Intake, Testing, Groups, Individuals, Family Sessions, etc.)
- Global Positioning Tracking
- Anti-androgen medication
- Polygraphs (Instant Offense, Sexual History, Maintenance, and Monitoring)
- Plethysmographs
- Biennial Exams
- Transportation needs

Upon entering the program, the SVP is assigned to a **case manager** who is the chair of the Interagency Case Management Team and is responsible for coordinating the treatment, supervision, and global positioning satellite tracking of the SVP. The Case Manager conducts between five to eight face-to-face contacts with the client and approximately eighteen collateral contacts per month. The Case Manager works closely with the treatment providers, the Department of

Public Safety, residential staff, parole officers (if applicable), and local prosecuting attorneys.

Only **registered sex offender treatment providers** who contract with the Council may assess and provide treatment to the SVP. Sex offender treatment groups are offense specific and limited to ten (10) offenders. Self-help, drug intervention, or time-limited treatment is used only as adjuncts to more comprehensive treatment. Typically, sex offenders on community supervision attend group treatment one (1) time per week and have one (1) individual session per month. Sexually Violent Predators subject to Civil Commitment attend group therapy two (2) times per week and have two (2) individual sessions per month. SVPs are mandated to take polygraphs regarding their Instant Offense, Sexual History, Maintenance, and Monitoring. The penile plethysmographs are utilized to assess sexual arousal. Sex offender treatment is multifaceted to include cognitive/behavioral approaches, arousal control, victim empathy, relapse prevention, biomedical approaches/psychopharmacological agents, increasing social competence, co-morbid diagnosis, increasing support systems, and after-care.

Failure to comply with the order of commitment can result in a 3rd degree felony charge, which may result in incarceration in the Texas Department of Criminal Justice-Institutional Division (Sec. 841.085).

The majority of the 9th Texas Circuit Court of Appeals (*Beasley*) concluded that "the legislature has not delegated its power to the trial courts to create a third degree felony but rather has authorized the trial courts to determine requirements that are necessary to ensure compliance of the person committed to treatment and supervision and to protect the community." The Court further concluded that "the legislature, not the judge, has determined the statutory requirements, as well as those necessary requirements set by the judge, are third degree felonies."

The SVP is entitled to a **biennial examination** (Sec. 841.101). The Council contracts an expert to perform the examination. Along with the examination, the case manager provides a report to the judge. The judge then conducts a **biennial review** of the status of the committed SVP. The SVP is entitled to be represented by Counsel, but is not entitled to be present at the judge's review. The judge sets a hearing if the judge determines at the review that:

1. A requirement imposed on the SVP should be modified; or
2. Probable cause exists to believe that the SVP's behavioral abnormality has changed to the extent that the SVP is no longer likely to engage in predatory acts of sexual violence.

If a **hearing** is set by the judge, the SVP and the State are entitled to an immediate examination of the SVP by an expert. Hearsay evidence is admissible if it is considered otherwise reliable by the judge. The SVP is entitled to be present and to have the benefit of all constitutional protections provided to the

person at the initial civil commitment proceedings. On the request of the SVP, or the attorney representing the state, the court shall conduct the hearing before a jury. The burden of proof at the hearing is on the state to prove beyond a reasonable doubt that the SVP's behavioral abnormality has not changed to the extent that the SVP is no longer likely to engage in predatory acts of sexual violence.

On a person's commitment and annually thereafter, the case manager is required to provide the SVP with written notification of the SVP's right to file with the court a petition for release without the case manager's authorization (Sec. 841.122).

The case manager may also file an **authorized petition** for release to the court and a hearing is conducted (Sec. 841.121). The State once again must prove beyond a reasonable doubt that the SVP's behavioral abnormality has not changed.

The Civil Commitment order is not effected by certain **subsequent convictions** including a new felony conviction if a sentence is not imposed, a conviction for a misdemeanor regardless of whether a sentence is imposed, and a judgment or verdict of not guilty by reason of insanity. The statutory duties imposed by the order are only suspended for the duration of any confinement of a SVP who receives a conviction (Health & Safety Code Chapter 841.150).

STATE BY STATE COMPARISON OF THE INVOLUNTARY CIVIL COMMITMENT OF SEXUALLY VIOLENT PREDATORS

STATE/CODE	TREATMENT FOLLOWING COMMITMENT	NUMBER COMMITTED	EST. COST PER YEAR PER CLIENT	COST PER DAY PER CLIENT	PROJECTED ANNUAL COST	DISCH. OR RELEASED
TEXAS Health & Safety Code 841.001 et seq. (1999)	**Outpatient containment model that incorporates intensive treatment, comprehensive case management, and tracking by global positioning satellites. Failure to comply results in a 3rd degree felony. The Council on Sex Offender Treatment administers program. Average of 15 commitments per year.**	38	**$30,000.00**	**$82.19**	**$1,140,000.00**	0
Arizona 36-3701 et seq. (1996)	Placed in custody of Dept. of Health Services. If appropriate, a judge may grant conditional release to a less restrictive alternative.	121	$75,920.00	208.00	$9,186,320.00	14
California W&I, 6600 et seq. (1996)	Confinement in a secure facility up to two years. SVP can petition for a conditional release or discharge; hearing may be held after one year.	428	$107,000.00 TO $125,000.00	$293.00 TO $347.00	$45,796,000.00 TO $53,500,000.00	N/A
Florida (1998) 394.910 et. seq.	Detained in a secure facility until disorder has changed so that is safe for the SVP to be at large.	117	$97,000.00	$266.00	$11,349,000.00	8
Illinois 725 ILCS 207/1 et seq. (1938)	Least restrictive manner appropriate. Judge has discretion to order institutional care or conditional release with necessary treatment and services	138	$87,000.00	$238.00	$12,006,000.00	1
Iowa (1998) 229.A1 et seq.	Committed to the custody of Dept. of Human Services for placement as inpatient. Right to petition for discharge or transitional release at annual review.	34	$80,000.00	$219.00	$2,240,000.00	1
Kansas 59-29a01 et seq. (1994)	Committed to the custody of the Secretary of Social and Rehab. Services for placement in a secure facility. Right to petition for discharge at annual review.	111	$80,000.00	$219.00	$8,880,000.00	3
Massachusetts Part I Title XVII, Chap. 123A 1 et seq.	Committed to a treatment center. May apply for community access program, but still requires residence at the treatment center until discharge.	12*	N/A	N/A	N/A	0
Minnesota 253B.01 et seq. (1994) 253B.185 (1939)	Least restrictive treatment program that can meet the SVPs and society's needs.	190	$110,000.00	$301.00	$22,220,000.00	0

CSOT 6/04

STATE BY STATE COMPARISON OF THE INVOLUNTARY CIVIL COMMITMENT OF SEXUALLY VIOLENT PREDATORS

STATE/CODE	TREATMENT FOLLOWING COMMITMENT	NUMBER COMMITTED	COST PER YEAR PER CLIENT	COST PER DAY PER CLIENT	PROJECTED ANNUAL COST	DISCH. OR RELEASED
Missouri 632.480 et seq. (1999)	Committed to the custody in a secure facility until the SVP is safe to be at large. Right to petition for release at annual review. Average 17 commitments per year.	40 (Plus 30 detainees)	$54,266.00	$149.00	$2,170,640	0
New Jersey 30:4-27.24 et seq. (1994)	Involuntary commitment to a designated facility. Dept. of Human Services can recommend conditional discharge if likely to comply with treatment plan, but the order is at the discretion of the court.	279 (plus 30 temporary commitment)	$57,000.00	$156.00	$15,903,000.00	30
North Dakota 25.03-3.01 et seq. (1997)	Committed to the custody of the Executive Director from the Dept. of Human Services. Director assigns the least restrictive treatment facility or program necessary.	10	$100,000.00	$274.00	$1,000,000.00	0*
South Carolina 44-48-10 et seq. (1998)	Committed to the custody of the Dept. of Mental Health as an inpatient in a secure facility. Right to petition for release at annual review.	71	$46,500.00	$127.00	$3,301,500.00	2
Virginia 37.1-70 et seq. **Effective 1-1-04**	Inpatient confinement in secure facility, unless less restrictive conditional release is appropriate.	None	Program start date 1/04			
Washington 71.09.010 et seq. (1990)	Committed to the custody of the Dept. of Social and Health Services for placement in a secure facility. Court can order less restrictive alternative placement only after a hearing following the initial commitment.	177 (Detainees and committed)	$70,000 TO $100,000	$191.00 TO $365.00	$12,390,000.00 TO $17,700,000.00	10 (less restrictive)
Wisconsin 980.01 et seq. (1994)	Institutional care at a secure mental health facility. Person may petition for supervised release 18 months after initial commitment	255	$84,000.00	$230.00	$21,420,000.00	10 (33 on supervise release)
Canada R.S., c. C-34, s. 688 (1977) Chapter 17 (1997) Dangerous Offenders Provision	An offender must have committed a "serious personal injury offense. Murder is not included since it results in an automatic life sentence. Evidence must show that the offender constitutes a risk to others and one of the following: a pattern of repetitive and persistent behavior that is likely to lead to injury or death; the likelihood of injury through a failure to control sexual impulses; or a crime so brutal that it	276 (2% of the Federal Offender Population 2000)	N/A	N/A	N/A	N/A

[redacted]	is unlikely the person can inhibit their behavior in the future.					

*** Denotes state statistics as of 1-1-02**

U.S. Civil Commitment Totals=2073(Includes detainees)
U.S. Discharged or Released from Commitment=69 (Does not include supervised or less restricted)

Texas Commitment

Behavioral abnormality means a congenital or acquired condition that, by affecting a person's emotional or volitional capacity, predisposes the person to commit a sexually violent offense, to the extent that the person becomes a menace to the health and safety of another person.

Predatory Act means an act that is committed for the purpose of victimization and that is directed toward a stranger, a person of casual acquaintance with whom no substantial relationship exists, or a person with whom a relationship has been established or promoted for the purpose of victimization.

Sexually violent Predator is a person who is a repeat sexually violent offender and suffers form a behavioral abnormality that makes the person likely to engage in a predatory act of sexual violence.

***Information provided by the Texas Council on Sex Offender Treatment and the National Center for Prosecution of Child Abuse.**

APPENDIX K

Department of Mental Health Facility Construction
Cost Projections for Future Space Requirements

SEXUALLY VIOLENT PREDATOR FACILITY

Location: Kirkland Correction Institute

Project Schedule:

Procure A/E Firm	4 months
Program Verification	1 month
Schematic Design Documents	1 month
Design Development Documents	3 months
Construction Documents	5 months
Bidding Phase	4 months
Construction Phase	16 months
Project Close-out	2 months
Total	36 months

Building Construction: 3 Plans

1. This facility is based on a typical correctional environment in lieu of a treatment facility design. Personnel are housed 4 per room in wet cells. There is a single story administrative/support area in the middle with two-story housing units attached. This type housing unit has a capacity of 384 beds. The planned construction is 4-48 bed units for a total of 192 beds. These type correction housing units need to be an even number of units for upper and lower housing areas. See DOC information attached. A 25,000 SF administrative/support building is adjacent and connected to the housing unit.

   $15.8 Million

Total SF:	53,000 SF
# Beds:	192
SF/Bed:	276

   Note: This facility is not licenseable by DHEC

   Note: This $15.8 million has not been escalated 2 years (8%) to account for future construction costs. ($17 Million)

2. This plan is a Facility reduced approximately 30% (by CBHS and PPS) from original facility proposed in 2001 by LS3P/KMD Justice. Personnel are housed 4 per room in wet cells located on 3-48 bed units. There is a central administrative/support/clinical area adjacent to each housing unit that contains treatment and evaluation spaces. Physicians, psychologists, and social workers offices are located within this area in addition to medical prep, clean and soiled linen, day room, etc. An administrative/support building of approximately 40,000 SF is adjacent and attached to the housing unit.

   $23.6 Million

Total SF:	85,800 SF
# Beds:	144
SF/Bed:	596

   Note: This is based on obtaining a DHEC License under DHEC Regulation #61-16, Standards for Licensing Hospitals and Institutional General Infirmaries, with exceptions given for a Psychiatric Hospital.

3. Facility reduced another 13% (total of 43%) from original facility proposed in 2001.

$19.0 Million	Total SF:	69,120 SF
	# Beds:	144
	SF/Bed:	480

Note: This size facility is comparable to the Nursing Homes at Tucker Center and Campbell in SF per bed. Psychiatric Hospitals SF per bed are approximately:

Harris	840 SF/Bed @ 206 Beds
Bryan	668 SF/Bed @ 288 Beds
MV	520 SF/Bed @ 174 Beds

This size facility has not been endorsed by CBHS.

Building Renovations:

1. Renovate Shand and Davis Buildings at Crafts Farrow DMH Campus. Each of these buildings would house approximately 96 personnel in a combination of 1-bed rooms and 4-bed rooms. Each building would contain administrative, support, dining, and treatment spaces. The bed rooms would be dry.

$11.0 Million	Total SF:	88,232 SF
	# Beds:	192
	SF/Bed:	459

Concerns:

- Extensive renovations on 50 year old buildings
- Unforeseen/hidden cost with renovations
- Local homeowners objections
- Operating cost per CBHS (staffing)
- Not on a DOC Institute, therefore no exterior security staff in place

Note: This is based on obtaining a DHEC License under DHEC Regulation #61-16, Standards for Licensing Hospitals and Institutional General Infirmaries, with exceptions and waivers given for a Psychiatric Hospital.

2. Renovate two buildings at Manning Correctional Institute next to DMH Crafts Farrow Campus.

$1.0 Million	Total SF:	29,800 SF
	# Beds:	192
	SF/Bed:	155

Concerns:

- Not Licenseable by DHEC
- SF Per Bed very small (1/2 DHEC required)
- No privacy with 6' high partitions
- Local homeowners objections

SC Department of Mental Health

Sexually Violent Predator Facility

at the

Kirkland Correctional Institution

Project Construction Estimate
Conceptual Phase

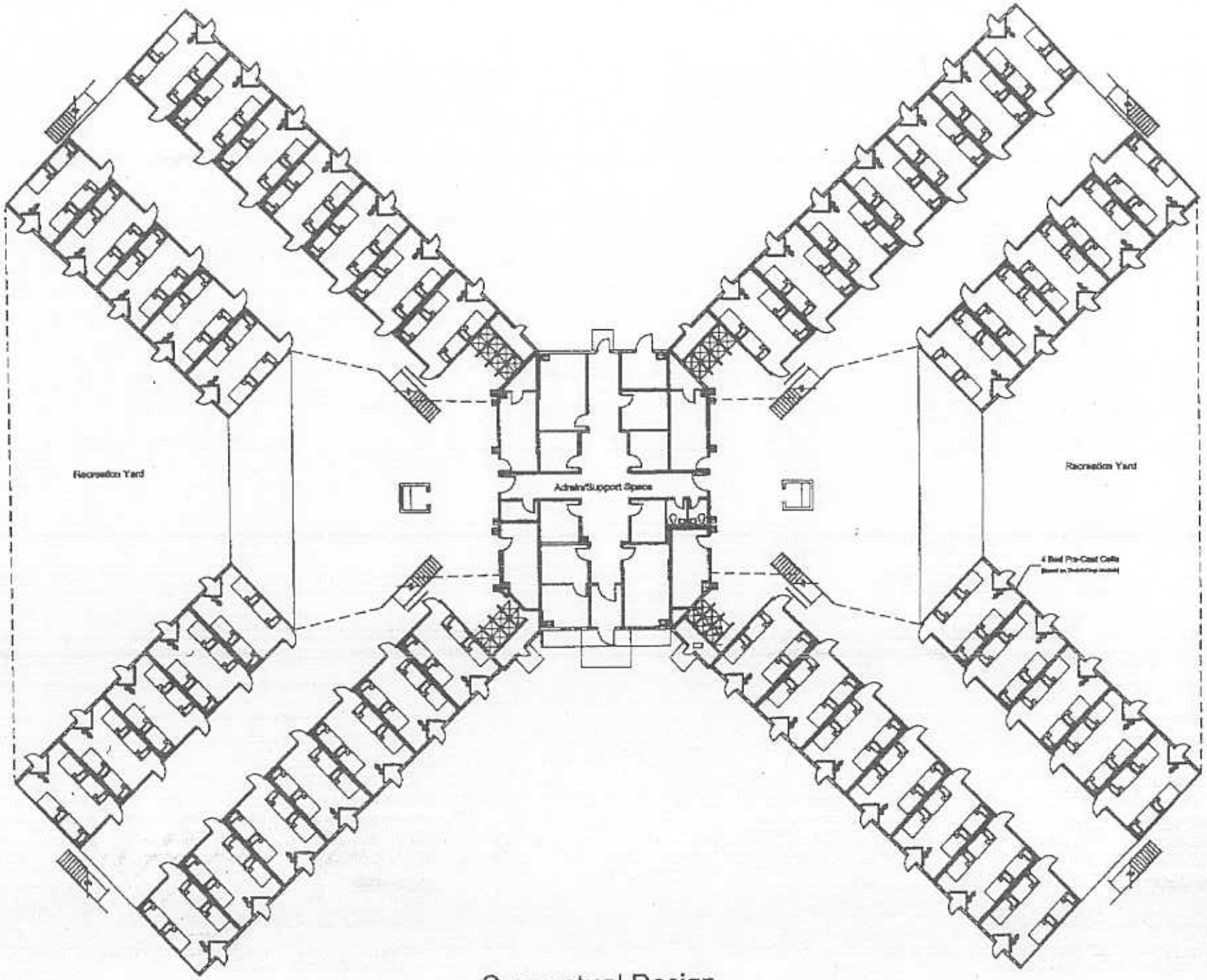
192 Bed Housing Unit (2 tiers of 48 beds upper/lower-- one wing)	$6.1 M
Admin. Bldg.	$5.0 M
Sitework (per Hanscomb estimate less tunnel)	$2.1 M
FF&E	$1.3 M
Project Contingency @10%	$1.3 M
Total Project Costs	$15.8 M

Project Schedule
Conceptual Phase

Procure A/E firm	4 months
Program Verification	1 month
Schematic Design Documents	1 month
Design Development Documents	3 months
Construction Documents	5 months
Bidding Phase	4 months
Construction Phase	16 months
Project Closeout	2 months
Total	36 months

Note: This information is schematic/programmatic and is based on a correctional environment in lieu of a treatment facility design. Areas such as courtyards, general storage, infirmary, medical testing, training, and library services are not included. The housing unit is based on four (4) beds per cell with 48 beds per upper and lower sides – 192 beds per wing – minimal dayroom space and a common recreation yard. The costs do not include any FF&E (fixtures, furniture & equipment), inflation factors, adverse weather delays, or any special foundation/sitework issues.

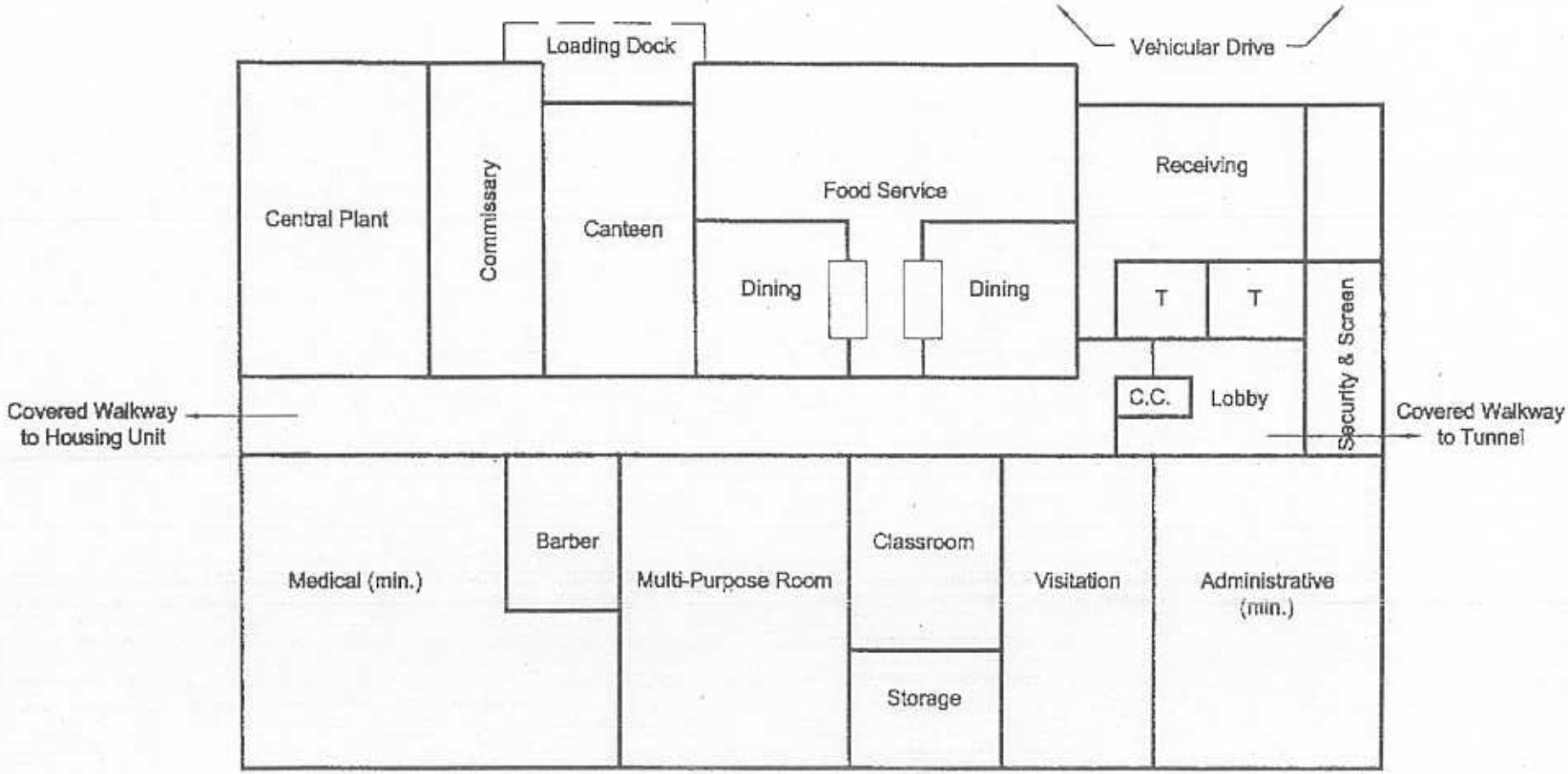
January 4, 2005



Conceptual Design –
384 Bed Housing Unit

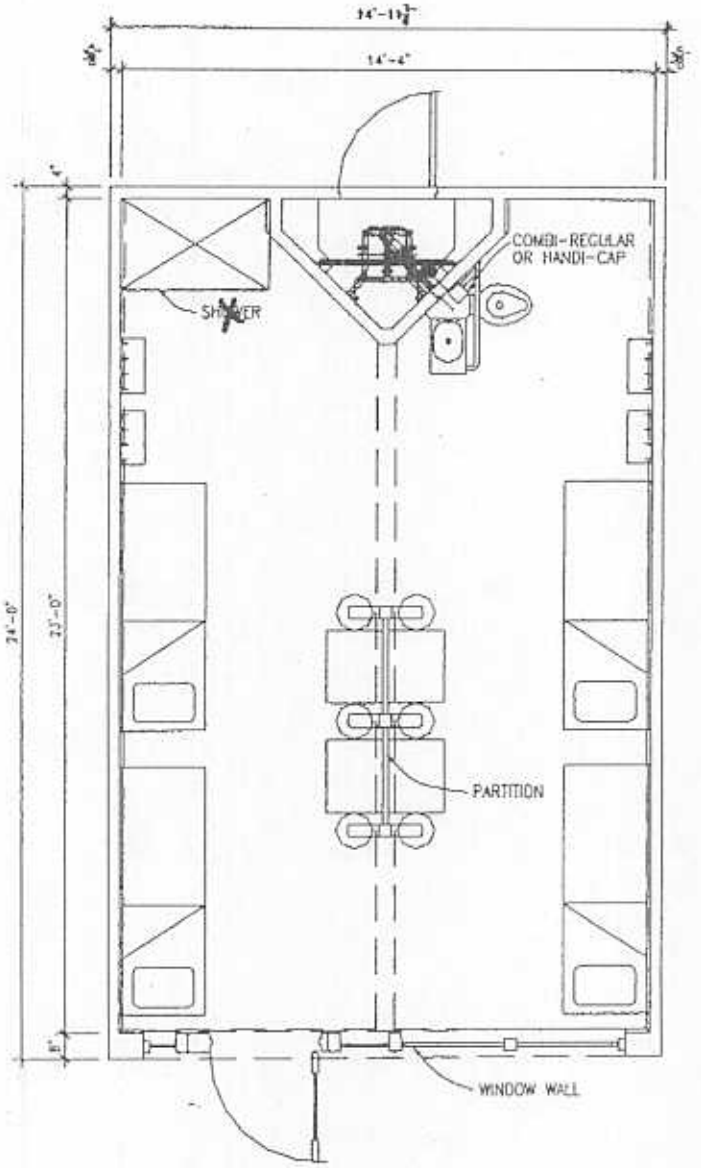
48 upper/lower - 192 Beds per Wing

December 28, 2004



Conceptual/Bubble Diagram
Administration Building

December 28, 2004



"ACA" STANDARDS

PLAN VIEW – INTERIOR

Tindall

TINDALL CORPORATION

CONLEY CORRECTIONS DIVISION

P.O. BOX 280, CONLEY, GEORGIA 30288

3361 GRANT ROAD, CONLEY, GEORGIA 30288

(404)366-6270 FAX (404)366-1736

DATE	DESIGN	JOB
02/06/02	AJK	PROPOSED MODULE
SCALE	DRAWN	FOR / JOB No.
1/4" = 1'-0"	AJK	

APPENDIX L

Department of Mental Health Staffing
Cost Projections for Future Staffing Requirements

SEXUAL PREDATOR PROGRAM
INCREMENTAL COST ANALYSIS - DMH ONLY

	Current Budget - 73 Clients - June 30, 2005			Additional Costs - 78 Clients - Jan 01, 2006			Additional Costs - 83 Clients - June, 30 2006		
	FTE'S	SALARIES	PER DAY	FTE'S	SALARIES	PER DAY	FTE'S	SALARIES	PER DAY
DIRECT STAFF SALARIES									
Clerical Spec B	1.00	22,562							
Admin. Asst	1.00	32,265							
Exec. Asst for Program Mngmnt	1.00	67,375							
LPN II	3.00	96,953		1.00	32,317		1.00	32,317	
Nurse	6.00	289,402		1.00	48,234		1.00	48,234	
Social Wrkr	4.00	149,974		1.00	37,494				
Clinical Security Spec	5.00	106,802		1.00	21,360		1.00	21,360	
MHS	9.00	212,997		2.00	23,666		1.00	23,666	
Activity Thrpy/Suprvsr	2.00	55,670							
Psychologist	1.00	68,245							
Program Mngr	1.00	50,418							
Human Svs Coordinator	1.00	35,535							
Lab Tech	1.00	33,287							
Security	14.00	383,759		1.00	27,411				
Psychiatrist	1.00	146,085							
Total Direct	51.00	1,751,329	65.73	7.00	190,482	6.69	4.00	125,577	4.15
INDIRECT STAFF (CBHS) SALARIES									
Admin/Support	3.70	119,874					0.25	8,000	
Psychiatrist	0.05	7,641							
Pharmacy staff	1.15	66,352					0.20	10,000	
Nurse	0.65	31,204							
Total Indirect	5.55	225,070	8.45				0.45	18,000	0.59
Total Salaries	57	1,976,399	74.18	7.00	190,482	6.69	4.45	143,577	4.74
Terminal Leave Pay		9,000	0.34						
Client Earnings		25,000	0.94		1,700			1,700	
Temporary Svs (nurse pool)		89,493	3.36		6,000			6,000	
Overtime/Shift Diff/On Call		119,367	4.48		6,000			6,000	
TOTAL PERSONAL SVS.	56.55	2,219,259	83.29	7	204,182	7.17	4	157,277	5.19
FRINGE		687,771	25.81		73,000	2.56		52,400	1.73
TOTAL OPERATING		352,156	13.22		24,000	0.84		24,000	0.79
EVALUATIONS		47,460	1.78		3,250	0.11		3,250	0.11
GENERAL & ADMIN. EXP.		47,669	1.79						
GRAND TOTAL		**3,354,316**	**125.89**		**304,432**	**10.69**		**236,927**	**7.82**

NOTE: Does not include costs associated with additional space requirements.

EWJ1/7/05

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APPENDIX M

Miscellaneous Informative Issues, Including Self Reported Contact Sexual Offenses by Participants in the Federal Bureau of Prisons

parole. The former is by far the more restrictive criterion, since offender has to have been found guilty and sentenced to priso Technical violations typically involve violations of conditions of release, such as being alone with minor children or consuming alcohol. Thus, the use of this definition will result in the inclusio individuals who may not have committed a subsequent crimina offense as recidivists. When one encounters the use of return prison as the criterion for recidivism, it is imperative to determi this includes those with new convictions, technical violations, o both.

Underestimating Recidivism

Reliance on measures of recidivism as reflected through official criminal ju system data obviously omit offenses that are not cleared through an arres that are never reported to the police. This distinction is critical in the meas recidivism of sex offenders. For a variety of reasons, sexual assault is a v underreported crime. The National Crime Victimization Surveys (Bureau o Statistics) conducted in 1994, 1995, and 1998 indicate that only 32 percen of three) of sexual assaults against persons 12 or older are reported to law enforcement. A three-year longitudinal study (Kilpatrick, Edmunds, and Se 1992) of 4,008 adult women found that 84 percent of respondents who ide themselves as rape victims did not report the crime to authorities. (No cur studies indicate the rate of reporting for child sexual assault, although it is assumed that these assaults are equally underreported.) Many victims are report sexual assault to the police. They may fear that reporting will lead t following:

- further victimization by the offender;
- other forms of retribution by the offender or by the offender's friends
- arrest, prosecution, and incarceration of an offender who may be a f member or friend and on whom the victim or others may depend;
- others finding out about the sexual assault (including friends, family media, and the public);
- not being believed; and
- being traumatized by the criminal justice system response.

These factors are compounded by the shame and guilt experienced by se assault victims, and, for many, a desire to put a tragic experience behind Incest victims who have experienced criminal justice involvement are part reluctant to report new incest crimes because of the disruption caused to family. This complex of reasons makes it unlikely that reporting figures wil dramatically in the near future and bring recidivism rates closer to actual r rates.

Several studies support the hypothesis that sexual offense recidivism rate underreported. Marshall and Barbaree (1990) compared official records o of sex offenders with "unofficial" sources of data. They found that the num subsequent sex offenses revealed through unofficial sources was 2.4 time than the number that was recorded in official reports. In addition, research information generated through polygraph examinations on a sample of im sex offenders with fewer than two known victims (on average), found that offenders actually had an average of 110 victims and 318 offenses (Ahlm McKee, and English, 2000). Another polygraph study found a sample of im sex offenders to have extensive criminal histories, committing sex crimes average of 16 years before being caught (Ahlmeyer, English, and Simons

The prediction of future violence is difficult, complex, and controversial, and psychologists and psychiatrists do not have a good track record in making accurate predictions. But since John Monahan's (1981) influential book on predicting violent behavior, there has been a great deal of research in this area resulting in improvement in the ability of clinicians and researchers to make these predictions (Monahan, 1996; Webster, Harris, Rice, Cormier, & Quinsey, 1994).

The fundamental problem is that in the general population, violent behavior is a low frequency event. Attempting to predict events in a population with a low antecedent probability leads to an unacceptable level of false positives. If the base rate for violence in a given population is very low, then the most accurate prediction is always to predict that a given individual will not be violent. Any assessments of individual cases will produce less accurate results over the long run.

When statistical methods are applied to a population with a higher frequency of violent behavior, i.e., the prison population or those with a history of violence, more reasonable predictions can be made. Therefore, recent research on high frequency violence populations indicates that the accuracy of predicting future violent behavior can be improved over chance by the use of actuarial methods.

This includes sexual violence since the research on predicting violent recidivism in general is relevant to predicting sex offender recidivism. In the procedures for assessing violent recidivism, sex offenses have been included in the category of violent recidivism. The sexual offense does not have to involve actual physical violence. Webster, Douglas, Eaves and Hart (1997) state that "all sexual assaults should be considered violent behaviour" (p. 25). Boer, Wilson, Gauthier, and Hart (1997) define sexual violence as "actual, attempted, or threatened sexual contact with a person who is nonconsenting or unable to give consent" (p. 328). Webster et al. (1994) include all sex offenses in their sample. Hanson and Bussière (1996), however, conclude on the basis of their meta-analysis that sexual recidivism is best predicted by a different set of factors, which includes sexual deviance.

The base rate for sexual recidivism for certain offenders is high enough that an actuarial prediction method can improve the accuracy of prediction when the definition of recidivism is in keeping with the sexual offender commitment laws. The recidivism rate, however, differs among various studies. Hanson and Bussière (1998) report that only a minority (13.4%) of their total sample of 23,393 subjects from their meta-analysis committed a new offense within the average 4- to 5-year follow-up period. Even with studies with thorough record searches and follow-up periods of 15 to 20 years, the recidivism rate never exceeded 40%. A universal finding in the literature is that incest offenders have the lowest rates of reoffending.

In contrast, Doren (1998), in a review of the research, reports that the true recidivism base rate over 25 years for extrafamilial sexual abusers is 52% and for rapists is 39%. Doren, who is involved with the sexual predator program at Mendota Mental Health Institute in Wisconsin, uses the recidivism rates from Prentky, Lee, Knight, and Cerce (1997). This is an extremely high risk sample. The Prentky, et al. sample consisted of 251 men who were committed to the Massachusetts Treatment Center for Sexually Dangerous Persons (MTC). Persons who were charged after being released from MTC and persons who were residents at MTC but were previously discharged, reoffended and were recommitted were included in the sample. Also, a charge, not a conviction, was used as the index of reoffense.

In addition, the figures of 39% and 52% are estimates from the survival analysis; the percentage of new offenses at the end of the study period (25 years) was 26%

Law and Psychiatry

Myths About Violent Sexual Predators and All That Pesky Legislation

WILLIAM H. REID, MD, MPH

Mental health has a new rallying cry: "Stop the sexual predator legislation." It seems the organizations that purport to speak for patients or mental health professions are falling all over themselves to criticize the 1997 U.S. Supreme Court decision in *Kansas v. Hendricks*, and to predict doom and gloom in other states' laws that are sure to follow in the next several years.

At the center of all this is a Kansas law that allows, with a number of "due process" safeguards, a form of involuntary commitment that focuses on violent sexual predators. Mental health professionals and public agencies are concerned about issues of government encroachment into professional issues, social policy encroachment into clinical policy, and substantial financial implications for public agencies. Many of the clinicians I meet from day to day misunderstand the Supreme Court's action, and the Kansas law that was allowed to stand.

Myth #1: Sexual predator legislation is a treatment issue, so psychiatrists and other professionals should get indignant about this new commitment process.

The purpose of recent sexual predator legislation is not so much to treat the perpetrator as to stop him. The commitment process thus has a social, rather than a medical, source. Before we leap to the conclusion that this is a bad thing, however, we should recall that civil commitment is no longer a parent-like state effort to help the patient. The constitutional basis for commitment has long been the State's police power, not its *parens patriae* responsibility.

Myth #2: Using a civil procedure to preventively detain someone is unconstitutional.

First, preventive detention is exactly what we do in other forms of civil commitment. Second, the U.S. Supreme Court in *Hendricks*—all the justices, not merely the majority that confirmed the Kansas law's constitutionality—found nothing unacceptable about adding a new category of commitment provided it serves a legitimate state interest and preserves the civil rights (including those of due process) of the person committed.

Myth #3: Paraphilias are not traditional mental illnesses, therefore they can't be reasons for commitment.

Many paraphilias are indeed manifested primarily by their antisocial or criminal behavior; it's the second part that makes the "myth." Commitment is a state-by-state issue. As the U.S. Supreme Court ruled, there is no constitutional reason that a state may not create a new class of people eligible for commitment (just as many have with substance abusers), and the justices unanimously agreed that sexual predator commitment procedures need not require a "traditional" mental illness in order to be constitutional.

Myth #4: Commitment is for treatment, and we can't treat these people.

Many clinicians believe that commitment requires treatment. In fact, the constitutional basis for commitment laws requires a generic *quid pro quo* of "something more" in return for detention, but not treatment *per se* (although a state may require it). What's more, we can often treat paraphilias, pedophilia, and violent predation as well as we treat many severely and chronically mentally ill patients. Whether doctors and legislatures choose to allow, provide, or afford the methods we know may work is another matter.

Myth #5: "Sexual predator" can be defined so broadly that we'll be on a slippery slope to social control and psychiatric abuses.

The current and proposed sexual predator statutes with which I am familiar contain so many modifiers and due process considerations that it is difficult to imagine the draconian scenarios that make my more liberal friends cringe. I admit that I'm glad the concept of "paraphilic rapism" fell on its figurative face and I'd hate to see "ordinary" and statutory rape by themselves become "sexual predator" issues; nevertheless, "slippery slope" makes a better sound bite than logical argument.

Social issues such as this are more often like a pendulum than a slippery slope. They oscillate. If things start to go too far in one direction, people protest, lawsuits get filed, and politicians get nervous. Exhibitionists, *frotteurs*, and adulterers seem unlikely to get caught up in sexual predator legislation. They just don't scare us—or hurt us—enough.

Dr. Reid is a forensic psychiatrist in Horseshoe Bay, Texas, and a past president of the American Academy of Psychiatry and the Law. His most recent book, *The Treatment of Psychiatric Disorders, 3rd Edition*, will soon be followed by *Legal Issues for Psychotherapists*. His website, Psychiatry and Law Updates, may be found at www.reidpsychiatry.com. This column contains general clinical and clinical-forensic opinions which should not be construed as applying to any specific case, nor as any form of legal advice.

Finally, we already define those diagnoses most likely to be associated with violent sexual predation. The trick is to remember that behavior and functioning are the point, not diagnosis. This is true whether one is speaking of patients with schizophrenia, mania, brain injury, rare impulse control disorders, primitive character pathology, or idiopathic paraphilia.

Myth #6: The causes of sexual predation are so varied that we must not lump them into a single form of "sexual predator" commitment.

But that's just what we do with other mental illness commitments. Psychiatrists and psychologists understand that involuntary hospitalization revolves, once some mental illness is established, around function, not diagnosis or prognosis. We generally agree that if the patient is a danger to self or others, or is at grave risk of marked deterioration, commitment is not only permissible but necessary, whatever the mental disorder. Some care during hospitalization is specific (e.g., treatment for the disorder), and some is generic (e.g., protection and support).

Myth #7: Treatment should start, and largely stay, in prison, while the person is serving his criminal sentence.

This one turns the idea of patients' rights on its ear. Years of Federal caselaw establish that prisoners have an almost inalienable right to refuse treatment. Biological therapies for paraphilic behaviors, often the treatments most likely to work and be socially reliable, are a real problem in prison—even when a prisoner wants them—since anything that suggests coercion (such as the prospect of an earlier release) can easily void the consent. Things look bad from the other direction as well. With few exceptions, the due process safeguards required for sexual predator commitment and treatment are far more difficult for the state to overcome than those for criminal incarceration. Once convicted, the state need not provide any care or treatment for the behavior itself. The commitment process, on the other hand, is so strict that few of even the most severe offenders are detained (see below).

Myth #8: Our treatments aren't reliable enough for such dangerous people.

It's often not so much a matter of what works but of using it; and it's not so much a matter of succeeding with everyone but of giving our best efforts and succeeding with some. Many offenders will be released eventually, often with community notices, close monitoring, and/or high-tech surveillance. Whatever treatment they receive will add to, not detract from, neighborhood safety.

The above having been said, medicine (particularly) and psychology do have a number of treatments that are reliable, when "used as directed," for many patients with predatory sexual behaviors (e.g., anti-androgenic medications, surgical castration, stereotactic neurosurgery, and treatments for primary disorders such as schizophrenia or bipolar illness). Note that I did *not* say that all are easily available or without controversy, but we do know about them, and given the seriousness of the conditions they are designed to address, their risk-benefit ratios are often quite good. If current social and political climates don't allow these treatments, this is a practical issue (and an important one), not a scientific issue.

Myth #9: Non-biological treatments are just as good as biological ones; empathy training, sex education, restructuring of cognitive distortions, and other psychosocial tools can take the place of biological modalities.

Here's where I may part company with some nonmedical colleagues (and a few psychiatrists). I believe that the basic treatment for primary paraphilia manifested as chronic, characterologic, violent, predatory behavior is *biological*. Many of the psychotherapeutic, operant, and cognitive approaches have merit, and I have treated many nonpredatory patients with them alone; however, they should be viewed as adjuncts to somatic therapies for changing the behaviors envisioned by most current sexual predator laws. One should not view the nonbiological treatments as reliable for dangerous people (see Myth #8).

Corollary 1. Every patient must have 6 or 8 hours each day of psychosocial groups, individual psychotherapy, sex education, self-esteem support, and the like. Some specialized nonbiological modalities (e.g., sequence-interruption strategies and other relapse-prevention training, or conditioning approaches similar to those developed by Abel and Becker) are very important to the outcome of the biological ones. Neither medication nor surgery should be provided in a vacuum, but it seems silly to require hours of nonspecific experiences for every patient every day, and even sillier to rely solely on even the most sophisticated behavioral or operant approach when the stakes are this high. If a program cannot, for whatever reason, use anti-androgenic medications (or their hormonal equivalent) or surgical approaches when indicated for patients who are a serious threat to society, then the community is justified in doubting its outcomes.

Corollary 2. Primary paraphiliacs undergo structural psychological change when they experience sex education, empathy training, "skills training," and/or psychotherapy for cognitive distortions. NAMBLA* and other groups and individuals who talk about children "wanting it," needing hands-on sex education, or being able to consent are not, in my opinion,

*North American Man-Boy Love Association. Honest

saying that because of some "cognitive distortion," but because they want to keep doing what they do. I'm a great believer in the unconscious and in overdetermination of behavioral motivation, but *these people have an extremely refractory motivation for what is for them an extremely pleasurable behavior; any statement of empathy for the victim at the time of the sexual act is purely, consciously or unconsciously, self-serving.* Treatment must focus on observable, measurable control of either the impulse or the pleasure it provides; anything less is usually insufficient.

Myth #10: The issue of coercion prevents prisoners and those committed for sex offenses from giving legally adequate consent.

I've read *Brave New World* and *1984*, too, but one should remember that we are starting with the premise that the patient has clearly demonstrated—to some high level of proof—chronic, violent, sexually predatory behavior. In existing civil commitments (of psychotic or severely depressed patients, for example), we already predicate discharge on clinical and behavioral improvement, treatment compliance, and follow-up monitoring, and thus "coerce" treatment compliance to some extent. It seems reasonable to consider the same for this new class of committed patients.

Myth #11: Allowing sexual predator commitment further stigmatizes mental illness, and the public will confuse mental patients with paraphiliacs.

We shouldn't fight stigma by saying that some patients are worthy and others aren't. The key to credibility in the fight to decrease stigma is to be honest about disorders that occasionally produce abhorrent behavior and those few which are routinely associated with it. Like it or not, some people with schizophrenia are dangerous and many are very hard to live with. Some depressed patients kill their children, and some hypomanic patients have bizarre sexual appetites. We try to help, and once it's feasible, we try to reconnect these patients with society.

Myth #12: Sex offenders represent a danger to vulnerable other patients.

I agree to some extent, but let's not become hysterical. I often suggest highly specialized programs in a separate and secure treatment environment, but the point is that these patients should be assessed and placed individually, just as one does (or should do) for other kinds of patients. Some states have programs in existing state hospitals where they have treated patients with paraphilias for years. They know that assaults occur with many kinds of patients, not especially paraphiles, and they cope with the danger (low or high) through recognizing individual impulses and control problems, adequate staffing and monitoring, appropriate treatment, and sometimes physical barriers.

The danger may be an emotional rather than physical one. Treatment programs should be sensitive to the needs of, for example, those women who are vulnerable to the *idea* of having an abusive or predatory male in the same milieu. This, of course, is not a concept limited to convicted sex offenders.

Many sexual predators—especially pedophiles—are model inpatients when the hospital environment is secure, monitored, and free of their victims-of-choice. Violent psychopaths or psychotic killers are a different story, and prudent hospitals shouldn't house them on an ordinary hospital unit anyway, regardless of their sexual behavior.

Myth #13: The very long length of stay associated with treatment of sexual predators will clog facilities and deplete scarce public mental health dollars.

Length of stay, facility crowding, and clinical priorities are operational issues, not clinical or constitutional ones. Of course there are practical problems, but that doesn't justify avoiding either patient or community need.

This Month's Take-Home Lesson

Much of the current criticism of modern sexual predator commitment laws by psychiatrists and psychologists is unreasonable. To dismiss these legitimate community issues and clinical needs out of hand with a few incomplete (or just wrong) phrases about rights or treatment refractoriness doesn't help the people who have these problems, their victims and potential victims, or the society in which we live and practice. Let's work *with* those who are trying to do good.

Self-Reported Contact Sexual Offenses by Participants in the Federal Bureau of Prisons' Sex Offender Treatment Program: Implications for Internet Sex Offenders

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Presented at the 19th Annual Conference Research and Treatment Conference
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San Diego, CA – November 2000

Introduction

With the explosion of the Internet as a medium of communication and commerce, there has been an increasing number of individuals using cyberspace to commit sexual crimes in recent years. These crimes include downloading, trading, and distributing child pornography, as well as luring children via the Internet for the purpose of sexual abuse and exploitation. Until recently, the Internet has been largely unregulated and unmonitored by law enforcement. This has enabled many individuals to access cyberspace for various illicit purposes with perceived anonymity.

Child pornography, relatively unavailable to many individuals until recently, is now readily available through the Internet. Individuals accessing child pornography typically do so through electronic communications in chat rooms and bulletin boards. They collect and trade child pornography with other individuals with similar interests. They may amass collections of several thousand images depicting children in sexually explicit poses or in the act of being sexually abused by adults. These offenders target children in cyberspace in a similar manner as offenders who prey on children in their neighborhood or nearby park. They seek vulnerable children, gradually groom them, and eventually contact them to perpetrate sexual abuse.

As more Internet sex offenders are adjudicated in federal courts, arguments are raised by prosecutors, defense attorneys, law enforcement personnel, and mental health professionals about the nature of this criminal activity, the typology of this offender population, and the risk posed to the community. In the prosecution of these offenders, some attorneys have argued that the Internet, with its apparent anonymity and easy access to sexually explicit materials (including child pornography), is the culprit of the aforementioned criminal activity. They have argued that

without the availability of child pornography on the Internet, these individuals would not engage in criminal behavior. They blame those who produce child pornography and then distribute the materials via the Internet for their clients' criminal behavior. Others have argued that the Internet has simply given many of these individuals (i.e., child pornographers) more access to already existing or established patterns of behavior and sexual interest (e.g., pedophilia). They suggest that the Internet has merely given those with pedophilic interest and behavior access to a medium of communication that facilitates sexual predation, but does not cause it. Still, others have suggested that child pornographers are not sex offenders at all, and that downloading an image containing child pornography does not make a person a sex offender or a pedophile.

While these arguments require considerable more debate, they also should be subject to empirical analysis. The following study attempts to understand this largely misunderstood criminal population by presenting data obtained in the course of treatment of inmates who volunteered to participate in the Sex Offender Treatment Program at the Federal Correctional Institution in Butner, NC. The primary objective of this exploratory study was to examine the incidence of sexual offending involving contact crimes (e.g., child sexual abuse, rape) of program participants, including those inmates convicted of non-contact sexual offenses (e.g., possession of child pornography).

Method

Overview of the treatment program

The Sex Offender Treatment Program (SOTP) was established in 1990 at the Federal Correctional Institution in Butner, North Carolina. It is an intensive, residential therapeutic program for male sexual offenders in the Federal Bureau of Prisons. The program is voluntary; participants do not receive special privileges and are not eligible for a sentence reduction. The program is housed within the general population of a medium security correctional institution. It employs a wide range of cognitive-behavioral and relapse prevention techniques to treat and manage sexual offenders. This prison-based program is probably the only treatment program for sex offenders in which the majority of the participants are Internet sex offenders.

Data Collection

The data in the present study were obtained from a review of the clinical charts of former participants of the SOTP. The raters in this study were comprised of SOTP staff members and pre-doctoral psychology interns.

There were two variables examined in this study. The first was the number of contact sexual crimes the subject was known to have committed prior to entering treatment. This information was extracted from the Presentence Investigation (PSI) Report, a formal court document prepared by the United States Probation Office. The criteria for scoring a contact sexual crime on the PSI were prior convictions or arrests for, and/or self-reported offenses involving any type of sexual assault or molestation of an adult or child. The second variable was the number of self-reported contact sexual crimes divulged over the course of evaluation and treatment in the SOTP. This information was extracted from the subject's discharge report. This document summarizes the offender's self-reported sexual history and list of victims. To appease subjects' concerns

regarding self-incrimination in divulging unreported or undetected sexual crimes during the course of treatment, they had the option of referring to their victims by first name or with a number (e.g., victim 1).

Subjects

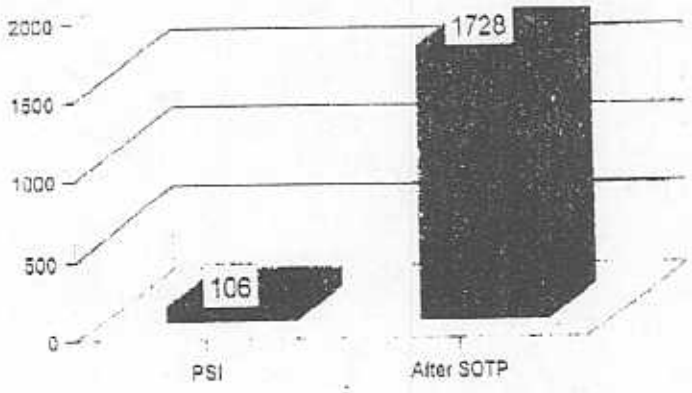
The subjects were 90 incarcerated males, ranging from 23 to 66 years of age, who volunteered to participate in the Federal Bureau of Prisons' SOTP. The racial/ethnic background of these offenders was 79% Caucasian, 19% American Indian, and 2% African-American. There were no Hispanics or Asians in the sample. Subjects were classified according to their instant offense and placed in one of three groups of criminal offense clusters.

1. Child Pornographer/Traveler (N= 62). These crimes involve the production, distribution, receipt, and possession of child pornography and crimes involving luring a child and traveling across state lines to sexually abuse a child.
2. Contact Sex Offender (N= 24). These crimes involve the sexual molestation, abuse, or assault of a child or adult.
3. Other (N= 4). These federal crimes are non-sexual offenses such as, bank robbery, mail fraud, or drug trafficking. All subjects except one did not have a history of sexual crimes for which they were previously adjudicated in state jurisdictions.

Results

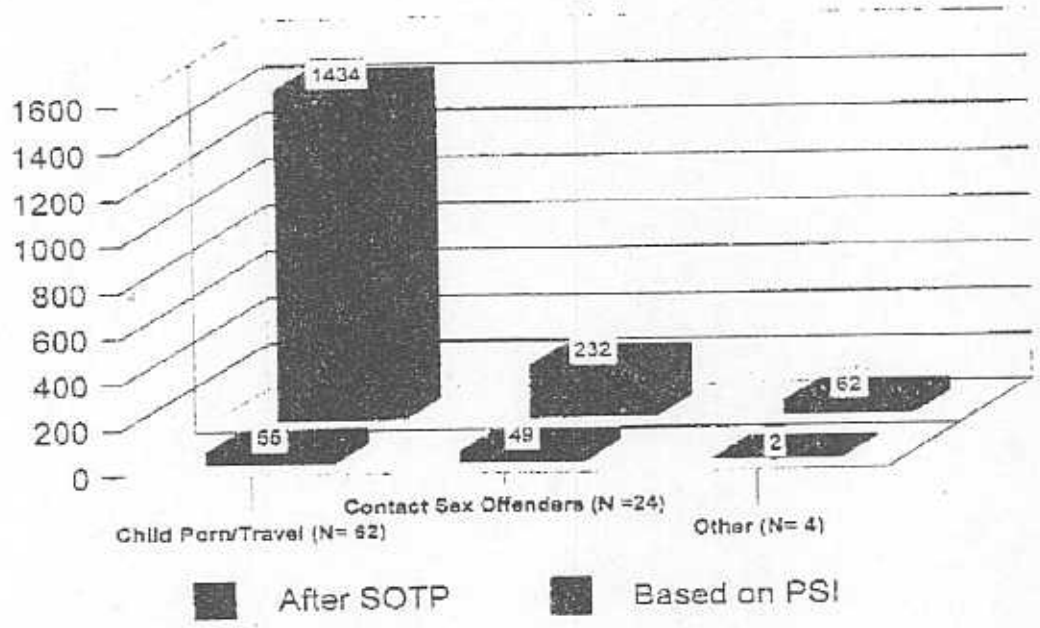
The review of clinical charts revealed that subjects in all three groups disclosed additional sexual crimes over the course of their participation in the SOTP. Subjects in the Child Porn/Travel and Other groups revealed extensive histories involving contact sexual crimes, including rape of adults and sexual abuse of minors. The 90 subjects in the sample recorded a total of 106 contact sexual crimes before they entered the SOTP (based on their PSI). After participation in the SOTP, these subjects divulged an additional 1,622 sexual crimes for which they were never detected by the criminal justice system (see Figure 1).

Figure 1: Contact sexual crimes based on PSI and self-report after SOTP participation



Of the 62 subjects in the Child Porn/Travel group, 55 contact sexual crimes were documented on their PSI. After participation in the SOTP, these offenders admitted to an additional 1,379 contact sexual crimes for which they were never detected by or reported to the criminal justice system. Of the 24 subjects in the Contact Sex Offender group, 49 contact sexual crimes were documented on their PSI. After participation in the SOTP, these subjects admitted to committing an additional 183 contact sexual crimes for which they were never detected. Of the four subjects in the Other group, two contact sexual crimes were documented on their PSI. After participation in the SOTP, these subjects admitted to committing an additional 60 contact sexual crimes for which they were never detected (see Figure 2).

Figure 2: Contact sexual crimes based on PSI and self-report after SOTP participation by criminal category



The increase in self-reported contact sexual crimes increased significantly in all three subject groups. The Child Porn/Travel group had an average of 0.89 victims per offender on the PSI, and 23.65 after participation in the Program. The Contact Sex Offender group had an average of 2.04 victims per offender on the PSI, and 9.6 after participation in the Program. Likewise, the Other group had an average of 0.5 victims per offender based on the PSI, and 15.5 after participation in the Program (see Table 1).

Table 1: The average number of contact sexual crimes for each subject group

	Child Porn/Travel (N=62)	Contact Sex Offender (N=24)	Other (N=4)
Average contact sex crimes based on PSI	0.89	2.04	0.5
Average contact sex crimes after SOTP	23.65	9.6	15.5
Range of self-reported contact sex crimes	0 to 202	1 to 40	0 to 25

Of the 62 subjects in the Child Porn/Travel group, 36 subjects had no documented history of contact sexual crimes based on the PSI. Of the 36 subjects in the Child Porn/Travel group with no prior history of contact sexual crimes based on their PSI, 15 (42%) subjects divulged no additional contact sexual crimes. If these 15 subjects are excluded from the calculations of average victims per offender, the subjects in the Child Porn/Travel group have an average of 30.5 victims per offender, rather than the 23.65 reported in the table above.

Of the 39 subjects in the Child Porn/Travel (36) and Other (3) groups who had no prior criminal history denoting a contact sexual crime, 24 subjects (62%), after participation in the SOTP, admitted to having committed 278 contact sexual crimes. These 24 subjects accounted for 19% of all of the sexual crimes committed by the Child Porn/Travel and Other subjects (see Table 2).

Table 2: Subjects without contact sexual crimes based on PSI who admitted to contact crimes

	Child Porn/Travel (N=36)	Contact Sex Offender (N=3)	Total (N=39)
Number of subjects in the group admitting to contact sexual crimes	21	3	24
Self-Reported contact sexual crimes after participation in SOTP	221	57	278

Discussion

The results of this study revealed findings consistent with other published studies on the incidence of sexual offending based on self-report (Abel, et al., 1987; Ahlmeyer, et al., 2000). While it is no surprise that sex offenders convicted of contact sexual crimes usually have committed more crimes than those for which they were apprehended, to date there has been no evidence to suggest that Internet sexual offenders (i.e., those in the Child Porn/Travel group)

engaged in sexual crimes other than the conduct for which they were convicted, particularly those involving physical/sexual contact with the victim. The results of the current investigation revealed that 76% of offenders convicted of crimes in the Child Porn/Travel category had contact sexual crimes. In fact, these offenders appear to have committed contact sexual offenses at higher rate (i.e., 30.5 victims per offender) than sex offenders convicted of contact sexual crimes (i.e., 9.6 victims per offender). There are some Internet sex offenders, however, whose PSI and self-report in the SOTP did not reveal any contact sexual crimes (25%).

These findings suggest that the majority of offenders convicted of Internet sexual crimes share similar behavioral characteristics as many child molesters. While these Internet sex offenders have unique patterns of sexual deviance, it appears that many can be equally predatory and dangerous as extra-familial child molesters. It is still unclear as to why some Internet sex offenders have had contact sexual crimes and others appear not to have had any. It may be that some offenders are simply denying past criminal behavior. Others may not have committed any contact sexual crimes because of lack of access to potential victims or poorly developed grooming and predatory skills. Future research should continue to examine this emerging and largely misunderstood criminal population.

References

Abel, G. G., Becker, J. V., Mittelman, M. S., Cunningham-Rathner, J., Rouleau, J. L., & Murphy, W. D. (1987). Self-reported sex crimes of nonincarcerated paraphiliacs. Journal of Interpersonal Violence, 2(6), 3-25.

Ahlmeyer, S., Heil, P., McKee, B., & English, K. (2000). The impact of polygraphy on admission of victims of offenses in adult sexual offenders. Sexual Abuse: A Journal of Research and Treatment, 12(2), 123-138.

Self-Reported Contact Sexual Crimes of Federal Inmates Convicted of Child Pornography Offenses

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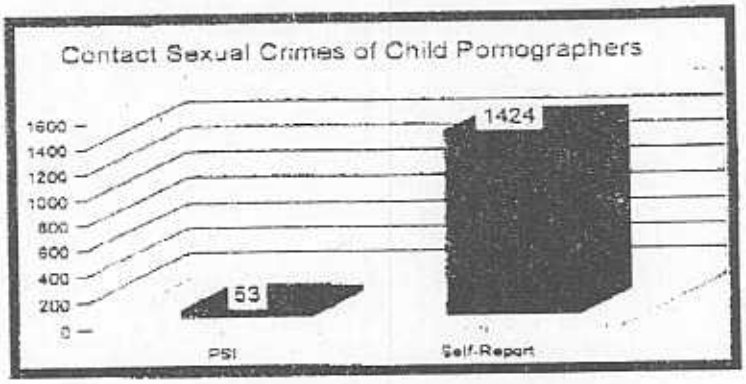
Highlights from a poster presentation
presented at the 19th Annual Conference Research and Treatment Conference
of the Association for the Treatment of Sexual Abusers, San Diego, CA – November 2000

Introduction

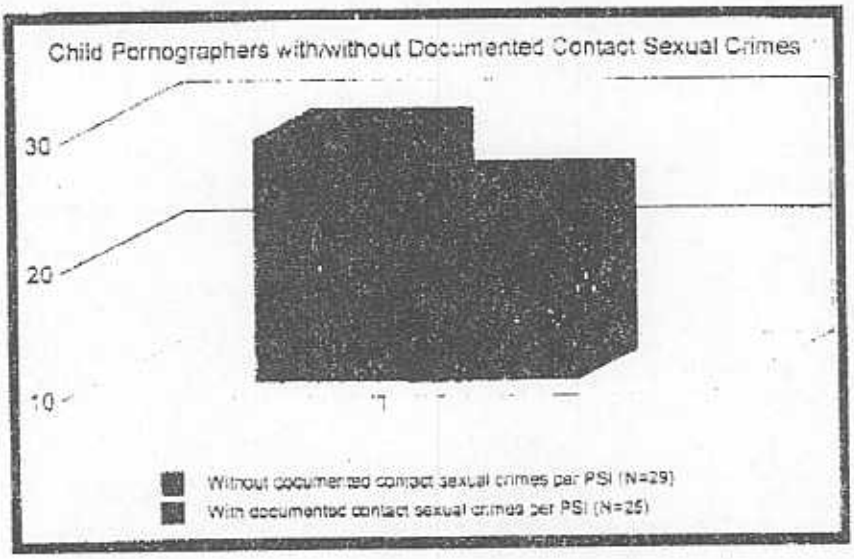
- Question: Are child pornography offenders at risk of committing child sexual offenses?

The Study

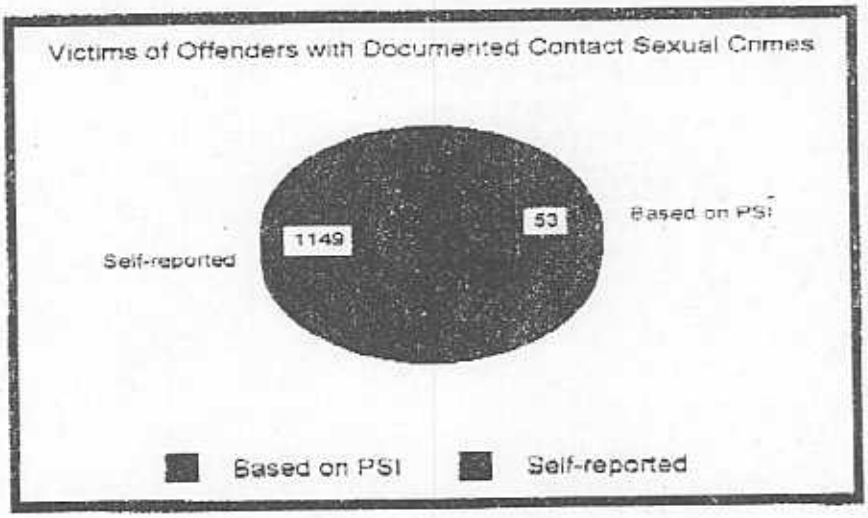
- the sample included 54 former inmates in the Sex Offender Treatment Program (SOTP) who were convicted of child pornography offenses (i.e., possession and distribution)
- two variables examined in this study:
  - the number of contact sexual crimes the offender was known to have committed prior to entering treatment (based on the PSI)
  - the number of self-reported contact sexual crimes divulged over the course of evaluation and treatment in the SOTP
- the results indicate that, as a group, the 54 offender recorded
  - 53 victims of contact sexual crimes, as indicated by their PSI reports
  - an additional 1,371 victims of contact sexual crimes for which they were never detected by the criminal justice system
  - an average of 0.98 victims of contact sexual crimes based on the PSI report
  - an average 26.37 victims of contact sexual crimes based on self-report



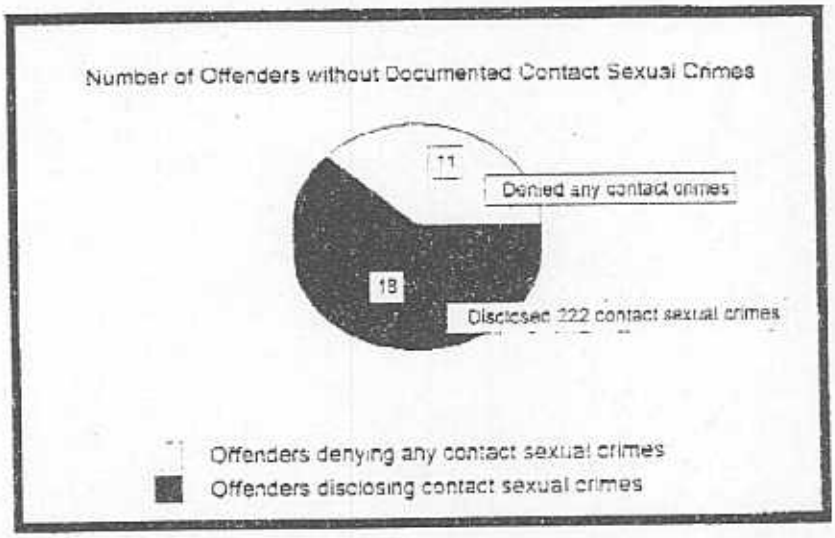
- of the 54 child pornography offenders, 29 (54%) had no documented history of contact sexual crimes based on their PSI. Conversely, 25 (46%) had some evidence of contact sexual crimes noted in their PSI:



- of the 25 offenders <u>with</u> a documented history of contact sexual crimes, they disclosed an additional 1,149 victims after participation in the treatment program:



- of the 29 child pornography offenders without a documented history of contact sexual crimes based on the PSI. 18 (62%) disclosed committing sexual crimes (i.e., 222 victims) and 11 (38%) disclosed no contact sexual crimes after participation in the treatment program.



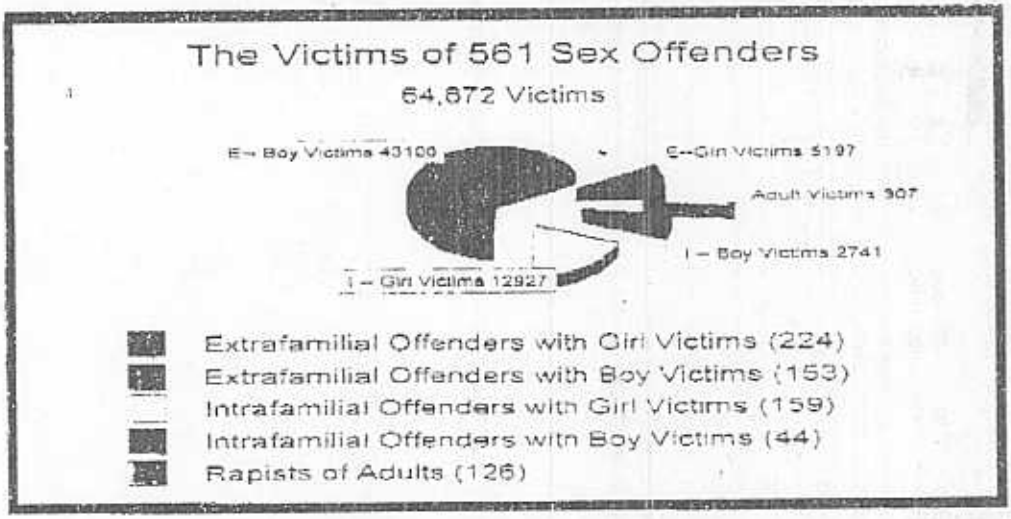
Summary and Implications

- The results of this study revealed findings consistent with studies on the incidence of sexual offending based on self-report, such as 1) Abel, G. G., Becker, J. V., Mittelman, M. S., Cunningham-Rathner, J., Rouleau, J. L., & Murphy, W. D. (1987). Self-reported sex crimes of nonincarcerated paraphiliacs. Journal of Interpersonal Violence, 2(6), 3-25 and 2) Ahlmeyer, S., Heil, P., McKee, B., & English, K. (2000). The impact of polygraphy on admission of victims of offenses in adult sexual offenders. Sexual Abuse: A Journal of Research and Treatment, 12(2), 123-138 (see the three figures on pages 4-5).

- It would be *imprudent to conclude* that a child pornography offender does not present a risk to the community just because his criminal history does not reflect a prior contact sexual crime against a minor

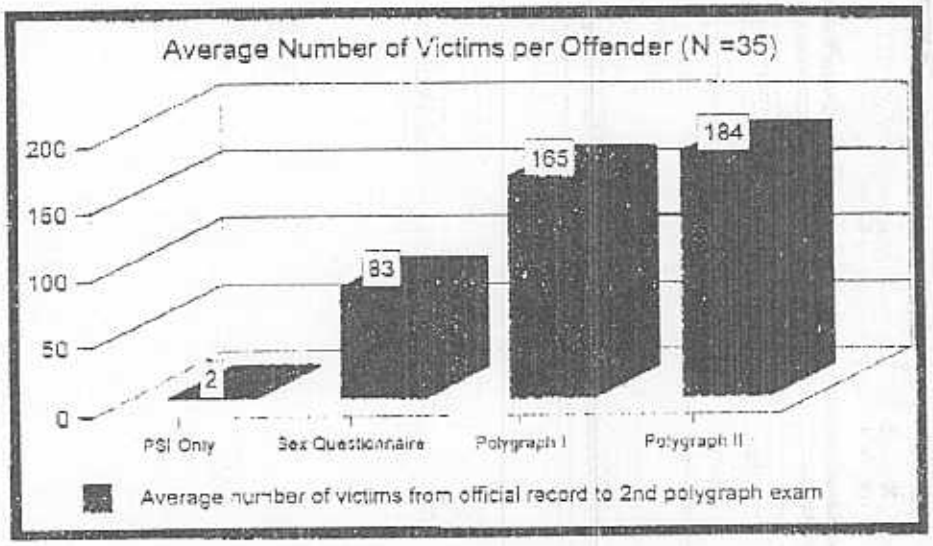
  - only 46% of the offenders initially appeared to have contact sexual crimes (PSI)
  - 79.6% of the offenders admitted to having prior contact sexual crimes after participation in the treatment program
  - 62% of the offenders who had no documented contact sexual crimes (based on PSI) admitted to having undetected contact sexual crimes

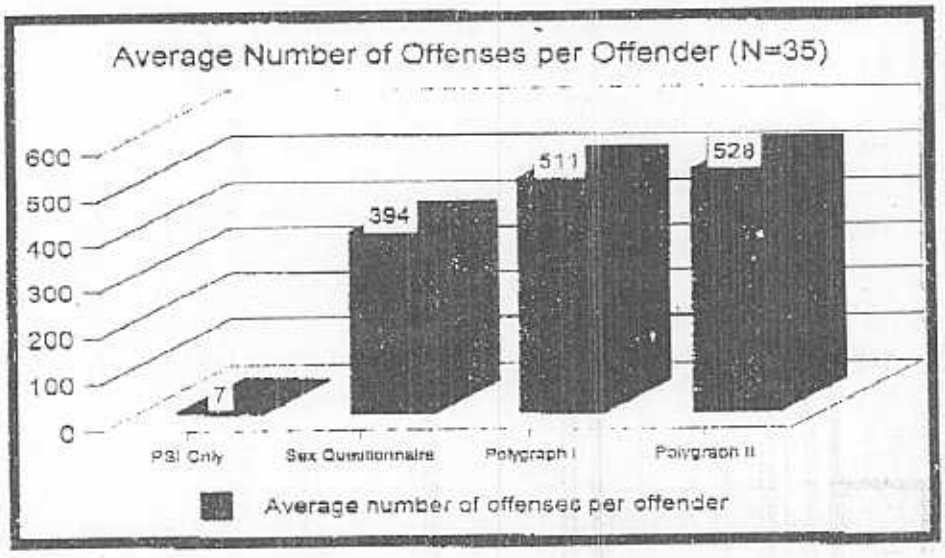
- Based on the results of this study, it is *reasonable* to hypothesize that offenders convicted of child pornography offenses are more similar to child molesters than previously thought
  - while some child pornography offenders appear not to have engaged in contact sexual crimes, some have committed many contact sexual crimes
  - it is unclear why some child pornography offenders have contact sexual crimes and others appear not to have any
- Abel et al. (1987) surveyed 561 incarcerated male sex offenders. The average age of subjects in the sample was 31.5 years. They were moderately educated, from all socioeconomic levels, and over one-half were married at the time of their offense. Most offenders' paraphilic interest became evident prior to age 18. While the majority of the offenders admitted to having engaged in multiple paraphilic and criminal behaviors (e.g., child sexual abuse, rape of adults, indecent exposure, bestiality, etc.), only five categories of victims are presented below. Note that the total number of offenders in each category exceeds 561. This is due to the fact that offenders participated in multiple paraphilic and criminal behaviors, and were therefore counted in each category of crime:



- Ahlmeyer et al. (2000) found similar results. The rate of self-disclosure in this study was enhanced by polygraph examinations. 35 offenders participated in the study. The average number of victims and sexual offenses were recorded based on PSI data alone, a sex questionnaire and two polygraph examinations. There

was considerable self-disclosure of unreported, undetected sexual crimes when offenders underwent polygraph examinations:





APPENDIX N

New Study on Re-Offense Rates
Of Untreated Sex Offenders

Lifetime Sex Offender Recidivism: A 25-Year Follow-Up Study1

Ron Langevin, Suzanne Curnoe, Paul Fedoroff, Renee Bennett, et al. **Canadian Journal of Criminology and Criminal Justice.** Ottawa: Oct 2004.Vol. 46, Iss. 5; pg. 531, 22 pgs

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Abstract (Document Summary)

A sample of 320 sex offenders and 31 violent non-sex offenders, seen for psychiatric assessment between 1966 and 1974, were compared retrospectively on lifetime recidivism rates to 1999 over a minimum of 25 years. A number of criteria and data sources were used; RCMP records and hospital records were the best sources, albeit the RCMP had records for only 54.1% of the cases. Approximately three in five offenders reoffended, using sex reoffence charges or convictions or court appearances as criteria, but this proportion increased to more than four in five when all offences and undetected sex crimes were included in the analysis. Group differences in recidivism were noteworthy, with child sexual abusers and exhibitionists most likely to reoffend and incest offenders least likely. Time at large and time incarcerated played a relatively minor role overall in results, except in the case of offenders who were sexually aggressive against adult females, courtship disordered, or violent. The typical known criminal career spanned almost two decades, indicating that sex offence recidivism remained a problem over a significant part of the offenders' adult lives. [PUBLICATION ABSTRACT]

Full Text (7664 words)

[Headnote]

A sample of 320 sex offenders and 31 violent non-sex offenders, seen for psychiatric assessment between 1966 and 1974, were compared retrospectively on lifetime recidivism rates to 1999 over a minimum of 25 years. A number of criteria and data sources were used; RCMP records and hospital records were the best sources, albeit the RCMP had records for only 54.1% of the cases. Approximately three in five offenders reoffended, using sex reoffence charges or convictions or court appearances as criteria, but this proportion increased to more than four in five when all offences and undetected sex crimes were included in the analysis. Group differences in recidivism were noteworthy, with child sexual abusers and exhibitionists most likely to reoffend and incest offenders least likely. Time at large and time incarcerated played a relatively minor role overall in results, except in the case of offenders who were sexually aggressive against adult females, courtship disordered, or violent. The typical known criminal career spanned almost two decades, indicating that sex offence recidivism remained a problem over a significant part of the offenders' adult lives.

À partir d'un échantillon de 320 délinquants sexuels et de 31 personnes condamnées pour actes criminels non violents et non sexuels et ayant fait l'objet d'évaluations psychiatriques entre 1966 et 1974, les auteurs ont mené une étude comparée rétrospective des taux de récidive jusqu'en 1999, et ce, en fonction d'une période minimale de 25 ans pour chaque sujet. À cette fin, les auteurs ont exploité plusieurs critères et sources de données, dont les dossiers de la GRC et des hôpitaux s'avéraient les meilleures. Ceci étant dit, la GRC disposait d'un dossier dans seulement 54,1 % des cas. Or, si l'on applique comme critère un chef d'accusation, une condamnation ou une comparution pour une nouvelle infraction d'ordre sexuel, on obtient un taux de récidive d'à peu près trois délinquants sur cinq. Cependant, en tenant compte de toutes les infractions et de tous les crimes sexuels non décelés, on obtient un taux de récidive de plus de quatre sur cinq. On constate d'ailleurs des différences notables entre les divers groupes : ainsi, les agresseurs sexuels d'enfants et les exhibitionnistes seraient les plus susceptibles de récidiver, alors que les personnes reconnues coupables d'inceste en seraient les moins susceptibles. Il convient d'ajouter que la durée de la période vécue en liberté et la durée de l'incarcération semblent avoir exercé une influence assez limitée sur les résultats, sauf dans le cas des agresseurs sexuels

de femmes adultes, des délinquants ayant manifesté des troubles au niveau des relations amoureuses et des personnes condamnées pour crimes de violence. Enfin, pour ce qui est du castype, le délinquant avait commis des actes criminels pendant près de 20 ans, ce qui laisse entendre que le récidivisme sexuel avait persisté pendant une partie importante de sa vie adulte.

Introduction

Sex offender recidivism studies have become increasingly prominent in the psychological and criminal justice literature over the past two decades. With the increase in the number of incarcerated sex offenders, such studies have become an important aspect of correctional planning and administration. Recent estimates indicate that 37% of sex offenders will return to the correctional system (Hanson and Morton-Bourgon 2004). Recidivism risk is also a prominent factor in evaluating the rehabilitation of sex offenders and any danger they present to public safety. The Correctional Service of Canada has long been a world leader in providing treatment to sex offenders, and recidivism results have become the most important criterion in evaluating treatment effectiveness and informing parole board decisions (see Hanson, Broom, and Stephenson 2004; Hood, Shute, Feilzer, and Wilcox 2002). The last two decades have also seen the development of a number of actuarial risk prediction measures that have consistently been demonstrated to be more accurate and reliable than clinical judgement. These instruments rely mainly on recidivism data to estimate their reliability and validity in prediction. Thus, how recidivism is measured has an important bearing on (1) correctional and administrative planning, (2) evaluating the effectiveness of sex offender treatment, and (3) the validity and reliability of actuarial instruments that predict risk of recidivism. The present study examines lifetime recidivism rates among various sex offender groups and evaluates the effect of data sources and criterion measures used in calculating recidivism rates, irrespective of any treatment intervention. Treatment and actuarial risk measures will be evaluated in separate reports.

A number of review studies have been reported in the professional literature and will not be duplicated here (see Cottle, Lee, and Heilbrun 2001; Doren 1998; Furby, Weinrott, and Blackshaw 1989; Hanson and Bussiere 1998; Soothill and Gibbens 1978). We were unable to locate any extensive reviews of the sex offender recidivism literature in the past five years, but the journal Sexual Abuse: A Journal of Research and Treatment devoted a special issue to the topic in 2002, and the problems discussed by Furby et al. in 1989 remained basically the same in 2002, when the research documented here was carried out (see Hanson 2002)

Published recidivism rates for sex offenders have been remarkably variable, but generally low. For example, Furby et al. (1989) reported on 42 studies and found that recidivism rates varied from 0% to 88%, the majority being under 30%. Hanson and Bussiere (1998) reported on 61 studies representing 28,972 cases and found an average sex offence recidivism rate of 13% and general recidivism of 36% overall. These rates are essentially unchanged in a 2004 update examining 95 studies on 31,216 sex offenders (Hanson and Morton-Bourgon 2004). There are several possible explanations for the great variability in results.

First, several criteria, which may produce different rates, have been used to define recidivism: sex offence re-convictions; any new charge or arrest for sexual offences; any type of new conviction; any type of new charge; self-report; or, less often, parole violations or number of court appearances. In the studies reviewed by Hanson and Bussiere (1998), re-conviction was used as the criterion in 64%, arrests in 54%, self-report in 25%, and parole violations in 16%. The most common source was national crime statistics, used in 41% of the studies. In the Hanson and Morton-Bourgon (2004) update, 53% of studies used national crime statistics, 41% provincial or state records, 22% records from treatment programs, and 22% other records (such as child protection or parole files); 15% used self-reported data, and the data sources for 15% were unknown. A total of 34% of the studies used multiple criteria.

Hood et al. (2002) have been critical of the low rate of recidivism based on re-convictions, noting in their own study that the decline in number of sex offenders re-convicted of a sex crime is probably due to the difficulty of securing convictions rather than to a decline in actual sexual reoffending. Thus rearrest rates may be more informative than re-conviction rates in evaluating the true incidence of sex crimes in the community. Both convictions and arrests are examined in the present study.

Researchers also dispute whether non-sexual offences should be considered in recidivism measures, especially if therapy for changing sexual behaviour is being evaluated. However, sex offences are often reclassified through plea bargaining as violent non-sexual charges (such as common assault) and even as property offences (such as break and enter) if, for example, an offender is foiled in an attempted rape (see Hood et al. 2002). Sex murders may be excluded altogether, as they would be labelled not as sex offences but with the more serious label "homicide." Schlesinger and Revitch (1999) report that even property offences are frequently sexualized in cases of

sexual homicide. It may therefore be valuable to examine all episodes of recidivism, whether they are labelled as sexual or as some other offence. In the present report, convictions and arrests leading to charges for sexual and non-sexual offences are examined separately.

A second problem with recidivism studies arises from the way in which charges are laid by the police. A single charge of sexual assault may represent years of abuse of a single victim, while multiple charges of sexual assault may involve a single victim on a single occasion. Examining actual numbers of victims or numbers of incidents of sex crimes is a daunting task in long-term follow-up studies, and it was beyond the scope of the present project to do this. One way of partially addressing at least multiple convictions for a single victim is to examine separate court appearances related to separate charges, as discussed in Doren (1998). Typically, recidivism is discussed as a dichotomous variable (Hanson and Bussiere 1998), but it may be informative to examine the number of times an offender reoffends. The number of court appearances for sexual offences may be a more sensitive index of recidivism in this respect than the number of convictions or charges. For this reason, court appearances for both sexual and other charges were examined in this study.

One of the major problems in recidivism studies contributing to low reported rates has been the generally short follow-up time. Of the 42 studies examined by Furby et al. (1989), over half had follow-up periods of less than three years, and the studies reviewed by Hanson and Bussiere (1998) and Hanson and Morton-Bourgon (2004) had an average follow-up of four to six years. Soothill and Gibbens (1978) noted that convictions were common for sex offenders after 10 years, with 33% of their own sample re-convicted after 10 years and an additional 15% after 24 years. Although relatively few studies have long follow-up periods, Furby et al. (1989) noted that long-term studies are not without problems. Changes in the law or in the arrest practices of police over an extended period can artificially influence the recidivism statistics. In the present study, a minimum 25-year follow-up period was used, and during that time reporting laws were enacted requiring mental health professionals and others to report physical or sexual abuse of minors to authorities. One might expect that reporting laws would lead to a reduction in the candidness of offenders about the extent and frequency of their sexual offences. Indeed, Langevin (2004) compared 196 sex offenders seen for psychological assessment between 1969 and 1974 with 226 seen between 1996 and 2001 and found that 90% in the older sample admitted to clinicians that they committed their offences, versus only 38% in the more recent sample (a statistically significant difference). A total of 63% in the older sample also acknowledged having a sexual disorder, versus 20% in the contemporary sample - again, a statistically significant difference. A further issue with respect to long-term follow-up is whether the offences were clustered over a shorter period of time (i.e., when the offender was younger and probably had a stronger sex drive) or distributed over the duration of the follow-up period, indicating that recidivism is a long-term problem. In the present study, duration of criminal involvement was examined

Soothill and Gibbens (1978) have argued that recidivism studies need to take into account the actual time at large when offenders have opportunities to commit offences. Long prison terms effectively remove offenders from the community and reduce their potential to reoffend. Furby et al. (1989), on the other hand, point out that the overwhelming majority of apprehended sex offenders are not incarcerated, since mandated treatment and probation is the most common disposition. This practice also contributes to the significant under-representation of the true reoffence rate. Furby et al. also claim that sex crimes are vastly under-reported, so that most recidivism measures are a gross underestimate of actual rates. For example, the Solicitor General of Canada reported in 1984 that only 38% of 17,300 sexual assaults were reported to police (see also Abel, Becker, Mittleman, Cuningham-Rathner, Rouleau, and Murphy 1987; Abel, Mittleman, and Becker 1985; Baker, Tabacoff, Tomusciolo, and Eisenstadt 2001; Lisak and Miller 2002). In the present study, time at large and time incarcerated or on probation are reported. With the long follow-up of at least 25 years, it was also considered informative to determine the shortest and the longest periods the offenders were at large between offences. In addition, an attempt was made to include crimes that the offenders disclosed to clinicians but that remained undetected or were not reported to authorities.

A final problem in recidivism studies, as noted by reviewers, is the variation in group composition and sample size. Small samples, of course, may not represent sex offenders in general. Similarly, one particular group, such as child sexual abusers, may not be representative of other sex offender groups. For example, incest offenders tend to have a lower reported recidivism rate than other sex offender groups, and sexual aggressives tend to be more antisocial generally and to have a higher recidivism rate. Cases in the present study are drawn from 2,124 offenders seen for psychiatric assessment from 1966 to 1999, representing a variety of sex offender groups.

Pilot study

The 1960s and 1970s, for a number of reasons, are ideal time periods to investigate recidivism. There were no

mandatory reporting laws, so offenders were more candid with clinicians, as previously noted. Moreover, in the 1960s there was an optimism on the part of therapists, police, the courts, and offenders that deviant sexual behaviour could be cured or changed permanently. This may have added to the candidness of the offenders. In the setting from which these cases were drawn, police themselves might have brought an apprehended offender for treatment without laying charges.

A surprise and a concern in 1994, when this project began examining all 2,124 cases, was that the RCMP had records for only 56% of the total cases seen from 1966 to 1994, when hospital records indicated that 100% had committed sex crimes. Results were not significantly different between more recent years (late 1980s and early 1990s) and the earliest cases reported here (n = 351), indicating that more recent cases were missing as often as older cases. The follow-up study, reported here, was undertaken in part to uncover the source of the disparity between RCMP and hospital records and to provide a more complete database of the offenders' criminal activities. Results for the later sample of cases (1975-1999) will be reported in a separate paper.

Method

Research participants

A total of 351 men referred for psychiatric assessment or treatment by the court, police, probation and parole services, defence lawyers, or other mental health professionals between 1966 and 1974 were the subject of this study. Cases were classified into groups on the basis of their presenting and lifetime criminal charges. The groups consisted of 46 incest offenders (36 against girls, 5 against boys, and 5 against both boys and girls); 51 genital exhibitionists; 142 extra-familial child sexual abusers (69 against boys, 54 against girls, and 19 against both boys and girls); 34 sexual aggressives against adult females; 19 miscellaneous courtship disorders (combinations of voyeurism, exhibitionism, and sexual aggression involving adult female victims); and 28 sexually polymorphous men who offended against both male and female victims and against both adults and children and engaged in a wide range of sexually anomalous behaviour. For comparison, a group of 31 violent non-sex offenders was included. Seventeen of these men had been charged with homicide and the remainder with serious assaults or wounding. Violent non-sex offenders were selected for comparison because if sex offences were reduced to lesser charges through plea bargaining, the most common charges, in our experience, were violent offences, such as common assault. It would therefore be interesting to know whether there are differences in recidivism or legal penalties between the sex offenders and the violent non-sex offenders.

There was considerable variation in age of the study participants, with a mean of 31.7 years, (SD = 10.5) at the time they first were assessed and a range from 15 to 70 years of age. The majority of the sample, 84%, was born before 1950; 26% between 1930 and 1940; and 16% before 1930. The oldest offender was born in 1902. Although the mean age differences were statistically significant among groups ($F = 7.84$, $p < 0.000$), there was considerable overlap in the distribution of group ages. The incest offenders were oldest, on average, at 39.7 years (SD = 9.5) and the exhibitionists youngest, at 26.3 (SD = 8.0). The sample averaged in their late 50s at the termination of the study, with 11% over 70 years of age. Death records were not obtained, but a total of five were known to be deceased by 1999.

Most study participants were high school dropouts, with an overall mean education of 9.3 years (SD = 2.3). A total of 10.0% had attended university, and 11.4% had attended community college. Again, group differences in education were statistically significant ($F = 3.11$, $p < 0.002$), with considerable overlap of group distributions. The violent offenders and sex offenders against extra-familial boys tended to be the best educated and the incest offenders least educated.

The majority of the offenders (96.9%) were Caucasian. Most offenders were Canadian born and resided in Ontario, but 54 (15.4%) were born abroad; the largest number, 16 (4.6%), were born in England. It is not known how many were deported as a result of their criminal activities. At least 39 (11.1%) had lived in other provinces during the study period. Of 239 cases with available data, 39 (16.3%) used aliases. Of these, 24 (10.0%) used one, 13 (5.4%) used two, and 2 (0.8%) used three or more aliases, adding to the difficulty of collecting recidivism data.

The groups did not differ significantly in admitting to their current offences, and overall 90.5% acknowledged committing the marker offences (for admitters versus non-admitters by group, likelihood ratio [hereafter LR] = 14.13, $p > 0.05$). The groups did differ significantly, however, in admitting to having a sexually anomalous preference. A total of 57.7% did so, the incest group being lowest at 23.1% and the polymorphous group highest at 85.0% (for admitter versus non-admitter to sexual anomaly by group, LR = 85.66, $p < 0.000$). This difference, in

part reflects the incidence of sexual deviance among the various groups reported in the professional literature, incest offenders having the lowest reported incidance. When the offenders were first assessed, 58.4% were already general recidivists and 25.6% were sex offence recidivists, based on convictions. There were no significant group differences in number of general or sex offence recidivists, violent offenders excepted (LR = 4.87, $p > 0.05$).

Procedure

An attempt was made to obtain the lifetime criminal history of the sex offender sample, from their first contact with the criminal justice system, irrespective of any treatment intervention or psychiatric assessment, to the last known criminal charge or conviction. The first arrest, charge, or conviction was used as the index marker event, and all subsequent charges or convictions were considered instances of recidivism. Several sources for recidivism data were used. First, the RCMP database of national criminal offences was examined in 1994 and again in 1999; second, hospital records from original assessments and any updates on those assessments were also examined; and, third, three legal databases were searched: the Canadian Criminal Law Library, the Canadian Criminal Law Partner database of York University, and Quicklaw, a commonly used database for Canadian lawyers. A separate record was kept of the total number of charges identified by the RCMP, the hospital, and each of the legal databases for comparison. The legal databases provided very poor returns, with only two cases identified in the present sample. These databases consist primarily of appeals and precedent-setting cases, intended for lawyers, and do not appear suitable for recidivism studies. They will therefore not be discussed further here.

The RCMP database provided the lifetime adult criminal convictions and charges for each offender, including date, place, charge, and disposition for each charge. These were requested in 1994 and again in 1999, providing a minimum of 25 years' worth of information on each offender from 1974 to 1999 as well as earlier convictions. There were RCMP records for 54.1% of the cases. The RCMP records did not have information on 643 convictions, or 21.7% of the total convictions in this sample. Of these 643 convictions, 599 (93.2%) were sex offence convictions. The number of known charges for the RCMP versus hospital records correlated at only 0.42, indicating that they are tapping different sources of information, although there was statistically significant overlap between the two data sources. For offenders who served time in a federal prison (i.e., those sentenced to more then two years less a day), the RCMP files were significantly better and had records for 80.3% of the cases. When offenders served time only in a provincial prison or were sentenced only to probation, the RCMP had records for 47.5% of cases (LR = 29.87, $p < 0.000$). For this time period, the hospital had criminal records for all cases. Hospital medical records contained information on every admission and often contained provincial probation records and pre-sentence reports, with lifetime previous history of criminal charges in the province. However, these records were also incomplete, as the offender often did not maintain contact for an extended period after being discharged. Moreover, 26.2% of the offenders for whom information was available (n = 191) committed offences in other provinces. A total of 114 men (59.7%) had committed offences in more than one city in Ontario, and the reporting practices of these various jurisdictions may have varied in reliability. It was beyond the scope of the present study to investigate further provincial correctional records for recidivism data. The combination of all information from RCMP and hospital records was used for the purposes of the present study.

Criminal history was divided into five types of charges based on legal labels: (1) sexual offences, including sexual assault, indecent assault, and sexual interference; (2) violent offences that were not indicated as sexual, such as common assault, wounding, and homicide; (3) substance abuse-related charges such as driving while ability impaired, possession of narcotics, and trafficking; (4) property offences such as break and enter, fraud, and possession of stolen property; and (5) other procedural offences such as failure to comply with a court order, unlawfully at large, and violation of parole. Legal labels were used to classify each charge, as it was beyond the scope of the study to investigate each court proceeding to determine if a sexual crime had been mislabelled or relabelled through plea bargaining as a violent or other offence. An attempt was initially made to count the number of victims in each charge and the number of instances of sexual contact with specific victims, but this was considered unreliable, and data were not available when RCMP sources of information were used. This particular data collection was discontinued and will not be reported here. A separate record was kept of the number of lifetime offence convictions, number of arrests, and number of charges that were dismissed, withdrawn, or acquitted or that did not come to trial. Duplication of charges in RCMP and hospital records was noted and each charge counted only once. Time served and probation time for each conviction were recorded, when available, and the times added together to produce total time served and total probation time. Because multiple charges related to a single incident or victim may be levied at one time, the number of court appearances was recorded, independent of the number of charges or convictions, providing a different index of the number of incidents of criminal activity. This was done separately for total offences and for sex offences. As the subject of this study is lifetime criminal history, irrespective of any treatment or other interventions, two separate incidents of a clearly labelled sex offence constituted sex

offence recidivism. A record was kept of the number of separate sex offence episodes to compute the total number of sex offence recidivisms. This procedure was repeated for lifetime total known convictions, total known charges, and court appearances separately for sex offences and non-sex offences.

Other measures recorded were the time span of criminal charges from first to last known charges; the minimum and maximum times at large for potential to commit offences; and the absolute maximum time served at one time, regardless of type of charge. A record was also kept of the number of offenders who disclosed committing sexual offences that went undetected and unreported; of the number admitting to committing their current offence; and of the number who acknowledged being sexually anomalous. Recidivism was re-computed including the admission of an undetected offence as one episode of sexual offending, regardless of the number of crimes the offenders reported as undetected. Results were analysed with the Statistical Package for the Social Sciences (SPSS), version 10. Analysis of variance and likelihood ratios were employed.

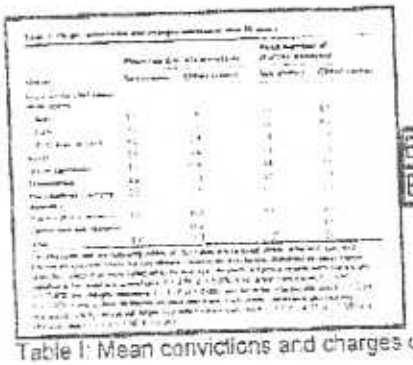

Table I: Mean convictions and charges dismissed over 25 years

Results

Table 1 shows the mean number of criminal convictions and charges for the various groups among the 351 offenders studied. There was a known lifetime total of 2,961 convictions, and 1,147 (38.7%) of these were labelled sex crimes. An additional 1,066 charges were dropped or dismissed, 379 (35.6%) of which were labelled sexual offences. The sex offenders averaged 3.6 convictions and 1.2 charges dismissed for sex crimes. The total sample averaged 5.3 convictions and 2.0 charges dismissed for all non-sex offences. There were significant group differences on each measure in Table 1, but there was considerable overlap of group distributions. The extra-familial offenders against children had the largest number of both convictions and charges dropped, the polymorphous group the smallest numbers of sex crimes. The sexual aggressive and polymorphous groups stand out for the large number of other crimes; they are comparable to violent offenders in this respect.

Table 2: Mean court appearances and prison time served over 25 years

Table 2 shows the known lifetime number of court appearances for each group, a measure of the number of recidivisms. The offenders were in court a total of 2,193 times, of these 822 times (37.5%) for labelled sex offences. On average, they had 6.3 court appearances, 2.6 of which involved some labelled sex offence. A total of 46 (14.6%) of the 316 sex offenders on whom data were available had never appeared in court on a sexual offence; 87 (27.5%) had appeared once, 69 (21.8%) twice, and 114 (36.1%) three or more times, the maximum being 17 times. There were significant group differences in court appearances for both sex and total crimes, reflecting the numbers of convictions and charges given in Table 1.

Table 3: A comparison of age of onset, duration of known criminal history, and undetected crimes among the offender groups*

Data on total time incarcerated were available on 259 men and data on probation time for 257 men. Total time spent incarcerated was low, on average 3.6 years (SD = 6.7), but there was considerable group variability on this measure (see Table 2). Of the 259 cases, 115 (44.4%) had not spent any time in jail, 35 (13.5%) had spent less than one year in total incarcerated, and another 25 (9.7%) had spent one to two years in jail. In many cases, fines were levied. Overall, 79.2% of the men had spent five years or less in prison. The sexual aggressives, violent offenders, and miscellaneous courtship disordered groups accounted for most of the incarceration time. Data were available on 61 of these 84 men, who accounted for 51.7% of the total time served by all 259 men. Results for total probation time were similar, with 75 of the 257 cases (29.2%) having no probation whatsoever, 30 (11.7%) one year or less, and 46 (17.9%) one to two years' probation.

Age at first involvement with the law varied from 7 to 67 years of age, with early 20s being the average age (n = 243 cases with available information) (Table 3). By age 16, 77 (31.7%) of the offenders were involved with the law, and by age 21, 146 (60.1%) had criminal charges. By age 30, 199 (81.9%) did. Sexual aggressives were significantly younger than the other groups at first charges, with a mean age of 15.4 years (SD = 5.1, range: 7-28 years). Incest offenders were oldest at 31.2 years (SD = 15.1, range: 12-67 years).

Survival analysis is often used to examine recidivism rates over time, but this measure tells only the number of cases reoffending and not reoffending within a given time frame. The men in this study had multiple convictions over time, so it was more informative to score minimum and maximum times at large between offences and the known span of their criminal involvement.

Duration of criminal history from earliest known to most recent offences averaged 19.1 years (SD = 11.2, range: 0-43 years). Mean group differences were not statistically significant (see Table 3). The shortest span was for exhibitionists at 15.2 years (SD = 10.5, range: 1-43 years); the longest were for sexual offenders against both boys and girls at 23.1 years (SD = 9.6, range: 11-42 years) and sexual aggressives at 23.4 years (SD = 9.5, range: 8-43 years). Only 15.0% of the total sample had a known criminal career of five years or less; 72.3% had criminal involvement for 10 or more years and 44.6% for 20 or more years.

Overall time at large was substantial in most cases and played little role in the present results, with three noteworthy exceptions. The majority of men had reoffended within five years at large: 65.6% before one year, 80.5% before two years, and 89.6% up to five years. However, 58.3% of the cases had some periods at large greater than five years, the longest being 38 years.

The groups did not differ significantly in terms of minimum time at large ($F = 1.43$, $p > 0.05$). The violent offenders tended to have the shortest overall time at large at 1.3 years (SD = 0.7, range: 1-3 years), along with the miscellaneous courtship disordered group, also at 1.3 years (SD = 0.5, range: 1-2 years), and incest offenders the longest period at 3.7 years (SD = 5.7, range: 0-24 years). The groups did differ significantly in maximum time at large ($F = 2.36$, $p < 0.02$). There was considerable overlap of group distributions, with incest offenders having the longest periods at large at 11.5 years (SD = 8.8, range: 1-35 years) and violent offenders the shortest period at 4.6 years (SD = 2.8, range: 1-11 years). Three groups of offenders against adults served substantial prison time, which played a role in their time at large: the sexual aggressives, the miscellaneous courtship group, and the violent offenders.

The large number of offenders reporting undetected crimes was noteworthy (see Table 3). Overall, 74.2% acknowledged offending without any legal involvement with authorities. Group differences were significant, with the exhibitionists reporting that they committed the most crimes for which they were not apprehended (at 98%) and the

violent offenders reporting the fewest (9.1%)

Recidivism rates were calculated in several ways. First, the most common methods in the literature were used: two or more separate occasions with convictions (1) for sex offences and (2) for any offences; (3) two or more separate occasions with charges for sexual offences and (4) for any offence, regardless of convictions: court appearances on separate occasions (5) for sex offences and (6) for any offence, two or more court appearances being used as a criterion for recidivism. Finally, sex offence recidivism was assumed (7) if the offender reported committing any undetected sex crimes and had one or more sex offence charges. Table 4 shows the results of these calculations.

There were significant group differences in convictions for sex offences. Extra-familial offenders against children (range: 71.0%-74.1%) and exhibitionists (68.6%) showed the highest recidivism rates, and polymorphous offenders showed the lowest rate (32.1%). There were no significant group differences in recidivism based on all offence convictions. A similar pattern of results was noted for charges: sex offence charges were significantly different between groups, but total charges were not.

As expected, basing recidivism rates on convictions or charges for any offence resulted in higher rates than using sexual offences alone. A total of 61.1% of all 320 cases reoffended based only on sex offence reconvictions, whereas 80.4% reoffended if any offence convictions were used as the criterion, a difference of 19.3%. There were noteworthy variations among groups. Extra-familial offenders against children showed the smallest differences between all offence convictions and sex offence convictions (range: 2.9%-10.5%), whereas the incest offender, sexual aggressive, miscellaneous courtship, and polymorphous groups showed the greatest differences (range: 31.1%-42.9%). Recidivism based on charges rose overall by only 6.6% and 5.7% compared to sex offence and all offence convictions respectively. There was little inter-group difference in recidivism based on sex offence convictions versus charges, with sexual aggressives showing the largest variation at 17.6% more recidivism based on charges than on convictions.

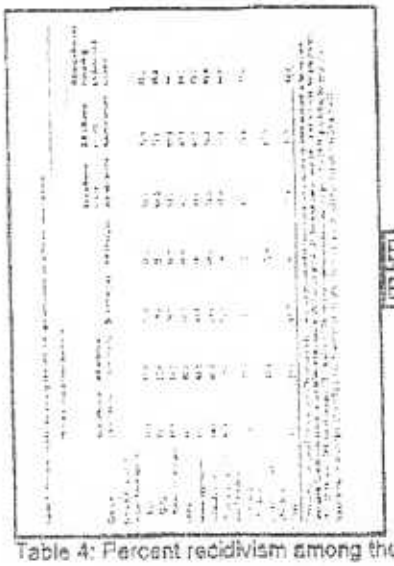

Table 4: Percent recidivism among the offender groups based on different assumptions

The recidivism rates based on court appearances as criterion were remarkably similar to those for convictions and charges, showing 57.9% sex offence recidivists and 79.7% general recidivists, a result that differed from conviction-based rates by only -3.2% and -0.7% respectively for the total sample. Extra-familial offenders against children and exhibitionists again had the highest recidivism rates; exhibitionists' rates were higher at 76.0% versus 63.2% to 64.8% for the former groups.

A substantial increase in recidivism rates was noted when undetected crimes were included. A total of 88.3% of offenders would have been considered sex offence recidivists if they had been caught, representing an increase of 27.2% over sex offence conviction rates and 20.6% over rates based on sex charges.

Group differences in recidivism were noteworthy. Paedophilic groups and exhibitionists showed the highest rates of sex offence recidivism no matter what criterion was used. When undetected crimes were included, almost all such

cases reoffended, with 95.9% of exhibitionists and 89.8% to 94.1% of the extra-familial child sexual abusers reoffending. There were surprisingly low sex reoffence rates for the sexual aggressive and miscellaneous courtship disorder groups when rates were calculated using official statistics, ranging from 44.1% for court appearances to 64.7% for sex charges. Both groups, however, had high conviction rates and reoffence rates for crimes in general, and 85.7% of the sexual aggressives and 63.8% of the miscellaneous courtship disorder group were found to have reoffended sexually when undetected crimes were included in the computation. These groups also had the longest prison terms, meaning that results were influenced by shorter periods at large.

Discussion

The recidivism rates found in this study support the contention of Furby et al. (1989) that long-term follow-up shows substantially higher recidivism rates than short-term studies. Results showed higher recidivism rates than other long-term studies, including somewhat higher rates than an Ontario sample reported by Hanson, Scott, and Steffy (1995), who found 35% sex offence recidivism and 62% general recidivism based on convictions. These lower rates may be attributed to the authors' reliance on RCMP records. In the present study, RCMP sources were found to have records for only 54% of our cases and to lack information on 599 sex offence convictions. In part, this lacuna appears to be due to a lack of communication between provincial and federal justice statisticians. When cases are selected on the basis of having served federal prison time, 80% are identified by the RCMP, compared to 48% of cases involved only with provincial correctional systems. It is also noteworthy that 11% of the offenders were known to have lived in provinces other than Ontario during the period of their criminal involvement, and additional charges might have been noted if the various provinces had been canvassed for criminal records on these men. Some men clearly moved about the country, and 16% used aliases to avoid detention and prosecution for their sex crimes. Unfortunately we were not able to access provincial correctional records at the time of this study; recidivism rates would likely be higher than reported here had such records been included. Future studies should include both federal and provincial records for a more accurate account of recidivism rates. An additional 15% of the men in this study were foreign born, and some may have been deported from Canada as a result of their crimes, removing them from the database of possible recidivists. A total of 11% were over 79 years of age at the termination of this study and may have been either deceased or "burned out" as far as committing sexual offences was concerned. Five men were known to be dead, but it was beyond the scope of this study to obtain death records.

There was little variation in recidivism rates overall if sexual charges or convictions or court appearances were used as the criterion. Approximately three offenders in five were convicted of sexual offences on two or more occasions; this, however, is an underestimate of actual sex offence recidivism. Some violent and property offences were clearly sexual in nature, but we were unable, because of the retrospective nature of the study, to evaluate the circumstances of all the labelled non-sex crimes in order to provide an estimate of how often this was true. It is therefore informative to examine general recidivism, which is 18% to 19% higher than sex offence recidivism, whether convictions or charges are used as the criterion. These results suggest that the sex offenders seen in this study were generally recidivists. Using either all offence convictions or all charges as the criterion, more than four in five reoffended. Based on sex offences and undetected sex crimes, almost 9 in 10 overall reoffended.

Group variation in recidivism rates using different criteria is noteworthy, as Furby et al. (1989) also found. The child sexual abusers and exhibitionists showed highest rates of recidivism, and almost all reoffended if undetected crimes were included. One might expect that studies employing any of the recidivism criteria would not differ significantly for these groups, but the same would not be true for some other groups.

Of particular note is the lower rate of conviction for sex crimes among sexual aggressive, polymorphous, and miscellaneous courtship disorders groups compared to all their offence convictions (see Table 4). Certainly time at large played a role in the results, but these offenders engaged in a wide range of criminal activities and often had sexual charges reduced through plea bargaining to common assault, lowering the apparent sex offence recidivism rates. When undetected sex crimes were included, these groups showed high rates of recidivism, comparable to those of paedophilic offenders. The incest offenders in this study also showed a large disparity in recidivism rates based on sexual and other offences; they also showed higher recidivism rates than generally reported in the literature, with one in two reoffending based on sex offence convictions (see Table 4). Their recidivism rates did not differ significantly from those of other sex offender groups when undetected sex crimes were included in the analysis. Results indicate that incest offenders merit longer-term follow-up and a re-evaluation of their sexual preferences and general criminality (see also Studer, Clelland, Aylwin, Reddon, and Monro 2000).

With recidivism rates so high, in the long term it may be more valuable to consider number of recidivisms in evaluating treatment studies or actuarial predictors of risk of reoffence. Some men repeatedly reoffend within a year

of release from incarceration, whereas others have extended periods at large. However, longer times between offences may also be associated with men moving from province to province and thus being missed in national and local or provincial crime statistics. The results of the present study support Furby et al.'s (1989) hypothesis that most sex offenders spent little time incarcerated. The offenders in this study averaged only 3.6 years incarcerated, and 44.4% did not spend any time in prison. Thus, examining time at large in general would not be informative, as Soothill and Gibbens (1978) have suggested. However, for specific groups, such as sexual aggressives, violent offenders, and offenders with miscellaneous courtship disorders, prison time is substantial, and this should be incorporated as a factor in recidivism studies. Thus the views of both Furby et al. (1989) and Soothill and Gibbens (1978) appear to be supported by different groups of sex offenders.

Although this was not a treatment study, the relatively long duration of criminal career among study cases, averaging more than 19 years, reinforces the fact that treatment follow-up studies are too short. Treatment failures may be detected in the short term, since 90% of cases in this study had reoffended before five years at large, a common follow-up time period for treatment studies. On the other hand, 58% had other periods at large greater than five years before reoffending, so many cases of recidivism would be missed in the typical treatment study.

The results of the present study support observations made by Furby et al. (1989) and Soothill and Gibbens (1978) that recidivism studies whose follow-up periods are too short artificially reduce reported rates. The average span of time for known criminal history in the present study was almost two decades, with over 44% of criminal careers lasting 20 or more years; this suggests that sexual offending behaviour remains a significant problem throughout the sex offenders' adult lives.

Results further suggest that correctional planning for sex offenders should be addressed as an integrated federal and provincial matter. Sex offenders' actual cost to society and the danger they present appear to be grossly underestimated using national statistics alone. Actuarial measures of risk, which rely on recidivism statistics, are becoming increasingly prominent in the mental health and criminology literature. They may currently be used in court proceedings and parole board decisions; the present study indicates that they should be considered with great caution and treated as experimental until longer follow-up studies are available, albeit actuarial measures remain better risk predictors than clinical judgement alone (see Hood et al. 2002; Langton, Seto, and Barbaree 2000; Quinsey, Harris, Rice, and Cormier 1998).

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[Footnote]
Note
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APPENDIX O

Recommendations for the General Assembly

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RECOMMENDATIONS FOR THE GENERAL ASSEMBLY

1. Appropriate funding for housing and treatment of SVPs.

2. Build or renovate a secure treatment facility for the increasing census of sexually violent predators.

3. Provide sex offender treatment within the Department of Corrections for inmates convicted of sexually violent offenses prior to their release and consideration for commitment under the SVP Act.

4. Make appropriate changes to the SVP Act, attached as Appendix C, to include the offense of Assault and Battery of a High and Aggravated Nature (ABHAN) if the assault was sexual in nature.

5. Evaluators should make appropriate referral to the probate court for outpatient civil commitment of inmates who do not meet the criteria for SVP commitment but who have a mental illness which makes them at increased risk to commit a sexual offense.

6. Appropriate funding for DMH to hire and train mental health practitioners in the treatment of sexual offenders to ensure the availability of such treatment at Mental Health facilities in those densely populated areas throughout South Carolina.

7. Modify sentencing laws to provide the Court with an option to impose a sentence in excess of 20 years for a sex offense against a child under age 12, including sexual exploitation of a child.

8. a.) Require courts to impose significant periods of probation for released sex offenders to include their mandatory treatment if warranted. Funding should be appropriated for Probation, Parole and Pardon Services as well for training agents with expertise in supervising released sex offenders, including necessary polygraph services.

b.) Allocate funding to provide presentencing forensic psychiatric evaluation for all sex offenders.

9. Create a certification process for sex offender treatment providers, and require providers to be certified in the treatment of sex offenders, as well as licensed mental health professionals. The certification process should be developed and overseen by the Department of Mental Health.

10. Establish a Commission to regularly monitor the operation of the Sexually Violent Predator Act and make recommendations to the involved agencies and General Assembly, as needed. This Commission should include the Director of the Department of Mental Health, a member of the South Carolina Victims Advisory Board, and a forensic psychiatrist/psychologist certified in the treatment of sex offenders.