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Assessing Readiness for Release With SVP Civil Commitment Cases

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Of the 17 jurisdictions in the U.S. with sexually violent predator (SVP) civil commitment statutes, 16 have inpatient commitments (with Texas being the exception, having outpatient SVP commitments). Those individuals committed by definition are those sex offenders found to be the highest risk for reoffense. For example, a recent study found that in Florida, those persons who were committed under the SVP statute had higher rates of antisocial personality disorder and paraphilia diagnoses, as well as higher scores on standardized sex offender risk scales than individuals not committed under the SVP statute. (Jill S. Levenson, "Sexual Predator Civil Commitment: A Comparison of Selected and Released Offenders," 48 *Int'l J. of Offender Therapy and Comparative Crim.* 638 (2004).)

The most fully researched aspect of risk assessment focuses on static, historical risk criteria. The Static-99 (R. Karl Hanson and David Thornton, *Static-99: Improving Actuarial Risk Assessment for Sex Offenders* (1999)), perhaps the most widely used scale in North America, as its name indicates, includes only static risk variables, such as characteristics of prior and index offenses. Such a heavy focus on static factors presents obvious challenges when assessing readiness for release
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from an SVP commitment facility. All the individuals in these facilities are likely to have high scores on instruments that are weighted towards static risk factors. These scores will change little, if at all, over time. An individual with a score of 5 or 6 on the Static-99 may well have that score for the rest of his life, even if he never commits another sex offense. How then can one assess readiness for release from an SVP facility?

Focus on Dynamic Risk Factors

Given that static risk factors will not change appreciably while an individual is committed under an SVP statute, the release assessment process necessarily focuses on dynamic risk factors—those aspects of the person that are amenable to change. Unfortunately, the dynamic risk assessment scale in broadest use, the SONAR (R. Karl Hanson and Andrew Harris, *The Sex Offender Need Assessment Rating* (2000)) was not developed for, or standardized on, an inpatient population. The SONAR divides dynamic risk factors into two broad areas, namely:

- **Stable:** Those dynamic risk factors that can change, but only slowly. These include broad personality traits that predispose an individual to commit sex offenses, sometimes referred to as “criminogenic needs.” (D.A. Andrews and James Bonta, *The Psychology of Criminal Conduct* (3d, 2003).) Some stable risk factors are appropriate targets for change in psychotherapy, such as capacity for intimacy or sexual self-regulation. (R. Karl Hanson, “Stability and Change: Dynamic Risk Factors for Sexual Offenders,” in William L. Marshall, Yolanda M. Fernandez, Liam E. Marshall, and Geris A. Serran, eds., *Sexual Offender Treatment: Controversial Issues* 17-32 (2006).)
- **Acute:** Those dynamic risk factors that immediately precipitate a sex offense, sometimes referred to as “triggers.” (A. Beech and Tony Ward, “The Integration of Etiology and Risk in Sexual Offenders: A Theoretical Framework,” 10 *Aggression and Violent Behav.* 31 (2004); R. Karl Hanson, 2006, *supra.*) These include negative emotional states and substance induced intoxication.

Although the SONAR does assess these areas, to date, no one has modified and standardized the SONAR on an inpatient

population, so it is of little use in solving the problem of assessing current and recent adjustment among SVP inpatients.

Reliable Dynamic Risk Assessment Lacking. The question now arises: How can one reliably assess dynamic risk factors among SVP inpatients? Relevant areas of institutional adjustment that may reflect these dynamic risk factors include:

- Institutional adjustment, including housing unit reports, work assignment report, and presence (or lack) of disciplinary infractions.
- Therapy involvement and progress, including nonspecific aspects, such as motivation, attendance, and compliance with therapy rules; and specific aspects, such as skill acquisition, quality of homework, development of a relapse prevention plan, and understanding of offense cycle. (See Michael C. Seto, “Interpreting the Treatment Performance of Sex Offenders,” in A. Matravers, ed., *Sex Offenders in the Community* (1999); Glenn Ferguson, Merrill Main, and Jennifer Schneider, “Assessing Treatment Progress in Civilly Committed Sex Offenders—The New Jersey Approach,” in Anita Schlank, ed., *The Sexual Predator, Vol. 3: Law, Public Policy, and Clinical Practice* 11-1-1-23 (2006) for a discussion of the distinction between specific and nonspecific aspects of treatment.)

Dynamic Risk Factors Make Difference. Although, as noted, static risk factors are by far the most heavily researched area, what limited research is available on dynamic risk factors does indicate that dynamic risk factors do make a difference with regard to recidivism. In a recent meta-analysis of 95 recidivism follow-up studies, Hanson and Morton-Bourgon found significant differences between sex offender recidivists and non-recidivists on a number of stable dynamic risk variables, including deviant sexual interests, sexual preoccupation, impulsivity, and intimacy deficits. (Hanson and Morton-Bourgon “Predictors of Sexual Recidivism: An Updated Meta-analysis,” Corrections Policy User Report No. 2004-02 (Corrections Policy, Public Safety, and Emergency Preparedness Canada 2004).) Acute dynamic risk factors, such as transient states of depression or anger, have even less research grounding, with the one major study being Karl Hanson and Andrew Harris’ validation study for the SONAR, in which they conducted retrospective interviews of community supervision officers.

(Karl Hanson and Andrew Harris, *The Sex Offender Need Assessment Rating (SONAR): A Method for Measuring Change in Risk Levels* (Dept. of the Solicitor General of Canada 2000); see also discussion in Hanson, 2006, *supra.*) To the extent to which psychotherapy affects these dynamic risk variables and to the extent to which these variables can be reliably assessed, they should be considered in determining when to release an individual from an SVP commitment program.

Assessment Process

Assessing dynamic risk factors and using the results of that assessment in making SVP release decisions is difficult. Two immediate problems are evident.

Reliability of Information. How can one ensure that dynamic risk assessment information entering the decision process is reliable? There are a number of potential solutions to these problems. There are steps that can increase the reliability of data used in the decisionmaking among evaluators. First, one can use structured scales to systematically assess these dynamic risk variables. Some scales exist that assess treatment progress of sex offenders, such as the Sex Offender Treatment Rating Scale (SOTRS) (R.D. Anderson, D. Gibeau, and B.A. D’Amora, “The Sex Offender Treatment Rating Scale: Initial Reliability Data,” 7 *Sexual Abuse: A J. of Res. and Treatment* 221 (1995)) and the Goal Attainment Scale (GAS) (T.S. Stripe, R.J. Wilson, and C. Long, “Goal Attainment Scaling With Sexual Offenders: A Measure of Clinical Impact at Post-treatment and at Community Follow-up,” 13 *Sexual Abuse: A J. of Res. and Treatment* 65 (2000)). Each has one supportive validity study. These scales have both strengths and weaknesses with regard to their applicability to SVP cases. On the positive side, first, these scales are structured, and in general, structured clinical judgment is more reliable than unstructured clinical judgment with respect to assessing dynamic risk. (See Hanson, 2006, *supra.*) Second, each scale has a supportive validity study. On the negative side, first, each scale has only one validity study. Neither study has been replicated, so the generalizability of these instruments is presently unknown. Second, each scale includes some criteria, such as victim empathy or acceptance of responsibility, that although widely used in sex offender treatment, have no empirical relationship with recidivism in meta-analytic studies.

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Although other sex offender treatment process scales exist, such as the Treatment Progress Index (TPI) (Robert J. McGrath, J. Livingston, and G.F. Cumming, "Development of a Treatment Needs and Progress Scale for Adult Sex Offenders" (U.S. Dept of Justice, Off. of Justice Programs 2002)), these additional scales include items that focus on community adjustment, so they are inapplicable to an institutionalized population.

Valid Use of Information. How can one ensure that the decision process itself makes valid use of the information entering? Once information regarding dynamic risk enters the decision process, one must ensure that it is used in a valid manner. We know of

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no empirical research on this topic, and in fact, there is scant research on procedures used in SVP facilities generally. We do, however, have a recommendation. SVP facilities should set up a system of checks and balances to reduce the likelihood that any one evaluator or any one assessment or decisionmaking committee is biased. These checks and balances can occur both within the SVP facility and through outside oversight.

Case Example: New Jersey's SVP Facility

As part of its sexually violent predator act, New Jersey employs a panel of doctoral-level psychologists to review the sexual offender's treatment progress annually. This panel, the Treatment Progress Review Committee (TPRC), is separate and distinct from the offender's treatment staff. The TPRC has two purposes, namely:

1. To form an opinion as to the phase of treatment in which the resident should participate; and
2. To determine the degree to which treatment thus far has served to mitigate risk.

The process by which the TPRC evaluates a resident's treatment progress consists of numerous steps, involving both internal

and external checks and balances. First, the resident's treatment team (not members of the TPRC) produces a Treatment Progress Report every six months, summarizing the resident's performance in treatment and indicating whether specific treatment goals were met. Second, the TPRC conducts a comprehensive annual evaluation of the resident's treatment progress, consisting of a consultation with the resident's treatment team representatives, a clinical interview of resident (if the resident agrees to participate), an archival review of discoverable documents in resident's file, and a review of treatment progress reports and other materials describing treatment participation and institutional adjustment. Subsequent to the interviews and review of documents, the

TPRC generates a psychological report in which a phase of treatment recommendation is made. Third, the TPRC's phase recommendation is reviewed by an independent panel of clinicians and administrators from the New Jersey Department of Human Services called the Clinical Assessment Review Committee (CARP). In the event that CARP disagrees with the TPRC's recommendation and a resolution cannot be met, CARP is ultimately responsible for making the final decision regarding appropriateness of treatment phase.

Standardized Instrument Used. In addition, the TPRC uses a standardized instrument, the PCL-R (Robert D. Hare, *The Psychopathy Checklist—Revised* (1991)) when considering a resident for Phase 3 of treatment. (NJ's SVP facility has five program levels, although Level 5 consists of supervised furloughs in the community.) The PCL-R is scored by the entire TPRC panel as a team for the purpose of inter-rater reliability. The consistent implementation of the instrument with every resident adds reliability to the TPRC's overall assessment procedure.

Inter-rater Reliability, Separation From Treatment Team. The TPRC evaluation process illustrates a number of points. First, having a panel of evaluators perform

the evaluation, as opposed to one psychologist, provides inter-rater reliability. A consensus among several individuals is likely to be more accurate than a single opinion. The presence of numerous evaluators serves to control for such inherent biases to which an individual assessor is more vulnerable. Moreover, a panel of evaluators is likely to have a broader perspective or conceptualization of the case, and may recognize certain elements that one person may miss. Second, the TPRC panel is separate from the resident's treatment team. It is generally accepted among forensic mental health experts that, when possible, treatment and evaluation/testimony functions should be separate to increase objectivity. (See, for example, Daniel W. Shuman, Stuart Greenberg, Kirk Heilbrun, and William E. Foote, "Special Perspective an Immodest Proposal: Should Mental Health Professionals Be Barred From Testifying About Their Patients?," 16 *Beh. Sci. & the Law* 509 (1998).) Third, within the SVP unit, treatment staff's clinical impressions are balanced by the TPRC's evaluation. Fourth, the TPRC's internal evaluation is balanced by the CARP's external evaluation. Finally, the TPRC uses a structured instrument, the PCL-R, with known relationship to recidivism as a measure of criminogenic needs.

Court Is Final Check. The final check in the system is, of course, by the court. Each sex offender has an annual review hearing at which the judge determines whether that resident continues to meet statutory criteria for civil commitment. The TPRC report is submitted to the court and a TPRC panel member will typically testify as to the content of this report. The judicial process involves several checks and balances in and of itself. Aside from the finder of fact's assessment of the TPRC's ultimate opinion regarding a resident's treatment progress, further challenges to the TPRC's findings are presented through cross examination by the resident's attorney, as well as through testimony by the resident's own expert psychologist or psychiatrist if one is retained.

Future Directions

We believe that the next decade will see a number of developments in assessing risk, generally, and determining suitability for release from an SVP facility, specifically. Our predictions follow.

Increased Research on Dynamic Risk Variables. To date, as noted above, much

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of the research on risk has focused on static risk variables. Static variables are inherently easier to study than dynamic variables, given that static variables can be retrieved from archival records. Research on dynamic risk variables is in its infancy. Nonetheless, both common sense and what limited dynamic risk research exists indicate that consideration of dynamic risk factors does increase one's ability to predict recidivism.

Increased Use of Structured Dynamic Risk Assessment Scales. The astute reader will note that NJ's SVP evaluation team, the TPRC, does not presently use a structured scale to evaluate a resident's treatment progress. Presently, the TPRC considers such scales to be insufficiently validated to use. However, we expect validation research to continue on these scales, and, within a few years, we anticipate that they will be in wider use in an effort to standardize and increase the reliability of treatment progress ratings.

Increased Use of Structured Rating Scales to Assess Criminogenic Needs. Stable dynamic risk factors, including personality traits, are a crucial area to assess, both in considering an offender's likelihood of recidivism and in assessing the impact of psychotherapy on personality functioning. NJ's SVP facility assessment team uses a structured rating scale, the PCL-R, to assess the personality variable with perhaps the most well established relationship to recidivism—psychopathy. Structured rating scales have the advantage of a higher level of objectivity and better predictive validity than self-report personality inventories, and we anticipate the increased use of such rating scales in coming years.

To increase the likelihood of success, SVP facilities will need to develop close working relationships with agencies that can supervise, house, employ, and help find support services, such as aftercare treatment, for released sex offenders.

Internal and External Checks and Balances. Regardless of how good the information coming into the decision process is, one needs to ensure that the use of that information is as free from bias as possible. We anticipate that SVP institutions will increasingly use internal and external independent panels to counterbalance each other. What these independent panels give up in efficiency, they will make up in objectivity.

Closer Relationship Between Inpatient SVP Facilities and Community Agencies. It is difficult to convince release authorities and the community that a civilly committed sex offender is ready to return to the community. Moreover, a civilly committed sex offender may have been institutionalized, either in the prison system or in the civil commitment facility, for many years, making his readjustment

to the community challenging. Consequently, to increase the likelihood of success, SVP facilities will need to develop close working relationships with agencies that can supervise, house, employ, and help find support services, such as aftercare treatment, for released sex offenders. A model might be the well-known containment approach, involving cooperation among a variety of supervising and treatment agencies in Colorado. (Kim English, "The Containment Approach: An Aggressive Strategy for the Community Management of Sex Offenders," 4 *Psychology, Public Policy, and Law* 218 (1998).)

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