

**THE CALIFORNIA SEXUALLY VIOLENT PREDATOR STATUTE:
HISTORY, DESCRIPTION & AREAS FOR IMPROVEMENT**

An informational guide for the citizens, professionals, and legislators of California



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INTRODUCTION

Across the nation, the subject of the violent repeat sexual offender elicits strong emotional reaction from the public, which in turn motivates legislators to increase criminal justice sanctions for sexual offense perpetrators. Among the most stringent of such responses is involuntary civil commitment legislation for sexual offenders, often referred to as Sexually Violent Predator (SVP) laws. In 1996, California emerged as the fifth state to enact SVP legislation. The SVP statute allows for post-incarceration detainment of sexual offenders determined to be mentally ill and dangerous (SVP, Section 6600, California Welfare & Institutions Code). Although the California Sexually Violent Predator statute was enacted over a decade ago, there remains much controversy among an array of professionals and private citizens regarding the purpose and merits of this legislation.

The California Coalition on Sexual Offending (CCOSO) is an organization representing the collaborative of professionals involved in sexual offender treatment and management. CCOSO has prepared **The California Sexually Violent Predator Statute: History, Description & Areas for Improvement** for the citizens, professionals and legislators of California in service to its mission, "Together we can end sexual abuse". This paper represents an effort to provide up-to-date accurate information on the California SVP Statute, its implementation through the California Department of Mental Health (DMH); the programmatic issues and public policy debate that arise from the civil commitment process, and areas for improvement regarding California's current response to its highest risk sexual offenders.

It is important to note that this paper is written in the context of the existence of the California Sexually Violent Predator statute. Its purpose is not to dichotomously opine for or against the existence of sexual offender civil commitment laws but to provide education and focused suggestions by experienced professionals to the citizens and policy makers of California with the goal of maximally reducing the prevalence of sexual abuse.

The California Sexually Violent Predator Statute: History, Description & Areas for Improvement begins with a history of sexual offender civil commitment in the United States and in California, so that readers can understand the socio-political context that helped shape the statute into its current application. This historical perspective includes Supreme Court rulings, public outcry over horrific sex crimes, developments in the field of offender treatment, and research findings on sexual offender treatment efficacy. Next, the legislation and its financial impact are described in detail, enabling readers to make informed opinions and decisions. California's inpatient and outpatient treatment and management program for the Sexually Violent Predator population is then described. This is followed by an examination of common but controversial program elements and the public policy debate elicited by civil commitment legislation. Lastly, areas for improvement are offered in the spirit of helping California's policy makers and researchers enhance the efficacy of managing the serious problem of repeat sexual abuse among high-risk sexual offenders.

THE CALIFORNIA SEXUALLY VIOLENT PREDATOR STATUTE: HISTORY, DESCRIPTION, & AREAS FOR IMPROVEMENT

I SEXUALLY VIOLENT PREDATOR LAWS ACROSS THE NATION

Impetus to Sexually Violent Predator Laws

The momentum of the United State's women's movement in the 1980's focused society's attention on the seriousness and prevalence of physical and sexual abuse of women and children. It illuminated the fact that the prevailing sociopolitical culture up to that time suppressed reporting, arrest, and conviction for these types of crimes. Society was shocked to learn that violence against women and children occurred with much greater frequency than previously thought. One result of this knowledge and attention was an increase in the number of convictions and length of sentences for sexual offenders. Consequently, the number of sexual offenders in California prisons, as in other states, reached an all-time high.

Despite significant increases in the number of convicted sexual offenders, the California prison system (California Department of Corrections and Rehabilitation, CDCR) have not implemented a formal sexual offender treatment program in its prisons to date. While there has been a compelling body of research accumulating to indicate that punishment is not as effective a crime deterrent as treatment (Cullen & Gendreau, 2000; Peebles, 2008), the underlying assumption in much of penal policy is that increased length of sentences will deter sexual offenders from committing sex crimes. Certainly, incarceration guarantees that offenders will not be a threat to the community during their incarceration period.

In California, after serving their criminal sentences, sexual offenders are released into the community untreated. Those who serve sentences under parole supervision may be required to participate in treatment through their parole agreements. Although some positive efforts have recently begun in California to provide more effective treatment for high-risk sexual offenders serving parole, historically, the quality of treatment provided by parole services for sexual offenders has been criticized due to a lack of standardization, quality review, and adequate resources.

In the late 1980's and early 1990's, intensive nationwide media focus on rare but horrific violent sex crimes against children further galvanized public opinion for increasing penalties for all forms of sex crimes. The political mantra among politicians was "get tougher on sex crimes." Many believed that providing treatment would be seen as ineffective, overly sympathetic, and impractical. Consequently, the expansion of civil commitment laws spread throughout the nation, arriving in California in 1996.

Summary and Common Features of SVP Laws

Since 1990, when the first SVP Statute was implemented in the State of Washington, twenty states have enacted laws that allow courts to civilly commit adult sexual offenders (Gookin, 2007). The twenty states that have civil commitment of sexual offender laws, -commonly called “SVP laws” are: Arizona, California, Florida, Illinois, Kansas, Massachusetts, Minnesota, Missouri, Nebraska, New Hampshire, New Jersey, New York, North Dakota, Pennsylvania, South Carolina, Texas, Virginia, Washington, and Wisconsin. This list includes one atypical SVP state, Pennsylvania, which allows only for the civil commitment of offenders who perpetrated as juveniles and are “aging out” of the juvenile justice system at age 21(Gookin, 2007). It also includes the Texas SVP law, which is atypical because it does not involve confinement; treatment occurs only in an outpatient setting. The states most recent to enact such legislation were New York and New Hampshire, both in 2007. More than 446 million dollars was budgeted in the U.S. for SVP Programs in 2007 (Goodnough and Davey, 2007). Compared to other states’ programs, California is second to Florida as having the largest number committed/ detained (Gookin, 2007). The following table, A National Perspective on California’s SVP Program, provides summary data on the numbers of sexual offender individuals detained pursuant to SVP laws and the associated costs.

A National Perspective on California’s SVP Program	United States*	California*
Number of Individuals Committed or Detained Pursuant SVP Law(s)	4,534	558
Number Fully Committed as SVP who were Discharged/ Released; (Number Died)	494 (85)	96 (15)
Average Annual SVP Program Cost per SVP	\$97,000	\$166,000
Average Annual Department of Correction Cost per Inmate	\$25,994	\$43,000

*For comparison, data reported is from 2006, as reported in Gookin, 2007. For updated CA data see: V Procedural Steps to SVP Commitment: Quick Facts & Figures.

While there are differences among the specific language of each state’s civil commitment law, these laws generally include the following four common components (Doren, 2006; Jackson and Hess, 2007):

1. At least one prior sexual offense involving some degree of violence or a hands-on sex crime against a child;
2. The presence of a current mental disorder;
3. The determination of a certain degree of risk for sexually violent acts in the future;
4. A relationship between the mental disorder and the likelihood of future sexually violent acts.

In order to be discharged from this type of commitment, most states require that the sexual offender no longer have the relevant mental disorder and/or no longer represent a significant risk for re-offense (Doren, 2006). However, some states, including California, allow conditional release in which SVP individuals are supervised and treated in the community under strict restrictions. The majority of states that do allow for conditional release require that the sexual offender continue to meet criteria for SVP legal commitment; but their condition must have changed to such a degree that they can now be safely treated and reintegrated into the community.

With the birth and proliferation of SVP laws across the nation in the 1990s came much legal challenge. One consequence of the escalation of such legal challenges is that the outcomes solidified the legal foundation and legitimacy of the civil commitment process.

Relevant Supreme Court Decisions

Kansas v. Hendricks:

On June 23, 1997, the United States Supreme Court reversed the decision to invalidate the SVP act made by the Kansas Supreme Court in the trial of Hendricks (*Kansas v. Hendricks*, 1997). In a five to four decision, the Supreme Court's ruling upheld the constitutionality of Kansas' SVP statute, which was essentially a copy of the Washington and California state statutes. The majority opinion, written by Judge Clarence Thomas, noted that previous civil commitment statutes had been legally upheld, "When they limited the class of persons eligible for confinement to those who are dangerous and who are unable to control their dangerousness due to mental illness (*Kansas v. Hendricks*, 1997 at 358)." The court further ruled that because the intent of the Kansas statute was not punitive, it did not violate the United States Constitution's provision against either double jeopardy or *ex-post-facto* lawmaking.

Justice Kennedy voted with the majority, but wrote a brief concurring opinion in which he cautioned that civil confinement should not be used to achieve retribution or general deterrence, and that "if mental abnormality" proves too uncertain a category to justify civil commitment, the Court should not condone its use. The dissenting minority opinion, written by Justice Breyer focused on the *ex-post-facto* claim. The dissenting view's opinion was that the statute impermissibly imposed punishment by delaying treatment until Hendricks completed his prison sentence. Under the Kansas SVP Statute and many other SVP statutes, including California, diagnosis, evaluation and commitment proceedings do not occur until the inmate's criminal sentence is about to expire. Additionally, when commitment proceedings are conducted, the decision-maker is not required to consider less-restrictive alternatives to civil confinement.

This last point was not fully embraced in a 2002 decision by the California Supreme Court involving a defendant named Marentez (*Cooley vs. The Superior Court of Los Angeles County, Marentez*, 2002). The court ruled in support of the SVP and added that the California DMH evaluators must consider whether a defendant can be safely

treated in a community setting.

Kansas v. Crane:

In 2002, *Kansas v. Crane*, further affirmed the constitutionality of the SVP laws, and allowed a broader interpretation of volitional control than *Hendricks*, by clarifying that complete inability to control behavior is not required (*Kansas v. Crane*, 534 US 407 2002).

II CALIFORNIA'S HISTORY OF CIVIL COMMITMENT OF SEXUAL OFFENDERS

Sexual Psychopath Laws

Involuntary commitment of sexual offenders to state hospitals in California dates back to the early 20th century. The "sexual psychopath laws" were indeterminate criminal sentences that allowed for commitment to state psychiatric hospitals for as long as the individual was deemed a threat to society. The purpose was to help sexual offenders by curing them in a shorter time than they would serve in prisons, and to protect society against release of sexual offenders who had not been cured within the maximum incarceration sentence (American Psychiatric Association, 1999).

At that time, there was little awareness of the prevalence of violence against women and children. Such crimes were rarely reported and even more rarely prosecuted. Those cases that did come to the attention of the authorities were extremely heinous and thus, individuals committed as "sexual psychopaths" tended to be the most serious offenders. Psychotropic medication did not yet exist and there were few non-biological treatment modalities. The dominant psychological theory of the time was psychoanalytic, but psychotherapy of sexual offenders based on this yielded little success. According to Morris:

"Sexual psychopath legislation was discredited; however, by the inability of psychiatrists and other mental health professionals to identify a specific mental disorder experienced by individuals, who should be included within the targeted group, and by the lack of successful treatment methodologies to improve their condition" (2000, p.1200).

As a result, by 1990 all but 12 states repealed their sexual psychopath laws. In California, the Sexual Psychopath Law was replaced by the Mentally Disordered Sexual Offender Law in 1944 (www.dmh.ca.gov).

California Mentally Disordered Sexual Offender Law

In 1944, the Mentally Disordered Sexual Offender (MDSO) statute was added to the California Welfare and Institutions Code as Section 6331-6332 (www.dmh.ca.gov). Although no new offenders have come into the system pursuant to MDSO since its repeal in 1982, persons who were in state hospitals and community programs at the date it was repealed continue to be subject to its provisions. These provisions include hospital treatment until such time as the court agrees that the person may be safely treated under supervised outpatient care. The outpatient period lasts until the court deems the individual "not a danger to the health and safety of others", in which case the person is discharged from jurisdiction, or until the person is revoked back to a state hospital.

The MDSO statute provided for the diversion from prison to forensic state psychiatric hospitals of those individuals whose sexual crimes were deemed to be due to a mental disorder. This determination of mental disorder was difficult, particularly in light of the fact that few studies had been done and research was not supported in this area. Therefore, the evaluator was left to rely on clinical experience and clinical impressions.

In June 1954, the California DMH opened a maximum-security forensic psychiatric hospital at Atascadero State Hospital (ASH) to house and treat MDSO patients and other categories of forensically committed individuals. With the recommendation of two "experts," the offender could go to a forensic psychiatric hospital (ASH or Patton State Hospital [PSH]) for treatment until the staff felt that the individual met particular parameters that were outlined in their treatment. The treatment goal was to reduce risk to such an extent that the individual was felt to be safe for release.

Although MDSO individuals could not earn "good time" to gain early release in the same way as they could in prison, they could be detained for less time than if they opted for prison if they were able to convince their treatment team that they had benefited from therapy. An individual committed as an MDSO could gain release by obtaining an "A" recommendation, which meant that the treatment team determined he was "cured," or by obtaining a recommendation and being accepted for an outpatient community treatment setting. Although it reflected the state-of-the-art of sexual offender treatment across the nation at that time, the quality of treatment during the time of the MDSO law (1944-1982) in the hospitals and community varied greatly as did the amount of supervision.

Conversely, individuals who received a "B" recommendation were returned to court having been determined to be unamenable to treatment. A "B" recommendation offender could be sent to prison to serve the remainder of his sentence. When many offenders found out they could serve more time by opting for MDSO treatment, they opted to be judged unamenable so they would be sent to prison where they could serve less time because they were eligible to receive "good time" credits. Thus, legal strategizing by MDSOs confounded the reliability of the MDSO discharge rating system.

Assembly Bill 1229, passed in 1969, and extended in 1980, mandated California state-supported outpatient treatment facilities in 16 counties. The intent of this legislation was to "...provide an alternative to the courts when considering treatment in a state mental hospital for a person who was found to be an MDSO and a stepping stone back into society for those persons already in the state hospital who are responding to treatment" (Sturgeon & Taylor, 1980, p. 66). This was an early predecessor to the statewide Conditional Release Program (CONREP), which was formally enacted in 1986 (Lee, 2003). Efforts to place MDSOs in state-supported outpatient treatment facilities were deterred by legislation implemented around 1980, mandating that convicted sexual offenders not reside within a mile of a school. This made it very difficult to get even those who appeared to have benefited from treatment into the community, especially because most CONREP agencies were near city centers and hence close to schools.

In the late 1970's and early 1980's, the trend in the field of psychology was behavior therapy, which was gradually evolving into cognitive-behavior therapy. Some of these emerging techniques were being used with sexual offenders. At that time, there were several staunch behaviorists working at ASH, including Dr. Richard Laws.

Consequently, much of the sexual offender treatment done at ASH, involved behavior modification techniques such as aversion therapy and counter-conditioning, which was applied on an individual basis and focused on deviant sexual arousal. There were also programs that utilized Reality Therapy and Family Therapy and others that focused on changing criminal thinking patterns based on the work of Samenow and Yochelson (1977). Both PSH and ASH had units where the primary treatment modality was assertion training, based on the belief that sexual offenders have difficulty relating appropriately to adults and, therefore, regressed to deviant behavior in order to meet their sexual needs. Much of the group treatment at both hospitals was conducted by level-of-care staff (psychiatric technicians) rather than professionally trained clinicians, and followed no consistent treatment philosophy or protocol.

In 1981, an MDSO named Theodore Frank was released from ASH into CONREP in Los Angeles, California, and within three months kidnapped and murdered a two-year-old girl who was playing in her front yard. This crime spelled the demise of state supported sexual offender treatment in California. Faced with an enormous public outcry, the state legislature declared sexual offender treatment under the MDSO statute a failure based on this single case and repealed the MDSO statute effective as of January 1982. Some opine that the motivation to repeal the MDSO law was based on emotional responses to such cases of "mistaken" release of a few notorious offenders who brutally re-offended, rather than concerns over the overall efficacy of the law.

Prior to the repeal of the California MDSO law, organizations such as the Group for Advancement of Psychiatry, the American Bar Association's Committee on Criminal Justice Health Standards, and the President's Commission on Mental Health, urged the repeal of MDSO laws around the country because of concerns about the efficacy of treatment and because MDSO commitment statutes amounted to preventative detention (American Psychiatric Association, 1999). A 1977 report issued by the Group for Advancement of Psychiatry wrote:

"First and foremost, sex psychopath and sexual offender statutes can be described as approaches that have failed. The notion is naive and confusing in that a hybrid amalgam of law and psychiatry can validly label a person a sex psychopath or sexual offender and then treat him in a manner consistent with a guarantee of community safety. The mere assumption that such a heterogeneous legal classification could define treatability and make people amenable to treatment is not only fallacious; it is startling" (cited in American Psychiatric Association, 1999; p. 14).

Although the law was repealed, there are few a MDSO sexual offenders who remain at ASH and PSH or in Conditional Release Programs throughout the state.

Mentally Disordered Sexual Offender Treatment Outcome Studies

As summarized in the California DMH 1969 research monograph, the first study of MDSO sexual offender recidivism rates was published in 1965 by Frisbie and Dondis (Frisbie, 1969). This study followed 1,921 MDSO individuals, who after a period of indeterminate treatment at Atascadero State Hospital, were discharged by a Superior Court based upon medical evaluation as improved and no longer dangerous, an “A” rating. Their recidivism rates were tracked between 1 to 6 years, using a formula that adjusted the recidivism rate to account for the varying lengths of time released to the community. Recidivism rates among child molesters ranged from 10.2% in cases of father-daughter incest to a 46.8% for individuals convicted of voyeurism, transvestism and lewd behavior with a minor. There was no state-supported outpatient treatment for this population during the time period encompassed by the study.

A second recidivism study by Sturgeon and Taylor (1980) reported on 260 MDSO individuals who were released from ASH in 1973. Similar data was collected on a group of 122 incarcerated sexual offenders who were paroled after receiving no treatment. Overall, 15% of the MDSOs were convicted of new sexual crimes during the five-year follow-up period. However, those who had received a “B” rating (i.e., were unamenable to treatment) were twice-as-likely to commit new sex crimes as those who received an “A” rating and re-offended at roughly the same rate as untreated parolees. Some are critical of this positive treatment effect because the assignment of subjects to treatment or no treatment groups was not random. The authors of this study note, “Since the founding of the hospital in 1954, very little systematic research has been done to examine what happens to these sexual offenders once they leave the hospital” (p.31). This conclusion reflects that sexual offender research at that time, was not embraced as a priority at the federal or state government funding level. It appears that whatever research was undertaken during this period was accomplished through the efforts of individual staff members who were interested in the issue of sexual offender treatment, and did not represent any systematic attempt of the government institutions mandating such programs to study treatment efficacy. Also noteworthy is that there were several thousand sexual offenders treated at PSH during the 1970’s and early 1980’s, the treatment approaches varied, and similarly, there were no structured follow-up outcome studies.

The Sexual Offender Treatment and Evaluation Project

Funded by the legislature, the Sexual Offender Treatment and Evaluation Project (SOTEP) was enacted at ASH in 1981 pursuant to SB 278. It is considered the gold standard study of whether sexual offender treatment at that time was effective. SOTEP was limited to 50 offenders at any one time who were recruited from state prisons and given the opportunity to spend the final 22 months of their sentences receiving treatment in a hospital setting rather than in prison. They received treatment based on a new model of sexual offender treatment, the Relapse Prevention model, which was derived from substance abuse treatment and adapted for sexual offenders by Marques and colleagues (Marques et al, 1989). The average recidivism rate of the treatment

group was compared with that of a matched group of sexual offenders who volunteered for but did not receive treatment, and a third sexual offender group in prison who did not volunteer for treatment. Sexual offenders who paroled from SOTEP were additionally provided with one year of community-based outpatient individual treatment twice per week.

The SOTEP program at ASH is widely regarded in the literature as the most extensive and well-controlled study of sexual offender treatment efficacy ever attempted in the United States due to its rigorous experimental design. The treatment program ended in 1995 and follow-up research continued over a period of eight years. The final analysis of the SOTEP data showed that the recidivism rates of the treatment group did not differ significantly from that of the control groups. To elaborate, 20% of the treated subjects sexually re-offended, 20% of the untreated volunteers for treatment (control group) sexually re-offended, and 19.1% of the non-volunteer, non-treated control group sexually reoffended (Marques, et al., 2005).

Importantly, however, a positive treatment effect was revealed when Marques et al. separated the treated group into two groups, those who “got it” (those individuals who were determined to have met the treatment objectives; N= 52) and those who were assessed to have failed to meet the treatment objectives (N= 103). Items on the “got it” scale included post treatment Penile Plethysmograph scores, Multi-Phasic Sex Inventory scores, and clinician rating of written relapse prevention assignments, the Cognitive Behavioral Chain and the Decision Matrix. The “got it” group had recidivism rates 50% less than those assessed to have not met the treatment program objectives. This positive treatment effect was greatest for high-risk members of the “got it” group, which had an overall recidivism rate of 10% while the high-risk group that did not meet program objectives had a recidivism rate of 50%. Further, the predictive value of the “got it” group was largely accounted for by the child molesters in the treated sample, the relationship between “got it” and re-offense was not significant for rapists. While this positive treatment effect is interpreted by many with hope that treatment with completion based on achieving defined treatment targets progress can be reduce the rate of sexual re-offense, skeptics point out that the “got it” group results were found upon post-hoc analysis of the data.

Other noteworthy findings from SOTEP include data on treatment drop-out and PPG sexual arousal to children subgroups. The highest group to recidivate sexually or violently was the treatment drop-out group, those who volunteered and were assigned to the treatment group who dropped out of treatment before 1 year. The sexual re-offense rate for the treatment dropout group was 35.7% and the violent re-offense rate was 28.6%. Sexual arousal to male children as measured on the PPG prior to treatment delivery distinguished the treatment participants who re-offended from the treatment participants who did not re-offend. On post-treatment measures, treatment participants who re-offended had higher PPG arousal scores to male and or female children compared to treated participants who did not re-offend.

Marques et al. (2005) reported no treatment effect in the final results of the longitudinal study of cognitive-behavior relapse prevention (RP) treatment for sexual offenders. Marques and colleagues speculated a number of possibilities for the lack of treatment effect, including that the program failed to embrace the Risk, Need, Responsivity framework (Andrews & Bonta, 1998). The treatment program components may have been too intense for the participants, who were categorized as low to medium risk on the actuarial scale. In addition failing to focus on high-risk offenders, the program did not include treatment modules on all known dynamic risk factors for sexual offending. Another possibility offered was discharge was unrelated to treatment progress or re-offense risk. The treatment group was not required to demonstrate a commitment to change, motivation of full engagement in treatment, or even show improvement to stay in the program.

The SOTEP authors suggested a number of ways in which the Relapse Prevention treatment program could be improved. Relapse Prevention Programs are traditionally focused on the maintenance stage of behavior change, the stage when one is committed to continue their success in stopping an unwanted behavior. Programs components that prepare individuals to change, engage them in treatment, and emphasize the need to build and maintain motivation are necessary prerequisites to programs that focus on maintaining success. Authors also suggested the program needs to target the decrease in motivation that is common in many released offenders and to implement treatment consistent with the containment model during the outpatient phase, which focuses on surveillance and trans-agency collaboration. In post recidivism interviews with treated subjects, Marques and colleagues learned that many did not use the self-management skills they learned from the program, and some did not accept the basic goals of self control and avoidance of relapse. Lastly, authors cautioned that manualized treatments may contribute to decreased efficacy due to their limiting individualized interventions.

Because it 's 1984 treatment model represented the best of available treatment and despite the lack of strong overall results supporting the efficacy of treatment, the SOTEP curriculum, augmented by the SOTEP results and suggestions, was used as the basis for SVP treatment programs in California and a number of other states. Caution is necessary in comparing the SOTEP results to the SVP population namely because the SOTEP study excluded very high-risk sex offenders (e.g. those with three or more felony convictions); such offenders would likely fall under the SVP statute.

While the overall goal remains "relapse prevention" in the broad sense, the field continues to develop. According to the California Sex Offender Management Board (CASOMB):

"Sex offending has a complex etiology, and there are numerous elements involved that have been suggested as potential causes of why individuals offend (i.e., Ward, 2003). A treatment model that does not incorporate numerous strategies to account for the complex range of factors involved with sexual offending behavior will not adequately correct this behavior" (CASOMB Initial

Report, 2008, p.139).

Newly emerging models of treatment focus on factors such as underlying attachment disorders, the various pathways of re-offense (Hudson, S. M., Ward, T., & McCormack, J.C., 1999) offender motivation and strengths (i.e. Good Lives model), therapist characteristics, and interventions strategies that specifically target empirically-defined dynamic risk factors.

Other Relevant Research

It is important to note that all recidivism research underestimates the true prevalence of sexual offending. It is a widely accepted fact that only a small fraction of sexual offenses are reported to authorities. Some studies have found that at least 90% of sexual assaults were not reported to authorities (Abel and Rouleau, 1990; Besserer and Trainor, 2000; Freyd et al., 2005; Kaplan, 1985).

To date there has been no formal research on recidivism among California's legally designated SVP population. However, evidence has emerged from other samples of sexual offenders that many sexual offenders do benefit from treatment. For example, two large meta-analyses (Hanson et al., 2002; Losel & Schmucker, 2005) of sexual offenders who participated in highly structured cognitive-behavioral programs found reductions in sexual recidivism, from a rate of 17% to 10%, and reductions in general recidivism from a rate of 51% to 32%. This overall 40% reduction in sexual recidivism (rates dropping from 17% to 10%) appears to be the result of treatment specifically focused on deviant arousal and other criminogenic needs found among sexual offenders, including sexual pre-occupation, antisocial orientation, attitudes tolerant of sexual offending and intimacy deficits (Hanson, 2007).

The findings by Hanson et al. (2002), while encouraging, must be tempered by the recognition that uncontrolled differences in characteristics between the treatment and no treatment groups may have contributed to the reduction in sexual recidivism in unknown ways (Rice & Harris, 2003). While there is a growing body of literature that supports the efficacy of sexual offender treatment, proving its efficacy remains elusive (Beech et. al, 2007, as cited in the CASOMB, Initial Report, p.141). The Collaborative Outcome Data Committee, as cited in the CASOMB Initial Report cautions:

“In the field of sexual offender treatment, it is unlikely that there will ever be a ‘definitive’ study, however desirable that would be. The complexity of the interventions and the long delays needed before knowing the ultimate outcome (i.e., recidivism) present significant technical obstacles, even if there was the social and political will for generous investment in sex offender research. Furthermore, the heterogeneity of the sexual offender population precludes the answers from being found in any single study. Consequently, the future of sexual offender outcome research will involve the accumulation of evidence given by small studies.”

The 2008 Initial CASOMB report correctly notes that, with the exception of treatment, “all the other tools of supervision are external controls” (p.138). We cannot watch all sexual offenders at all times. There are simply too many of them for us to put all of our reliance on policing while ignoring the encouraging advances made in treatment in the past 20 years. Therefore, it is imperative that programs such as the SVP program have a viable and well-funded research component at all levels.

Research on the SVP population should be two-pronged. Obviously, high-quality outcome research is essential in order to know whether those who have completed treatment recidivate. But there is also increasing empirical support for research which focuses on “therapy process variables,” although such variables previously have been largely ignored in sexual offender research. As opposed to the content of what is taught, the therapy process includes attention to therapist characteristics that promote effective treatment and factors that are related to promoting offender engagement in treatment and preventing drop-out (Hanson, 2007; Marshall et al., 2006).

III THE BIRTH OF THE CALIFORNIA SEXUALLY VIOLENT PREDATOR STATUTE

In 1995, the California Legislature passed the SVP Act as a component of the Welfare and Institutions Code (WIC, Section 6600), to address the concern expressed in the preamble of this legislation: “[A] small but extremely dangerous (number of) sexually violent predators exist...”The implementation of the SVP Act as a statute commenced on January 1, 1996. California was the fifth state to enact a sexual offender civil commitment statute. California’s SVP statute was closely modeled after that of the first state to enact an SVP statute, -Washington state (1990).

Like that of many other states across the country, the cultural context of California in the second half the 20th Century gave rise to the enactment of civil commitment for sexual offenders. The most influential factors were a perception of failed penal policies, massive media attention to horrific crimes by repeat sexual offenders and a steady increase in recognition of the rights of women and children. California enacted its civil commitment statute as an attempt to address these factors. Legislators promised to enhance public safety via extended detention and treatment of dangerous mentally disordered sexual offenders. This section provides an understanding of the history of the California SVP Statute in context of criminal sentencing policies.

The SVP Act as a Response to a Change in Penal Policy

Prior to 1977, California had an indeterminate sentencing scheme for persons convicted of sexual offense felonies. Prison officials, thus, had some flexibility in determining an offender's release date. Likely a response to "incorrect" decisions to release of offenders who went on to commit heinous crimes; a 1976 ballot initiative changed California's sentencing to a primarily determinate sentencing program which went into effect in July 1977. For example, a rapist who might serve anywhere from one day to three years or up to life in custody as determined by prison officials under the indeterminate sentencing scheme that existed prior to 1977, was, subsequent to the 1977 Determinate Sentencing Act, subject to a 3, 4, or 5 year terms of incarceration which could not be altered following court sentencing.

A determinate sentence is one that mandates confinement for a fixed or minimum period specified by statute. An indeterminate sentence does not state a specific period of time or release date, but just a range of time, such as "five-to-ten years". The Uniform Determinative Sentencing Act of 1976 went into effect on July 1, 1977. Until 1977, in California, most felonies had a range of sentences (indeterminate sentences), or had what is called a "life top".

Examples of Sentencing Prior to July 1, 1977 (Sentencing was Indeterminate Type)

1. *Rape (PC 261): a maximum three-year prison sentence, or, if great bodily injury was inflicted, a range of three years-to-life.
2. Child Molest (PC 288): one-year-to-life.
3. Drug Possession (HS 11350): two-to-ten years.

This means that prior to 1977 person who was sentenced for “straight” rape could do as little as a day or as much as three years prior to July 1,1997, but, if great bodily injury was substantiated, the offender could receive as much as a life sentence.

Examples of Sentencing After July 1, 1977 (Sentencing was Determinate Type)

1. Rape (PC 261, CA Penal Code, 1978): three-to-four-to-five years (specific term imposed by Judge at time of sentencing)
2. Child Molest, PC 288 was three-to-four-to-five years
3. Drug Possession, HS 11350 was 16 mos.-to-two-to-three years.

Opposition by Notable Associations

The emerging prevalence of SVP Statutes across the country was not without controversy. The American Psychiatric Association’s Task Force on Dangerous Sexual Offenders strongly opined that psychiatry was being used to preventatively detain a class of people for whom confinement rather than treatment is the real goal (American Psychiatric Association, 1999). In their Task Force Report, this group of medical professionals asserted that such laws were a clever way of circumventing determinate sentencing reform through permitting further punishment of sexual offenders and enhanced protection of society. The American Psychiatric Association Task Force Report argued for indeterminate sentencing and treatment of dangerous sexual offenders in the criminal justice system.

Other groups such as the California Psychological Association, the American Civil Liberties Union, California Attorneys for Criminal Justice, the California Psychiatric Association and the Forensic Mental Health Association are known to have made public their opposition to the passage of the California SVP law.

During the 1995 legislative hearings, the California Psychiatric Association expressed their opposition firmly:

“Psychiatry must always guard against psychiatric treatment being used as a method of social control devoid of treatment. Unfortunately, we have no known effective treatment for a number of these predators. As much as we agree that such behavior requires strong social control, mental health treatment facilities cannot be used as a gulag (Transcript of testimony before the California State Legislature Re: AB 888)”.

In addition, some legal scholars were critical of the enactment of such statutes (e.g., Morris, 2000), stating they are a reincarnation of the older sexual psychopath laws: “But unlike its sexual psychopath predecessor, which substituted indeterminate treatment for determinate punishment, the SVP statutes added indeterminate confinement upon completion of the offender’s criminal sentence (p.1202).” Those in opposition to the sexual offender civil commitment laws generally agreed that the need for deterrence and punishment of sexual offenders should be met through the criminal justice system and not through involuntary civil commitment statutes.

The Evolving California SVP Statute: Court Rulings, Proposition 83 & The Governor’s Task Force

California Court Rulings

Case law is created by judges in their rulings when they write their decisions and give the reasoning behind them, including precedents in other cases and statutes that had a bearing on their decision. Due to the courts ability to exercise a moderate amount of quasi-legislative power through the use of precedent and case law, judicial application of the SVP law is continually evolving.

Some of the most influential CA SVP court rulings are summarized below.

1. ***Turner v. Superior Court of San Diego County (2003)***
The appellate court set forth a special evaluation requirement in cases where the person has previously been found by a jury NOT to be an SVP. The Turner decision requires evaluators acknowledge the prior NO SVP finding in their reports and rely on facts subsequent to the NO SVP finding to support their conclusions.
2. ***People v. Burris (2002)***
CA appellate court ruled *against* the argument that an urge not resisted means the person can control their behavior and thus does not have a statutorily defined mental disorder. It ruled that he who offends, feels remorse, and continues to offend, *AND* he who offends, feels no remorse, and continues to offend despite criminal sanctions both lack control because neither offender is likely to be deterred by the risk of criminal punishment thus both should be dealt with civilly.
3. ***People v. Superior Court of Marin County (2002, “the Ghilotti Decision”)***
The CA Supreme court ruled on the meaning of “likely” relative to the third criteria of SVP, “Is the inmate **likely** to engage in sexually violent predatory criminal behavior as a result of his or her diagnosed mental disorder without appropriate treatment and custody?” The court defined “**likely**” as “...a substantial danger-that is a serious and well founded risk of re-offending in this way if free.” “**Likely**” does not mean, “greater than even chance”.
4. ***Cooley v. Superior Court of Los Angeles (2002, Marentez)***
The CA Supreme Court ruled that evaluations should consider the inmate’s amenability to voluntary treatment in determining the risk of committing sexual

violent predatory criminal acts. The evaluator should have a high degree of confidence that the inmate's expressed desire to seek supervision and treatment in the community without the SVP commitment is meaningful, sincere, and sufficiently significant.

5. ***People v. Hurtado (2002)***

The court resolved a question left open after *People v. Torres (2001)* by clarifying that the trier of fact must determine not only that the person is likely to engage in "sexually violent criminal behavior" but also that the behavior is likely to be "predatory". "Predatory acts," defined within WIC 6600, are "directed toward a stranger, a person of casual acquaintance with whom no substantial relationship exists, or an individual with whom a relationship has been established or promoted for the primary purpose of victimization".

6. ***People v. Torres (2001)***

Relative to the first criteria of the SVP statute, the CA Supreme Court ruled that there is no requirement that prior sex offenses be "predatory acts" to find a person is a Sexually Violent Predator.

7. ***People v. Hubbart (1999)***

The CA Supreme court ruled that the civil commitment of individuals under the stature of the CA SVP Act does not violate state or federal constitutions.

Proposition 83, "Jessica's Law"

California witnessed an unprecedented amount of sexual offender public policy in 2006. In November 2006, the SVP statute was amended when California voters passed Proposition 83, by more than 70%. Proposed by Senator George Runner and his wife and former assemblywoman, Sharon Runner, the ballot initiative was strongly supported by Governor Schwarzenegger who had recently signed Senate Bill 1128, the Sex Offender Punishment and Containment Act and Senate Bill 1178. Proposition 83 is also known as "Jessica's Law," named after 9 yr-old Jessica Lunsford who was kidnapped, sexually assaulted and murdered by John Couey, a convicted sexual offender in Florida. Numerous states have implemented similar laws in response to this notorious murder. The enactment of Proposition 83 changed several key elements of the SVP statute.

1. An offender can be found to meet the SVP criteria by having only one victim while previous to the passage of Proposition 83 at least two victims were required. At this juncture (2009), this specific change has not resulted in significant increase in the number of sexual offenders who are found to meet SVP criteria. The likely reason is because the offender is still required to be diagnosed with a mental disorder and such diagnoses usually require demonstration of a pattern of behaviors, fantasies or urges that have occurred for at least six months. We do know, however that this change resulted in an increase in the average number of referrals to DMH for SVP review from approximately 50 per month to about 600 per month.
2. Proposition 83 increased the number of penal code sexual offenses that prompt

review for SVP criteria from 9 to 34. In addition, certain juvenile sexual offenses which were previously not included in the initial 1996 SVP commitment criteria can be considered.

3. Proposition 83 added a large number of sex crimes to the Penal Code, enhanced minimum sentences for sex crimes, eliminated “good time” credits for habitual sexual offenders, and increased parole terms from three-to-five years to up to ten years for the most severe sex crimes.
4. Possibly the most significant change to the SVP statute brought about by Proposition 83 (initially by SB 1128) legislation is the change in the commitment period from two years to an indeterminate period unless the court finds that the individual no longer meets the definition of an SVP. The SVP patient can still petition the court to be conditionally or unconditionally released on an annual basis, but, the court can choose not to hear the case if there is insufficient evidence to suggest that the individual’s condition has changed significantly.

While not SVP specific, two additional very significant changes to California’s response to sexual offenders elicited by Proposition 83 are mandatory lifetime GPS monitoring for registered sex offenders and prohibition against sex offenders living within 2,000 feet of a school or park. The residency restriction shuts sex offenders out from living in several cities. Notable community protection groups, such as the California Coalition Against Sexual Assault, the Santa Barbara Rape Crisis Center, the California Coalition on Sexual Offending, Community Solutions, and the Young Women’s Christian Association openly opposed Proposition 83 opining it would result in unintended negative consequences that would ultimately make communities more dangerous. A November 2008 report by the CASOMB, “Homelessness Among Registered Sex Offenders In California”, reported an 800% increase in homelessness among paroled sex offenders due to the residency prohibition (CASOMB, 2008). Some community members, media, and professionals opine Jessica’s Law is a shortsighted costly failure (i.e. Santa Rosa Press Democrat, 8/18/08).

Governor’s High-risk Sex Offender and Sexually Violent Predator Task Force

One of the most significant recent efforts to review and revise policies and to stimulate new legislation related to the California Sexually Violent Predator Civil Commitment Program took place under the auspices of the Governor’s High-risk Sex Offender and Sexually Violent Predator Task Force – Phase II. This group of decision makers, co-chaired by Assemblyman Todd Spitzer (R) and Assemblyman Rudy Bermudez (D), met during September, October and November of 2006; and developed a set of twenty-six recommendations to address a variety of perceived problems in both the structures and in the operations of the SVP system.

The background for these meetings can be briefly described follows: Citizens, local officials and media in a number of local communities around the state had focused attention on controversial placements of paroled sex offenders by the CDCR.

Concerned about such negative attention, Governor Schwarzenegger convened a High-risk Sex Offender Task Force to address the issue of community placement of paroled sex offenders and other related matters. This Task Force, convened and co-chaired by the above-named legislators, reviewed the situation and made ten recommendations. The Task Force also acknowledged that no solution had been found to many of the problems posed by sex offender placement and asked the Governor to extend its working life for an additional three-month period to further consider those issues. This extension was granted, but in doing so, the Governor expanded the scope of the Task Force to include issues related to the Sexually Violent Predator system. Membership of the Task Force was also expanded to include officials from the California Health and Human Services Agency (HHS) and one of its branches, the California DMH, within which the SVP Program operates.

The Task Force heard testimony from a number of DMH administrators and from other experts and sub-contractors. The task of understanding the workings of the SVP system imposed a steep learning curve. Numerous suggestions and recommendations were put forward by presenters and were explored by the Task Force members.

As happens frequently, the complexity and notoriety of the placement problems and related systemic difficulties faced by the SVP Program absorbed the attention of the Task Force and concerns about the obstacles to placing the few conditionally released SVPs completely overshadowed the issues related to the thousands of released High-risk Sex Offender parolees. As a result, little additional attention was devoted to HRSO placement problems and virtually all of the twenty-six recommendations of this second phase of the Task Force focused on SVP system issues.

A number of those final High Risk Sex Offender Task Force Recommendations are closely related to some of the concerns raised in this paper. The Task Force had nearly completed its work at the time that Proposition 83 passed in November of 2006. As such, the changes brought by that Initiative were not considered by the Task Force. Nevertheless, in terms of a significant effort by influential policy-makers to review the SVP system and recommend changes to improve its functioning, the efforts of the Governor's Task Force and its recommendations must be considered a major event in the history of SVP policy development, the consequences of which may continue to unfold.

[The Final Reports of both phases of the Governor's High Risk Sex Offender Task Force can be found at the website of the California Sex Offender Management Board – www.CASOMB.org]

IV FINANCIAL CONSIDERATIONS OF THE SEXUALLY VIOLENT PREDATOR STATUTE

The overall goal of SVP Statutes is to reduce the prevalence of sexual abuse crimes against victims and collective society. Indeed, the effects of one act of sexual abuse against one victim can potentially cause serious disruptions in psychological, emotional, and social development in a large number of people both directly and indirectly affected at the time of the abuse and generations beyond. Affected individuals may perpetuate the cycle of abuse against themselves or others. In addition to these pervasive and often unseen costs, there is a financial cost. Rape and child sexual abuse crimes are estimated to cost victims and society approximately \$123,000 to \$141,000 per victimization (Heil and English, 2007). How much does evaluating, committing and treating one perpetrator in the SVP civil commitment program cost?

Financial Facts

1. In **1998 ASH received 33 million** dollars to build a 250 bed addition to the hospital specifically for the growing SVP population.
2. The California State Budget of **2001** included a total of approximately **42 million** dollars allocated to the Sexual Offender Commitment Program (SOCP). In 2001, there were approximately 400 individuals committed pursuant to the SVP statute. All were at Atascadero State Hospital, except for the one female SVP who was and remains at Patton State Hospital.
3. The California State Budget of 2005 allocated approximately **400 million** dollars for the **construction of Coalinga State Hospital (CSH)**, a 1.2 million square-foot facility constructed for the sole purpose of retaining and treating the SVP population that had become too large to maintain at ASH (www.dmh.ca.gov). As of Jan 2009, it is more than half full; at full capacity, CSH can serve 1500 residents and over 2,000 staff; the annual operating budget is estimated at 152 million yearly.
4. The summary of all SVP-related costs for the budget year **2005-2006** was approximately **64 million dollars**; this includes DMH screening, evaluation and testimony but not courtroom or attorney costs (www.dmh.ca.gov), It also includes cost of treatment at DMH psychiatric hospitals, and CONREP costs. Broken down by number of patients— this results in a **cost of approximately \$150,000 per patient annually**.
5. For comparison, it cost approximately **\$37,000 per inmate annually** for detainment in the California Department of Corrections and Rehabilitation.
6. It should be noted that the above 2005-2006 budgetary information does not reflect costs associated with the significant legislative changes to the SVP statute made by the passage of Proposition 83 in November 2006. As of this date, the full financial impact of Proposition 83 on the SVP statute is unknown. It is known that because Proposition 83 lowered the required number of victims from two to one, the number of referrals to DMH screenings and evaluations rose tenfold by January 2009, from approximately 50 per month prior to the passage of

Proposition 83, peaking to approximately 1500 per month, and currently at approximately 600 per month. **Proposition 83 resulted in a 27 million dollar increase in cost for evaluators.** Despite the tenfold plus increase in screenings the average number of newly committed SVPs has not increased significantly since the enactment of Proposition 83 (www.dmh.ca.gov).

7. Further delineating the cost of evaluation for SVP commitment, doctors are paid **\$3,500 per initial evaluation** as of January 2009. Two to four initial evaluations are required for each potential SVP. Court preparation, testimony and travel time are paid at a rate of \$200 per hour. Travel expenses, for example airfare, mileage, car rental, are also paid.
8. The California State General Fund Budget allocates **\$50,000 annually for victims of sexual assault services.** With an average of nearly 30,000 victims served by rape crisis centers, this results in a cost of between **\$1.50 and \$1.66 per victim annually** (California Coalition Against Sexual Assault).

V THE LEGAL PROCESS OF SEXUALLY VIOLENT PREDATOR COMMITMENT

The SVP statute was implemented on January 1, 1996, and is a post-incarceration civil commitment. It is mandated through the WIC 6600 et seq. and is implemented by DMH as the Sexual Offender Commitment Program (SOCP). The SVP statute requires DMH to develop and utilize “A Standardized Assessment Protocol” in determining whether an inmate is a sexually violent predator (WIC 6601). The purpose of the Protocol is to set forth the statutory, regulatory, and court decisions that must be followed by evaluators, not to prescribe how the doctors should exercise their independent professional judgment in performing SVP evaluations. This section details the procedural steps involved in legally determining SVP status.

Who Qualifies? How are Potential “SVPs” Identified?

The law may only be applied to an inmate in the custody of CDCR; this includes parolees in revocation status who have been returned to CDCR. The inmate’s juvenile (age 16 and older) and entire adult criminal history can be considered in determining the clinical diagnosis and risk assessment (California Welfare & Institutions Code 6600 et seq.).

According to WIC 6600, a “Sexually Violent Predator” is a person who has been convicted of a sexually violent offense against one or more victims, and, who has a diagnosed mental disorder that makes the person a danger to the health and safety of others, in that it is likely that he or she will engage in sexually violent predatory behavior. A “diagnosed mental disorder” is defined in the statute as “A congenital or acquired condition affecting the emotional or volitional capacity that pre-disposes the person to the commission of criminal sexual acts.”

Thus, to be committed pursuant to the SVP statute, an individual must have been previously convicted of a statutorily defined violent sex offense(s) against one or more victims. To qualify, these sexual offenses must have involved force, violence, duress, menace or fear of injury of a victim or another person unless the victim of the sexual offense is a child under age 14. The specified sexual acts are “hands-on” offenses and include: rape, sodomy, oral copulation, spousal rape or lewd and lascivious acts with a child.

The offenses must be “predatory acts,” defined as “directed toward a stranger, a person of casual acquaintance with whom no substantial relationship existed or an individual with whom a relationship was established for the primary purpose of victimization.

The final criteria is that it must be determined that the individual’s diagnosed mental disorder makes it likely that he or she will engage in sexually violent predatory behavior if released into the community. Case law also clarified that the “likely” criteria is to be interpreted as a substantial risk that is a serious and well-founded risk.

When Does the Review for SVP Begin? Pre-Evaluation Screenings

The CDCR and the Board of Prison Terms (BPT) review each inmate's records six months prior to his release to identify a qualifying sexual offense history. Qualifying inmates are referred to DMH for forensic evaluation. If the BPT finds probable cause that an inmate or parolee may meet criteria as an SVP, it may order the individual to be held up to a maximum of 45 days beyond the person's scheduled release date.

DMH then screens CDCR referrals to determine if there is a diagnosed mental disorder that makes it likely that the person will engage in acts of sexual violence without appropriate treatment and custody.

How is the Determination of SVP Made? Formal DMH Evaluation

Those cases that positively meet the criteria at this level of screening are forwarded for formal full evaluation by DMH evaluators. The determination of whether the person meets full SVP criteria is made by an examination of the inmate by two independent evaluators (any combination of licensed psychiatrists or psychologists) contracted by DMH. If both evaluators concur that the person has a diagnosed mental disorder and is likely to engage in sexually violent predatory behavior without appropriate treatment and custody, the Director of DMH will refer the case to the district attorney or county counsel of the county where the current controlling offense occurred.

If the evaluators do not agree, two more independent clinical evaluators under contract with DMH will examine the inmate. If the second set of evaluators do not agree, the inmate will be paroled at the end of his CDCR term or unconditionally discharged if he has no parole time remaining. If the second set of evaluators finds the inmate to meet SVP criteria, the Director of DMH will refer the case to the district attorney or county counsel to petition the superior court for commitment. If the county district attorney concurs with DMH, a petition for commitment of the individual to the SVP program will be filed in the County Superior Court.

How does a "WIC 6602" SVP Differ from a "WIC 6604" SVP? Legal Determination of Probable Cause and Fully Committed SVP

In California, as in the majority of other states with SVP statutes, there are two broad SVP commitment categories, the civilly committed and civilly detained. The civilly detained category refers to individuals who have been legally determined to meet a minimum SVP threshold and are detained awaiting civil commitment trial. In California, the civilly detained SVP category is called Probable Cause SVP or 6602 SVP. Pursuant to WIC 6602, subsequent to the filing of a petition for civil commitment, a probable cause hearing must be held wherein a judge determines whether the petition contains sufficient facts that constitute probable cause to believe the individual is likely to engage in sexually violent predatory criminal behavior. The individual is entitled to assistance of

counsel at this hearing. California appellate case law allows the individual in an SVP proceeding to examine witnesses. As a result, many probable cause hearings include the entering of evidence and testimony of the state clinical evaluators. The individual for whom an SVP petition has been filed is detained by order of the court during this process. If the court determines that there is probable cause, a commitment trial is ordered and the person remains in custody pending the outcome of the petition.

Individuals who have legally met probable cause criteria for SVP are often identified as “6602s” based on the corresponding WIC section code number. The “6602s” can be detained at either county jail or at CSH, the current designated DMH facility for SVP individuals. This fact has led to controversy and concern by professionals, citizens and SVPs largely related to the exponentially higher cost of detaining a person at DMH compared to CDCR and also the ethics of jurisprudence involved in detaining individuals who “probably” meet full commitment criteria. Approximately 40% of the SVPs at DMH are “6602s”, and, hence have not yet been legally determined to meet the SVP criteria. While they are afforded full treatment and psychiatric care, they are significantly less likely to enroll in the treatment program compared to fully committed SVPs (WIC 6604). Noteworthy is that five out of the twenty states with sex offender civil commitment law hold only fully civilly committed sexual offenders (Deming, in press, 2009).

The SVP hearing is a civil procedure and requires a trial by a judge or jury. In order for a “6602” (Probable Cause, SVP) to become a “6604” (SVP), the jury must unanimously decide beyond a reasonable doubt the individual meets all three SVP criteria.

Procedural Steps to SVP Commitment: Quick Facts & Figures

The following is synthesized from data made available by the DMH and can be considered current as of January 2009

(http://www.dmh.ca.gov/Services_and_Programs/Forensic_Services/Sex_Offender_Commitment_Program).

- From the date of implementation in January 1996 to January 2009, 24,396 total cases have been referred to DMH for initial screening for SVP.
- The exponential increase in evaluation for SVP due to the passage of Proposition 83 is demonstrated in the fact that 17,513 of these cases were referred during the post- Proposition 83 period from November 2006 to January 2009.
- After conducting the screening, DMH determined less than one third (7,827) of those referred (24,396) met initial record review criteria and these cases went on for formal evaluation by independent doctors. DMH record review is still pending in 443 cases.
- The evaluators determined that approximately 21% (1,651) of the cases receiving formal clinical evaluation (7,827) met full SVP criteria. Clinical evaluation is still pending in 249 cases.
- Of the 1,651 cases that evaluators determined met SVP criteria, DMH referred 1,639 of these cases to the District Attorneys’ Offices (DAs) to file court petitions

for SVP commitment. The DAs rejected approximately 12% (198) of the cases and decisions are pending in 41 cases. Petitions were filed in 1,397 cases.

- Of the 1,397 cases in which the DA filed petitions for commitment, judges made rulings in 1,253 cases. Judges ruled that Probable Cause (WIC 6602) was found in 86% of cases (1,078) and Probable Cause was not found in 14% of cases (174). A Probable Cause finding is still pending in 143 cases.
- The 1,078 cases that were judicially determined to meet Probable Cause proceeded to trial for SVP commitment (WIC 6604).
- Of those receiving trial for SVP commitment, 15% (166) were not committed while 57% (616) were committed to DMH as full SVP (WIC 6604) and 27% (295) are still pending trial.
- SVPs legally determined to meet full criteria are committed for an indefinite period to the Department of Mental Health for “treatment and confinement in a secure facility (CSH).” Prior to 11/2006, the commitment period was two years.
- Since the statute was enacted in 1996 to January 2009, approximately 2.5% of the sexual offenders initially screened were eventually committed as SVPs.
- Since the statute was enacted, approximately 130 have been conditionally or unconditionally released.
- As of January 2009, approximately 825 individuals are housed in DMH facilities (CSH, ASH and PSH) pursuant to the SVP statute. Approximately 522 have been legally determined to meet SVP (WIC 6604) criteria and another 304 individuals are being detained in DMH facilities after meeting Probable Cause (WIC 6602) criteria.
- Of the 805 (6602 & 6604) SVPs at CSH, 217 were enrolled in active phases (Phase II-IV) as of January 2009.

How Can an “SVP” Get Released? Conditional Versus Unconditional Release

An SVP individual (WIC 6604) may petition the court for unconditional release or conditional release after one year, as per WIC 6608. However, the burden falls on the individual to demonstrate to the court by a preponderance of the evidence that his condition has sufficiently changed allowing him to be safely conditionally or unconditionally released to the community. A conditional release will be granted when an individual is deemed to still meet all SVP criteria, but a court determines that he can be safely treated in the community. An unconditional release occurs when a court or jury determines that the SVP individual no longer meets SVP criteria and that he must be released from his DMH civil commitment.

As a part of the continuing review of SVP individual progress during the commitment process, DMH must conduct a yearly examination of each SVP individual's (WIC 6604) mental condition and submit that Annual Report (WIC 6605), to the court. The Medical Director must state whether the SVP individual continues to meet the definition of an SVP and his suitability for conditional or unconditional release. If DMH determines conditional or unconditional release conditions exist, the director authorizes the SVP to petition the court for conditional or unconditional release. The SVP individual can also submit a petition for conditional or unconditional release without DMH authorization.

After a petition for conditional or unconditional release is received, the court holds a “show cause hearing” to consider the petition and other documents submitted by the SVP individual, the district attorney or the medical director. If the show cause hearing determines that probable cause exists to believe the person’s diagnosed mental disorder has changed such that he is no longer a danger to the health and safety of others and he is not likely to engage in sexually violent criminal behavior if discharged, then a hearing on the issue is set. The person will be evaluated by two independent state evaluators and has a right to commission his own expert evaluators. When the legal issue is unconditional release, the burden of proof is on the state to prove beyond a reasonable doubt that the person’s diagnosed mental disorder remains such that he or she is likely to engage in sexually violent criminal behavior, if discharged. When the SVP petitions for conditional release, the burden of proof is on the petitioner to prove by a preponderance of the evidence that he or she is not a danger to others in that he or she is not likely to engage in sexually violent criminal behavior due to his or her diagnosed mental disorder if under supervision and treatment in the community.

VI THE CALIFORNIA DEPARTMENT OF MENTAL HEALTH SVP TREATMENT PROGRAM

There are more than 90,000 registered sexual offenders living in California communities and institutions (CASOMB Report, 2008). Each year, approximately 8,000 sexual offenders are convicted of a felony sex offense each year and roughly 39% of those convicted are sent to prison. Pursuant to the 1996 SVP Statute, those considered the most severe of the approximate 23,200 sexual offender inmates in the CDCR are committed to the DMH as Sexually Violent Predators subsequent to serving their prison sentences. The number of SVPs, including detained and committed, is approximately 825 as of January 2009. This represents less than 1% of California's registered sexual offenders.

These individuals are confined and treated by DMH in the Sexual Offender Commitment Program (SOCP) until they either no longer meet the definition of an SVP or that they can be safely and effectively treated in the community. The SOCP is the operational title used by the DMH in implementing the SVP civil commitment statute. The Phase Program is the approved sexual offense specific treatment program of the California Department of Mental Health.

From enactment on January 1, 1996 to August 2005, ASH was the designated inpatient facility for all the male SVPs (California DMH website). Female SVPs, to date one, are housed at PSH. To accommodate the rising number of male SVPs, Coalinga State Hospital (CSH) was built in Coalinga, California, and opened in August 2005. This state hospital is a 1,500 bed, 1.2 million square ft. facility) maximum security, forensic facility that replaced ASH as the designated inpatient facility for the male SVPs.

While all individuals legally determined to meet Probable Cause or full SVP criteria are committed to CSH for inpatient sexual offense treatment, participation in the Sexual Offender Commitment Program (SOCP) treatment, called the "Phase Program", is voluntary because the SVPs are civilly, rather than criminally, committed. This means they have a statutorily defined mental illness related to their sexual offending that renders them a danger to others but because they have served their criminal sentence they have a legal right to refuse the treatment program. The intention of the legislature is that these "persons shall be treated, not as criminals, but as sick persons" (AB 888, Assemblyman Rogan, Chapter 763, 1995).

High Percentage of Treatment Refusers

On average, only 25-30% SVP individuals, (includes WIC 6604 (committed) and WIC 6602(detainees)) consent to participate in the active phases of the SOCP Phase Program (D'Orazio & Arkowitz, 2008). While the courts and the DMH recommend that all SVPs enroll and complete the Phase Program, the majority of SVPs do not. Community members, professionals, and courts express concern about the large number that refuse to participate in treatment. Such concerns are generally rooted in an interest in community safety and/or financial costs. Many SVP individuals and their

attorneys often cite the low treatment participation rate as evidence that the DMH program is not successful. Given the high cost of SVP commitment and that the ultimate purpose of the statute is community safety, the fact that a low portion of SVPs participate in treatment is considered to be a waste of valuable resources. For example, the cost of DMH hospitalization is the same for the SVP individual who participates in the treatment program and the SVP individual who refuses to participate in treatment and spends his days watching television, working out in the gymnasium, taking college correspondence courses and working on his legal case.

Most Common Reasons for Refusing Treatment

Those who do not participate in the Phase Program generally report one or more of six reasons for doing so:

1. They state they have not committed any sexual offenses (i.e. "I am wrongfully committed") or that their offenses were not harmful (i.e. "There is nothing wrong with having sex with consenting minors.")
2. They state they do not need to participate in treatment in order to never re-offend sexually (i.e. "I can change on my own").
3. They state their attorney advises them not to. They state that in order to increase their chance of being unconditionally released, or not committed at all in the case of Probable Cause (WIC 6602) detainees, they should not consent to treatment because the court will conclude that treatment consent is an admittance that they have a problem with sexually abusive behavior and cannot succeed offense-free, without it (i.e. "My attorney won't let me").
4. They state that they want to regain their freedom as quickly as possible. They cite that the likelihood of release is greater for those who are not in the treatment program. The majority of the approximate 160 unconditional releases have been of those who have not completed the treatment program. This number includes an unknown number who were in active Phases of the treatment program. Note that as of this date, it is uncertain whether the 2006 SVP statute change from two-year to indeterminate commitment will change the number released unconditionally and therefore also lead to the decrease of treatment refusal (i.e. "My chances of getting out are better if I don't enroll in treatment")
5. They state that if they enroll, their written treatment assignments, assessments and progress notes will be subpoenaed by courts and used to prove they continue to need inpatient detainment and treatment (i.e. "The court will see how sick I am and use it against me").
6. They state the treatment program is a hoax. They state the real goal of the SVP statute is to keep them locked up forever and the treatment program is a facade that covers a desire for indefinite commitment (i.e. "The treatment program is a scam").

The Influence of SVP Legal Classification on Treatment

The proportion of Probable Cause SVPs (WIC 6602) that consent to the Phase Program is generally 10-20% less than fully committed SVPs (WIC 6604) and no Probable Cause SVP has ever completed the treatment program. It is important to note that while Probable Cause SVP individuals (WIC 6602) comprise over one third of the total SVP population, they have not been formally legally committed as SVPs. Their defense attorney on their behalf, the district attorney, or the court, can delay their commitment trial indefinitely; the attorneys can do this by filing for a continuance. Thus, delaying the commitment trial (WIC 6604) of Probable Cause SVPs can be utilized as a strategy by defense counsels. While Probable Cause SVPs can participate in Phases I, II and III of the SOCP Phase Program, they are ineligible for Phases IV and V because these phases involve conditional release of legally committed SVPs to a DMH supported outpatient treatment and supervision program.

Another distinction between Probable Cause SVPs (WIC 6602) and SVPs (WIC 6604) since the passage of Proposition 83 that may influence treatment enrollment is that parole time of committed SVPs (WIC 6604) "tolls" until the person is found to no longer be a sexually violent predator, at which time the period of parole, or the remaining portion thereof, shall begin to run. This means that for 6604s, the time they spend in DMH does not get subtracted from the term of their parole. However, the parole time for Probable Cause SVPs (WIC 6602) does not toll. The differential application of tolling parole to these two legal types of SVPs means that, considering the parole sentence is equivalent, SVPs with longer inpatient time served pursuant to WIC 6602, will have reduced time under the conditions of parole upon release from DMH than those with larger portions of their DMH commitment served pursuant to WIC 6604.

What is the SOCP Phase Program? Overview & Completion Requirements

Except when noted, the sources of information for this overview of the Phase Program are the 2008 presentation by D'Orazio and Arkowitz.

The Phase Program is the approved sexual offense specific treatment program of the CA Department of Mental Health. It is rooted in Cognitive Behavior Theory and applied within a DMH-wide Wellness and Recovery Model. This Wellness and Recovery Model focuses on the importance of capitalizing on motivation, stage of change, individual strengths and resilience and all spheres of life functioning. The Phase Program is based upon some of the treatment methods and results generated from the Sexual Offender Treatment and Evaluation Project, an eight-year study examining the effectiveness of Relapse Prevention inpatient treatment in reducing recidivism of sexual offenders (Marques et al., 2005; Marques et al., 1999) and also upon other more recent research and theory in the field of sexual re-offense prevention. The program is continually being developed according to new research, theory and hospital mandates.

The Phase Program includes comprehensive and ongoing assessments (i.e. Penile Plethysmograph, Polygraph Examination, Cognitive Assessment, Psychological

Assessments) and individualized treatment planning. A Tutorial Track is available for developmentally delayed, learning disabled, and severely psychiatrically impaired participants. The program is organized into five Phases. The first four phases are inpatient treatment and the fifth phase occurs in the community following court approval for conditional release from the hospital. The core phases of the program, Phases II-IV, generally include at least five hours of group therapy per week, at least one hour of individual therapy per month, plus numerous required specialty group therapy courses. Formal Staffing Reviews are conducted by an objective panel that determine each participant's advancement through each of the active Phases. Approximately 85 psychologists and social workers provide clinical support services to the treatment program at CSH. A basic overview of the four inpatient Phases of SOCP follows:

1. **Phase I - Contemplating Change:** Phase I is comprised of weekly informational sessions held in an educational group format. Phase I does not require acknowledgment of criminal responsibility, any discussion of participants' crimes, participant desire for change or even active participation. Phase I prepares the person to make an informed consent to actively participate in the active sexual offense specific treatment Phases. It describes the goals and objectives of each of the subsequent "active" Phases. It motivates participants toward the goal of relapse prevention. Some examples of content from the Phase I modules are the following: overview of SOCP and the Phase Program, the Wellness and Recovery Model, the Stage of Change, the WIC 6600 statute, prison versus hospital attitudes, interpersonal skills, anger management, mental disorders, victim awareness, cognitive distortions, relapse prevention and establishing realistic life goals.

After completing Phase I, individuals who do not consent to move on to Phase II have a wide variety of non-sex offense specific treatment and wellness groups available for them to participate every day of the week (e.g. substance abuse groups, anger management groups, depression management groups, Post-Traumatic Stress Disorder groups, coping with aging groups; spirituality groups, meditation groups, yoga groups, education classes; arts and crafts, gardening, exercise, leisure and religious activities).

Completion Requirements: Individuals can choose to participate in Phase I as many times as they and their Wellness and Recovery Team deem it appropriate. In order to progress to the next Phase of the Program, Phase II, the individual must consent to sex offense specific treatment. The individual is required to acknowledge committing past sexual offenses; express motivation to reduce the likelihood of re-offense and make a commitment to non abusive behavior. They must be willing to discuss their sexual history; agree to participate in required assessment procedures; and agree to behave appropriately in treatment and assessment sessions.

2. **Phase II - Preparation & Skills Acquisition:** Phase II marks a shift in the individual's motivation from contemplation to preparation for change. The

treatment modality deepens and becomes more personalized, shifting from an educational classroom style to a group therapy format. The goal of this first active Phase is to lay the groundwork for longstanding change. This is accomplished by identifying and developing existing strengths, new fundamental skills, and coping strategies based on a thorough analysis of the individual's life and sexual history. Participants learn the concepts of relapse prevention and the "how to's" of basic tools they can use throughout their lives to amend unhealthy behaviors. Assignments typically include: autobiography, behavior chains, decision matrices, identification of core unhealthy beliefs and high-risk situations, and reports on readings and videos. Specialized focus on identifying and appropriately responding to emotions in self and others, victim empathy, and blocks to pro-social behavior and intimacy begins. A thorough assessment and individualized treatment plan called the Phase Evaluation and Action Plan guides the focus of the individual's treatment and the assessment of progress during formal staffing reviews.

Completion Requirements: To progress from Phase II to Phase III, the individual must complete all required Phase II assignments, supplemental groups and assessments; maintain skills, knowledge, and motivation in several objective criteria. Skill, knowledge and motivation criteria include: full accountability for past sexual offending, acceptance of lifetime management, a commitment to abstinence from abuse reflected in daily behavior; the ability to identify and correct cognitive distortions, identification of known high-risk factors; a rudimentary cognitive and emotional understanding from victims' perspectives, generally consistent emotion and behavior management, and full motivation and at least partial ability to manage deviant sexual arousal and any tendency to identify with children. When the individual, his Wellness & Recovery Team, treatment providers, and the objective staffing panel concur that he has successfully acquired the skills for change, he moves on to the practice phase of the program, Phase III, Action & Skills Application.

3. **Phase III - Action & Skills Application:** Individuals in Phase III are typically in the action stage of change. They practice in their current daily living the new Phase II skills they learned through thorough examination of their past behavior patterns. They actively work in the 'here and now' on altering dynamic risk factors. Participants learn to identify and challenge maladaptive thoughts, feelings and behavior on an everyday basis to restructure maladaptive cognitive patterns. Through therapy, journaling, and, out of group assignments, relapse prevention skills and personal strengths are deepened and applied to daily living. Consistent management of deviant sexual arousal may require sexual arousal modification treatment. Significant community supports, such as a spouse, family member or sponsor may become involved in participants' treatment.

Completion Requirements: To advance from Phase III to Phase IV, the participant must be fully legally committed as an SVP (WIC 6604). He must maintain competence in Phase II and III objectives, have successfully completed

all Phase III assignments, specialty groups and assessments; and he, his Wellness & Recovery Team, treatment providers and an objective panel concur that he has proficiency in the following: he takes full accountability for his sexually abusive behavior; he can describe the potential negative impact of his abuse on his victims; he demonstrates empathy and concern for others to the best of his ability; he demonstrates a commitment to abstinence from abusive behavior in his daily living"; he recognizes and corrects the cognitive distortions that led to his offenses; he identifies and effectively copes with internal and external high-risk factors including deviant arousal, intimacy deficits and problem solving deficits; and he is cooperative with rules and appropriately manages impulses and emotions.

4. **Phase IV - Skill Consolidation and Transition:** The focus of Phase IV is planning and preparing for outpatient supervision and treatment while continuing to actively practice and refine strengths and relapse prevention skills. Community supports and the outpatient treatment provider are integrated into the individual's treatment. In-depth preparation for conditional release through completion of a detailed community safety plan assists the individual in preparing for the challenges and opportunities of supervised community reintegration.

Completion Requirements: When the individual, his Wellness & Recovery Team, treatment providers, the hospital medical director, and the Superior Court agree that the individual can be safely and effectively treated in the next phase of the DMH SVP Treatment Program, he graduates to **Phase V, Maintaining Change through Supervised Community Reintegration**. Phase V is interchangeably called CONREP or Liberty. Upon determination that safety can be reasonably assured through conditional release, the SVP individual is discharged from inpatient status and treated as an outpatient by the Conditional Release Program.

Although the DMH program is designed with the goal that all SVPs complete the inpatient phases prior to entering Phase V, Supervised Community Reintegration, it is possible for SVP individuals to be unconditionally or conditionally released not having participated in the treatment program. Any fully legally committed SVP (WIC 6604), including those not enrolled the Phase Program, those enrolled but not having completed Phases I-IV, and those whom the treatment providers, DMH, and/or the Conditional Release agency opine is not suitable for Supervised Community Reintegration can petition for conditional release or unconditional release yearly.

The California Department of Mental Health SVP Conditional Release Program

The Forensic Conditional Release Program is the California Department of Mental Health's statewide system of community-based supervision, treatment and monitoring for all of its qualifying committed DMH patients. DMH contracts with county and private agencies to provide the forensic conditional release services. In the case of individuals committed under WIC 6604 of the SVP Statute, DMH has contracted with a single

private agency, Liberty Healthcare¹, to administer its conditional release program for SVP individuals throughout the state. The DMH works closely with the Liberty Conditional Release Program providing administrative and clinical direction and monitoring of the contract. In addition, DMH has assigned a liaison to assist Liberty Healthcare to implement the conditional release program (CONREP) for SVP individuals.

The CONREP program employs clinicians who are required to meet every six months with all inpatient SVP individuals actively involved in Phases III and IV and every year with patients involved in Phase II treatment. Among other domains, the liaison assesses the individual's progress in treatment, recent behavior, motivation for outpatient treatment and goals. A written report is generated that includes the above assessments and specific treatment goals identified by the liaison.

In addition to the bi-annual individual interviews, a clinical liaison generates individualized terms and conditions of the SVP individual's outpatient treatment. These include: standardized terms and conditions for all sexual offenders, conditions designed specifically for rapists or child molesters, and, finally, conditions particular to the individual's offense patterns and risk factors. SVP individuals are required to sign this document prior to their discharge into the community. Violations of these terms and conditions may result in a range of sanctions including a revocation of conditional release and a return to inpatient hospitalization. The CONREP program utilizes a community "containment approach" for the treatment and supervision of SVP individuals released from the state hospital. The containment model reflects a multi-disciplinary management strategy with an emphasis on offender accountability and consistently applied policies and protocols. The community containment model has a clear and common goal of public safety.

The Community Safety Team is one of the fundamental ways that the containment model is implemented. The Community Safety Team provides input to the CONREP program regarding the individual's treatment and progress. This team is chaired by the CONREP Community Program Director (or his designee) and consists of the conditional release case manager (also referred to as a Regional Coordinator), sexual offender treatment providers, a polygraph examiner, victim advocates, and, if possible, representatives from local law enforcement. The Community Safety Team meets regularly to discuss the status of the patient's treatment and supervision.

Primary supervision and case management responsibilities are performed by Regional Coordinators (RCs). These individuals are employed by the CONREP program and have experience, training and skills specific to the supervision of sexual offenders in the community. Regional Coordinators are required to meet face-to-face with conditionally released individuals a minimum of once a week; however, these contacts often occur

¹ Liberty Healthcare is a contract medical management organization based in Pennsylvania. The agency has over 25 years of experience staffing and managing a variety of healthcare and treatment programs throughout the United States.

more frequently. In addition, RCs are in daily telephone contact with the individuals they supervise. The RCs also perform weekly drug and alcohol screenings, home visits and random searches of the individual's residence. Furthermore, RCs are required to make regular contact with others who play a significant role in the individual's life. Individuals who have recently been conditionally released are required to be monitored 24-hours-a-day with Global Positioning System (GPS) technology. This technology is used to track an individual's movements and provide real-time alerts to both Liberty representatives and the individual when he enters "off-limit" zones. The RC is responsible for daily reviews of GPS data regarding the individual's movements.

Once an SVP individual is discharged to the community, he will be required to undergo periodic assessments including monitoring and maintenance polygraph exams, phallometric assessment and the Abel Assessment of Sexual Interest (AASI). Additionally, he will be administered assessments to evaluate current dynamic risk factors every three months and acute risk factors on an ongoing basis.

Furthermore, conditionally released SVP individuals are required to participate in weekly individual and group therapy sessions. Therapy generally follows the Relapse Prevention Model. A primary emphasis of treatment is for the individual to identify behavioral patterns in his new phase of life outside the hospital that are related to his offense history. Moreover, treatment involves the development of adaptive coping skills to deal with these patterns and risk factors.

Based on the needs of the individual, he and his spouse may also be encouraged to participate in marital therapy. While not a general requirement for discharge to the community, an SVP individual may also be required to take anti-androgen medications. In this case, the individual will have blood and testosterone levels measured on a regular basis. Additionally, as part of anti-androgen therapy, the individual will be required to meet with a physician and have his bone density assessed on an annual basis. Moreover, if it is believed to be appropriate, CONREP individuals may also be administered additional adjunctive behavioral interventions such as olfactory aversion and covert sensitization treatments.

The CONREP program maintains a list of local treatment providers who are knowledgeable in sexual offender relapse prevention treatment and behavioral interventions. These treatment providers must meet required educational qualifications, have specialized education, up-to-date training and sexual offender and forensic experience. The CONREP program then contracts with these clinicians to provide appropriate sexual offender therapy to SVP individuals conditionally released to the community.

At this time, one of the biggest obstacles to a smooth transition to community outpatient treatment is difficulty in finding suitable housing. In general, board and care homes and other residential facilities have been very reluctant to house SVP individuals, despite their intensive supervision by CONREP. The CONREP program has attempted to house individuals in the community in rental houses or apartments when the individual

has not had other housing options available to him (e.g. a family-owned home). Outcry and pressure from the community have made it very difficult for landlords to step forward and rent to SVP individuals. As a result, SVP individuals have sometimes been temporarily housed in less-than-ideal settings such as motels and trailer homes on state-owned land. Until community sentiments change, it is unlikely that housing difficulties will diminish for conditionally released SVP individuals.

Prior to the anticipated conditional release of an SVP individual to outpatient treatment, the Department of Mental Health makes efforts to conduct community education and outreach programs. The goal of these programs is to inform and enlist the support of local law enforcement agencies and public officials regarding the nature of the commitment process, release requirements and measures taken to ensure public safety. It is hoped that these education and outreach efforts will result in collaborative relationships that will serve to reduce the intensity of public controversy that inevitably follows the release of an SVP patient to community outpatient treatment.

Once DMH considers a recommendation to the court for community outpatient treatment for an SVP individual, the department notifies the sheriff or chief of police and the district attorney who has jurisdiction over the community in which the individual may be released. The notice is given at least 15 days prior to the department's submission of that recommendation to the court.

A newly-enacted addition to the SVP Statute (Welfare and Institutions Code 6608.5), requires that SVP individuals return to their county of domicile when they are conditionally released. The Court in the individual's county of commitment determines where the individual's county of domicile is located. In general, the county of domicile is the individual's "true, fixed and permanent home and principal residence...." In addition, as of November 2006, with the passage of Proposition 83, all sexual offenders (including SVP individuals) released from prison are required to **not** "reside within 2,000 feet of any public or private school or park where children regularly gather." (California Penal Code 3003.5[b]). This has further increased the difficulties in finding adequate housing for conditionally released SVP individuals.

As of January, 2009 sixteen SVP individuals have been placed in the community through the Conditional Release Program. Twelve of these have completed the inpatient Phases of the program and have been placed in Phase V, interchangeably referred to as Supervised Community Reintegration, Conditional Release, and/or CONREP. The other four have won conditional release without having completed the inpatient treatment program. In addition, four others have completed all inpatient phases and are awaiting housing so that they can be treated in the community in CONREP/ Phase V.

VII PROGRAMMATIC ISSUES RELATED TO THE “SEXUALLY VIOLENT PREDATOR STATUTE”

Confidentiality

The California SVP law contained in the Welfare and Institutions Code Section (6600 et seq.) provides the legal authority to disclose confidential information without the individual’s consent. It is stated in the American Psychological Ethics Code that “Psychologists may disclose confidential information with the appropriate consent of the organizational client, the individual client/patient or another legally authorized person on behalf of the client/patient unless prohibited by law” (APA Ethical Principles of Psychologists and Code of Conduct, 2002, 4.05 Disclosures). The APA ethics code also states in absence of client consent information obtained during the course of the psychologist’s work may be disclosed, if, there is legal authorization for doing so (APA Ethical Principles of Psychologists and Code of Conduct, 2002, 4.07 Use of Confidential Information for Didactic or Other Purposes).

The SVP statute designates the Department of Mental Health to assign clinical evaluators (licensed psychologists and psychiatrists) to determine if an identified individual is likely to engage in acts of sexually violent predatory behavior. The evaluators are required to review confidential legal, prison, medical and psychiatric records. If the individual being evaluated agrees to cooperate, then each evaluator conducts an empirically guided structured clinical interview. Based on this data, the evaluators submit a written report to the District Attorney’s Office of the county where the individual was convicted, when the findings indicate that the individual meets the criteria for SVP commitment. Evaluators may then be required to testify in court regarding the case findings. In order to comply with the legal mandate and ethical standards, evaluators disclose to the individual the limitations of confidentiality and obtain permission to conduct a clinical interview. However, even if the individual declines to be interviewed, the evaluator must complete a report without the benefit of direct contact with the individual.

In addition to the evaluator, staff at the treatment facility may be required to provide information about the SVP without the SVP individual’s consent or agreement. This occurs as a routine part of the treatment program, assessment process, hospital operations and the individual’s legal proceedings, wherein, the DMH staff and treatment providers must disclose information to other DMH treatment providers, staff and the courts.

There are important discretionary decisions to be made by evaluators and treatment facility staff regarding disclosing information personal to the SVP individual. Although the SVP statute permits disclosing confidential information without consent of the individual, there is no requirement that the mental health professional disclose all information known about the SVP individual. The decision about which information to disclose in SVP cases is at the discretion of the professional unless otherwise directed by court mandate.

DMH evaluators and treatment providers have an ethical obligation to both the SVP and also to society as a whole. Ultimately, the goal of all civil commitment programs is community protection. It can be argued that it is unethical to disclose confidential information without an individual's permission in SVP cases because it may cause harm to the client-therapist relationship, and, thereby decrease disclosures to the therapist. Furthermore, disclosure of previously undisclosed offenses may make the individual open to further prosecution due to the Child Abuse and Neglect Reporting Act's mandate to report such incidents. As a result, individuals may be unwilling to be entirely forthcoming and honest in their assessments and treatment. Undisclosed offenses potentially may minimize treatment effectiveness, since revelation of previously undisclosed offenses can assist in more accurate risk assessments and treatment plans, identification and treatment of victims, and more effective treatment and community supervision strategies.

Community safety and an individual's right to confidentiality are at times competing interests that the treatment provider must reconcile before participating in the SVP arena. Consultation with professional colleagues may help shape the professional's opinions. As it stands, the law states there are no parameters around the confidentiality of information disclosed by the client to the evaluator or treatment provider, as long as the disclosure of confidential information is made to designated members of DMH or the court system that are responsible for the detainment and care of the individual or involved in the ongoing determination of the SVP's legal status. However, a disclosure of confidential information cannot be made solely for the personal gain of the professional (e.g., to write a book or article about the SVP individual.)

Phallometry

Phallometry, formally referred to as penile plethysmograph (PPG), is used within the SOCP Phase Program, both in the inpatient Phases and after the SVP is transitioned to Phase V, the supervised community based reintegration Phase. The PPG is used as a measurement of sexual preferences. It involves recording male erectile responses by measuring change in penile circumference or volume in response to various sexual and non-sexual stimuli. It is considered a more reliable estimate of sexual preferences than a subject's self-report (Harris, G. T. and Rice, M. E., 1996; Haywood and Grossman, 1990; Abel et al., 1985; Murphy, W. D. and Barbaree, H. E., 1994).

Phallometric assessment requires an awareness of the limitations of and ethical challenges to this type of assessment. There is uncertainty regarding how well stimuli and procedures used in phallometric assessment match real world conditions, raising concerns about the ecological validity of erectile preference testing (Harris, G. T., and Rice, M. E., 1996). Further, phallometric tests lack standardization of test procedures and stimuli between different laboratories, which can result in contradictory findings. There are very few studies evaluating the reliability and validity of phallometry. Some would refer to phallometric testing as an art rather than a science because there is no consistent standard for performing the procedure; although it can be stated that there is

a “family of procedures” which share common aims and features (Laws, D. R., 2003).

Thus far, most studies have shown much less variability and more agreement in the profiles generated by child molesters than those generated by rapists and exhibitionists, lending greater credence to using phallometry with child molesters, especially in non-familial molesters who admit their deviancy (Quinsey, V. L. et al., 1995). However, newer studies of rapists reflect that about 60% of rapists show indices that are larger than the rape indices of about 90% of non-rapists, thereby weakening the argument that phallometric assessment of rapists has little value (Lalumiere, M. L. et al., 2003). Although there have also been advances in detecting faking and improving countermeasures detection, faking during phallometric procedures continues to limit the potential value of the assessment (Card, R. D. and Farrall, W., 1990; Laws, D. R., 2003).

An important limitation to the use of phallometry is that there is insufficient evidence supporting its use to decide guilt or innocence in criminal matters. Courts have uniformly declared that PPG findings are inadmissible as evidence because there are not accepted standards for this test in the scientific community (United States v. Glanzer, 2000; United States v. Powers, 1995). Supreme Court decisions have supported denying the admissibility of expert testimony on plethysmograph under *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 509 U.S. 579 (1993), while acknowledging the usefulness of phallometry in the treatment of sex offenders. Therefore, evaluators and treatment providers should limit the use of phallometry as a tool to assess an individual’s sexual interest profile and not as a determinate of guilt or innocence.

Another ethical concern is the invasiveness of the PPG. Because the PPG requires those assessed to place a gauge on their penis and view and/or listen to sexual material, the privacy of the individual’s body and mind is threatened. In addition it is not uncommon for those that have undergone PPG assessment to complain of feelings of degradation and humiliation.

Despite findings reflecting the value of phallometry, Marshall (2006) has raised concerns over the use of this procedure including the psychometric properties of the PPG (i.e., reliability and validity); differences in the representativeness of study groups (e.g., types of offenders and size of the study groups), and measurement differences (i.e., what constitutes clinically significant response and how is this measured), which may confound the ability to determine definitively the accuracy of this assessment procedure. In conclusion, Marshall states:

“The evidence, in my opinion, does not justify the routine use of phallometry in the clinical evaluation of sexual offenders. Indeed, at present the evidence does not justify any use of phallometry unless the clinician can provide data showing that his/her specific evaluation procedure is reliable and valid. Even the use of phallometry to explore theoretical issues seems unjustified given the failure in the present review to find support for the psychometric bases of phallometry. Indeed, the findings of such research may be misleading and would certainly require

several independent replications before confidence could be placed in the results. At present it is difficult to recommend any use of phallometry; researchers and clinicians are encouraged to seek alternative evaluation procedures.” (p. 17).

On the basis of the available research and best practice procedures, the ethical use of phallometric assessment requires that the test user become knowledgeable about the test, its appropriate uses, recognition of its limitations, potential negative impact upon the client and appropriate professional manner in which to communicate the findings.

Chemical Castration

In 1996, California passed a law that mandated chemical castration for second-offense child molesters involving victims under age 13 (CA PC 645). Although it remains on the books, this law is not being enforced. At least five other states have enacted similar legislation as a means to reduce recidivism of sexual offenders. But as with many laws designed to protect society, these laws may infringe on an individual’s personal freedoms. Currently, there is no mandate that SVP individuals become chemically castrated or take testosterone-reducing medications, and there are very few if any SVPs in DMH who take anti-androgen medications as a component of their individualized treatment program. However, it is possible that a court may impose that requirement for approval of a petition for conditional release.

Chemical castration either eliminates or reduces the level of androgen, generally testosterone, in the body. There are a variety of testosterone-lowering medications used in the United States. The first use of these agents was in 1966 at Johns Hopkins (Money, 1986). Since then there have been a number of studies related to their effects. The varied agents include Medroxyprogesterone Acetate (MPA, Provera) and luteinizing hormone-releasing agonists. These include Leuprolide (Lupron), Goserelin (Zoladex), Nafarelin (Synarel) and Triptorelin (Trelstar). Each of the testosterone-lowering medications takes a short period of time before the full effects of medication are evident. Each of the testosterone-lowering medications are prescribed in a variety of doses and all have notable adverse side effects that bring into question the negative effects on health and corresponding health-related costs versus the positive benefits that decreased testosterone may have on reducing sexual aggression.

For example, Depo-Provera lowers testosterone over one-to-two months of treatment. Side effects include: weight gain, increased blood pressure, increased blood sugar, hot flashes, fatigue, headache, blood clots, testicular shrinkage, decreased sperm count and decreased bone density. Side effects usually occur within one month of administration, and sex drive and potency return to normal within weeks of stopping treatment.

Hormonal (LHRH) agonists (Depo-Lupron) create a continuous stimulation of the pituitary after one-to-two months, causing a shut-off of LH/FHS hormone secretion and lowering of testosterone to pre-pubertal levels. The lowered testosterone essentially

results in asexuality (80%) with virtually no sexual desire, fantasies or behaviors, either deviant or non-deviant, particularly in men over 35 (Tucker, 2004). The results of the use of Depo-Lupron have been reported as promising. Rosler (1998 & 2000, cited in Tucker, 2004,) found zero recidivism in more than 40 treatment-resistant subjects over five years, also noting significant decreases in testosterone levels.

Long-term castration effects have been studied and it has been found that the longer the term of castration, the more profound the negative effects. For example, researchers (1933) found enlarged pituitary glands in individuals castrated prior to puberty. In addition, the reduction in testosterone levels was found to have contributed to a variety of physical difficulties. For example, thinning of the bones of the skull and kyphosis or spinal curvature was common (Koch, 1921). Osteoporosis was also noted to be common due to bone density decreases after castration. Gynecomastia or the enlargement of breast tissue was observed in individuals who were castrated for long periods of time, especially those who were castrated in childhood. Shrinkage of the prostate gland was another negative effect.

Anti-androgen medication use has been shown to be useful in the reduction of sexual offender treatment recidivism. For example, Weinberger, Sreenivasan, Garrick and Osran (2005) reported that castrated sexual offenders exhibited a very low incidence of sexual recidivism. In addition, Hall (1995) found significant efficacy for hormonal and cognitive-behavioral treatment as opposed to behavioral treatment alone (Tucker, 2004). However, there have been well-designed testicular and prostate cancer studies that have demonstrated that while sexual desire is reduced by orchiectomy, the capacity to develop an erection in response to sexually stimulating material is not eliminated. In an article rebutting some of the points made by Weinberger et al. (2005), Berlin (2005) notes that the use of chemical and physical castration in sexual offender treatment is not to eliminate erectile capacity but to slow down the rate, intensity, and frequency or physiological sexual arousal, which can help the offender gain control of a compulsive deviant sex drive.

According to Tucker, (University of California—San Francisco, Department of Psychiatry), the biological treatment of sexual offenders is appropriate in cases of multiple paraphilias, intense hyper-sexuality; and in order to maximize efficacy of psychosocial treatments by reducing symptom intensity. “Chemical castration should never be used as a panacea; it is but one component of a biopsychosocial treatment program. It enhances the efficacy of other treatments by reducing symptoms, and increasing behavioral controls,” (Tucker, 2004).

In addition to anti-androgen medications, serotonin-enhancing medications (SSRIs) are also used in the management of sexual deviance problems. This treatment is usually tried prior to testosterone-lowering medications. SSRIs are typically used to treat depression and anxiety disorders with one side-effect being decreased sex drive, which, in the case of sexual offenders is a benefit. Decreased impulsivity, aggression and suicide are also side benefits. Serotonin-enhancing medications have the additional benefit of lessening sexual obsessions and compulsions.

When using any potentially harmful medications, informed consent is clearly necessary. However, when someone is being detained involuntarily and the individual believes that his freedom may be contingent upon his use of these medications, it is questionable if truly informed consent can be obtained. In addition, there is no requirement or guarantee that an individual who consents to chemical castration or anti-androgen treatment at one juncture, will continue the medication regimen upon unconditional release.

Ethical considerations for use of SSRIs and anti-androgen treatment procedures are clearly defined by the Association for the Treatment of Sexual Abusers (ATSA, 1997). Some of these elements include obtaining informed consent when anti-androgen therapy is implemented. Also, anti-androgen therapy should be prescribed by a licensed physician only after medical examinations and assessment deem that the individual is healthy enough to receive such treatment. Moreover, anti-androgen medications should be administered under ongoing medical supervision by a licensed physician and should be coupled with appropriate monitoring and counseling within a comprehensive plan and with the prescribing licensed physician. If surgical castration is elected rather than chemical castration, the client is provided with information about the risks and consequences of the procedure, in order to provide informed consent for the procedure. While it is recognized that surgical castration has been demonstrated to reduce 95% of testosterone production, part of the informed consent process should include education on less invasive measures that are available for arousal reduction.

Polygraphy

Another common but controversial component of sexually violent predator treatment programs involves the use of polygraph examinations. Polygraph examinations involve a trained examiner recording an examinee's physiological responses to structured questions. Following this interview, the examiner reviews the data on the physiological responses and forms an opinion about whether the examinee attempted to be deceptive when answering each of the relevant questions. Polygraph examinations are generally used to obtain objective verification of truthfulness regarding the individual's reported sexual history and other pertinent treatment issues. The CA DMH Phase Program of the Sexual offender Commitment Program uses polygraph examination. Polygraph examinations are not used in the evaluations that determine whether an inmate legally becomes committed as an SVP.

The fifth amendment to the U.S. Constitution states that no person "Shall be *compelled* in any criminal case to be a witness against himself." For individuals living in California, the controlling case regarding this issue comes from *U.S. v. Antelope*. The 9th Circuit U.S. Court of Appeals stated that a polygraph condition cannot force someone to incriminate himself and that individuals have a right to remain silent unless and until given immunity. The 9th Circuit goes on to cite Justice Thomas, "By allowing a witness to insist on an immunity agreement before being compelled to give incriminating testimony in a non-criminal case, the privilege preserves the core Fifth Amendment right from invasion...." (*Chavez v. Martinez*, 538, U.S., 760, 771, 2003).

There is significant reference in the Antelope case to the U.S. Supreme Court case *McKune v. Lile* (2002) as the ultimate ruling in the Antelope Case hinged on the Lile decision. The nine Supreme Court Justices examined the Lile case and in a close decision, ruled that the consequences imposed on Mr. Lile for not completing a polygraph examination were not severe enough to compel self-incrimination. Therefore, polygraph examinations may be used in treatment in custody settings for individuals determined by the court to be sexually violent predators.

In addition, the 2nd Circuit Court of Appeals issued a decision (*US v. Johnson*) that indicated that a polygraph examination is acceptable if the defendant retains the right to challenge any incriminating statement as a violation of his 5th Amendment rights at a later proceeding. The 2nd Circuit Court, therefore, does not see the right to “silence” as part of the 5th Amendment. Many argue that it would be too late at that point to protect oneself from prosecution.

In addition, there are 58 counties in the state of California and only one has an immunity agreement regarding the polygraph and sexual offenders. Immunity in this context means that previously unreported incidents of sexual offending behavior that are disclosed in the course of treatment, including assessment such as polygraph, for individuals who have pled guilty, placed on probation and enter a “containment model based” treatment program will not be prosecuted by district attorneys. One concern about this application of immunity is that, because it is not implemented in all counties, if the newly reported offense occurred in a county that does not have an immunity agreement, the district attorney in that county may prosecute it.

Whereas individuals in the DMH SVP treatment program, the Phase Program, are not required to disclose details of every crime they have committed, they are required to provide enough data on their sexual history to create a comprehensive list of their high-risk factors. The truthfulness of their self-report of the summary of their sexual history is assessed through a sexual history disclosure polygraph. In addition to the Sexual History Polygraph Test, other polygraph examinations that may be required by participants of the Phases of the program include the Maintenance Polygraph Test, the Monitoring Polygraph Test, and the Specific Issue Test. These tests are designed to assist in determining non-deception or attempted deception about sexual thoughts and fantasies, compliance with treatment and assessment components, or issues of concern regarding specific incidents or personal history.

In addition to the above described ethical concerns regarding use of polygraph with civilly committed sexual offenders, there is some disagreement among researchers and other professionals about the accuracy of polygraph in determining truthfulness and deception. While research indicates use of polygraph does facilitate sex offenders’ self report of their offending history, test validity and reliability vary across studies with some types of tests providing more accurate findings. Further, the manner in which polygraph examiners synthesize the data and conclude whether the examinee was deceptive often varies from one examiner to the next. The lack standardization of test procedures between different examiners can often result in contradictory findings.

VIII The Public Policy Debate Over Sex Offender Civil Commitment

Creating rational public policy regarding sex offenders is difficult because the topic arouses strong emotions that influence the perspective of all who are directly and indirectly involved. This “network” of those involved in sexual offending not only includes the victim and the perpetrator, but the families of the victim and perpetrator; the community in which they reside; the professionals that investigate, prosecute, defend, and treat the perpetrator; those that treat the victim; the lawmakers, the media, and each generation of children who learn about sexual offending through the lens of the adults around them. Considered an extreme response to a severe problem, the creation of SVP laws has evoked widespread controversy. Consistent with our attempt to fully inform the reader, the positions in support of, and in opposition to, the California SVP statute are summarized below.

Support Argument for the Civil Commitment of Sexual Offenders in California

Civil commitment of the most dangerous sex offenders protects children and women, and, in the most extreme cases, it actually saves lives. Considering the far reaching negative effects of just one act of sexual abuse on the victim, the victim’s loved one’s and future generations of the victim’s family, there should be no question that the voters of California want severe and increased criminal penalties and restrictions imposed upon those that perpetrate sexual crimes.

Legislation and propositions such as the SVP Act and Proposition 83 (Jessica’s Law) legislatively mandate the state to hospitalize sexual offenders whose mental disorder predisposes them to commit future sexually violent crimes until they no longer pose a threat to the community. The civil commitment of sexually violent predators is not punishment but detainment and treatment and has been determined constitutional by the state and federal courts.

Those that oppose the civil commitment of sex offenders make a number of claims that are not reason enough to abandon the involuntary commitment of California’s most dangerous sex offenders. Simply, the negative consequences of civil commitment do not outweigh the positive consequences of keeping dangerous people off the streets until they are successfully treated. Opponents of civil commitment of sexual offenders state that it is too expensive and the money would be better spent elsewhere. This argument holds no merit to the victim of a sexual crime whose life may forever be changed. It is the government’s role to protect its citizenry. It has both a responsibility and obligation to prevent sexual crimes. The community cannot allow violent sex offenders to walk among us preying on others simply because it requires taxpayer money. The passage of a civil commitment law indicates that the community is willing to spend whatever is necessary to keep us safe.

Some may claim that the civil commitment is not fair. It is fair when considering the impact that sex offending has upon an individual and our society, and fairness is

guaranteed by law. The very large majority of sex offenders are not civilly committed as sexually violent predators because they are screened out of the evaluation process by mental health experts who have specialized training and experience to determine who is most likely to be a threat. Further, a person is not civilly committed until a jury of peers finds him to be a Sexually Violent Predator beyond a reasonable doubt. The individual's legal representatives may include mental health expert witnesses who hold a different view as to his diagnosis and/or dangerousness. Personal rights are vigorously upheld in civil commitment proceedings assuring us that only the most dangerous individuals are committed. The law is fair.

Some claim the prediction of risk is not based on valid science. This claim is merely an excuse for those that oppose civil commitment and attempt to distract from the reality that some people are mentally disturbed and require hospitalization. Science does not provide us with the ultimate truth, but it helps guide decision makers to identify those who are the most dangerous. It is true that scientific risk prediction is not perfect, and science will never allow us to predict the future with absolute certainty. However, the field of risk assessment has advanced considerably over the last two decades to a point that is clearly superior and more accurate than un-empirically informed clinical opinion.

Another claim is that the civil commitment laws have brought forth unintended consequences. Although the current civil commitment of sexual offenders laws have roots in earlier laws, they are a relatively recent public policy response to a longstanding, serious, and pervasive public health concern. It is no surprise that this law, like so many other new laws, requires adjustments to make its implementation more effective. Remedies will be found in time to improve the law consistent with its intent to detain and treat sexual offenders until they no longer pose a significant risk to reoffend.

The civil commitment laws are necessary for our society and must remain. We cannot ignore the fact that some people are too mentally ill and dangerous to be free in the community. It is difficult for those who do not witness the effects of violent sexual abuse first hand to understand the dangerousness of some offenders. Enhancing the effectiveness of the application of the law undoubtedly requires education and some changes to the current implementation, but in no way should an important community safeguard for our women and children be dismantled.

Opposition Argument for the Civil Commitment of Sexual Offenders in California

Regrettably, some proponents of the SVP law ignore legitimate concerns about the unintended consequences of the law and dismiss those who express such concerns by implying that opponents of the law in its current form are extremists who do not care about public safety. CCOSO opposed Proposition 83 (Jessica's Law), which included changes in the SVP law because the organization foresaw that many Proposition 83 changes would result in a huge increase in cost without any resulting a substantial increase in public safety. This has in fact occurred. In addition, it has become clear that measures that isolate and stigmatize sex offenders actually make them more dangerous

by “driving them underground”.

Opposition to Sexually Violent Predator legislation is generally based on three issues: It is not fair. It is not based on valid science. It has too many unintended negative consequences.

1. Is it fair?

The constitutionality of SVP statutes has been challenged on a number of legal grounds, but the two primary issues are double jeopardy and *ex post facto*. Double jeopardy means punishing an individual twice for the same crime. In *Kansas v. Hendricks* (1997), the Supreme Court ruled that because SVP statutes established a civil rather than a criminal proceeding their intent was not punitive and therefore did not constitute double jeopardy. The second is *ex post facto* law making, which refers to subjecting persons to laws that were not in effect at the time of their criminal offenses. The United States Supreme Court has consistently upheld SVP laws but usually in very close judicial decisions, reflecting a great deal of disagreement among the Justices and producing some strong dissenting opinions (Morris, 2000).

Some scholars have criticized SVP laws for relying on poorly defined mental health terms (Morris, 2000; Prentky et al., 2006; see number 3, below). At least one critic has focused on the opinion that SVP laws represent a dangerous departure from precedent (Zander, 2005). It has been argued that civil commitment for sexually violent predators represents the first time that psychiatric commitment has been allowed without proof of the presence of psychosis, which is typically defined as a severe detachment from reality, including extreme disturbances in perceptions, thoughts, and emotions, auditory or visual hallucinations or delusional thoughts.

2. Is it based on valid science?

The central issue here is whether or not we can be certain that we are correctly identifying the most dangerous sex offenders, for whom civil commitment is warranted. Objections based on scientific validity typically involve three issues. The first is concern about the accuracy of the current generation of actuarial risk assessment instruments; such instruments are used to predict whether an offender is likely to be detected by law enforcement for a future sexual offense. Because the purpose of evaluation for SVP is to determine lifetime likelihood of sexual re-offense, not offense detection, pure actuarial approaches to risk assessment are not sufficient. An empirically guided clinical interview approach to risk assessment can assess for lifetime risk for re-offense. This approach is more accurate and reliable than non-empirically guided clinical interviews. A second concern cited regarding the scientific constructs used in civilly committing sexual offenders is the relative paucity of research on the validity and reliability of the Diagnostic and Statistical Manual of Mental Disorders diagnoses upon which most SVP commitments are based. The third scientific issue cited is a lack of professional consensus in defining and therefore also assessing the statute term “emotional or volitional impairment”; legally a mental illness must affect emotional or volitional

capacity and predispose the person to commit criminal sexual acts.

While there is widespread agreement as to the inaccuracy of non-empirically guided clinical prediction of recidivism, there is little consensus within the professional community regarding whether the accuracy of the current generation of risk assessment instruments is high enough to warrant their use in making decisions that have such far-reaching consequences (Campbell, 2000; Rogers, 2000; Zonana, 2000; Prentky et al., 2006). One criticism is that it is inappropriate to apply group data to make predictions about the future behavior of an individual (Petrila, 2007; Hart, 2001; Berlin et al., 2003). Another argument focuses on the fact that because the average rate of being detected for sexual re-offense among known sexual offenders is low, it is very difficult to make accurate re-offense predictions without inaccurately classifying a number of cases to re-offend that do not re-offend (Janus and Meehl, 1997; Prentky et al., 2006; Wollert, 2006). Because the best current science can only inform us about detected recidivism rates, any attempts to predict actual recidivism is speculative. Recent findings (Harris et al., 2008) appear to support the criticism that the most widely used actuarial instrument, the Static-99, does not accurately predict sexual recidivism. Critics such as Hart et al. (2007) argue that the present generation of actuarial instruments are appropriate for making lower level decisions such as assigning treatment priority or intensity, but that it is unethical to use them in situations where their inaccuracy can have far-reaching consequences, such as indeterminate commitment. Indeed, even the best of the actuarial tools are not tailored specifically for use with a very high-risk sex offender population, such as SVPs, but rather they are based on data from the general group of all sexual offenders.

Those who raise concerns regarding the diagnosis of mental disorders indicate that most experts believe that the majority of sex offenders do not suffer from a paraphilia or other mental disorder (American Psychiatric Association, 1999; Kaplan and Saddock, 2005). There is little agreement among professionals as to how to distinguish those offenders who do have a mental disorder from those who do not, since the criteria in the DSM-IV-TR are not precise, and there are no definitive tests or questionnaires for making diagnoses (Prentky et al., 2006). Research on the paraphilia category of mental disorders is particularly limited, and some opine that what does exist suggests that the diagnoses in the paraphilia category are not reliable (Marshall, 1997; O'Donohue, Regev & Hagstrom, 2000). This means that those making the diagnoses are not necessarily basing their decisions on the same criteria.

Related to the concern about the accurate diagnosis of mental disorder, the third scientific concern arises from the fact that "emotional or volitional impairment" is vaguely defined in the statutes and therefore very difficult, if not impossible to assess. "Not only is there no method developed by which to assess behavioral control (emotional or volitional capacity), there is no clear definition of what is being measured. Any standard would appear more normative than scientific" (Miller et al. 2005, p.42).

3. Do the positive effects override the Unintended Negative Consequences?

Those who oppose the SVP statute based on unintended consequences assert that its implementation has proven to be seriously cost ineffective. They point out that many millions of dollars have been spent to commit fewer than 1% of the registered sex offenders in the state. This exorbitant use of state finances and experts' time drains financial and treatment resources away from the other 99% of sexual offenders who are not deemed to be SVPs. In addition, the SVP commitment process possibly uses resources that could be allocated to prevent sexual abuse from happening in the first place. Some treatment programs have lost experienced treatment staff who have left for more lucrative positions as evaluators on the DMH evaluator panel. Very little money has been put into treatment that would benefit the large majority of sex offenders rather than the small minority of sex offenders who are classified as SVPs. Lastly, the labeling of a sub-group of sex offenders as "Sexually Violent Predators" conveys to the public that these individuals are dangerous and inhuman "monsters" who can never change. It is very costly, dangerous, and difficult for these individuals to reintegrate into the community no matter how much treatment they complete.

IX AREAS FOR IMPROVEMENT REGARDING THE CALIFORNIA SEXUALLY VIOLENT PREDATOR STATUTE

1. THE “LAST RESORT”

Given its high cost and severe restriction of liberties to those subject to commitment, SVP commitment should be reserved for those who have had opportunities for treatment yet continue to present a high likelihood of sexual re-offense.

A 2006 survey indicates that 44 of 49 responding states provide treatment for sexual offenders in their prison system (Heil & English, 2007). California is among the few states that have never provided sex offense specific treatment in its prisons. Despite this absence of prison treatment California enacted a post-prison civil commitment program that uses treatment completion as a requirement for state supported release.

It is necessary that the SVP net capture those offenders most likely to re-offend. The Risk, Need, and Responsivity paradigm widely accepted in the field of forensic psychology posits that re-offense is most reduced when the level of criminal justice response, including treatment, matches the offender’s risk for re-offense (Andrews & Bonta, 1998). Applying this model to the problem of sexual offending, the greatest amount of intervention resources should be dedicated to the prevention of re-offense by the sexual offenders who pose the greatest likelihood of re-offense (those in the highest risk category). The highest risk sexual offender group should receive the greatest number of therapeutic interventions and the most intensive supervision in comparison to the lowest risk offenders.

Failure to treat sexual offenders in prison means that every offender evaluated under the SVP process spends years in prison with no access to help. Those motivated to change must wait until they are released or civilly committed. The cost of civil commitment is extremely costly; it is over \$100,000 more than the cost of incarceration per individual per year. This is largely because treatment must be offered in the Department of Mental Health’s psychiatric hospitals, and such treatment must meet high standards of certification required for hospital care. Many are willing to support the cost rather than release a potentially dangerous sexual offender. Because freedom and community safety are at stake, it is necessary to ensure that every dollar is spent in a manner that maximally enhances community safety though the least restrictive means possible.

In August of 2006, the California High-risk Sexual Offender Task Force made the following similar recommendation regarding High-risk Sex Offenders (HRSOs): “All California inmates required to register as sexual offenders that are designated as HRSOs should be required to receive appropriate specialized sexual offender treatment as warranted while incarcerated.”

Utilizing prison time to provide assessment and treatment to sexual offenders will provide the following benefits:

- a) In-Prison treatment will capitalize on psychological factors in offenders related to proximity in time to offense, such as guilt, the desire to regain freedom, the desire to regain familial support and the emotional crisis that often occurs after incarceration.
- b) In-Prison treatment will counter the learning of new anti-social behaviors that generally occurs in prison.
- c) In-Prison treatment will reduce the reinforcement of unchecked deviant sexual arousal patterns that often occur when sexual offenders continue familiar, unhealthy fantasies and arousal to past sexually-deviant behaviors.
- d) In-Prison treatment that is provided in a location where sexual offenders are segregated from the general prison population will greatly reduce the effects of exposure to trauma in prison (i.e., sexual offender abuse by non-sex offenders). Such makes sexual offenders more dangerous and increases the necessary duration and costs of psychiatric treatment.
- e) In-Prison treatment will reduce the resentment that is common in many who go on to be civilly committed and it will facilitate readiness and motivation to enroll in the civil commitment treatment program. This will likely result in both a higher degree of participation, and increased success in achieving program objectives, thereby expediting the treatment process, allowing for a more efficient release, and a reduced overall cost.
- f) An In-Prison sexual offender treatment program that is highly related to the civil commitment treatment program will ensure continuity of services and maximize treatment gains. This will require on-going collaboration and reciprocal approval for treatment providers across DMH and CDCR to share relevant treatment information.
- g) For offenders with long sentences, treatment interventions that occur or increase near the time of release will maximize treatment gains.

In summary, In-Prison treatment will not necessarily eliminate the need for the SVP evaluation process or treatment program. However, it could sufficiently reduce risk for a portion of sexual offenders who come under review for SVP such that SVP commitment will not be required or it may result in reduced length of some SVP commitment terms due to more effective accomplishment of program objectives. Exposure to treatment in prison prior to civil commitment can only serve to enhance treatment gains and mitigate risk of re-offense for SVPs who are eventually released. In-Prison treatment will ultimately save a great deal of money while enhancing community safety.

2. **BETTER MANAGEMENT OF RESOURCES RELATIVE TO PROBABLE CAUSE SVPS (WIC 6602)**

The significant number of pre-commitment SVP individuals who are being held at CSH (WIC 6602) leads to great concern about efficient use of resources. These “detainees” have met the legal threshold of Probable Cause but have not been formally determined to meet SVP criteria by superior court and they are not eligible to complete the treatment program. It is not uncommon for some of these individuals to wait more than ten years before they have their WIC 6604 SVP trials. At times, delay is the legal strategy of the defendant; but in some cases, the defendant wants to move ahead with the trial and the delay is caused by the courts, which prioritize criminal cases over civil cases for jury trials. As of January 2009, approximately 37% of the total SVP population was pre-commitment detainees.

The first concern relative to the Probable Cause SVPs is that significant resources are being expended in housing these pre-commitment detainees in an expensive hospital setting. Yet, the majority of them, approximately 80% as of January 2009 are not participating in the treatment program. In addition, the current DMH inpatient treatment program is not suitable for Probable Cause SVP individuals because a core goal of the program is preparation for *conditional release*. Due to their legal status, Probable Cause SVPs are not eligible for conditional release. Because of this, among the small number of Probable Cause SVPs who participate in treatment, none complete the program and only a few have progressed beyond the first active phase. This contributes to the finding that compared to fully committed SVPs (WIC 6604), Probable Cause SVPs are much less likely to enroll in the treatment program, and they are more likely to be actively treatment resistant and retaliatory against the treatment program, the active SVP participants and the providers.

A second concern regarding Probable Cause SVPs involves parole time that is required upon release from DMH. The parole time of the Probable Cause SVPs (WIC 6602) reduces during their detainment in DMH, while that of the fully committed SVPs (WIC 6604) does not. This can result in differential parole requirements for sexual offenders of equivalent risk.

A possible solution to the above concerns is to set a maximum time permitted to remain under WIC 6602 status. This is necessary because, under the current system, the Probable Cause SVP individuals are not eligible for conditional release, meaning that they cannot complete the inpatient treatment program; and thus their only release option is unconditional.

Because of the concerns elaborated above regarding the Probable Cause legal category of SVPs (WIC 6602):

- a) **It is recommended that Probable Cause SVP individuals who desire a**

speedy WIC 6604 receive it.

- b) **It is recommended that Probable Cause SVP individuals who decline to enroll in the treatment program not be housed in DMH facilities as they are currently configured.**
- c) **It is recommended that Probable Cause SVP individuals who desire sex offense specific treatment not be included in the current DMH SOCP Phase Program, but that they be afforded alternative DMH sex offense specific programming that better suits their only release option, Unconditional Release.**
- d) **It is recommended that parole time toll (halt) for Probable Cause SVPs, as it the case for fully legally committed SVPs.**

3. **CONDITIONAL RELEASE REQUIRES COMPLETION OF INPATIENT TREATMENT PROGRAM**

A viable supervised reintegration phase for qualified SVP individuals is central to program efficacy and program credibility. The large number of unconditionally released SVP individuals who have not completed the inpatient treatment program (approximately 160) compared to the number who have been awarded conditional release *after completing the treatment program* (16 as of January 2009) is inconsistent with the goal of treating all SVPs before they are returned to communities. Clearly, this conveys the message to the SVP population: “You stand a better chance of being released if you do **not** participate in the treatment program than if you commit to participating in and completing the treatment program.” Given this fact, it is not surprising that on average only 25-30% of SVPs enroll in the treatment program. Release statistics undoubtedly undermine the motivation of some SVPs to get treatment for their sexual offending problems.

A second related concern is that SVPs are eligible to petition the court for conditional or unconditional release yearly; a recent trend has been that conditional release is awarded to individuals who have not completed the inpatient treatment program. This is problematic because the Phases of the treatment program build upon each other, advancement corresponds to an improvement in dynamic risk factors, and conditional release is the final Phase of the cumulative and comprehensive treatment program.

It is recommended that SVP individuals complete the inpatient phases of the treatment program in order to be eligible for Conditional Release.

This recommendation is consistent with that of the California Governor’s High-risk Sexual Offender Task Force (2006), which suggested adding the following criteria for conditional release to Welfare and Institutions Code section 6608:

“The court may not authorize conditional release, unless, based on all of the reports, and evidence presented, the court finds that both of the following criteria are met: the person has successfully completed all phases of DMH inpatient treatment through active participation and progress in the treatment program.” The Task Force further recommended operational definitions for terms such as “active participation” and ‘progress in treatment’.”

The implementation of this recommendation requires a change in the SVP statute in terms of requirements for conditional release. It does not change the statutory mandate that allows for unconditional release of any SVP determined to no longer meet the definition of SVP. As such, this recommendation does not eliminate the possibility of unconditional release, which occurs in circumstances wherein the SVP individual’s mental or physical status has changed significantly such that conditional release is not necessary to ensure he is not likely to sexually re-offend.

Lastly, recognizing that reluctance to enroll in the treatment program is related to the fact that few have been released (16) since the law went into effect in 1996, it is noted that DMH officials have often failed to support the conditional release recommendations of DMH treatment staff. This surely has further contributed to skepticism among SVPs. Steps need to be taken to expedite progress through the program and acceptance for conditional release, without weakening the integrity of SOCP phases and requirements.

4. ENHANCE COLLABORATIVE COMMUNITY EDUCATION EFFORTS

Despite the fact that treatment completion leads to release, it has been speculated that the intent of civil commitment laws is to remove dangerous sexual offenders from society forever. Some espouse a deep skepticism about the ability of treatment to actually reduce dangerousness while others’ genuinely believe in the treatability of SVPs. Out of this matrix of competing values and beliefs grow some of the major challenges of the SVP system.

When the SVP statute was originally created, it is unlikely that the difficulties related to supervised re-integration into the community were fully anticipated. For example, the CONREP agency often cannot find suitable housing due potential renters being dissuaded by the negative effects of the SVP label. In particular, the degree of media exposure, negative publicity and community outrage has gone beyond any expectations. A significant deficiency is the lack of proactive structured community education efforts.

Community education that includes descriptive data about SVPs and the treatment and supervision programs is recommended in order to decrease community hysteria and misperceptions and increase the likelihood of the SVP individual’s safe reintegration.

Ideally such needed community education efforts will fall under the joint responsibility of the various stakeholders involved in the SVP process (i.e. District Attorney and Public Defender Offices, law enforcement, DMH, CDCR, Parole/Probation and CONREP). This recommendation is consistent with that of the California Governor's High-risk Sexual Offender Task Force (2006), which recommended that the Department of Mental Health collaborate with other state and local stakeholders in preparation for upcoming releases of SVP individuals.

5. GRADUAL REINTEGRATION & STATE-PROVIDED TRANSITIONAL HOUSING

A maximally effective civil commitment program includes gradual re-integration into the community through a well-designed re-entry program that utilizes intensive supervision and full-spectrum services implemented through a "containment" model. Given the severe residential restrictions imposed by current sexual offender legislation and the community outrage elicited by notification practices and media exposure, sexual offenders in California are experiencing unprecedented difficulty finding places to live. Because of this, registration rates for transient sexual offenders have topped 10% in some counties.

The lack of suitable housing generally elevates the risk of re-offense for SVP individuals as a result of increased stress, isolation, and reduced employment and treatment opportunities. The anticipated lack of suitable housing for those who are working to complete inpatient treatment programs has a serious negative impact on the morale of SVP individuals and CSH staff members. Some that have achieved completion of the inpatient phases and court awarded conditional release have been further detained well over one year in DMH due to having no housing option.

Lack of suitable and timely housing for those conditionally released likely contributes to the low Phase Program enrollment rate, thus diverting resources at CSH away from treatment activities to custodial management. The message conveyed to SVPs by the courts and the state is that they should participate in the Phase treatment program. However, there is a lack of ability to provide the final phase of the program (Supervised Community Reintegration Phase V/CONREP) in a timely fashion. This mixed message leads to the inference that the program is flawed at best and a ruse at worst.

Acknowledging this serious problem, the California Governor's High-Risk Sexual Offender Task Force (2006) recommended that the Governor, the League of Cities and the California State Association of Counties convene a statewide conference to address issues related to housing for sexual offenders, including SVPs.

In order to maximally reduce the risk for re-offense, increase treatment enrollment rates and facility morale, and enhance staff job satisfaction, recruitment and retention, a viable Phase V, Supervised Community Reintegration, is necessary. **It is recommended that the state provide transitional housing programs for**

conditionally-released SVPs. These housing programs should be identified prior to the court-ordered conditional release of the SVP individual. This would allow for a rapid and smooth transition to the community with reduced media attention and negative community reaction.

6. ESTABLISH & FUND RESEARCH ON TREATMENT OUTCOME AND PROCESS

“It is very important that once a treatment program has begun with all the elements that are evidence-based, that a program evaluation be part of the implementation process. It is important that both research and policy-makers work together to create programs that are effective from a scientific, as well, as an administrative vantage point” (CASOMB Initial Report, 2008, p.149). Authors of this paper fully agree with the California Sexual Offender Management Board on the importance of empirically informed treatment and assessment of sexual offenders. Because there is no research on the efficacy of California’s SVP statute there is no convincing rebuttal to the argument that it merely provides an illusion of public safety (Levenson, 2003).

It is recommended that a comprehensive, empirically based evaluation and treatment program be provided for in the Sexual Offender Commitment Program and across all Phases of treatment.

This is not possible in the current system because resources are not allocated for outcome evaluation and research. Of most significance, the DMH does not receive recidivism data on SVPs who are released.

It is recommended that recidivism data on all released SVPs be regularly collected so that the effectiveness of the SVP evaluations and the treatment program can be evaluated and data driven enhancements can be made.

Since it’s inception in 1996, the average length of inpatient treatment, the time from enrollment in the active Phases to completion of Phase IV is 6 yrs 10 months with a range from 3-9 years (D’Orazio& Arkowitz, 2008). Research will not only to ensure the most dangerous sexual offenders are committed, but it will maximally enhance the efficiency and effectiveness of the treatment program. This will enhance community safety and reduce the attendant costs of SVP evaluation and treatment.

7. COLLABORATION AMONG STATE AGENCIES SERVING SEXUAL OFFENDERS FACILITATED BY THE SEXUAL OFFENDER MANAGEMENT BOARD

Making the SVP statute more effective in reducing instances of repeat and severe sexual offending is one objective toward accomplishing the larger goal of reducing the prevalence of sexual abuse. The problem of repeat severe sexual offending is most

efficiently and effectively addressed from a perspective that encompasses the functioning and integration of all the various systems and agencies involved in responding to sex offending and sexual offenders. Until recently there was no statewide entity that could provide a comprehensive and cohesive perspective on all of the complex state and county systems that respond to California sexual offender management issues. CCOSO lauds the Governor for signing off on the creation of the California Sexual Offender Management Board (CASOMB, 9/30/2006).

This seventeen-member, legislatively-established board is tasked with a mission that is stated as follows in Section 9002 of the California Penal Code:

The board shall address any issues, concerns, and problems related to the community management of adult sexual offenders. The main objective of the board, which shall be used to guide the board in prioritizing resources and use of time, is to achieve safer communities by reducing victimization.

It is recommended that CASOMB review and consider the recommendations of this paper and commit its expertise and influence to supporting the implementation of the recommendations provided.

Those recommendations that require a perspective that transcends the work of any single agency are precisely the focus of such a multi-agency entity as CASOMB. All readers interested in the problem of sexual abuse in California are strongly encouraged to read the CASOMB's reports. Further, CASOMB is encouraged to seek ongoing collaboration with CCOSO in creating its recommendations and implementing its tasks.

8. REDEFINE SEXUAL OFFENDING AS A PUBLIC HEALTH PROBLEM THAT MUST BE ADDRESSED AT ALL LEVELS

The problem of sexual abuse includes abuse committed by first time and repeat offenders. It is an extremely serious and complex public health problem that requires comprehensive cross-agency collaboration. Given that the general body of research indicates that the best way to reduce the prevalence of sexual abuse is to prevent it from happening in the first place, **it is recommended that much more resources be expended toward primary prevention goals than is current practice within California** and across the nation. Parents, educators and caregivers must be trained not only to assess when children are being abused but when children begin to show signs that they are becoming abusive to others. The cycle of abuse must be interrupted as early as possible to maximize the likelihood of the individual not becoming characteristically abusive. Sexual abusers are more likely than non-abusers to have been physically, sexually, emotionally abused, or neglected as children. Thus enhanced treatment of victims of sexual abuse will go far toward reducing the prevalence of sexual abuse.

9. COST BENEFIT FINANCIAL ANALYSIS

The SVP statute is costly and resource-intensive. The statute affects less than 1% of registered sexual offenders in California, but has already cost more than a billion dollars. This is money that is not allocated for primary prevention and other less costly forms of sexual offense containment.

It is recommended that a thorough assessment of the scope of sexual offending in California and a thorough financial analysis be conducted. Recommendations for budget spending and best practice programs can be made by a collaborative body of stakeholders including DMH, CONREP, CDC-R, Probation, Parole, Victims Advocacy, the CASOMB, and the CCOSO.

10. RETHINK EXISTING LAWS THAT MAKE SELF-DISCLOSURES OF SEX OFFENSES RISKY

It is crucial that sexual offenders in treatment be able to disclose information about their own sexual histories, including their prior sexual offending histories. Knowing the details of an offender's prior offenses can greatly assist treatment providers in addressing key risk factors. Recent revisions to California's Child Abuse and Neglect Reporting Act (CANRA) were designed to support agency responses to abused and neglected child victims. However, these changes have created a situation in which any information disclosed by an offender about previously unreported child victims (those who are still under the age of 18) triggers a reporting requirement. This is true even if the offender does not provide actual identifying information about specific victims and only the identity of the disclosing offender is known. California appears to be one of only two states mandating that a report be made in the case of an unidentified victim. This requirement appears to have occurred as an unintended consequence of other revisions to CANRA.

The resulting situation requires that an offender be fully informed of his Fifth Amendment rights to not make self-incriminating statements before being asked about previously unreported victims. After being informed of the potential consequences, many offenders elect to claim their constitutionally guaranteed right to not incriminate themselves. Ultimately, this does not result any additional assistance being provided to victims of sexual abuse; instead, important information about offenders is not made available to treatment providers.

It is recommended that this application of CANRA be revised so that this obstacle to offenders' full disclosure of offending patterns is removed.

11. DEVELOP A CALIFORNIA-BASED RISK ASSESSMENT INSTRUMENT

It is recommended that California track sex offender recidivism and develop a sexual offense risk assessment tool specific to the CA sex offender population.

By no means is there consensus among professionals regarding the appropriateness of procedures currently being used to predict recidivism in SVP cases. Some critics of actuarial risk assessment tools contend that mechanistic actuarial prediction is likely to seriously *overestimate* re-offense risk. Proponents of current actuarial instruments argue that these instruments are an *underestimate* of actual re-offense rates, due to the fact that many sex crimes go unreported or do not result in convictions.

There is general consensus that actuarial prediction is superior to unguided, non-empirically informed clinical prediction. However, experts are advised to exercise great caution when using any kind of risk prediction tool on which to base decisions that have life-long consequences. The most commonly used risk assessment instrument, was created using subjects from Canada and the United Kingdom (Static-99, Hanson & Thornton, 2000). Recent studies have shown that the instrument's ability to predict recidivism rates varies greatly across samples. The controversy over assessment of dangerousness is unlikely to be settled in the immediate future. Nevertheless cross-agency research that examines group and individual recidivism patterns and specific risk factors related to dangerousness for the variety of California sexual offenders is an absolute necessary step toward reducing the prevalence of sexual abuse.

12. CHANGE THE LABEL FOR THIS GROUP OF DANGEROUS SEX OFFENDERS

Due to inaccuracy and negative effects of the label, "Sexual Violent Predator", it is recommended the label be replaced with "Sexually Dangerous Person".

Labels serve as brief phrases designating certain characteristics of a person or group. The goal of the SVP statute, to enhance community safety, is not optimally served through use of the emotionally charged label "**Sexually Violent Predator**". Firstly, the label is misleading. There a significant number of SVP individuals who did not engage in overt *violent* acts, for example, the person who gains the consent of a child by grooming him with toys and attention so as to avoid any need for force. Further, the noun, *Predator* is most typically used to denote any member of the animal species that lives by preying on other animals. There are a number of SVP individuals that engaged in violent sexual crimes but did not *prey* on victims in the sense that they did not overtly plan the offense, stalk or groom victims.

The second reason the label should be changed is that it results in extreme negative stigmatization that undermines treatment efficacy. The "**Sexually Violent Predator**" label sends the message that those committed are more animal than human and this sub-human nature renders them incapable of change. It does not encourage

dangerous sexual offenders to take accountability for the harm they've committed and it undercuts the sense of self-efficacy necessary to make the everyday choice not to re-offend throughout the remainder of the person's life. Treatment is most effective when the environment reflects the target behavior, thus, the civil commitment context must be non-punitive, respectful, and supportive of change. The extremely negative stigma and shaming that accompanies the label, "Sexually Violent Predator", provokes negative responses from others and virtually eliminates housing, employment, interpersonal relations and reintegration efforts. It may even produce hostility and further deviance in some offenders (Prentky, 1996).

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XI APPENDIX

The Female Sexually Violent Predator

Criminal justice statistics have consistently demonstrated that female sexual offenders exist in considerably smaller number than their male counterparts. For example, the Federal Bureau of Investigation (FBI) in 2006 reported that arrests of women represent only 1% of all adult arrests for forcible rape and 6% of all adult arrests for other sex offenses. Females account for less than 10% of all adults and juveniles who came to the attention of the law enforcement authorities for sex crimes (FBI, 2006).

As of May 2006, five states had civilly committed female sexual offenders, California, Illinois, Minnesota, Montana, and Washington (Deming, 2009). Since the implementation of the California Sexually Violent Predator Act in 1996, the California Department Corrections and Rehabilitation (CDCR) referred 6,330 inmates to DMH for review of SVP eligibility. Of the 522 sexual offenders who have been fully civilly committed (WIC 6604) as of January of 2009, only one is female.

There is other information that suggests the number of female sexual offenders may in fact be considerably higher than official arrest rates suggest. This data is revealed by surveys of victims, many who may not have reported these incidents to law enforcement (Schwartz & Cellini, 1995). The National Criminal Victimization Survey reported that female perpetrators represented up to 6% of rapes or sexual assaults by an individual acting alone and up to 40% of sex crimes involving multiple offenders (Bureau of Justice Statistics, 2006). Nevertheless, because of the small number of female sexual offenders found in the criminal justice system, the primary focus has been on male sexual offenders at all levels.

