

Treatment of Sexually Violent Persons

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Presentation for the Forensic Division 2007 Annual
Meeting of NASMHPD

SVP Laws Now Found in 19 States

- Currently, 19 states have civil commitment, as follows:
 - AZ, CA, FL, IA, IL, KS, MA, MN, MO, NH, ND, NJ, NY, PA, SC, TX, VA, WA, & WI.
- 11 civilly commit juveniles: CA, FL, IL, MA, NH, NJ, PA, SC, TX, WA, WI.
- PA is the only state that civilly commits juveniles but not adults though they commit them when they age out of being a juvenile.

Experience

- In most States there are few releases through treatment
- Rates of release depend on who makes the decisions (politicians or courts)
- In one State there have been more escapes than releases through treatment
- SVP populations start small but they grow
 - Small legal changes can trigger big changes in growth rate
- Costs average over \$100,000 a year
- 10 years civil commitment makes them Million Dollar Men

Political Context

- Moral panic about sexual offending
- Very limited concern for the human rights or welfare of men with a history of sexual offending
- Public anxiety over inability to detain sexual offenders who were “obviously” going to re-offend
- Lengthened sentences, three strikes laws etc not retrospectively applicable

Legal Context

- Typical requirements
 - Qualifying sexual offense
 - About to be released from prison or another commitment
 - Posing an “exceptional” risk
 - Predisposing mental disorder
- Many surprised that SVP laws were found constitutional but the courts have consistently supported them

Ethical Context

- Is this is a thinly disguised use of mental health laws to achieve preventive detention?
- Is the science good enough to implement what the law demands?
- Is this really a mental health commitment similar to an NGI decision for someone with severe and persistent mental illness?

Social Policy Context

- Are the number of sexual offenses prevented by SVP laws sufficient justification for the cost involved in their implementation?
- Could this money, spent another way, prevent more harm, even more sexual offenses, than spending it on civil commitment?
- What weight do we give to the harm done to the civilly committed patient by his involuntary detention?
 - Is his life better in the community or in SVP center?

In an ideal world

- Treatment would be sufficiently effective that the majority of civilly committed sexual offenders would be returned safely to the community within 24 months, “cured” of the mental disorders that predisposed them to offend.

Second best, but maybe acceptable

- Only used with exceptional sexual offenders
- Credible treatment
- Plausible route to release that operates routinely

Is it possible to achieve even this second best?

- Can we identify “exceptionally” risky sexual offenders with predisposing mental disorders?
- Can we provide credible treatment?
- Can we make sufficiently credible assessments of change to justify release to the community?
- Can we place civilly committed patients in the community?

- Let's look at these issues

Can we identify “exceptionally” risky sexual offenders with predisposing mental disorders?

- Exceptionally risky?
 - There are now a range of well cross-validated actuarial risk assessment instruments that have demonstrated moderate predictive accuracy
- Predisposing mental disorders
 - Paraphilias (pedophilia; NOS Non-consent)
 - Personality disorder (ASPD)

Limitations of risk assessment

- Uncertain evidence about modifiers
 - Older age; treatment completion; psychological risk factors
 - Application may not increase predictive accuracy but relevance raises doubt
- Recidivism estimates for “high risk” only somewhat in excess of 50%
- Issue of net-widening

Limitations of Diagnosis of Predisposing Mental Disorders

- Reliability and consistency of use
- Reasonable reliability within some States
 - Agreement about the presence of a requisite mental condition is found in around 90% of cases
- Difference between States in which diagnoses are accepted by courts as predisposing
 - ASPD; Paraphilia NOS Non-consent
- Disconnect between diagnoses and treatment needs
 - We generally treat to reduce risk rather than to change diagnoses

Can we provide credible treatment?

- No direct controlled studies of treatment of SVPs
 - Too hard to do
- We have to turn to the more general literature
 - Limited literature on treatment of sexual offenders; difficulty implementing random allocation studies
- Larger, better controlled literature on offender treatment programs

The Nature of Offender Treatment Programs

- Offenders, perhaps especially those in confinement, suffer from mental illnesses just like any other segment of the population.
- Accordingly they require mental health services
- This is NOT what is meant by “offender treatment programs”

Offender Treatment Programs - continued

- Offender treatment programs are interventions designed to impact the psychological factors that are thought to predispose to repeated offending

Examples of Offender Treatment Programs

- Substance Abuse Treatment
- Remedial Education
- Cognitive Skills programs (designed to reduce impulsiveness)
- Offense-focused programs
 - Target factors thought to be associated with specific kinds of offending

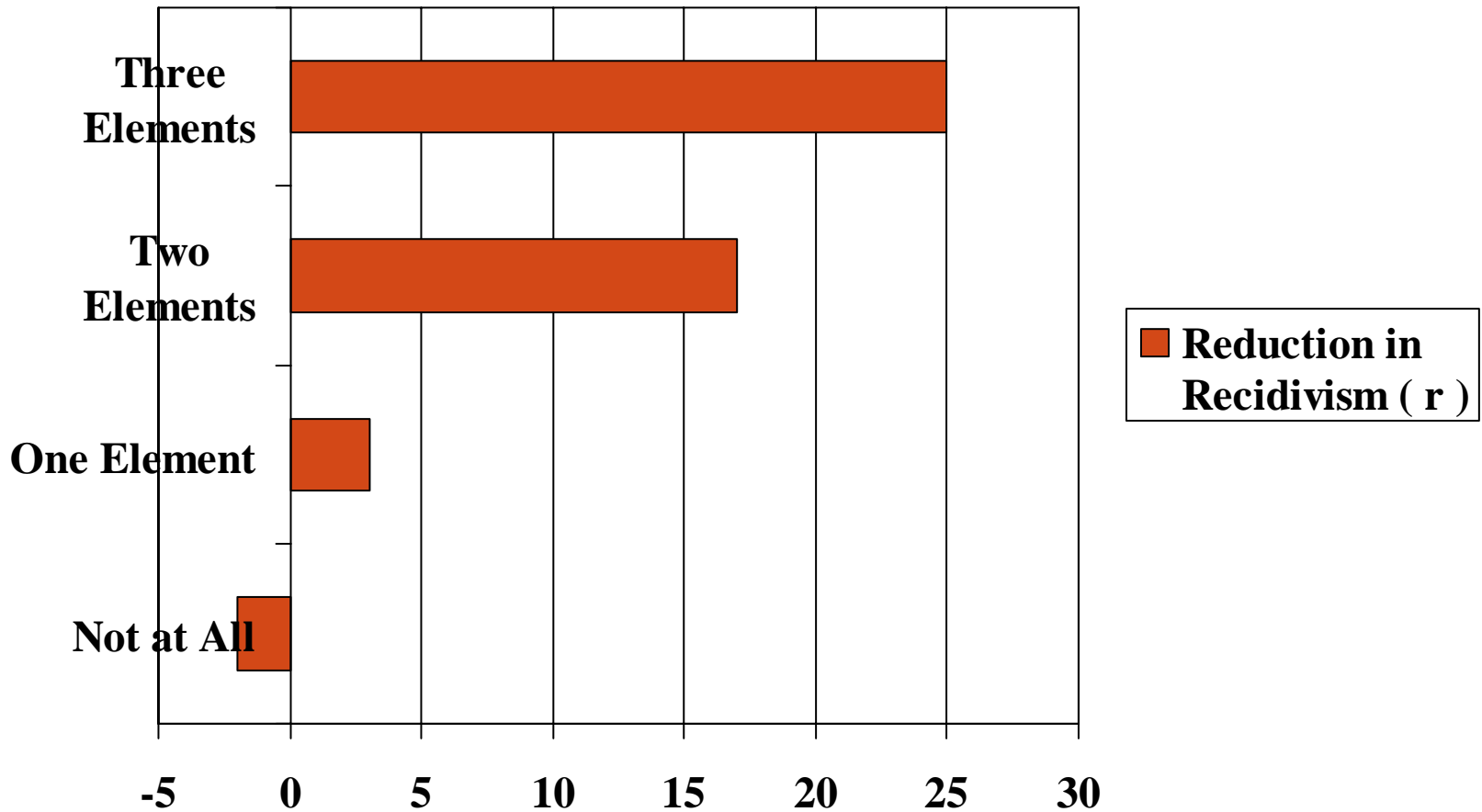
Conditions for effective treatment of offenders

- Risk Principle: duration and intensity of treatment should be proportionate to the risk presented by the offender
- Need Principle: concentrate treatment on changing factors closely linked to re-offending
- Responsivity Principle: use methods appropriate to the learning style and culture of participants

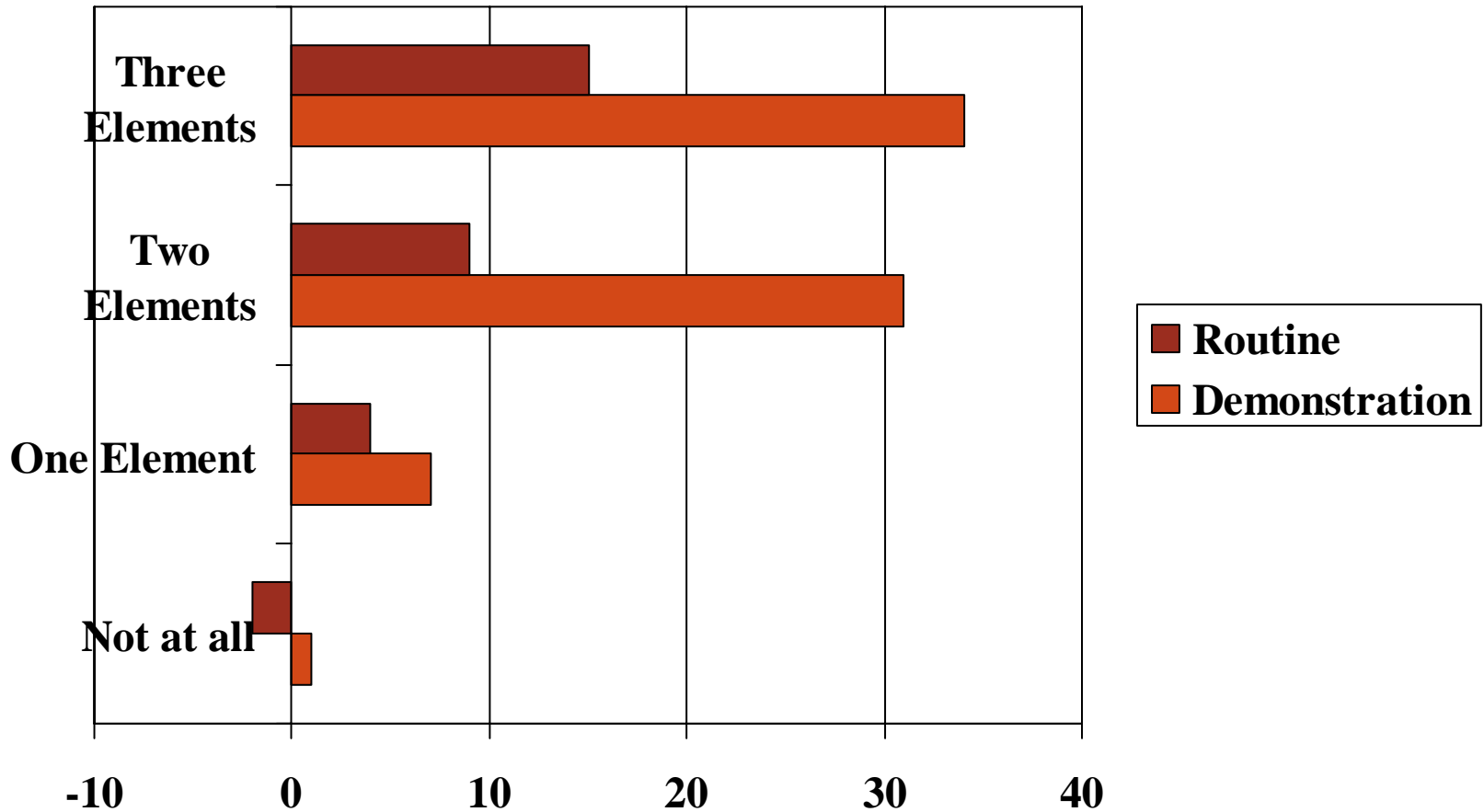
Sources for Following Data

- Andrews, D. A., & Bonta, J. S. (2006). *The psychology of criminal conduct* (4th edition). Cincinnati, OH: Anderson.
- Hanson, R.K. (2006) What Works: The Principles of Effective Interventions with Offenders. Presentation at the 25th Annual Convention of the Association for the Treatment of Sexual Abusers, Chicago, September 29, 2006

Adherence to Effectiveness Principles (Studies of Offender Treatment in General)



Adherence and Implementation (Studies of Offender Treatment in General)



What is meant by Criminogenic Needs?

Criminogenic Needs (Studies of Offender Treatment in General)

- Antisocial Personality
 - Impulsive, adventurous pleasure seeking, restlessly aggressive, callous disregard for others
- Grievance/hostility
- Antisocial associates
- Antisocial cognitions
- Low attachment to Family/Lovers
- Low engagement in School/Work
- Aimless use of leisure time
- Substance Abuse

Non-criminogenic needs

- Personal distress
- Major mental disorder
- Low self-esteem
- Low physical activity
- Poor physical living conditions
- Low conventional ambition
- Insufficient fear of official punishment

Conditions for effective treatment of sexual offenders

- The same three principles apply but the factors closely linked to sexual recidivism differ in some respects
- The following slides are based on the Structured Risk Assessment model
- Thornton (2002). Constructing and Testing a Framework for Dynamic Risk Assessment. *Sexual Abuse: A Journal of Research and Treatment*, 14, 137-151.

Criminogenic Needs for Sexual Offenders can be divided into four groups

- Sexual Interests
- Distorted Attitudes
- Socio-affective Functioning
- Self-management

Sexual Interests

- Sexual preference for children
- Sexualized violence
- Sexual preoccupation

Distorted Attitudes

- Child abuse supportive beliefs
- Adversarial sex role attitudes
- Seeing women as deceitful and malicious
- Excessive sense of entitlement
- Machiavellianism

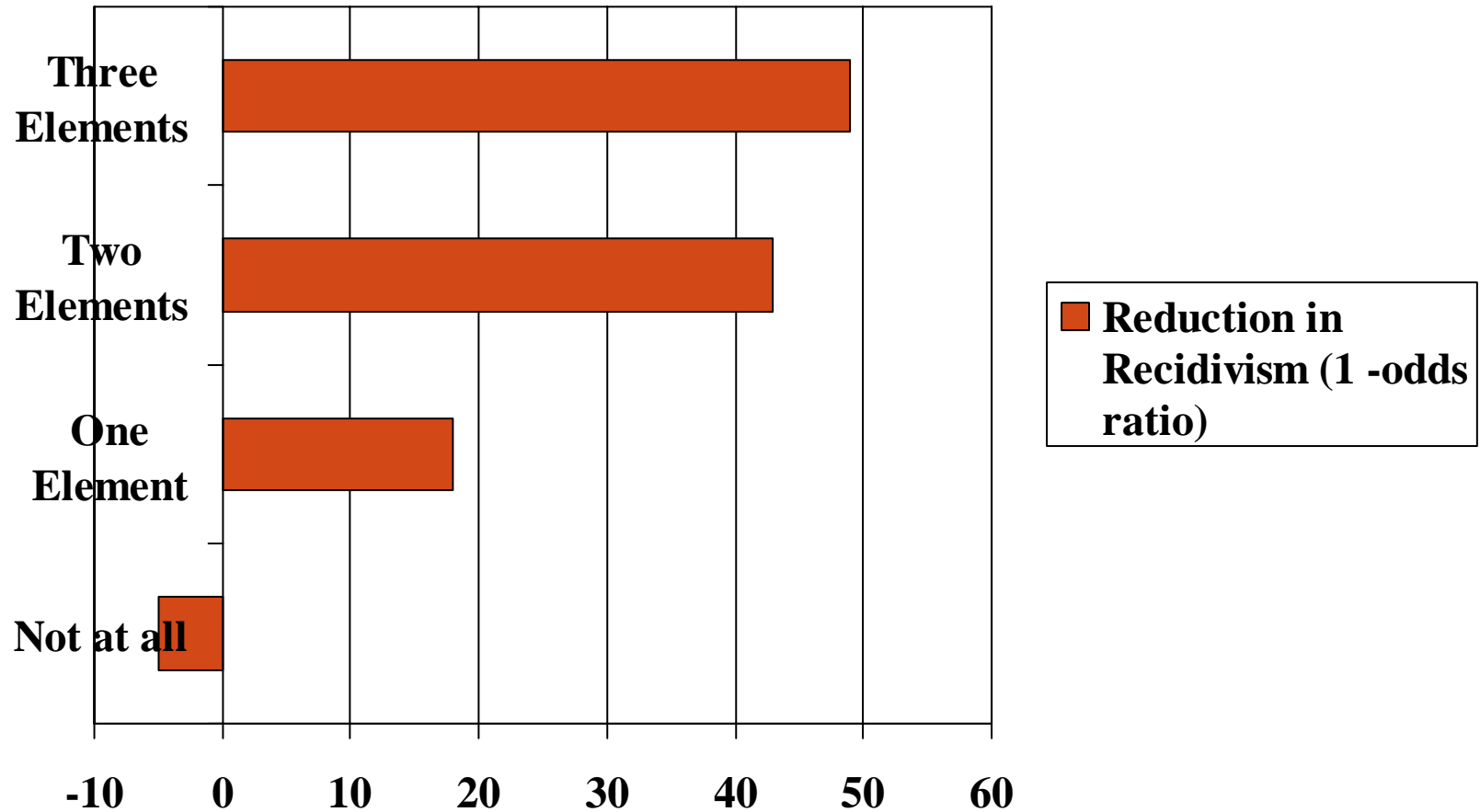
Socio-affective Functioning

- Dysfunctional self-evaluation
- Emotional congruence with children
- Lack of emotionally intimate relationships with adults
- Callousness
- Grievance Thinking

Self Management

- Lifestyle impulsiveness
- Oppositional reaction to rules and supervision
- Poor problem-solving
- Poor emotional control

Adherence to effectiveness principles in SOT



Treatment Interfering Factors

- PD / MI / Cognitive Limitations
- Hopelessness
- Suspicion
- Strong schema based distortion of experience
- Miserable life in which sexual offending is only reliable source of pleasure

Implications

- Similar results for sexual and non-sexual offenders
- Treatment of higher risk offenders can be expected to produce a moderate reduction in recidivism rates so long as criminogenic needs are targeted and treatment methods are responsive to cultural/learning style factors
- It is not clear that the magnitude of the treatment effect would be sufficient to produce a large enough reduction in recidivism for all offenders
- It is not clear how responsive some very high risk offenders (e.g. psychopaths) or the poorly motivated are?
- This leaves a critical need for determining whether this patient has made enough change given his prior level of risk

Can we make sufficiently credible assessments of change to justify release to the community?

- This is the hardest part
- Very limited research
- Structured assessment of post-treatment performance on measures of psychological risk factors look the most credible
- Need for multi-step release process in which security and support is gradually varied in response to improved conduct rather than all or none high security/ free

Most Relevant Study

- Marques, J.K., Wiederanders, M., Day, D.M., Nelson, C., van Ommeren, A. (2005). Effects of a relapse prevention program on sexual recidivism: Final results from California's Sex Offender Treatment and Evaluation Program (SOTEP). *Sexual Abuse: A Journal of Research and Treatment*, 17, 79-107.

Sexual Recidivism by Response to Treatment

Got It?	Low Risk	Medium Risk	High Risk
No	16% (6/37)	21% (8/38)	50% (14/28)
Yes	5% (1/22)	25% (5/20)	14% (7/52)

Can we place civilly committed patients in the community?

- Degree of community resistance varies
- Wisconsin experience is that we can place throughout the State, except in Milwaukee
- Laws restricting where sexual offenders can live make this increasingly difficult
- Curiously Discharge may arouse less opposition than Supervised Release

Questions?