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Comparing Sexual Offenders at the Regional Treatment Centre (Ontario) and the Florida Civil Commitment Center

Robin J. Wilson[1], Jan Looman[2], Jeffrey Abracen[2], and Donald R. Pake[1]

Abstract

Sexual offender civil commitment (SOCC) continues to be a popular means of managing risk to the community in many U.S. jurisdictions. Most SOCC states report few releases, due in large part to the reluctance of the courts to release sexually violent persons/predators (SVPs). Contemporary risk prediction methods require suitable comparison groups, in addition to knowledge of postrelease behavior. Low SVP release rates makes production of local base rates difficult. This article compares descriptive statistics on two populations of sexual offenders: (a) participants in high-intensity treatment at the Regional Treatment Centre (RTC), a secure, prison-based treatment facility in Canada, and (b) SVP residents of the Florida Civil Commitment Center. Results show that these two samples are virtually identical. These groups are best described as "preselected for high risk/need," according to Static-99R normative sample research. It is suggested that reoffense rates of released RTC participants may serve as a comparison group for U.S. SVPs. Given current release practices associated with U.S. SOCC, these findings are of prospective value to clinicians, researchers, policy makers, and triers of fact.

Keywords

sexual offenders, civil commitment, Static-99R, treatment, risk management

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Sexual offender civil commitment (SOCC) is predicated on the belief that some offenders will be "more likely than not" to commit a new sexual offense if they are not preventively detained and offered treatment designed to lower their risk for recidivism. However, once committed, a majority of civil committees are held for lengthy periods, often because the courts have difficulty ascertaining which offenders are most inclined to reoffend. This leads to low rates of release, which makes completion of follow-up studies of this population difficult or impossible. Some (particularly, Static-99 cocreator Karl Hanson) have suggested that prediction of recidivism in a certain jurisdiction may require composition of a comparison sample of analogous persons previously released in that same jurisdiction. Referred to as "local norms," such samples require that jurisdictions release enough participants to actually comprise the comparison sample against which those who might potentially be released would be gauged. However, the aforementioned low rates of release currently observed in most SOCC states makes this next to impossible.

One potential solution to this problem is to investigate whether a group of sufficiently high-risk sexual offenders (analogous to typical civilly committed sexual offenders) can be identified in a jurisdiction where no commitment laws have been enacted and where offenders are therefore routinely released to the community. Comparisons of these groups would provide insight as to the criminal trajectories of such groups post release. Long-term follow-up data on such a population would also provide helpful clarification as to whether such groups are actually "more likely than not" to reoffend sexually if released to the community. In addition, information could be extrapolated regarding the potential mediating effect of successful completion of treatment and/or provision of coordinated postrelease follow-up treatment and supervision.

Canada and the United States share the longest unprotected border in the world. Both enjoy a very similar standard of living; however, in spite of the myriad similarities between the United States and Canada, there are some key differences. In particular, correctional philosophies and practices can be quite different, with criminal sentences in the United States tending to be longer and more frequently employed in managing risk posed by offenders. In regard to sexual offending, the vast majority of offenders in Canada receive determinate sentences and return to the community at the end of those sentences. In the United States, nearly half of the 50 states have enacted laws allowing for SOCC. As described above, this has resulted in the indeterminate and involuntary preventive detention of many sexual offenders *after* their criminal sanction has been satisfied.

Most SOCC statutes require the state to demonstrate that a potential candidate for this measure has (a) a history of engaging in criminal sexual behavior and (b) a "mental abnormality" that without treatment would preclude him (the overwhelming majority of such persons are male) from being able to manage his criminal sexual propensities in the community. These "criteria" form the principal basis for SOCC, and persons committed as Sexually Violent Persons/Predators (SVPs) under SOCC laws are then held until such time as the Court finds they no longer meet criteria. The Supreme Court

of the United States has twice ruled on the constitutional aspects of SOCC (*Kansas v. Crane* [2002]; *Kansas v. Hendricks* [1997]). In the first of these two cases, the court set forth procedures for the indefinite civil commitment of prisoners convicted of a sexual offense whom the state deems dangerous due to a "mental abnormality." In *Crane*, the court ruled that in civil commitment cases, there must be proof of serious difficulty in controlling behavior sufficient to distinguish dangerous sexual offenders from dangerous but typical recidivists.

The contemporary research and clinical literature on sexual abuse has tended to focus on four main areas: (a) sexual psychodiagnostics, (b) risk assessment and prediction, (c) best practices in treatment, and (d) methods for community-based risk management. All four remain a source of considerable professional controversy, and each will be addressed in this article.

Sexual Psychodiagnostics

It is generally believed that sexual offenders can be separated into two relatively discrete groups—those who are paraphilic (see *Diagnostic and Statistical Manual of Mental Disorders* [4th edition, text revision; *DSM-IV-TR*]; American Psychiatric Association, 2000) and those who opportunistically engage in sexually abusive behavior without necessarily having a strong sexual interest in or preference for a particular group of persons (e.g., children) or a certain behavior (e.g., exposing).

According to current diagnostic criteria as defined by *DSM-IV-TR*, paraphilias are sexual impulse disorders characterized by intensely arousing, recurrent sexual fantasies, urges, or behaviors (of at least 6-months duration) that are considered deviant with respect to cultural norms. Furthermore, these disorders must produce clinically significant distress or impairment in social, occupational, or other important areas of psychosocial functioning. In contrast, the aforementioned "opportunistic" offenders engage in sexually abusive behaviors for reasons other than those highlighted in the diagnostic criteria for paraphilias (e.g., poor problem solving, substance abuse, antisocial values and attitudes, etc., or any combination thereof). By way of example, men who sexually abuse female children within family contexts are less likely to be pedophilic than are men who solicit male children who are not members of their family (Freund, Watson, & Dickey, 1991).

It is also generally believed that persons diagnosable as "paraphilic" are at higher risk to engage in sexually deviant behaviors (e.g., sexual interactions with children, exposing one's penis, or sexually sadistic conduct, among other expressions). However, recent research has questioned the validity of this assumed link between diagnosis and behavior (Kingston, Firestone, Moulden, & Bradford, 2007; Wilson, Abracen, Looman, Picheca, & Ferguson, 2011), at least as it applies to pedophilia. In regard to SOCC, a paraphilia diagnosis is often held up as evidence of the aforementioned "mental abnormality" that could preclude a candidate for civil commitment from managing his sexually offensive propensities in the community. As such, the reliability and validity of the criteria used to diagnose such disorders have been debated in the

literature; particularly of late, as discussions continue with respect to proposed changes to the diagnostic criteria in advance of the release of the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-V*; see Franklin, 2010; Marshall, 2007; Marshall & Kennedy, 2001).

Risk Assessment and Prediction

Current literature on risk assessment and prediction suggests that evaluations are likely to be more accurate when the protocols used are comprehensive and empirically based. Most North American jurisdictions now expect risk assessments to be anchored by an actuarial scale (e.g., Static-99R; Hanson & Thornton, 1999; Helmus, 2009) with adjustments made depending on other factors (e.g., dynamic predictors or criminogenic need variables) also demonstrated in the literature to be predictive of recidivism. For a detailed explanation of this process, readers are encouraged to review the Dynamic Supervision Protocol (see Hanson, Harris, Scott, & Helmus, 2007; Mann, Hanson, & Thornton, 2010). Typically, the offender being evaluated is compared with a larger sample of offenders for whom outcomes (e.g., percentage reoffending) are empirically supported, also known as a normative sample. However, debate in the field continues as to how best to delineate appropriate normative samples given that the population of sexual abusers in general is quite heterogeneous (see Campbell & DeClue, 2010; Thornton, Helmus, & Hanson, 2009; Wilson & Looman, 2010). Furthermore, it would appear that the jurisdictions into which offenders might be released may also be different from one another, which recalls the possible need for local norms as noted previously. In this article, we present results we believe offer some clarification as to potential reoffense trajectories of a population of U.S. civilly committed sexual offenders.

Best Practices in Treatment

Contemporary reviews of treatment methods for sexual abusers suggest that programs must match treatment intensity to the level of risk posed by the offender. Such programs should ensure that assessed criminogenic needs are specifically addressed in a manner which appreciates the idiosyncratic presentations of clients and promotes motivation to acquire primary human goods in prosocial ways (see Andrews & Bonta, 1994, 2010; Andrews et al., 1990; Wilson & Yates, 2009; Yates, Prescott, & Ward, 2010). This same literature tells us that cognitive-behavioral methods are most likely to achieve better results but that we must be holistic and comprehensive in attending to the entirety of client dysfunction.

Community Reintegration of Sexual Offenders

With respect to community-based risk management, legislators and citizens alike continue to express anxiety over the potential for reoffending posed by identified

sexual abusers returned to society following incarceration. A number of social control measures have been imposed in various jurisdictions (e.g., sexual offender registries, community notification protocols, laws regarding how close offenders may reside to schools, parks, community centers, etc., among others). Nonetheless, some researchers have questioned the true value added to community safety provided by these measures (see Levenson & D'Amora, 2007).

Current meta-analytic reviews suggest that the average sexual reoffense rate for all known sexual offenders, postcriminal sanction, is approximately 13% to 15% over a follow-up period of approximately 5 years (see Hanson & Morton-Bourgon, 2005). However, it is also clear that when we hierarchically subdivide the whole population of known sexual abusers according to risk levels, sometimes based on various grouping variables (e.g., sexual deviance, personality disorders, offense type; see Hanson, Phenix, & Helmus, 2009; Helmus, 2009), the rates of reoffending can be quite divergent. Of greatest concern to the community should be those sexual abusers judged to be at high risk to reoffend and who present high levels of criminogenic need. In the United States, these are the offenders to whom SOCC is presumably most appropriately applied. However, the U.S. Supreme Court has opined that SOCC should not be solely for preventive detention (see *Hendricks*, noted earlier). Rather, civil committees are to be afforded the opportunity to participate in treatment designed to address their criminogenic needs such that, on completion of a program, they may be suitable for reintegration to the community. This has proven to be a quite difficult process in most jurisdictions, as relatively few adjudicated SVPs have been released to the community in the majority of states with SOCC programs.

Predicting Sexual Reoffense Rates for Civil Committees

At present, very few civil commitment programs have released sufficient numbers of offenders to comprise a comparison group. Across those 16 SOCC programs reporting data to the annual survey of the Sexual Offender Civil Commitment Programs Network (SOCCPN, 2010), the average number of releases per program was less than 10. Furthermore, of those programs that have released offenders, these practices are relatively recent, meaning that follow-up times are quite short. Critics (Campbell & DeClue, 2010) of the normative samples provided by the www.static99.org work group (Hanson, Phenix, & Helmus, 2009) have suggested that there is no appropriate normative sample against which to compare civilly committed SVPs. Echoing suggestions by the Static-99's authors, these critics maintain that "local norms" must be created. However, for reasons stated above, this has been and will continue to be difficult given current court decision-making practices. As such, as a field, we must search for an appropriate comparison group outside of the SOCC realm; at least, until such time as there have been sufficient SOCC releases to comprise an adequate normative sample.

As an initial investigation into this topic, we questioned whether a group of sexual offenders attending a high-intensity sexual offender treatment program at the Regional Treatment Centre (RTC) in Canada could serve as a reasonable comparison group for SVPs civilly committed at the Florida Civil Commitment Center (FCCC) in the United States. In this study, we compared these two groups on a variety of measures including actuarially assessed risk for sexual offense recidivism; number and type of sexual offenses in the offenders' history, age, and personality profile; and a variety of other demographic and clinical variables. We hypothesized that, should these two groups of offenders prove similar in terms of comparisons made on the variables noted above, it may then be argued that the long-term follow-up data that exist for the RTC program could be useful in projecting what the postrelease experiences of the Florida SVPs might be.

RTC

The RTC sexual offender treatment program is located in Kingston, Ontario, Canada, and was started by Dr. William Marshall in the early 1970s. The RTC is a psychiatric treatment center fully within the secure perimeter of Kingston Penitentiary, a maximum-security Federal correctional institution. It is important to note that in Canada, the Federal prison system, operated by the Correctional Service of Canada (CSC), houses inmates serving sentences of 2 years or more. Those with shorter sentences serve time in provincially operated facilities. For example, in 1997 to 1998, 57% of sentenced sexual offenders (1,533 of 2,788) received a custodial sentence. Of offenders who received a custodial sentence, 291 (19%) received a sentence of 2 years or more, placing them in Federal custody. Thus, the sexual offenders housed in Federal penitentiaries make up only 10.7% of convicted sexual offenders and 19% of sex offenders receiving custodial sentences (Juristat, 1999).

The RTC program is designed to serve the needs of sexual offenders deemed to be at high risk—based on actuarial assessment data—or at high needs (e.g., presenting with concurrent disorders or many criminogenic needs). In practice, the majority of the clients attending the program represent at least a moderate risk of recidivism based on actuarial assessment and present with a multitude of treatment needs. Typically, about 15% of sexual offenders entering CSC in Ontario are referred for programming at the RTC. Assuming the national numbers apply on a provincial level, this amounts to approximately 2.8% of offenders who receive a custodial sentence (Juristat, 1999).

Although the focus of the program has changed somewhat over the years, there have always been certain common elements to treatment at the RTC. The program has maintained a cognitive-behavioral orientation since its inception, and advances in theory and treatment have been incorporated on an ongoing basis. The RTC program focuses on a large number of treatment targets associated with traditional criminogenic needs (e.g., criminal associates and personality, criminal thinking style, poor problem-solving abilities) and sexual offender specific needs (e.g., deviant arousal, intimacy deficits). The program is inpatient and largely group based, with individual therapy provided to ensure that the specific needs of individual clients are met. The

RTC provides the only high-intensity sexual offender treatment program within the Ontario Region of CSC and is part of an integrated system of assessment and treatment programs operated in this region (see Mailloux et al., 2003, for a discussion). The program as applied to the participants included in this study runs for approximately 7 months. Following completion of this program, some participants will "cascade down" to additional programming in institutions with lower security levels; however, they may also be released to the community directly from the center.

In keeping with contemporary research and practice in sexual offender treatment suggesting greater emphasis on holistic approaches (e.g., Good Lives, Risk-Needs-Responsivity [RNR]), newer versions of the program have increasingly focussed on the criminogenic and interpersonal difficulties presented by this population including, at times, complex psychiatric histories. Given the level of treatment resistance sometimes seen in this population, individual therapy provides an opportunity to address issues which may serve as a distraction in the group setting. An essential component of treatment from the RTC perspective is that clients attending the program are able to interact with program staff on the unit when not attending individual or group therapy. Individual sessions can also be used to address issues associated with psychiatric symptomatology—issues that may be difficult to address in a group setting. This allows the treatment staff to interact on a daily basis with clients when not attending therapy as well as to monitor behavior on an ongoing basis.

FCCC

The FCCC is a secure treatment facility for sexual offenders civilly adjudicated as SVP or who are detained awaiting the civil trial that will ultimately decide their commitment status. The FCCC was established in 1998 after the Florida legislature passed the Jimmy Ryce Involuntary Civil Commitment for Sexually Violent Predators' Treatment and Care Act, named after a young boy who was abducted, sexually assaulted, and murdered in 1995. Since January 1, 1999, all sexual offenders held in Florida prisons have been screened by the Florida Department of Children and Families for possible referral to the courts as candidates for involuntary civil commitment at the FCCC. Over the 12 years that the FCCC has been in existence, more than 40,000 sexual offenders have been screened, but fewer than 625 (approximately 1.5%) have been adjudicated as SVPs, which demonstrates the uniqueness of the class of offenders to whom such laws have been applied. To date, approximately 70 civilly committed residents have been released by the courts (31 from the final stage of treatment) while others have left the center either because of new charges or death.

The goal of clinical programming at the FCCC has been to help residents develop balanced, self-determined lifestyles. The evidence-based Comprehensive Treatment Program (CTP) for persons who have sexually offended is a multiphase program, based in the Risk-Needs-Responsivity (Andrews & Bonta, 2010) and Self-Regulation/Good Lives (e.g., Ward & Maruna, 2007; Yates, Prescott, & Ward, 2010) modalities. The goal of the program has been to integrate best practice models (see Wilson & Yates, 2009) from current research and treatment literatures into the interventions

taking place at the FCCC to assist residents in leading "better" lives, free of antisocial behavior and sexual recidivism. Programming at FCCC is a "comprehensive" endeavor and can take 5 years or more to complete.

CTP programming at the FCCC is streamed according to responsivity factors, with the majority of residents falling in the "conventional" track. Residents with entrenched antisocial values and attitudes and other treatment interfering factors are maintained in a specialized track ("corrective thinking"), as are residents with intellectual, cognitive, and other limitations that prevent them from attending conventional treatment programming ("special needs"). The program is divided into four phases:

Phase 1: Preparation for Change
- Moral Reconation Therapy (MRT; see Little & Robinson, 1988; Little, Robinson, Burnette, & Swan, 1999)
- Thinking for a Change (T4C; see Glick, Bush, & Taymans, 1997)
- Treatment Readiness for You (TRY; Cullen & Wilson, 2003)

Phase 2: Awareness
- During this phase, residents develop an agreed on and comprehensive identification of the main factors that contributed to their past offending. They are then provided opportunities to demonstrate insight into the current expression of personal risk factors and personal life-barriers.

Phase 3: Healthy Alternative Behaviors
- In Phase 3, participants reevaluate justifications and attitudes that supported offending behavior. This leads to increased awareness of deficits in emotions regulation, acknowledgment of and strategies for the reduction of deviant sexual arousal/interest, and the application of new lifestyle management (coping) strategies.

Phase 4: Maintenance and Comprehensive Discharge Planning
- During the Maintenance Phase, participants behaviorally demonstrate the attitudes and skills critical to avoiding future sexual offending behavior while making preparations for life in the community.

Research Hypotheses

In conducting this study, we wished to test several hypotheses regarding the nature and offense propensities of sexual offenders in Canada and the United States, focusing specifically on the relative likelihood of recidivism considering what differences might exist in regard to their personal histories, psychological presentations, and treatment and release experiences. Three of the authors (RJW, JA, and JL) have worked in both Canadian correctional and U.S. SVP settings as either evaluators or treatment providers, which caused us to ponder the respective experiences of offenders in each of those circumstances.

Specifically, we hypothesized that there would be no appreciable international differences between high-risk, high-need sexual offenders with respect to demographic variables, actuarially assessed risk potential, or psychological makeup. We also hypothesized that the postrelease experiences of offenders

Table 1. Descriptive Statistics—RTC and FCCC

Factor	RTC (Total $n = 459$)	FCCC (Total $n = 120$)
M Age*	37.69 (9.71)	45.72 (10.16)
M (Sexual convictions	3.63 (4.67)	4.29 (3.14)
M (Static-99 score*	5.13 (2.0) / $n = 378$	5.86 (1.84)
M (Static-99R score*	4.05 (2.27) / $n = 377$	4.85 (2.23)
M (PCL-R score	22.47 (7.64) / $n = 340$	22.70 (6.78)
Sexual reoffense rates	5.5% (14/253)	3.2% (1/31)
Follow-up time	2.54 years	2.54 years
Static-99 high-risk base rate for a score of 5 (5-year logistic regression norms)	26.2	26.2
Static-99R high-risk/need base rate for a score of 4 (5-year logistic regression norms)	20.1	20.1

Note: RTC = Regional Treatment Centre; FCCC = Florida Civil Commitment Center; PCL-R = Psychopathy Checklist–Revised 2nd Edition. Static-99 and Static-99R base rates reflect 5-year logistic regression estimates (see Hanson, Phenix, & Helmus, 2009).
*$p < .01$.

released following high-intensity sexual offender treatment programming in Canada might provide a useful analog of what could happen for similar offenders (if the first hypothesis were true) if they were to be released following similar treatment in an SVP program in Florida. This latter hypothesis was seen as being directly related to the issue of whether or not analogous offenders in other jurisdictions could be used in lieu of local norms when no such local norms are presently available.

Method

Participants

Participants included in this study were 459 male adult sexual offenders treated at the RTC in Kingston, Ontario, Canada, and 120 male adult SVPs treated at the FCCC in Arcadia, Florida, United States. Each of these programs is known for its provision of treatment services to sexual offenders demonstrating high risk to reoffend and high criminogenic needs. Table 1 shows comparative descriptive statistics regarding pertinent demographic and risk assessment data. Due to missing data on some variables, not all comparisons have the same sample sizes.

Measures

Static-99/Static-99R. The Static-99R (Hanson & Thornton, 1999; Helmus, 2009) is a tool that actuarially assesses risk for sexual and violent recidivism based on static risk variables. It consists of 10 static items and scores range from –3 to 12. Moderate to

good predictive validity has been found for the Static-99 across several studies (average $d = .70$ across 42 studies; Hanson & Morton-Bourgon, 2009). Scores on Static-99/Static-99R were computed from file information specifically for use in this study.

Psychopathy Checklist–Revised 2nd Edition (PCL-R). The PCL-R (Hare, 2003) is a 20-item scale designed to measure the presence of particularly severe antisocial personality orientations—known as psychopathy. Although the PCL-R was developed as a diagnostic tool for psychopathy, research has consistently demonstrated a positive correlation between PCL-R scores and propensity for violence (Hare, 2003).

Millon Clinical Multiaxial Inventory, Third Edition (MCMI-III). The MCMI-III (Millon, Davis, & Millon, 2006) is a screening instrument that can be used in a wide range of applications such as forensic mental health settings where there is a need to assess individuals for emotional and interpersonal difficulties. It is not recommended for general use outside the clinical setting. The MCMI-III consists of 175 items and renders 28 subscales under five headings: Clinical Personality Patterns, Severe Personality Pathology, Clinical Syndromes, Severe Clinical Syndromes, and Modifying Indices. MCMI-III scale scores are presented as base rates. Interpretation of the scores provides the evaluator with an indication whether the trait is common in a clinical sample. Base rate scores on the MCMI-III simply indicate the presence or absence of a given trait, as it is measured by the MCMI-III, with higher scores indicating greater prominence of the construct being measured. Table 2 below presents scale scores and comparisons on the MCMI-III by participant groups.

Results

The two groups were significantly different from one another in regard to age, $t(577) = 7.99$, $p < .01$, with the FCCC group being approximately 8 years older on average. The groups were significantly different in their scores on the original Static-99, $t(496) = 3.55$, $p < .01$, and the Static-99R, $t(495) = 3.38$, $p < .01$. Static-99 and Static-99R scores for the FCCC group were on average less than one point higher than their peers in the RTC group. There were no other differences in regard to variables included in Table 1. Typically, treatment participants reside at the FCCC for about 6 to 7 years before release. The two groups were not different in their mean scores on the PCL-R.

Recidivism was assessed using a fixed 2.54-year follow-up for the RTC sample as that was the length of follow-up available for the FCCC sample. As can be seen in Table 1, 14/253 (5.5%) of the RTC offenders committed new sexual offenses in that time, compared with 1/31 (3.2%) of the FCCC men. Comparison using chi-square was not significant ($\chi^2 = .29$, *ns*).

Participants in the two treatment programs were also compared with respect to personality profile as measured by the MCMI-III. With respect to MCMI-III Modifying Indices, the FCCC participants gave answers to questions significantly more demonstrative of Social Desirability, $t(455) = 2.61$, $p < .05$. In regard to the Moderate Personality Disorder Scales, the participants of the FCCC program were

Table 2. MCMI-III Scale Scores—RTC and FCCC

MCMI Scales	MCMI Scale nomenclature	RTC (n = 364) *M* (*SD*)	FCCC (n = 93) *M* (*SD*)
Random Response Indicator			
V	Validity	.042 (.202) n = 187	.078 (.269) n = 90
Modifying Indices			
X	Disclosure	59.89 (20.65)	59.18 (19.60)
Y*	Desirability	60.69 (20.07)	66.66 (18.06)
Z	Debasement	49.87 (23.68)	48.81 (21.97)
Moderate Personality Disorder Scales			
1	Schizoid	59.57 (25.67)	56.15 (26.66)
2A	Avoidant	53.98 (31.57)	54.30 (29.64)
2B	Depressive	61.68 (29.72)	56.05 (30.47)
3	Dependent	48.91 (28.93)	49.66 (23.08)
4	Histrionic	42.49 (17.89)	46.26 (16.77)
5*	Narcissistic	50.54 (17.99)	57.75 (16.73)
6A	Antisocial	66.82 (18.28)	64.89 (17.11)
6B	Sadistic (Aggressive)	47.57 (20.14)	47.97 (20.94)
7*	Compulsive	47.60 (14.98)	52.14 (14.06)
8A	Negativistic (Passive-Aggressive)	47.06 (30.35)	49.02 (29.15)
8B	Masochistic (Self-Defeating)	51.65 (30.15)	51.22 (26.99)
Severe Personality Pathology Scales			
S	Schizotypal	48.24 (28.91)	52.45 (27.68)
C	Borderline	51.54 (22.98)	48.12 (21.74)
P	Paranoid	47.13 (29.43)	51.02 (30.08)
10 Clinical Syndrome Scales (coordinate with *DSM-IV* Axis I disorders)			
Moderate Syndrome Scales			
A	Anxiety	54.43 (34.94)	51.18 (37.31)
H	Somatoform	43.62 (28.68)	42.78 (29.37)
N	Bipolar: Manic	48.35 (23.32)	53.24 (21.40)
D	Dysthymia	52.29 (28.94)	52.82 (28.09)
B	Alcohol Dependence	66.89 (20.67)	64.49 (22.44)
T	Drug Dependence	64.79 (19.89)	62.81 (16.86)
R	Posttraumatic Stress Disorder	48.49 (28.20)	44.31 (29.05)
Severe Syndrome Scales			
SS	Thought Disorder	39.82 (28.04)	38.67 (26.25)
CC*	Major Depression	46.44 (28.08)	37.37 (27.45)
PP	Delusional Disorder	36.71 (29.60)	39.62 (30.78)

Note: MCMI = Millon Multiaxial Clinical Inventory; RTC = Regional Treatment Centre; FCCC = Florida Civil Commitment Center; *DSM-IV* = *Diagnostic and Statistical Manual of Mental Disorders, 4th edition*.
*p < .05.

significantly higher on the Narcissistic, $t(455) = 3.50$, $p < .05$, and Compulsive, $t(455) = 2.64$, $p < .05$, scales. The RTC inmates were significantly higher with respect to Major Depression—Severe Syndrome Scales, $t(455) = 2.73$, $p < .05$. There were no other significant differences between the two participant groups on MCMI-III scale scores.

Discussion

Prior to conducting any comparisons, it was our expectation that the RTC and FCCC client populations would be similar. Direct clinical experience has suggested that both samples represent offenders with significant risk and needs profiles. However, we were ultimately struck by just how similar these two populations were. Indeed, with the exception of mean age and scores on Static-99/Static-99R, the two groups were not significantly different on any other pertinent demographic or clinical factor. Interestingly, the difference in age is approximately the length of time that an average FCCC resident spends at the center prior to release. Had those FCCC offenders been released to the community at the completion of their correctional sanction (like their compatriots in the RTC program), mean age might not have been different. These two groups were significantly different in their scores on Static-99 and its successor Static-99R. The FCCC residents had average scores that were two thirds of a point and three quarters of a point higher, respectively. However, on both instruments, the two samples fell within the same nominal risk category—high moderate. Although this difference is statistically significant, it is unlikely to be of any clinical or practical significance, particularly, given that case managers and other supervisors would be more than likely to see the members of each group as being worthy of the same degree of attention.

There were also a small number of significant differences in scores on scales of the MCMI-III, a personality inventory described above. Specifically, the FCCC residents were significantly higher in their scores on the Desirability modifying index, $t(455) = 2.61$, $p < .05$. We interpret this as being a by-product of the highly litigious nature of civil commitment and the general tendency toward social desirability response set in that population. The FCCC residents were also significantly higher in their scores on the Narcissistic and the Compulsive Moderate Personality Disorder Scales. These differences suggest a greater tendency on the part of civil committees to present characterological difficulties which may, in part, be a result of the institutionalization that comes with long periods of incarceration.

The distinct similarity between the two groups on most variables is important regarding community risk management in that it presents us with an opportunity to potentially use the postrelease experiences of one group to extrapolate what the postrelease outcome might be in the other. Specifically, the vast majority of offenders referred to the RTC's program are eventually released to the community. U.S.-style civil commitment of sexual offenders does not exist in Canada. Release to the community for residents in the FCCC is entirely at the discretion of the court. As such, few

residents have been released, presumably because the courts and the community fear what such offenders might do on release. There are few (perhaps, none) SOCC outcome studies because most programs of this sort do not release many participants.

The results of a variety of meta-analytic reviews of the treatment literature (e.g., Hanson et al., 2002; Lösel & Schmucker, 2005; Hanson, Bourgon, Helmus, & Hodgson, 2009) suggest that *treated* sexual offenders recidivate sexually at rates significantly lower that those who do not complete treatment, the results of California's Sex Offender Treatment and Evaluation Project (SOTEP) study (Marques, Wiederanders, Day, Nelson, & van Ommeren, 2005) notwithstanding.[1] Specifically regarding high-risk/need populations of sexual offenders, there are a number of outcome studies related to the RTC program that bear on whether such persons can be safely managed in the community following participation in treatment. An initial outcome study based on the RTC program, as it was delivered up to 1989, compared 89 offenders treated and released prior to 1992 with an untreated group of offenders who were matched for pretreatment risk and release date (Looman, Abracen, & Nicholaichuk, 2000). Results suggested a 45% reduction in recidivism with treatment (23.6% vs. 51.7%). A subsequent study in which a group of men who scored 5 or higher on the Static-99 (Abracen & Looman, 2006) were followed for approximately 5 years reported an overall sexual recidivism rate of 13.3%. It was also found that the presence of a paraphilia or personality disorder did not predict sexual recidivism in this already high-risk group. However, the subgroup of sexual offenders who were diagnosed with a paraphilia and personality disorder reoffended at the highest rate (20.6%). It should be noted that although the RTC group represents a high-risk/need population, no subgroup (including those scoring high on the PCL-R) reoffended at a rate equal to the "more likely than not" standard common in civil commitment. In a more recent investigation (Abracen et al., 2010), very low rates of sexual offense recidivism were observed (approximately 10% over follow-up of 9 years) among clients receiving treatment at the RTC.

It is important to remind readers that both samples are highly selected for risk and treatment need. As noted in the introduction of this article, only 2.8% of sexual offenders receiving a custodial sentence in Canada would be referred to programming at the RTC, based on 1997-1998 convictions. This observation is relevant given that many supporters of SOCC note that the SVP population is also "highly selected" with only a small percentage of offenders being referred in most jurisdictions (Stern, 2010; see also below).

In many U.S. SOCC jurisdictions, preventive detention is imposed or maintained when there is a belief that the offender in question poses a risk to the community that meets a "more likely than not (to reoffend)" standard. Predicting reoffense has become a quite contentious topic of research and discourse with each side making strong arguments as to best practices. Most jurisdictions in Canada and the United States suggest that risk assessments must include some mix of actuarial prediction tools and clinically relevant factors. Perhaps, the most commonly used actuarial scale is the Static-99 (Hanson & Thornton, 1999) or its variants (Static-2002 and revised versions

of each; see Helmus, 2009). For all but a very small group of sexual offenders, the base rates for reoffending appear to be well below 50%, which complicates the more-likely-than-not standard. For many risk assessors and triers of fact, the important issue has become how best to characterize offenders, so as to compare them against an appropriate normative sample.

In various conference presentations, Static-99 coauthor Karl Hanson has regularly stated that it is preferable to use "local norms" when assessing risk to reoffend in a particular jurisdiction. However, for some populations of offenders, this is a particularly challenging endeavor. Using Florida as an example, more than 40,000 sexual offenders have been screened for possible referral to the courts for SOCC proceedings since the law came into effect in early 1999. However, approximately 9% of those screened offenders were referred for psychological/psychiatric evaluation. Of those referred for evaluation, only about 3.5% were passed on to the Court for civil trial. Even fewer of those referred for civil commitment were actually found to be SVPs—in fact, less than half (1.7%). This makes those sexual offenders declared to be SVPs an "elite" group, at least as far as Florida is concerned, although other SOCC programs report similar numbers (i.e., less than 2%). The point of this example is that, because most SOCC jurisdictions do not regularly release offenders back to the community, constructing local norms is difficult at best or virtually impossible. This will continue to be the case until such time as the courts begin to routinely release SOCC participants. This is something they currently appear reluctant to do without some instruction as to how these men might perform on community release. This is a veritable Catch-22.

A small number of FCCC residents ($n = 31$) have been released after having reached the maintenance phase of treatment (i.e., Phase 4 as described earlier), although the mean length of community follow-up is admittedly quite short (approximately 2.54 years). Interestingly, in comparing the rate of sexual recidivism (3.2%) in the FCCC group to facilitate comparison with the known sexual recidivism rates (5.5% in 2.54 years of fixed follow-up) of the larger RTC sample, the two groups of offenders are also similar. Both samples are certainly reoffending sexually at rates considerably below rates projected by the Static-99 (26.2%) or Static-99R (20.1%) experience tables using the 5-year logistic regression results. This suggests that, even though these two programs may provide treatment to offenders substantively meeting the "high-risk/needs" standard (see Helmus, 2009), the attendant actuarial normative data may not apply. It is also possible that the offenders included in the Static-99R normative data set for "high risk/needs" includes a higher percentage of persons who either did not attend or did not complete a CTP for persons who sexually offend.

In this study, we reported that the two programs sampled employed a largely similar treatment methodology based in the same general theoretical models; specifically, the Risk-Needs-Responsivity Model and the Good Lives Model. Each of these overlapping and ultimately complementary models (see Wilson & Yates, 2009) enjoys considerable popularity in contemporary treatment for sexual offenders. However, it is important to note that the time frame in which treatment objectives are achieved is quite different between the two programs presented here. Time to

completion for members of the RTC program is well less than half that of the FCCC participants. This is a commonly found difference between programming in Canada and the United States (see McGrath, Cumming, Burchard, Zeoli, & Ellerby, 2010), and we contend that this difference is more cultural than practical. It is well known that criminal justice practices in the United States are more conservative than those in Canada, as evidenced by the often much longer sentences assessed to offenders in U.S. jurisdictions. Indeed, this is reflected in the fact that Canada does not presently possess postsentence, SVP-type measures. As noted above, we believe that a greater degree of institutionalization may result from such practices and that this provides an explanation for some of the differences noted in personality on the MCMI-III (e.g., narcissism, compulsiveness). Notwithstanding these difficulties and issues, it is our overall belief that these two programs are analogous in their intents and objectives and that persons graduating from each have achieved similar treatment outcomes. However, this remains a question for future, more direct investigation.

We initially considered that there may also be factors related to differential levels of community aftercare treatment and supervision post release; however, it would appear that the "stipulated agreement" practice in Florida is actually quite similar to the sort of community follow-up enjoyed by those released from RTC. Regarding postrelease aftercare and supervision, there are some differences between the two samples reported here. Clients treated at the RTC are typically released to close monitoring of their behavior and a requirement that they attend maintenance sexual offender treatment programming in the community. Although some residents released from the FCCC may have postrelease probation supervision to complete, there is no *formal* mechanism for providing community supervision in Florida post civil commitment as an SVP. This is likely also true in other jurisdictions where high-risk/need offenders might be released. As such, if clients are *unconditionally* released from a civil commitment center, such community-based structure may well be absent thus increasing the potential risk of the client.

In Florida, lawyers with the State Attorney's office have attempted to accommodate this lack of formal aftercare by entering into "stipulated agreements" with SVPs released to the community. Although the legal foundation underscoring these agreements is tenuous, they appear to provide a basic framework for postrelease offender accountability not unlike probation supervision or the sort of structured aftercare enjoyed by those released from RTC. Offenders released under such agreements pledge to check in with local authorities and to attend community-based treatment, or face possible return to the civil commitment center.

Notwithstanding these ad hoc attempts to increase public safety, risk management professionals and government officials in Florida continue to advocate for the development of a formal model for the community management of high-risk/need sexual offenders. We strongly believe that this would be of value in reducing the risk for such groups when/if they are released.

Given the currently available normative rates of sexual recidivism observed when treated-high-risk/need groups of sexual offenders are released to the community with aftercare and supervision requirements (e.g., in the case of many RTC clients; see also

Wilson, Cortoni, Picheca, Stirpe, & Nunes, 2009; Wilson, McWhinnie, & Wilson, 2008), we believe that this approach may assist SVP jurisdictions in balancing the need for protection of community safety while maintaining offenders in less restrictive environments where appropriate. Furthermore, given that maintaining offenders in the community represents a fraction of the cost of maintaining them in institutional settings, this approach offers the possibility for significant savings in those jurisdictions, while offering a comprehensive system of treatment and supervision that includes systematic plans for community risk management.

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Note

1. The Sex Offender Treatment and Evaluation Project (SOTEP) study is unique in that it employed random assignment of participants to the treatment and no-treatment groups. The findings were that no differences in reoffense rates could be demonstrated between these two conditions. However, a closer examination of the data suggests that treatment completers who "got" the material did actually reoffend at lower rates than those who did not complete treatment.

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