Greenberg Traurig

Privileged/Confidential
Attorney/Client Communication

Ian S. Marx
Direct Dial: (973) 360-7951
Direct Fax: (973) 295-1307
Email: marxi@gtlaw.com

CONFIDENTIAL-LEGAL MAIL

January 6, 2009

Mr. Rodney Roberts
Mr. Joseph Arruano
STU-Kearny
P.O. Box 699
Kearny, NJ 07032

Mr. Jeremiah Simons
Mr. Richard Bagarozy
Mr. Walter Harrell
Mr. Gilbert Davis
STU-Annex
P.O. Box 905
Avenel, NJ 07001

Re: Bagarozy v. Harris
Civil Action No. 04-CV-3066 (JAP)

Gentlemen:

Enclosed is a copy of the final report that we have received from Dr. Becker, a copy of which has also been provided to Judge Falk. You will see that with respect to each of the 12 numbered issues as to which she reached a conclusion (there is no number 8), she has found that the program is not minimally adequate/or satisfactory (and thus non-compliant with clinical standards). Dr. Becker also identifies 24 overall recommendations for the program. Under the protocol, the Court will now supervise settlement discussions based upon the report, in which we must participate. We should set up time to speak after you review the report to discuss your thoughts. Once again, please do not distribute this outside of the facility.

Very truly yours,

IAN S. MARX

ISM/bap
Enclosures

Judith V. Becker, PhD
Psychologist
430 N. Tucson Blvd
Tucson, AZ 85716
(520) 240-3875

FINAL REPORT

December 29, 2008

Dear Mr. DaCosta, Mr. Ahzmey, Mr. Furlong, Mr. Marx[1]:

Re: Alves/McGarrry/Bagarozy, et al. v. Ferguson, et al. (consolidated)
U.S. District Court, District of New Jersey, Docket No. 01-0789

The following report is based on information I gleaned from the following activities: tours of the Kearny and Annex facilities; review of the treatment program and related documentation, including 23 resident charts, prior consultation reports, other documents that I had requested and were provided, and interviews and/or communication with the following: clinical staff members, including the Clinical Director, the Director of Psychology, the Director of Psychiatry, the Director of Rehabilitation, the Director of Social Work, and relevant DOC administrators. I also interviewed a representative sample of 40 residents including those nominated by the Plaintiffs' attorney, as well as telephonic interviews with 10 residents on conditional release, one of whom did not want any of the information he provided to be summarized for the report. It should be noted that I was allowed access to everything I had requested and all mental health and correctional staff were extremely cooperative and welcoming. I also received and continued to receive numerous materials sent by mail or handed to me by residents. As per an agreement between counsel and the State, I have not read any of those materials and will not until the Court rules as to whether I should include that information in my report.

It should also be noted that because there does not currently exist a universal set of professional standards for institutions that provide for the care and treatment of civilly committed sexual offenders, this evaluator was unable to rely on such during the evaluation. There are, however, universal standards for the care of criminal offenders, such as the American Correctional Association's Standards for Adult Detention Facilities, though this evaluator found that such standards were not applicable to many of the questions asked. In addition, this evaluator inquired as to what the licensing standards were for this facility, since different states have different licensing procedures, and was informed by Mr. DaCosta of the following: "While there is no 'licensing' of the facility or program per se, the DOC does check to see that medical and MH professionals have their professional licenses before they are approved to be in the facility. Moreover, there are general codes for fire, basic construction, etc., which would be found in New Jersey Administrative Code section 10A, but different parts fall under different departments.

[1] I hope I have not omitted anyone else who should have received this.

Finally, with respect to the policies and procedures under which the STU is operated, the DOC and DHS jointly adopted regulations on October 20, 2008 that may be found at NJAC 10:36A-1.1, et seq, which I have attached for your review." In preparing this final report, this evaluator relied in part upon standards established in the following resources: *Civil Commitment of Sexually Violent Offenders*, Association for the Treatment of Sexual Abusers, http://www.atsa.com/ppcivilcimmit.html; Dr. Anita Schlank, *Guidelines for the Development of New Programs*, The Sexual Predator: Law, Policy, Evaluation, and Treatment (Kingston, NJ: Civil Research Institute), 1999; Dr. Janice K. Marques, *Professional Standards for Civil Commitment Programs*, The Sexual Predator: Law, Policy, Evaluation and Treatment (Kingston, NJ: Civil Research Institute), 1999; Dr. Rebecca Jackson, et al.'s *Annual Survey of Sex Offender Civil Commitment Programs* (SOCCPN; http://www.soccpn.org/research.html), 2008, in which the State of New Jersey was included; Practice Standards and Guidelines for Members of the Association for the Treatment of Sexual Abusers (ATSA), 2001; as well as numerous books and professional articles pertaining to the assessment and treatment of sexual offenders, including Roxanne Lieb's *After Hendricks: Defining Constitutional Treatment for Washington State's Civil Commitment Program*, Annals of the New York State Academy of Science (pp. 474-488), 2003, which this evaluator believes to be particularly relevant to the present litigation. In addition, I have relied on more than 30 years of professional experience as a clinician and clinical researcher, evaluating and treating sexual offenders, as well as having served as the clinical consultant to a civil commitment center for sexual offenders, and having been involved in the evaluation of two other SVP programs.

I had initially submitted a draft report, dated September 8, 2008, to which both the State and Plaintiff's attorneys had the opportunity to respond. I have taken those responses into consideration in authoring the final report and I have opted to address issues raised by the State and the Plaintiffs as follows and made alterations to what was the draft report when such suggestions were in line with my clinical opinion.

Response to the State's Comments

Regarding queries as to the professional standards I relied upon in determining the State's compliance in each of the areas of evaluation, please see the above list of resources. Regarding my suggestion in terms of using dynamic risk assessment instruments, while not all of the information can be obtained in a secure environment, clearly some of the information can be, such as general self-regulation, sexual regulation, substance abuse and negative mood state. Therefore, it is appropriate to use applicable parts of dynamic risk assessment instruments. Moreover, it should be noted that 54.6% of civil commitment programs which responded to the SOCCPN annual survey used a dynamic risk assessment instrument, specifically the STABLE 2007.

Also, I do want to acknowledge that PCL-R documentation was provided in the more recent material I received in November. Regarding assessment, the Division might also find useful an article that my colleague and I recently published in *The Journal of Psychiatric Practice* entitled, "Assessing Sexual Deviance: A Comparison of Physiological, Historical, and Self-Report Measures" (Stinson & Becker, 2008). The sample that was used in that study consisted of civilly committed sexually violent persons.

You inquired as to whether or not this evaluator would agree that if the Division were to implement all of the recommendations set forth in the "Clinical Assessments, Evaluations, and Treatment Team Reports" section, then it would be minimally adequate/satisfactory in this respect. The answer is yes.

In response to your inquiry, this evaluator does believe that the rate at which a resident progresses through the program phases is idiosyncratic, and it is in fact, an interaction between amenability to treatment and a resident's risk level, needs, and responsivity. In regard to your question as to how long it takes for a person to move through the phases of treatment, in reviewing the Annual Survey of Sex Offender Civil Commitment Programs, data regarding that information was absent. However, I have contacted several SVP programs and have made that inquiry. To date, one program has responded. That particular program uses seven phases, and indicated that people take from three to seven years to complete the program. I am awaiting responses from other programs and will forward that information as part of an addendum.

In regard to orientation and rapport-building, I agree that it is important that when residents are entering a new institution or beginning a new program, they need to be oriented to the policies and procedures of the new facility. I also agree that it is necessary to build rapport as part of the therapeutic alliance. I am unaware of any literature that would indicate that it takes a year to orient people to an institutional setting. I acknowledge that counsel may advise residents not to discuss their criminal history prior to having their commitment hearing. Rapport, however, can be established during that waiting period. For example, if vocational skills and substance abuse issues are assessed, staff can begin to establish a relationship around those issues. As Dr. Marques notes in her article, "goals should address not just sexual deviance, but the resident's functioning in other life domains as well. These include health issues, substance abuse, family relationships, educational, vocational and recreational needs, and resident strengths. Although such areas may be considered ancillary to the treatment of sexual deviance, you must consider factors that are predictive of the individual's success on release" (p. 2-9 – 2-10). It is possible to focus treatment on these areas without requiring criminal history information.

Regarding individual therapy, I would like to note that every resident is unique and his treatment needs are unique. Some residents function well in group, others, because of anxiety or other issues, find this more difficult. Consequently, I believe that a decision about whether or not an individual is in need of individual therapy should be based on his unique combination of personal characteristics and mental health needs. With respect to special programming for residents with special needs, this evaluator would like to note that of those programs that responded to the SOCCPN 2008 survey, 80% had a Special Needs treatment track and 60% had a Psychopathy treatment track. My professional opinion is that residents who have learning disabilities, cognitive impairments, English-language deficiencies or serious mental health issues should be provided with equivalent services and mainstreamed whenever possible.

With respect to process groups and modules, in reviewing the SOCCPN survey, the report indicates that in the 14 SVP centers which responded, hours in sex offender specific treatment ranged from 3 to 20 hours per week. It is clear from the data that this evaluator collected that the Division's current program is at the low end of that range. With respect to how clinical services should be broken down, I recommend the following: a daily one hour process group; one and a half hour long therapeutic modules every other day; one hour daily groups for such things as life skills and therapeutic recreational activities; and individual therapy, as needed. At the current time, how clinical services are broken down at other sex offender civil commitment facilities are not known to me. If this information becomes available, I will revise my recommendations accordingly.

While I understand and am sensitive to the severe budget constraints under which the State is currently operating, and the fact that the provision of the level of services I am recommending would require the hiring of additional staff, I would like to quote what Judge William L. Dwyer said in *Turay v. Weston, 1999*: "Nothing compels a state to adopt a statute of this nature in the first place, and many states have not done so, but a state that chooses to have such a program must make adequate mental health treatment available to those committed." I am of the opinion that the New Jersey legislature needs to appropriate adequate funding to the Division for this purpose.

With respect to employment for residents, the SOCCPN survey did not report on number of hours that residents in other civil commitment centers are employed. One program that responded to my inquiry noted that residents in this state's facility work on average, three to five hours per week, which is commensurate with the Division's current practice.

The Division respectfully submitted that the overall recommendations I made in the draft report exceeded the scope of my retention. I agree that some of the recommendations I made, particularly those to the New Jersey legislature, exceeded the scope. I have deleted those recommendations.

Responses to other suggestions regarding the draft report have been incorporated into the appropriate sections.

Response to the Plaintiffs' Comments

Although I am sympathetic to concerns raised in the Plaintiffs' comments and appreciate the need for specific recommendations as outlined in the Plaintiffs' comments, doing such would be beyond the scope of the Contract that this evaluator agreed to. I have responded to some of the comments and perhaps have overstepped my bounds in terms of what the Contract dictated.

1. Overall Therapeutic and Rehabilitative Milieu

As the Department of Human Services, Division of Mental Health Services (the Division) notes, the contract states "...a Joint Expert to conduct an evaluation of the sex offender treatment program at the Special Treatment Unit in Kearny, New Jersey and the Annex in

Avenel, New Jersey." The Division notes that they have no control over the facility issues that I had addressed in the draft report. Consequently, it would appear that it is beyond the scope of the contract and inappropriate for me to provide information or recommendations regarding room size, food quality, number of showers and urinals, etc. I do, however, strongly suggest that environment and conditions of confinement matter, both for residents and for staff who work in facilities that appear to be less than therapeutically adequate. Also, as the State notes in the 10/20/08 letter, the Contract indicated I am to opine as to whether the present program is minimally adequate or not, and not to reconstruct the State's treatment program from the ground up or make findings that must be implemented. Consequently, I must confine myself to the scope of the issues to be addressed in the Contract and I cannot provide the degree of specificity as to recommendations the Plaintiffs want me to make although I acknowledge the importance of them. Below are some specific responses, and the remainder comments are addressed in the body of the report and in the Overall Conclusions section, when this evaluator felt they were applicable.

a. Treatment Space and Confidentiality

I have added a recommendation to the overall opinion and recommendation section of the final report that follows.

b. Living Conditions and Resident Health and Safety

As noted above, issues related specifically to the facilities, which are run by the Department of Corrections, were not to be included in my evaluation, as noted by the State. Consequently, although I feel such factors as room size, resident safety, and resident hygiene, can all contribute to a therapeutic environment, my contract with the State does not provide for me to comment specifically on these factors.

c. Resident-Staff Interactions

i. Strip Searches: While some residents may pose a risk to other residents and to staff, I am of the opinion that a screening procedure other than strip searches be employed. I am aware that at many United States airports devices are being used, such as body scans, to ensure that passengers are not carrying any illegal weapons or drugs that would place other people at risk. I would recommend that such procedures be utilized, but not a "one-size-fits-all" approach, specifically, only those residents who have a history of having difficulty within institutional settings, of following the policies or procedures of the institution should be subjected to such screening. While I do not have data available on the use of strip searches, I am aware of at least one civil commitment program where strip searches are not conducted on residents on a routine basis.

ii. The grievance process was mentioned as an issue by some residents I interviewed. Those few residents who brought it up complained about the length of time the process took. Moreover, the grievance process appears to be less than adequate, in that residents reported that over 90% of their grievances are not addressed.

2. Clinical Assessments, Evaluations, and Treatment Team Reports

a. I would like to note that the ATSA Practice Standards and Guidelines for Members of the Association provided a list of assessment instruments which have been used in assessing sexual offenders. Also, a 2006 article entitled *Assessing Treatment Progress in Civilly Committed Sex Offenders*, coauthored by Drs. Ferguson, Main, and Schneider, outlined measures of treatment progress and linking treatment progress to treatment completion. The authors also identified a number of assessments and measures of treatment progress. Some of those measures could be used in the program.

Assessments should be conducted by licensed staff members who have had supervised training in utilizing such instruments. It is recommended that once residents have been oriented and consented to the treatment program, assessment should begin. The sooner a comprehensive assessment is completed, the sooner therapy can begin. As noted in my report, there should be pre and post testing for each module so that one can attempt to assess a resident's progress over the course of his treatment. Evaluation of progress should be based not only on a resident's self-report, but also on psychometric evaluations and observations made by staff and therapists. The final report as well as the draft report outlined the type of comprehensive assessment that should be conducted.

I wholeheartedly agree with your concern about the need for detailed recommendations to residents about the content of their assessments, phase placements, and the requirements to move to the next phase of treatment. It was not my charge to design or redesign the treatment program, however, each resident should have a clear understanding of the reasons for his phase placement and specifically what goals he must attain to move to the next phase. It is recommended that residents be updated regularly (i.e., monthly) on their current phase status and goals for promotion to the next phase. It should be the responsibility of the resident's primary therapist to provide an update in writing to the resident each month.

b. There are methods by which to assess if progress is being made within a specific phase of treatment. One could utilize a Treatment Progress Scale, the Goal Attainment Scale, unit staff and therapist observations, and paper and pencil testing. What was striking in my interviews with residents was that they were at a loss to describe what actions they needed to take to advance in phase and ultimately be conditionally released. In my interviews with residents on conditional release, they were also at a loss to describe what needed to occur in order for the conditions of release to be decreased or for them ultimately to be unconditionally discharged from the program.

Regarding the suggestion that more detailed recommendations be made regarding the appropriate content of treatment plans and content requirements being reflected in relevant treatment protocols, I must observe that I agree completely. I have added the recommended list of issues to my final report.

Below is my final assessment of each of the areas of evaluation indicated in the Contract.

FINAL REPORT: Areas of Evaluation

1. Overall Therapeutic and Rehabilitative Milieu

In terms of evaluating a therapeutic and rehabilitative milieu it is important to look at the environment and conditions that the residents inhabit, in addition to the treatment and clinical office spaces.

Living Conditions

Annex Facility. The living areas at the Annex facility consisted of dorms, which appeared extremely overcrowded. The men had a lot of personal property in the incredibly small space in which each resident was housed. Many of the men also had coolers in which they stored food brought to them by their visitors because they reported that the food served at the facility wasn't very good. In one dorm housing 68 men, there were only 6 shower stalls, 2 urinals, and 4 toilets. Residents reported that they frequently had to wait in line to use a toilet or to shower. This waiting put men at risk of being late to either their work assignments or therapy groups. Moreover, this is particularly problematic for individuals whose work assignments are in the kitchen because they must observe hygienic regulations prior to reporting to their food service work. Although there is a regulation against smoking within the facility, it was reported by residents that some individuals do smoke in the bathroom; as such, secondhand smoke then reaches the men in the dorms. This is problematic for those men who have respiratory problems. As I was walking through one of the dorms, a resident pointed out that the conditions under which they were living could represent a fire hazard given the large number of people in the small space and the amount of property that the residents had.

A further concern involves physical safety of the men. A correctional officer is stationed in each dorm 24 hours per day; however, given the crowding and the physical layout of the dorm, I question an officer's ability to have full visual access to all residents, particularly those men who occupy the lower bunks.

Kearny Facility. This facility had previously operated as the Hudson County Jail; it is a very old facility. Men are in single cells/rooms, within which there is a bed, a toilet and a sink. As in the Annex, the men appeared to have significant amounts of personal property in their cells. The facility did not appear clean, and there were no pictures on the walls or other decorations that would bespeak the rehabilitative nature of the facility, unlike what I saw in the Annex. During my tour of the facility, a resident expressed concern about resident safety in the event of an emergency or fire. His concern was that the cell locking system has reportedly malfunctioned, and consequently each cell has had to be manually unlocked.

Overall Assessment. In my professional career, I have had the opportunity to visit a number of secure mental health and correctional facilities around the United States. The

living conditions that I witnessed at both the Annex and Kearney facilities are among the worst that I have ever seen. Such conditions of confinement have served to lead many of the residents to believe that they are simply being warehoused and punished within deplorable conditions. This belief can lead to a sense of hopelessness and is ultimately counter-therapeutic. If ultimately a goal for the residents is to be discharged back to the community, then one would hope that the environment within an institutional setting would be such that they could acquire the living skills necessary to succeed in the community outside of the facility. Moreover, the design of living spaces at the Annex and the assignment of men to those spaces are not clinically driven. For example, developmentally disabled residents might be better served by having their own wing, so that they are not preyed upon by more sophisticated or psychopathic residents. Ideally individuals should be housed based on what phase of the program they are in. The currently overcrowded conditions put men at risk for infection, lead to safety issues, and are detrimental to mental-health well being. Moreover, the environment is experienced as punitive by the residents, which only serves to increase malaise and hopelessness, which are ultimately counter-therapeutic. As noted by Dr. Marques, in *Professional Standards for Civil Commitment Programs*, "the program [should be] housed in a treatment oriented (not punitive) environment, adequate space is provided for living, treatment, other activities, and for separation among resident groups" (p. 2-11 - 2-12). This is clearly not the case at the STU.

Treatment Environment

Annex. There appeared to be an adequate number of therapy rooms and within them were pictures and decorations which bespoke the therapeutic and rehabilitative atmosphere. Treatment rooms were large, adequately furnished, and generally appropriate for conducting group treatment.

Kearny. The majority of groups occur in a trailer, some in small rooms, and some in a large room separated by a divider. A correctional officer sits in a booth in the middle of the trailer where he/she can observe the groups. It was apparent that this booth is not soundproof; as during my visit an officer was able to interrupt an ongoing group by shouting from the booth to a resident that he had a visitor. The resident got up and left the group. In addition, it was also possible to hear what was going on in another group occurring at the same time in an adjacent room. This set-up is questionable with regard to maintaining confidentiality of treatment group proceedings.

Overall. The treatment space at Kearny did not appear to be adequate for conducting group therapy. Group therapy rooms should be designed so that there are no extraneous noises and so that residents feel that they can participate without fear of being overheard. Moreover, there are no rooms available for individual therapy.

Clinical Staff

It is my opinion that the office space and general work conditions for staff are wholly inadequate. Clinical staff share offices, and these spaces are crowded, poorly lit, and not well furnished. Clinical records are not available online and computer equipment is dated, making it more difficult for staff to do their jobs. These inadequate work conditions may also affect staff morale.

At the Annex facility, staff are officed in trailers with no restroom. In order to use the restroom, staff must exit the trailer and walk to the main building to use restroom facilities that were inadequate with respect to general cleanliness and upkeep.

Overall Opinion and Recommendations

Based on my tour of the facilities, interviews with residents and communications from staff, my opinion is that **the overall therapeutic and rehabilitative milieu is *not minimally adequate/unsatisfactory***. Overall, the conditions are in no way facilitative of positive resident or staff morale. Due to this environment, staff and residents are demoralized, and residents have a sense of utter hopelessness.

Residents and staff should be inhabiting a facility that is truly therapeutic and safe. Such a facility needs to provide adequate space for residents. Each resident should have his own room and adequate personal hygiene amenities. Such a facility should look like a therapeutic environment. Wall surfaces should include artwork and preferably art produced by residents. Such a facility should have adequately sized and comfortably furnished dayrooms. There should be sources of recreational materials for the men, and both indoor and outdoor recreation spaces. Such a facility should have different wings or tiers, and the placement of residents should be clinically driven based on treatment needs, cognitive abilities, and phase in the program. Such a facility should have adequate programming spaces for individual treatment sessions, group treatment sessions, educational classrooms, staff training, and therapeutic community meetings. Such a facility should also provide adequate office space for staff including rooms for training and staff meetings, with clean restrooms located nearby. Also, staff should have access to state-of-the-art computer technology so that residents' charts can be easily accessed and updated for best therapeutic benefit.

2. Clinical Assessments, Evaluations, and Treatment Team Reports

In reviewing residents' charts, I found the following: charts for the most part contain confidential forensic psychiatric and psychological evaluations, informed consent, a checklist for orientation of new residents, an admission note, next of kin emergency contacts, an individualized treatment plan, annual review checklists, psychosocial assessments, treatment plan status reviews, a resident input form, multidisciplinary reports for the TPRC, TPRC reports, process group notes, rehabilitation notes, educational assessments, vocational and recreational notes, and substance abuse assessments. Documents in the charts also contained MAP notes, if a resident was on MAP status, notes if a resident was a treatment refuser, and educational module or process notes.

For the most part, the confidential forensic evaluations were detailed. Two actuarial risk assessment instruments were being utilized to assess risk. Psychopathy Checklist Revised (PCL-R) scores were included when residents entered Phase 3 of treatment. There was, however, no specific dynamic risk assessment instrument being utilized. Both the psychosocial assessment and the substance abuse assessment appeared to be comprehensive. There were also forms when an educational assessment had been completed, and there were also rehabilitation and vocational notes. On rare occasion, charts were incomplete and had items missing. One item that was frequently missing from the charts was the resident's autobiography. This evaluator asked a clinical staff member about this omission, and was informed that staff are sometimes told to keep these items in charts and at other times are told to keep them in a separate file. This contradictory instruction appears to result from disparity among supervisors.

The pre-treatment assessment is, in this evaluator's opinion, not very comprehensive. Other than the assessments mentioned above, residents are assessed with a personality inventory (MMPI-2) and the Bumby Cognition Scale, the Wide Range Achievement Test and an intelligence test. None of the test protocols were in the charts reviewed. After the submission of the draft report, I did receive two boxes of resident clinical files. Apparently, a third box was sent but not received by this evaluator. While there were some additional assessment materials included, the assessment still did not appear to be comprehensive.

Also at some point in treatment, individuals are assessed with polygraphy. Plethysmography, however, is not being used. I was informed, however, that after repeated requests the STU has just been given permission and funding to obtain a plethysmograph. A concern is the lack of pre-and post-module testing. Pre-post testing is imperative in order to assess each resident's strengths and weaknesses prior to beginning treatment so as to best develop an individualized treatment plan tailored to each resident's needs, as well as to provide an objective measure of changes that occurred as a result of treatment. There is a post-test for arousal reconditioning, but this is a paper and pencil test. While such tests and the current practices of assessing the resident's sexual acting out, possession of pornography, and polygraph testing of current arousal patterns are informative, none are direct and objective measures of sexual arousal, such as the penile plethysmograph. Without pre-and post-testing and without an objective assessment of sexual arousal, decisions about progress apparently then are made on a subjective basis. It is critical that other than subjective means be used to evaluate residents' treatment progress or lack thereof. It is critically important that dynamic risk factors be the targets of any intervention. The static risk factors are risk factors that are not changeable. Intervention needs to focus on assessed, stable, and acute risk factors. Dr. Schneider, a staff member at the STU, has written a chapter for a book in which she reviews the literature to date on dynamic risk assessment instruments and describes the development of a dynamic treatment monitoring scale. There are, as she notes in her chapter, a number of scales that are currently in use nationally, and which this evaluator believes potentially could be used at the STU. These include: the standardized goal attainment scale, the sex offender treatment rating scale, and the stable and acute 2007. The scale which she and her colleague have developed looks very promising. It consists of 17 variables which each

resident should be rated on. Dr. Schneider reports that she plans to have staff utilize this scale in assessing treatment progress among the population of civilly committed sex offenders. This evaluator looks forward to the development of psychometric properties on this scale.

The yearly TPRC evaluations are based on reviews of collateral material, input from the multidisciplinary team, and a brief interview with the resident. The multidisciplinary team subjectively evaluates the resident on performance in eleven areas. It is on the basis of these evaluations and interviews with the resident that the TPRC makes their determination of a resident's phase level.

The group process notes and educational module notes are minimally documented on checklists. These notes are relied upon by the multidisciplinary team to make assessments about a resident's progress or lack thereof. However, the form of the checklist is too generalized to allow for an evaluation of a resident's progress. The checklists are not sensitive enough to capture and report the small changes in a resident's attitude or self-comprehension. It would be more useful to both residents and clinical staff if progress notes and observations were written in a narrative form.

Overall Opinion and Recommendations

This evaluator finds it difficult to give an overall rating on clinical assessment, evaluation, and treatment team plans. The reason for this difficulty is that some of the forms of assessment appear adequate while other methods of evaluation are not minimally adequate. As mentioned, there has been no objective measure of sexual arousal patterns. Yet, the recidivism literature informs us that deviant sexual arousal is highly predictive of recidivism. Furthermore, as noted above, there are not pre and post test measures for the modules to date, and there are no dynamic risk assessment instruments utilized, although such an instrument has been developed by a staff member, and there are plans to utilize it in the future. Residents, following their orientation and signing a consent to be assessed, should receive a comprehensive assessment. Since many residents had previously received treatment, they should be evaluated on what they gleaned from that treatment, and assigned to modules or treatment phase based on the results of that assessment. Residents should be informed as to why they are being placed in a specific phase and what specifically needs to be done to complete to a phase and advance to the next one. Both residents within the facility and those on conditional release informed this evaluator that they were unaware as to what specifically was required to advance in phases, to advance to conditional release, and to be unconditionally released. Residents also commented on how repetitive the treatment was, some being assigned to the same module three times, and having to take many modules over and over again. Each resident's primary therapist should meet with a resident at least monthly to provide feedback on their progress.

Based on my review of records, my finding is that some parts of the **clinical assessment, evaluation, and treatment team plans are *not minimally adequate/unsatisfactory*** while other parts are ***minimally adequate/satisfactory.*** Each resident upon entering the facility should receive a comprehensive psychological

evaluation including the following elements: intellectual, psychological, neurological (when indicated), psychiatric, psychosocial, vocational, education level, as well as medical. An experienced clinical staff member should take a thorough sexual history that covers all of the paraphilias as well as the sexual dysfunctions. Given that many of the residents are diagnosed with antisocial personality disorders, there is much that can be gleaned from the core principles that have been helpful in intervention with antisocial populations (Andrews & Bonta, 2003; Cullen and Gendreau, 2000). Specifically, the principles of risk, need, and responsivity would apply to the residents. As mentioned above, it is critical that pre and post module testing be done. Instruments such as the Multi-Phasic Sex Inventory (MSI-II) and the Psychopathy Checklist Revised (PCL-R) should be utilized for each and every resident. Plethysmography should be utilized with every resident who is willing to undergo such assessment. There are instruments available to assess sex education, empathy, cognitive distortions, dynamic risk factors, vocational skills, educational ability, and readiness to enact change. It would appear, based on all material and information reviewed, that frequently, decisions about advancement to a phase are based on subjective assessment as opposed to having established clear goals for an individual and assessing other than subjectively their progress in having obtained those goals. In making these recommendations, I referred to ATSA's *Practice Standards and Guidelines for Members of ATSA*, which outlines requirements for sex offender evaluation, including types and sources of information, psychophysiologic testing, and an extensive list of psychological instruments commonly used in the evaluation of sexual abusers. While the ATSA standards do not specifically require assessment prior to treatment, good clinical practice dictates that baseline measures be obtained prior to beginning treatment. This appears to be particularly relevant for individuals have been in treatment elsewhere for a period of time, to assess what they have learned and what has yet to be learned. Furthermore, as noted by Dr. Janice Marques in her chapter, *Professional Standards for Civil Commitment Programs*,

> "...adequate treatment begins with an evaluation of the client and the development of a comprehensive treatment plan. This is an industry-wide standard, of course, but individualized treatment planning is even more important in civil commitment programs than in some other treatment settings...to be individualized, treatment plans must assess the special needs of each resident... Psychiatric evaluation and psychological/neurological testing are often needed before the team can determine how a resident's treatment should proceed" (p. 2-9).

3. Program Phases

The written plan and resident handbook outline five phases of treatment. Phase 1: Entry; Phase 2: Rapport Building; Phase 3: Core/Intensive; Phase 4: Advanced/Honor; and Phase 5: Transition. The phases seem appropriate based on their descriptions in these documents with respect to goals for each phase. Upon entry into the facilities, all residents are placed in Phase 1, where they are expected to orient to the STU and demonstrate a basic understanding of the commitment program, the treatment plan, and the journaling process. The written plan indicates that it is anticipated that residents move through Phase 1 in one year. In Phase 2, residents are expected to gain an understanding of core sex offender specific treatment concepts and to fully participate in treatment. Residents are anticipated to progress through Phase 2 in one year. For Phase 3, while criteria are stated, including

such things as: presenting a sex offense history, understanding motives underlying sexual assault, completing an autobiography, accepting responsibility for sex offenses, and completing a relapse prevention plan, residents must remain in this phase until their self-reports are consistent with polygraph testing. For Phase 4, the resident is expected to apply and "live" the principles learned in Phase 3, as well as sustain all significant treatment gains over a "significant period of time". It should be noted that "significant period of time" is not defined. Phase 5 is a transition phase, and residents must demonstrate consistency in meeting earlier goals and expectations. They will have been given increased privileges and responsibilities, both on and off the grounds of the facility. In order to progress out of Phase 5, residents must also pass a polygraph examination in addition to meeting all the other criteria for the phase. Successful completion of all phases suggests that the resident is a viable candidate for release to the community.

In my examination of the amount of time that all residents have been at the facilities and their current phase in the program, I found that residents do not appear to be progressing through the program along the timeline suggested in the written plan. On average, residents have been in the program for 69 months (5 years, 9 months), but the average phase in the program was 2.2 (the modal phase was 2). Of the residents I interviewed, their average length of stay at the facilities was 57 months (4 years, 9 months) and their average phase was 2.3 (the modal phase was 2). Given that the written plan indicates approximate completion times for Phases 1 and 2 of one year each, it is perplexing that many of the residents appear to be spending significantly more than 2 years in these phases. Moreover, it is questionable why it takes a year each for orienting and rapport building, especially since half of the men committed to STU came from the Adult Diagnostic and Treatment Center where they were receiving sex offender specific treatment.

I have several issues with respect to progress through the treatment phases. First, there appears to be no objective measure of treatment progress. Although each phase has specific criteria that must be met, there is no information as to how these criteria are assessed. It appears that there is no pre-post testing conducted to assess progress other than the polygraph, which can only provide information regarding physiological changes that occur as a resident answers specific questions. Second, when the residents were asked what they needed to do to move through the phases, many were stymied and unable to articulate the criteria, others said, "I don't know, things keep changing." Third, it is unclear why all residents are automatically placed into Phase 1 upon commitment, particularly if they have had extensive sex offender treatment in the past. Moreover, I am concerned with the length of time that is required to progress through the first two phases, given that the criteria listed seem to require significantly less time than one year per phase.

It is important for the residents and the treatment staff of a therapeutic treatment center to be able to assess, prior to any component of treatment, exactly what the resident's strengths or deficits are in any area, to have clear criteria as to how to make changes, then to be able to reassess any progress that has been made so that the resident is informed of what further is expected and so that changes can be made to an individualized treatment plan.

Overall Opinion and Recommendations

While it is clear that there are discrete phases of treatment, and the phases as written seem appropriate, it is of extreme concern that residents are not progressing through the phases. It is understandable why a sense of hopelessness exists among the residents. Without clear criteria and without residents seeing that people are being discharged from the program, a sense of hopelessness will persist. It is clear that the residents are not receiving sufficient therapeutic intervention based on a review of the number of therapeutic contacts they are having on a weekly basis. This evaluator questions how residents can be expected to progress through the phases of the program when they are not provided the amount of therapy necessary to gain the skills required for progress. Moreover, clear criteria need to be communicated to residents as to treatment objectives and goals.

It is also problematic that residents are not provided with individual therapy. It appears that a one-size-fits-all approach is being utilized in that all treatment occurs in a group setting. It may not be the case that all residents require individual treatment, however, it is likely that many would benefit from it. This of course, should be assessed when men first enter the program. There also needs to be specialized programming for the cognitively impaired and for those individuals for whom Spanish is their primary language.

It is recommended that at the Kearny facility, group and individual therapy rooms are needed. As noted above, the trailers did not appear soundproof, and this evaluator was able to overhear a therapy session in the next room. This obviously compromises a resident's right to confidentiality.

Overall, based on my tour of the facilities, interviews with residents and staff, and reviews of collateral materials, my finding is that **the phases of treatment as outlined in the written plan are *minimally adequate/satisfactory***. However, I have also determined that **resident progress through the phases and the means by which progress is evaluated are together *not minimally adequate/unsatisfactory***.

4. Process Groups and Modules

Of the 40 men interviewed, when asked what groups they were presently in, the majority reported being in a process group which meets two times per week for an hour and a half each time. Two men were in a MAP group which meets once a week. The total number of weekly therapeutic hours that these 40 men reported being involved in was on average 3 hours per resident per week. At the time of my visit, no core modules were being run at the Annex. They apparently had completed on June 23rd and reportedly were to be restarted in August. Of the men interviewed, 85% were currently engaging in treatment.

Apparently a number of self-help groups (run by residents) are in existence at the facility. These groups include Arousal Reconditioning, Relapse Prevention 1-3, Anger Management, Alcoholics Anonymous, Adult Children of Alcoholics, Sex and Love Addicts

Anonymous, Open Floor, Health, Music, Spiritual Development, and Meditation. I have been informed that staff are not present in these self-help groups, but the groups are audiotaped and listened to by staff and staff can provide guidance to the residents based on the tapes. Given the number of self-help groups it certainly appears that many of the residents are motivated to engage in therapy. This was corroborated by information obtained during resident interviews. While it is to the credit of the program that it offers both modules and process groups, unfortunately, there are not sufficient modules offered, and space in offered modules is limited. Consequently, a number of men are waiting to get into modules.

Based on my interviews with the residents, it appeared that they are receiving minimal clinical contact time. Since clinical staff schedules are not available, it is difficult to quantify exactly how much time clinical staff are actually spending with the residents, but based on resident report and records, it does not appear that they are receiving sufficient therapeutic contact hours. Moreover, it is worrisome that developmentally delayed residents and predominantly Spanish-speaking residents are placed in the same treatment groups, as there should be specific tracks for individuals with developmental disabilities, other forms of cognitive deficits, and the seriously mentally ill, and they should be mainstreamed when possible.

I had the opportunity to review the findings of a 2007 resident survey conducted by Jennifer Schneider, PhD, who is employed by the STU. Of the 360 residents available to survey, only 195 elected to participate in the survey; a 54% participation rate. Residents were surveyed as to numerous aspects of the treatment program. Twenty-three percent felt that the process groups should meet more frequently than twice per week. Thirty-nine percent felt that the module meetings should occur more frequently than once a week. When asked to rate their overall experience of the groups, 85% ranked their experience as positive in nature. When surveyed as to what issues they would have liked to spend more time on during treatment, 40% reported wanting to spend more time on victim empathy, 44.8% reported wanting to spend more time on relapse prevention, and 42.8% reported wanting to spend more time on distorted thinking. When asked about the least helpful components of treatment, 35% cited the size of treatment groups. When questioned as what should be improved, 44.6% reported that the content of group session and 40.5% reported increase in the amount of therapy offered.

Overall, the mission of the program, the use of psycho-educational and process groups, and the types of treatment modules denoted in the handbook are most appropriate. Unfortunately, what appears in the manual does not appear to be fully carried out in practice. This is a particularly critical point, given that the liberty of these men is at stake. It is impossible for residents to progress through the phases of treatment if core groups are not available to them, or do not meet with sufficient frequency to allow for therapeutic change.

<u>Overall Opinion and Recommendations</u>

This evaluator really struggled in terms of reaching an overall opinion in this area. While the use of psycho-educational groups and process groups is a good model for treatment, there are clearly not enough groups offered. Moreover, there are other types of groups that I would recommend including in the program including groups relevant to motivational interviewing, managing behavior and affect, and healthy relationships.

Based on the model described in the manual, my finding is that the **process groups and modules are *minimally adequate/satisfactory*.** However, based on resident interviews, and review of materials, my finding is that the availability and intensity of **the process groups and modules are *not minimally adequate/unsatisfactory*.** It is my recommendation that the clinical staff be required to provide a minimum of 15 to 20 hours in direct clinical service to each resident. This can be accomplished by providing individual therapy and by increasing the number of psycho-educational modules and having daily process groups.

Individual therapy can motivate residents working on their individualized treatment plans and assist them in working on trauma and other psychologically relevant issues.

5. Vocational, Recreational, and Educational Therapy

The vocational program aspires to deliver programming that will provide skills to prepare residents for life outside of the institution, which include writing resumes, filling out job applications, and preparing for job interviews. This is an important goal of overall programming and a critical life skill for survival in the community. Of those residents who were questioned about vocational training, none mentioned that they received training in these skills, (perhaps this is a result of the majority of residents still being in Phase 2). Residents did indicate that there is a culinary program, a computer class, a sewing class, and a past program on electronics, though some of the residents were unaware of the existence of these programs.

Residents are employed within the institutional setting at jobs such as cleaning, cooking, laundry, and general maintenance as long as they are not treatment refusers. The number of hours they work depends on the treatment phase they are in. For example, residents in Phase 1 work 5 hours per week, while residents in Phase 3 work 15 hours per week. During my tours of the facilities there appeared to be many residents in their rooms or living spaces during daytime hours, with little or nothing to do.

With respect to recreation activities, a schedule provided to me indicated that there are arts and crafts, music relaxation, games socialization, and bingo. Of the men who were asked about recreational activities, although games and bingo were mentioned, none mentioned arts and crafts or music, though I did see one man working on an art project at the Annex. It seems that limited recreational opportunities are available. The men at the Annex have a relatively large yard outside, but the outdoor space at Kearny was small. Moreover, there appeared to be minimal indoor recreational space. The amount of time that men can spend in recreation yards is limited, and there is limited recreational equipment.

With respect to exercise equipment, there were two elliptical machines, and I was told additional equipment was ordered, but is on hold. Overall, the amount of exercise equipment and recreational space and equipment is woefully inadequate for the number of men housed at these facilities. There appear to be occasional social gatherings planned for residents; a barbecue was being held during my visit, and I was informed that parties are held for Thanksgiving and Christmas.

With respect to education, opportunities are limited. However, basic educational skill training is available, and residents are able to receive help in working towards a GED. A staff member pointed out to me that while in the past, men might have been able to access correspondence courses, the majority of such courses have gone online and it is difficult for men to take them, given that they are not allowed access to the Internet and there are a limited number of computers.

There is a law library available at both sites. Residents have access to Lexis/Nexus, however one of the more knowledgeable residents informed this evaluator that there are certain law treatises that are required but were not available. (It should be noted that this evaluator does not claim expertise in evaluating what a state-of-the-art law library should contain). It should be noted that I was informed that less than 10% of residents participate in any type of educational program. It is unclear why this is the case, however, and may be due to lack of interest, lack of course variety or availability, or other factors.

Overall Opinion and Recommendations

Based on my tour of the facility, resident and staff interviews, and review of materials, my finding is that **the vocational, rehabilitative, and educational programming is *not minimally adequate/unsatisfactory*.** Overall, opportunities for residents are extremely limited in these areas.

First, there is limited staff in these areas, and efforts should be made to hire additional staff as soon as possible. The Director of Rehabilitation indicated that she is attempting to develop relationships with outside companies to allow for contract work in the facility. Second, comprehensive vocational evaluations should be conducted on every resident. Vocational modules should be based on the needs of the residents. For example, how many residents aspire to go into the culinary arts profession or to go into sewing? It would appear based on information from residents that courses in auto mechanics, electronics, or other skills that would lead to jobs on the outside should be offered. Third, residents need to learn the basic skills for employment. There is some discrepancy between what residents report as being available and what staff report, but regardless, greater effort should be made to incorporate basic job preparation skills and inform residents of their availability. Current job options are adequate and teach skills that are valuable for life in the community, however, it is my opinion that residents should be allowed to work a greater number of hours at their jobs.

With respect to recreation, it is clear that more opportunities for residents are needed. Perhaps residents could be surveyed to assess the types of activities most desirable,

and an effort made to include the most popular activities in the recreational programming. They also need a gym, with up-to-date fitness equipment in appropriate numbers for the resident population. In addition, regularly scheduled team sport activities such as basketball and volleyball games and exercise classes are recommended. Such activities would increase both physical and mental well-being among the residents, as well as provide them with skills for when they leave the facility, such as social skills, cooperation and team building, and help them learn to manage leisure time when outside of the institution. In addition, there needs to be an increase in time allowed for recreation and supervised recreational activities should be available seven days a week.

With respect to education, there needs to be more extensive educational programming, including preparation for GED, courses in health education including basic hygiene, smoking cessation, infectious disease prevention, diabetes and blood pressure management. It is recommended that outreach be made to local junior colleges and colleges to see if faculty might volunteer to come in and teach courses, or if graduate students could somehow get course credit for teaching courses at the facility. Outreach should also be made to retired persons organizations to see if retired teachers or individuals with specific skills might volunteer to teach at the facility. The state and the institution could then provide certificates of appreciation to honor such volunteerism. Overall, education needs to include a greater variety of courses, needs to be better tailored to the educational needs of residents, and needs to increase vastly in terms of frequency of course offerings. While this important for all residents, it is particularly important for those who are not participating in treatment. As Dr. Marques noted:

> "*There is general agreement that programs need to provide structure and activities for those [not in treatment] and must not ignore or warehouse them... It means that they should have treatment plans to address their individual needs, to describe possible therapeutic engagement strategies, and to identify goals such as those related to fitness, health, education, vocational skills, hobbies, or family and social relationships. This in turn requires the program to have sufficient staff and resources to provide educational, vocational, recreational, and family/social programs as well as resident job assignments.*" (p. 2-13)

6. Release Preparation and Programming

The following data were provided to me regarding how many individuals have been discharged from the program: 110 residents have been discharged since the inception of the program. Of those, 69 were discharged at the initial 20-day hearing, 23 via court order, 5 via treatment recommendation, and 13 died. A document provided to me after my visit to the STU, dated October 30, 2008, indicates that 16 men are on conditional release (one, however, was incarcerated at the Essex County Jail).

In interviewing ten of the residents who were on conditional release and gave permission to share their comments anonymously, the following is a summary of their comments: "treatment was good, but I had to do the same thing over and over again," "it's repetitious and gets hopeless," "I am not a group man," "everything was good, I have no recommendations," "some therapists are there just for a job, others are there to help you,"

"therapists are afraid of DOC," "I'd be lying if I didn't say I benefited," "treatment was very inadequate, staff are arbitrary," "it's run like a prison," "some staff/officers are emotionally abusive," "the crowding is a nightmare," "inadequate recreation and medical care," "transition inadequate," "we're not prepared for a return to the community," "a lot of staff are not qualified," "no one is given a plan to come off conditional release." While a several men felt that the treatment was helpful, the majority of comments related to the repetitiveness of the treatment and the lack of preparation for transitioning to the community, suggesting that overall, treatment and release planning are inadequate.

There is no independent living program for men getting ready for discharge. The institution however, does have a furlough program. Social work staff reported that efforts are made to assist those men who have been approved for conditional release in finding housing and obtaining needed support, though some of the residents who were interviewed and on conditional release reported otherwise.

I had the opportunity to review the findings of a 2007 resident survey conducted by Jennifer Schneider, PhD, who is employed by the STU. Of the 360 residents available to survey, only 195 elected to participate in the survey; a 54% participation rate. Residents were surveyed as to numerous aspects of the treatment program. When surveyed as to resources required for discharge planning during transition and upon release, roughly a third felt that they needed skills training in each of the following areas: money management, resume writing, interviewing skills, employment counseling, and relationship/social skills.

Overall Opinion and Recommendations

Overall, based on my interviews with staff, current residents, and residents on conditional release, it is my opinion that **release preparation and programming are *barely minimally adequate/satisfactory***. Although a number of men are on conditional release, a majority of them felt that they had to find housing and jobs on their own. Furthermore, several men were concerned about what would happen to them if they no longer had the finances to pay for their outpatient treatment, which is a condition of their release. Also at issue is the difficulty of having to register as a sexual offender and inform potential employers, landlords, and neighbors of their sex offender status.

7. Therapist Training and Supervision

I was informed that the STU provides one hour of group clinical supervision at each site per week and one to one and one-half hours of grand rounds per month for all staff. Regarding external training opportunities, few staff members attend external training on a regular basis due to the fact that paperwork required for the approval of external training is a cumbersome process that must be completed 40 days in advance and requests to attend external training are frequently denied for budgetary reasons. Attendance at out-of-state training, such as ATSA and MASA conferences has been denied for several years. Staff who attended such conferences must pay their own travel expenses and had in the past been required to utilize vacation time.

Some staff expressed concern about the quality of the clinical supervision received, which is critically important when working with such a diverse and at-risk population as those being served at the STU. It also appeared that some clinical staff were overseen by program coordinators with less education and experience than the people that they were supervising.

When staff schedules were requested, I was informed that therapists are not required to turn in weekly schedules of activities. This is of concern particularly given that I was also informed that some staff members reportedly spend time on other jobs, were not being truthful on their timesheets, and utilized work time for inappropriate personal activities on the Internet. It should be noted that more than one staff member made these allegations.

DOC Staff Training

I met with the Director of DOC and had requested to meet with a number of other DOC officers, but only one officer and a DOC supervisor agreed to meet with me. However, another correctional officer did contact me and provided information. This evaluator would like to note that all members of the DOC staff with whom she had contact were professional and courteous. It was clear that the correctional staff have not received what this evaluator would consider to be sufficient and on-going training in working with this specialized population. It was reported that more correctional staff are needed, and on one shift there are only 12 officers and 2 supervisors for 227 residents. Actually, it is quite amazing that there have not been more incidents given the low staff to resident ratio.

There is a daily meeting between correctional and mental health staff. In general, the officers interviewed felt that corrections and mental health staff worked well together and all officers were aware of the mission of the facility.

One of the DOC officers who contacted this evaluator raised questions as to why modules were not offered more frequently; why the program was not designed and implemented to allow residents to exit into the community; why the program was designed so that residents could not easily advance through phases of treatment; why residents appeared to be warehoused; and why there weren't more work furloughs, halfway houses or group homes within the facility.

It is recommended that DOC officers receive, at a minimum, yearly ongoing training by mental health staff as to issues in working with this specialized population. I would also recommend that more officers be hired given the current low staff to resident ratio. I offer the opinion that more officers are needed given that the special treatment program is jointly run by DOC and the Division. I would like to note, however, that there are other models for such programs. But given the existing program, it appears understaffed.

<u>Overall Opinion and Recommendations</u>

Based on my staff interviews and correspondence, and review of materials, my finding is that **the therapist training and supervision is *not minimally adequate/unsatisfactory.*** Clinical staff working with this population need to receive at least one-hour of individual supervision weekly as well as weekly or bi-weekly group supervision by an individual who has had prior experience in conducting both individual and group therapy with the population being served. Those providing supervision should be documenting what was discussed in the supervision meetings as well as ensuring that their supervisees are providing clinical services to the residents, preparing materials for clinical work, taking part in training, or updating clinical records during work hours. Furthermore, clinical staff needs to be afforded the opportunity to attend ongoing trainings at either ATSA or any other state or professional national organization where the most up-to-date clinical and research findings are provided.

Note: no number 8 was listed in the contract

9. Therapeutic Community

The written plan for the provision of resident care indicates that the STU strives to maintain an environment where residents work on appropriate treatment goals as close to 24 hours a day, 7 days a week as possible. According to the written plan, the STU has designed a structured therapeutic community program for residents who are sufficiently motivated to benefit from a more intensive treatment regimen. The written plan indicates that community meetings occur that include elements of "peer assistance, constructive criticism for potentially dysfunctional behaviors, praise for pro-social behaviors, and behavioral interventions to diminish unwanted behaviors." A major goal is to promote prosocial values. At the present time, there are 37 men in the therapeutic community, housed in one wing of the Annex. The living conditions for those in the therapeutic community were as poor as those of the rest of the residents. Unfortunately, the community meeting for the day of my visit had been cancelled, so I was unable to see what occurs in that meeting.

In a conversation with staff regarding the therapeutic community, it was reported that it began approximately two years ago. That initially the therapeutic community consisted of the entire dorm (69 men), but in the words of a staff member "that wasn't working how we hoped with that large a number," so in June 2008, the TC was virtually cut in half. The therapeutic community is located in Dorm C at the Annex. Currently, men in Phases 2-5 comprise the TC. It was learned that one can become part of the TC either by recommendation by the clinical team or self-referral. If a person is self-referred, he undergoes an interview, meets with a treatment team, and is assessed based on his engagement in treatment as well as his "willingness to fully engage in TC functions and buy into tenets." The TC team holds a weekly meeting. The TC operates under a "pull-up" system where residents learn to take responsibility for their behavior, and gain

assertiveness and comfort with the supervisory process. TC residents reportedly have the same number of treatment groups, but have more committee functions. Staff report that TC residents "live the therapy" for a greater proportion of their time. The TC also has a number of self-help groups, run by TC members. There are reportedly also a number of committees that TC residents are appointed or volunteer into. Staff are not members, but act as consultants. Most committees meet at least weekly, according to staff. Committees are as follows: Remedy Committee; Advisory Committee; Media Committee; Socialization Committee; Transition Committee; and Mediation Committee.

Several of the residents I had interviewed had been in TC but were no longer members. When asked about the treatment in general, few spoke of the therapeutic community, and those that did simply stated that they had been in TC but no longer were. While it is important to have a therapeutic community so that individuals are "living the program" and can receive greater privileges based on their performance in treatment and the living milieu, and although efforts are being made to have such a TC, it appears that due to staff shortages and the design of the facilities, the current TC is not reaching its potential. Furthermore, only approximately 10% of all residents at STU are in TC, and those that are in TC do not seem to be experiencing a therapeutic community of sufficient intensity with respect to number and frequency of TC activities. While there are no universally accepted standards as to what percentage of residents should be in a therapeutic community, ten percent appears to be a very low number and this evaluator would like to see at least one third of the residents in the therapeutic community.

Overall Opinion and Recommendations

Based on my tour of the facility, resident and staff interviews, and review of materials, my finding is that the **therapeutic community is *not minimally adequate/unsatisfactory.*** In my opinion, a greater percentage of the STU population should comprise a therapeutic community, such a community should have a living space that is commensurate with a physical community so that residents are not sharing living spaces with non-TC residents, and it should offer more advantages in terms of the physical plant, treatment, and community activities, so that other residents should aspire to be part of the therapeutic community. In my interviews with residents, not one of them volunteered that they desired to be part of the TC. Given that this is designed to be a therapeutic community, it is necessary that therapeutic activities play a significantly larger role than they currently do.

10. Confidentiality

Confidentiality within therapy groups varies across facilities. At the Annex, groups occurred in relatively large rooms, and there did not appear to be any issue regarding the confidentiality of information conveyed in groups at that setting. At Kearny, the set-up of treatment groups within the treatment trailer allows for others (including correctional officers) to easily overhear group proceedings (please see the section on Treatment Environment above), which, in my opinion, greatly compromises confidentiality of

therapy. In addition, during my visit a correctional officer escorted me to a treatment group at the Kearny facility and proceeded to sit in on the group, while the therapist leading the group did not request that he leave. When I asked the Clinical Director if correctional officers generally sit in on groups, he reported that they do not, but opined that the correctional officer probably thought that it was his responsibility to escort me and accompany me throughout the group session. It concerns me greatly that correctional officers can potentially hear group therapy sessions, and greater attention needs to be paid to ensuring confidentiality between resident treatment and correctional staff.

While there is an inherent double bind for civilly committed sex offenders, it appears that there are few protections in place at these facilities to mitigate the consequences of such. For example, all residents should be informed that any statements that they make in group or individual contacts with therapists potentially could possibly be used against them in a court of law, but can also be used in determining whether and when they will be advanced in phase and released from the facility. This should be clearly stated in the resident handbook and a statement to this effect included in the resident's consent form.

Overall Opinion and Recommendations

Based on my tour of the facility, presence in treatment groups, interviews with residents, and review of materials, pending issuance of my final report, my preliminary finding is that **the level of confidentiality is *not minimally adequate/unsatisfactory.*** It appears that there is limited confidentiality of group therapy sessions at the Annex facility and there is minimal separation between treatment and the DOC with respect to punitive DOC repercussions for violations of treatment rules and policies. I recommend that greater efforts be made to ensure that treatment sessions remain confidential from correctional officers and other residents not participating in the treatment group.

11. Gradual De-Escalation of Restraints

It appears that de-escalation of restraints comes in two forms. In one form, as individuals pass through the different phases in treatment and continue to work at their therapy, they are granted increased work hours. In the other form, as Phase 5 of the treatment program is achieved, residents are granted furloughs to the community. It is my opinion that while the program does provide de-escalation, it does not occur at the quantity or rate that one would hope to see in a therapeutic program.

Although this evaluator is unable to cite any scholarly literature, I am aware of a 2000 court order in the State of Washington which determined that a separate, "step-down" facility was necessary. In this order, Judge Dwyer states "mental health treatment, if it is to be anything other than a sham, must give the confined person the hope that if he gets well enough to be safely released, then he will be transferred to some less restrictive alternative" (p. 11).

Overall Opinion and Recommendations

Based on resident and staff interviews and review of materials, my finding is that **gradual de-escalation of restraints is *not minimally adequate/unsatisfactory***. Perhaps due to limitations in staff and opportunities for other activities, current de-escalation is limited; however, I am of the opinion that greater thought needs to be given to increasing the de-escalation of restraints. The program has been creative in developing a furlough program, in which some men can go out into the community accompanied by a staff member, however. It is this evaluator's opinion that a greater number of men should have the opportunity to have supervised furloughs into the community. Specifically, if a resident is participating in therapy and evidencing general self-regulation skills, then he should be afforded the opportunity, under supervision, to have brief forays into the community. For those men who have cognitive limitations and significant substance abuse histories, it is recommended that a group home or similar type of facility be created to allow them to have greater freedom while at the same time providing the level of care that they require. Other areas to include in a de-escalation system would be increased visitation or recreation schedules, changes in living arrangements or placement, more freedom of movement, among other privileges.

12. Increased Visitation

Residents are allowed two hours of visitation, three days per week. In speaking with the residents, they felt that visitation is not long enough or frequent enough, and they also expressed concern about the rooms in which visitation occurs, as visitation rooms at both facilities are rather stark. Residents have also voiced concern about how their families are treated by corrections officers. One resident reported that his partner stopped coming because of things that were said to her by correctional staff. It should be noted however, that while some of the residents complained about how visitors were treated, others felt that their visitors were "treated good."

Overall Opinion and Recommendations

Based on my tour of the facility, and resident interviews, my finding is that **visitation is *minimally adequate/satisfactory***. It is recommended, however, that the rooms used for visitation be made more "user-friendly." Also, correctional officers should be trained in relating more appropriately to visitors and instructed not to engage in any conversation that is demeaning to residents or their visitors. Visitation is important given that the residents need to be able to maintain contact with family members and friends in the event that they are released. Such visits enable residents to establish a social support network that will prove beneficial for their successful reintegration into the community. Perhaps increased visitation could be used as a privilege for those residents who are in the therapeutic community and in later phases of the program. Family support groups should be held regularly and DOC staff should be educated in how to be respectful towards family members during their visits.

13. Availability of Psychiatric Consultation

At present there is only one psychiatrist for both the Annex and the Kearny facility. There had been six other consulting psychiatrists, but for one reason or another, they all left over the past year. The present psychiatrist not only is responsible for providing psychiatric care to those residents who are in need, but he also conducts some of the commitment evaluations. I have some concern that this potentially places the psychiatrist in a dual role. The psychiatrist has done due diligence in making sure that none of the individuals that he is presently treating are individuals who are assessed for commitment. It is clear that the current psychiatrist is well trained, well respected and is doing the best job that he can given how staffing shortages at the facility.

Overall Opinion and Recommendations

Based on the services this psychiatrist provides, my finding is that **the *availability* of psychiatric consultation is *not minimally adequate/unsatisfactory*.** This rating is based exclusively on the lack of psychiatrists, not on the performance of the present psychiatrist. It is imperative that positions be posted so that the positions that were vacated can be filled immediately. The October 30,2008 SOCCPN report indicates that the average ratio for residents to Psychiatrist is 122:1

Overall Recommendations

The joint expert opines that the mission of the STU would be better served if the following were to occur:

1. It is recommended that the State of New Jersey model their Civil Commitment Center on a therapeutic environment and not on a jail or prison-like environment. Adequate living space needs to be provided for residents and adequate office space and treatment rooms need to be available for staff. In such a facility, a fully-equipped infirmary should also be established. Recreational space and classrooms for educational and vocational training should also be abundant. Such a facility should also provide adequate and "friendly" visitation space.

2. It is abundantly clear that more clinical and custody staff are needed at the facility.
3. It is also recommended that treatment providers receive more training and individualized supervision. Information obtained from residents and professional staff (this evaluator interviewed a number of staff members and also obtained information from staff telephonically) indicates that residents and some staff see the milieu as one of punishment. Some staff members expressed concern about administrators not being on-site as frequently as they should, not

being involved with clinical staff as much as staff would like, and also exhibit a pattern of favoritism. Concern was also raised regarding case supervision and the clinical experience of an individual providing supervision who may not have had any direct experience in treating this specialized population.

4. Weekly therapist schedules should be made available to the Clinical Director.
5. All files should be computerized so that clinical staff can access medical records, assessments, treatment notes, homework assignments and other information pertinent to a resident's course of treatment.
6. Assessments should begin as soon as possible after a resident's orientation to the facility, and consent has been signed.
7. Assessments should be comprehensive and include those areas outlined in Section 2 above. A determination based on the comprehensive assessment should be made as to whether the resident would benefit from group, individual or group, or individual treatment. Also, an assessment should be made as to which phase of treatment a resident should be assigned upon arrival. Specifically, some residents may have had prior treatment while incarcerated in prison, and it is possible that they will not require all the modules in a particular phase of treatment.
8. Specific short and long-term treatment goals should be part of the treatment plan. Requirements to move to the next treatment phase should also be part of the treatment plan.
9. Pre- and post-testing should be conducted for every module.
10. Requirements for discharge should be given to each resident upon entering the facility.
11. Residents should receive monthly feedback from their primary therapist on their progress.
12. Process groups should occur daily.
13. Specialty modules should occur at least twice per week, for an hour and a half each time.
14. Both group and individualized supervision should be provided to treatment staff.
15. Funds should be made available for staff to attend either regional or national conferences related to sex offender assessment and treatment.
16. Professional staff who do risk assessments should keep up with research in the risk assessment area, and resident risk levels should be modified based on recent research.
17. A comprehensive treatment plan should be made available and explained to each resident within one month of his comprehensive assessment.
18. Special needs tracks should be made available.
19. Men should be housed based on special needs and phase level.
20. Vocational, educational, and life skills services should be increased.
21. Individuals on MAP status should receive more in the way of therapeutic contact time.
22. The treatment rooms should be such that material being discussed is confidential and rooms are soundproof.

23. It is recommended that an external advisory board be appointed, and that part of their charge be to conduct a yearly external review of the program. It is also recommended that an Ombudsman be appointed.
24. It is recommended that there be a resident council that can meet monthly with the Clinical Director.

Final Comments:

The clinical staff I communicated with appeared to be a very dedicated group of individuals who cared deeply about the residents in their care. This evaluator would like to thank the administrators, residents, clinical staff, and correctional staff for their openness and the courtesy they extended her. Residents and staff are both in a difficult situation given the environment they are in and the lack of resources allotted to the facilities.

I respectfully submit this final report.

Judith V. Becker, Ph.D.

APPENDIX A
List of Documents

1. Division of Mental Health Services, Administrative Bulletin Transmittal Memo, 6/6/2002 (pp. 1-8)
2. Raymond Alves et al. complaint, dated 10/28/2004 (pp. 9-26)
3. Richard Bagarozy complaint, dated 6/28/2004 (pp. 27-40)
4. William Moore complaint, dated 4/21/2005 (pp. 41-75)
5. Expert reports of Prentky (3/20/05), App (3/4/05), and Schlank (5/29/04) (pp. 76-116)
6. Plaintiff summary of resident phase status data (pp. 117-150)
7. Parties' settlement correspondence, including letter from Plaintiffs (5/18/06) and letters from the AG (12/1/06) (pp. 151-174)
8. Special Treatment Unit, Written Plan for the Provision of Care, (3/30/06) (pp. 175-395)
9. Residents Guide to the STU, March 12, 2004 revision (pp. 396-436)
10. Residents Guide to the STU, June 2001 revision (pp. 437-466)
11. Residents Guide to the STU, unknown date (pp. 467-518)
12. DMHS TPRC Review Committee, revised 6/8/03 (pp. 519-526)
13. STU Policies and Procedures, effective 12/16/04 (pp. 527-536)
14. Ann Klein Forensic Center Special Treatment Unit Sex Offender Disclosure Questionnaire (pp. 537-554)
15. Education Modules Curriculum (pp. 555-989)
16. Plaintiff Summary of STU Job Descriptions (pp. 990-1469)
17. Sex Offender Treatment Skills for Corrections Professionals Participant Manual, written by the DOJ, Nat'l Institute of Corrections, (pp. 1470-1949)
18. Workshop materials and relevant chapters (pp. 1950-2821)
19. Guidelines for the Development of New Programs by Anita Schlank
20. ATSA Civil Commitment of Sexually Violent Offenders
21. Professional Standards for Civil Commitment Programs by Janice K. Marques
22. Book Chapter entitled *Assessing Treatment Progress in Civilly Committed Sex Offenders- The New Jersey Approach*
23. Article entitled *Assessing Inpatient Treatment Progress: The Development of the Dynamic Treatment Monitoring Scale* authored by S. Katz Schivone and J. Schneider
24. Letter from Mr. DaCosta, dated 10/15/08
25. Letter from Mr. Marx, et al., dated 10/15/08
26. Letter from Mr. DaCosta, dated 10/20/08
27. Letter from Mr. Marx, et al., dated 10/29/08

Materials requested and provided following my visit to the STU facilities:

28. Resident Charts
29. Findings from 2007 Resident Survey Conducted by Jennifer Schneider, PhD
30. STU Treatment Plan, dated 07/21/08
31. STU Morning Meeting Agenda, dated 07/28/2008

32. Resident Module Assignment, dated July 2008
33. STU Program Schedule, effective 07/14/2008
34. ANNEX MAP Roster, dated 07/21/2008
35. Email Communications regarding the Number of Residents Discharged, dated 08/27/2008
36. STU ANNEX and Kearny Group Schedules 2007 and 2008
37. STU Staff Schedules, various dates in 2008
38. Therapeutic Schedule entitled New Beginnings, 05/2008
39. Document entitled Residence by Admission Date: Sending Institution and Discharge Status
40. Document Entitled STU Polygraphs
41. Document entitled Transitional Planning, Conditional Discharges, Potential Conditional Discharges
42. Several Documents Entitled Comprehensive Discharge Plan
43. Several Annex Clinical Supervision Notes
44. Arousal Reconditioning Final Exam
45. Recreation Schedules (March 2003)
46. Law Library Hours
47. Sex Education Module Syllabus
48. Residents Currently in MAP Group as of 07/10/2008
49. Two boxes of resident clinical files (though I was told an additional box was lost in the mail)

APPENDIX B
Interview Schedule

<table>
<tr><th>Tuesday, 7/22 (Kearny)</th><th>Wednesday, 7/23 (Annex)</th><th>Thursday 7/24 (Annex)</th><th>Friday 7/25 (Annex)</th><th>Monday 7/28 (Kearny)</th></tr>
<tr><td>Meeting with Plaintiff residents at Kearny facility</td><td>Meeting with Plaintiffs at Annex facility</td><td>Meeting with a DOC lieutenant</td><td>Meeting with Substance Abuse Counselor</td><td rowspan="4">Resident interviews</td></tr>
<tr><td>Tour facilities at Kearny and meeting with all residents at Kearny</td><td>Tour facilities at Annex and meeting with all residents at Annex</td><td>Meeting with a DOC officer*</td><td rowspan="3">Resident interviews</td></tr>
<tr><td>Meeting with Clinical Director, Merrill Main</td><td>Sit in on a process group</td><td rowspan="2">Resident interviews</td></tr>
<tr><td>Meeting with Natalie Barone, Director of Psychology</td><td>Sit on a process group</td></tr>
<tr><td>Lunch with psychiatrist Dean Michael De Crisce</td><td>Lunch with a staff therapist</td><td>Lunch with a staff therapist</td><td>Lunch with a staff therapist</td><td>Lunch with Clinical Director and Director of Psychology</td></tr>
<tr><td>Meeting with DOC administrator for both facilities (Goodwin and Sheehan)</td><td rowspan="3">Resident interviews**</td><td>Meet with Brian Friedman (psychologist that conducts assessment)</td><td rowspan="2">Resident interviews</td><td rowspan="3">Resident interviews</td></tr>
<tr><td>Meeting with Quality Assurance Specialist (Natasha Walker)</td><td>Met with Jennifer Schneider, head of Quality Assurance and Research</td></tr>
<tr><td>Meeting with Director of Rehabilitation (Terri Roth)</td><td rowspan="2">Resident Interviews</td><td rowspan="2">Record review</td></tr>
<tr><td>Meeting with Social Work Supervisor (Heather Burnett)</td><td>Record Review</td></tr>
</table>

* I had requested to meet with officers, only one volunteered to be interviewed. However, while at one of the facilities, another officer approached me. He did not wish to be identified but did share with me his views and suggestions.

** A total of 40 men had been interviewed. This included the residents who were randomly selected and the residents who were nominated to be interviewed by the Plaintiffs' attorney. One man who had been randomly selected chose not to be interviewed, consequently a person who had committed his offenses as a juvenile but was then civilly committed was selected to be interviewed.

APPENDIX C

Resident Interviews

Summary of the people who were interviewed (randomly selected to be representative sample based on commitment date, facility (Annex or Kearny) and phase in Program:

- Commitments ranged from 1999 to 2008.
    - Average time since commitment: 57 months
- Phase in program (based on resident report):
    - Range Phase1-4
    - Mode: Phase 2
        - Phase 1: 3 residents
        - Phase 2: 18 residents
        - Phase 3:10 residents
        - Phase 4: 2
        - Treatment Refusers: 6 residents
        - Unknown: 1 resident (did not know his phase)

List of Questions Asked

Name:
DOB:
Date admitted:
Sex offender treatment history:
    In prison:
    Other:
Arrest history:
    Sex offenses:
    Non-sex offenses:
Diagnoses:
Phase in Program:
    Time spent in each phase of program:
What have you been told you need to do to be released?
Currently employed?
    Wages:
    Hours/week:
How much individual therapy?
    Name of primary therapist:
How many groups currently in?
    Group names:
    Meeting frequency:
Treatment goals:
    Have they been attained?
In your view, how is progress measured?
What has been most helpful to you?
Perceived strengths of the program?
What needs to be changed?
Opinion of professional mental health staff:

Overall Rating:

1 (Poor) **2** (Less than adequate) **3** (Adequate) **4** (Good) **5** (Excellent)

Opinion of corrections staff:

Overall Rating:

1 (Poor) **2** (Less than adequate) **3** (Adequate) **4** (Good) **5** (Excellent)

Opinion of living conditions:

Overall Rating:

1 (Poor) **2** (Less than adequate) **3** (Adequate) **4** (Good) **5** (Excellent)

Overall rating of STU/Annex:

1 (Poor) **2** (Less than adequate) **3** (Adequate) **4** (Good) **5** (Excellent)

Summary of Ratings by Resident Interviewees:

- Opinion of professional mental health staff
  - Range: 1-5 (ratings of 0 not included)
  - Mean: 1.97
  - Mode: 1
- Opinion of corrections staff
  - Range: 1-5 (ratings of 0 not included)
  - Mean: 1.93
  - Mode: 1
- Opinion of living conditions:
  - Range: 1-4 (ratings of 0 not included)
  - Mean: 1.24
  - Mode: 1
- Overall rating of STU/Annex:
  - Range: 1-5 (ratings of 0 not included)
  - Mean: 1.5
  - Mode: 1

APPENDIX D

Recommended Standards for Civil Commitment Programs*

Standards	Marques, 2001	ATSA, 2001	Shlank, 1999	**STU BECKER 2008**
Training and Supervision				
Staff adequately trained	X	X	X	?
Clinical direction by qualified professionals	X	X	X	YES
Gender balance of staff			X	YES
All staff understand model	X		X	YES
Treatment planning and clinical decisions consistent	X			?
Staff rotate assignments			X	?
Treatment staff do not take role in initial commitment			X	NO
Treatment Components and Measures of Progress				
Complete background information			X	YES
Use of polygraph			X	YES
Individualized, comprehensive treatment plans	X	X	X	YES
State-of-the-art components	X	X	X	YES**
Ongoing monitoring	X	X	X	YES
Systematic measures and regular feedback	X	X	X	NO
Identifiable phases, including community release	X	X	X	YES
Vocational and educational training			X	YES
Treatment Environment				
Treatment-oriented environment	X	X		NO
Adequate space and separation of resident groups	X	X		NO
Staff behavior	X			YES
Consistently enforced rules	X			Questionable****
Respectful treatment and grievance procedures	X		X	Questionable****
Program for residents who refuse treatment	X			NO
Program Review and Oversight				
Internal review procedure	X			YES, QA
External review procedure	X	X		?***

*Adapted from Prentky report (3/20/05)

**Should be more focused on individual trauma issues.

***Apparently, an advisory board is in the process of being formed. ****Per residents' reports.