



STATE OF CONNECTICUT

DEPARTMENT OF MENTAL HEALTH
AND ADDICTION SERVICES
A HEALTHCARE SERVICE AGENCY

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**Testimony of Dr. Thomas A. Kirk, Commissioner
Department of Mental Health & Addiction Services
Before the Judiciary Committee
March 20, 2006**

Good afternoon, Sen. McDonald, Rep. Lawlor and distinguished members of the Judiciary Committee. I am Commissioner Thomas Kirk of the Department of Mental Health and Addiction Services, and I am here to testify on **HB 5812, An Act Concerning the Registration and Supervision of Sex Offenders**, that proposes to establish a Sex Offender Risk Assessment Board, of which DMHAS would be a member. With me today is Dr. Michael Norko, Acting Director of Whiting Forensic Division of Connecticut Valley Hospital and associate professor of psychiatry for the Yale Law and Psychiatry program. I would like to identify some concerns for your consideration.

First, it is important that whatever risk assessment scale is developed by this Board be the right tool for the job. It must be valid and reliable, that is, have support in the research and literature as having a reasonable degree of predictive value regarding the risk of sex offending recidivism for any individual who is assessed. Otherwise, the assignment of risk scores will have no meaning and will be more misleading than informative or useful. This bill proposes the development of a "risk scale" that assigns weight to any number of risk factors. There are many assessment tools and methods in use throughout the country to predict sex offender recidivism, many of which consider

some of the factors enumerated in subsection (b) of this bill, but that have not demonstrated any predictive reliability based on the research. There is an extensive body of research by experts regarding the prediction of sex offender recidivism.

Assessment tools have been developed and tested on large numbers of individuals, some of which are more reliable than others, but all of which have limitations. Generally, such assessments are either actuarial or clinical, or a combination of both. Actuarial assessments generally involve obtaining and reviewing the records of the individual and developing a risk rating via comparison, based on the rate of recidivism of persons with similar histories and characteristics. This process is similar to that used by insurance companies to set rates by determining a person's heart attack risk based on age, weight, and whether or not s/he smokes. While this approach may help an insurance company manage prediction of risk for large populations of persons, it cannot accurately predict the likelihood that any one individual will actually have a heart attack. Clinical assessments, on the other hand, involve face-to-face, structured interviews with the individual, as well as record review. In general, clinical interviews alone have been demonstrated to be very unreliable predictors of risk of sex offending.

Many current sex offender risk assessment protocols include some combination of actuarial and structured clinical assessments. My point is that accurate prediction of sex offender risk is very difficult. Any scale that is developed must be consistent with the state of scientific knowledge regarding reliability and validity, and the state of scientific knowledge has serious limitations. It is

likely that the Risk Assessment Board will find that the use of a weighted “scale” alone, as proposed in this bill, will not be a sufficient basis upon which to assign risk. In addition, an offender’s risk changes over time, such that a one-time assessment may not reliably identify one’s current risk. In any event, any risk assessment scale at minimum will involve compiling an as yet undetermined amount of past and current information regarding individual sex offender registrants. It may require in-person assessments of all or some sub-set of those to be assessed. It is clear that no matter what scale is developed, the task will be time consuming and will require trained and dedicated staff resources.

The ethics of forensic psychiatry would require that a psychiatrist performing such a risk assessment conduct an in-person interview and an individualized assessment of the subject in rendering any opinion about the individual. The ethics of psychological assessment would probably require that the specific use to which assessment instruments are put must be validated scientifically for that purpose.

As of February 2006, there were an estimated 4,154 persons subject to sex offender registration in Connecticut. Section (c) of this bill requires the Board to use the risk assessment scale to assess each of these individuals, but it is not clear how this will be implemented and with what resources. Also, if an in-person component is necessary for the assessment, it is unclear whether this Board can require participation by the registrants, most of whom are living in the community. It is not known at this time whether certain records protected by law, regulation or policy – for example,

psychiatric or medical records – will be essential to the assessment. It would be helpful to clarify what the consequences of a determination of high, medium or low risk are to be, both in deciding the criteria to be weighed and to address any reluctance by registrants to participate in such assessment. It may be preferable, given the sheer numbers of registrants and the complexity of the issues involved, to modify this bill by providing the Risk Assessment Board an opportunity to consider these concerns and to make recommendations to this committee on the proposed risk assessment scale and a plan for implementation of an assessment process, identifying reasonable goals, the resources required, and any statutory or constitutional issues that may need to be addressed.

Secondly, I appreciate that this bill does not provide for the creation of Sexually Violent Persons (SVP) civil commitment law in Connecticut, as exists in 17 other states. These laws became popular in the 1990's as a way to detain convicted sex offenders after they completed their sentence by finding them to have a "mental abnormality" that makes them a danger to others and committing them to a treatment facility for indefinite confinement. The states that have implemented such laws have experienced huge, largely unanticipated costs associated with such confinements; difficulty in predicting when such persons are, or are not, safe for discharge; and an "industry" of experts and litigants associated with the process. No state with such a law has demonstrated a positive impact on sex offender recidivism. Connecticut studied and rejected this approach in a 1998 report to the Governor by a committee that included broad agency participation and consultation with experts. That committee unanimously agreed that sex offending was a criminal behavior that required

criminal justice solutions. Civil commitment to psychiatric treatment should and does occur when a defendant or inmate has an underlying psychiatric disorder that requires such intervention.

Thank you for the opportunity to comment on H.B. 5812. I would be happy to take any questions you may have at this time.