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SUPERIOR COURT OF NEW JERSEY
APPELLATE DIVISION
DOCKET NO. A-1056-13T2

IN THE MATTER OF THE CIVIL
COMMITMENT OF F.T., SVP-416-05.

Argued May 13, 2014 – Decided June 24, 2014

Before Judges Sabatino and Rothstadt.

On appeal from the Superior Court of New Jersey, Law Division, Essex County, Docket No. SVP-416-05.

Michael Timothy Denny, Assistant Deputy Public Defender, argued the cause for appellant (Joseph E. Krakora, Public Defender, attorney).

David L. DaCosta, Deputy Attorney General, argued the cause for respondent (John J. Hoffman, Acting Attorney General, attorney).

PER CURIAM

Appellant F.T. appeals from the September 9, 2013 order continuing his involuntary commitment to the Special Treatment Unit (STU), pursuant to the New Jersey Sexually Violent Predator Act (SVPA), N.J.S.A. 30:4-27.24 to -27.38. We affirm.

Appellant is a forty-seven-year-old male with an extensive history of sexual offenses and other criminal behavior, dating back to when he was fourteen. That history included convictions

for multiple sexual assaults on nonconsenting adult and adolescent women, which qualify as "sexually violent offenses" under the SVPA. N.J.S.A. 30:4-27.26.

In 1984, appellant pled guilty to the first-degree aggravated sexual assault of a twenty-nine-year-old woman whom he encountered while driving around with a friend in a stolen vehicle. He was later convicted for the 1995 sexual assault of a twelve-year-old girl, which he committed while on probation for terroristic threats arising from his 1993 sexual assault of a twenty-seven-year-old women, who was mentally challenged. After pleading guilty to the 1995 offense, the court sentenced him to fifteen years in State prison.

Prior to appellant's release from prison, on December 15, 2005, the State successfully petitioned for appellant's involuntary commitment pursuant to the SVPA. Subsequent annual review hearings have resulted in the continuation of appellant's commitment.[1] The instant appeal arises out of his most recent review hearing, held on September 9, 2013, before Judge James F. Mulvihill. At the hearing, the State presented testimony by psychologist Nicole Paolillo and psychiatrist John Zincone.

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[1] We affirmed those prior commitments in earlier decisions. See In re Commitment of F.T., A-3825-05 (App. Div. Jan. 21, 2009), cert. denied, 199 N.J. 130 (2009); and No. A-0677-10 (App. Div. April 21, 2011).

Appellant presented testimony by psychologist Christopher Lorah. After the witnesses testified, the court entered an order continuing appellant's commitment.

Dr. Paolillo was a member of the Treatment Progress Review Committee (TPRC) at the STU, which reviewed appellant annually to assess his progress and recommend future treatment. The review was conducted approximately nine months before the hearing. Dr. Paolillo prepared a report as part of the review, in the normal course of business. The TPRC report was submitted as evidence at the hearing, while Dr. Paolillo gave testimony consistent with that report.

The TPRC and Dr. Paolillo based their opinions and recommendations on treatment notes and reports, information in appellant's STU files, and a clinical interview with appellant on December 14, 2012. Dr. Paolillo testified that these sources were of the type normally relied upon by persons in her profession when making these types of assessments. Some portions of the materials contained diagnoses, but Dr. Paolillo testified that she formulated her own.

According to Dr. Paolillo's report, appellant "clearly experiences some degree of cognitive impairment," and meets the criteria for borderline intellectual functioning. However, the report stated that his special needs are accommodated in his

treatment, and that appellant is making positive strides. Appellant is described as "pleasant, quiet and sometimes anxious" in treatment. "His cognitive limitations lend him to struggle with expressing himself; however, he is active and engaged in treatment."

Appellant is supportive of peers. Furthermore, while he has experienced memory gaps with respect to his sexual offenses, his account of his predicate offense is consistent with the record. His understanding of his sexual assault cycle is rudimentary, but improved. "He can identify basic connections, thoughts, feelings, and triggers that initiated the cycle." His understanding of relapse prevention is elementary. Appellant has also completed a significant number of modules, including relapse prevention, anger management, substance abuse relapse prevention, and criminal and addictive thinking. He had completed Sexual History Questionnaire and Current Arousal polygraph examinations, and no deception was indicated on either polygraph.

Dr. Paolillo noted that appellant seemed "very proud of himself" during the interview. This was "meaningful" to the doctor because "he does have a history I think of self-esteem issues, which . . . do relate to his dynamics, and his overall treatment effect because . . . his insecurities, low self worth,

have impeded him from being able to meaningfully engage." He seemed proud to have advanced to the Therapeutic Community (TC), and reported that he was attending multiple self-help groups, such as relapse prevention, Alcoholics Anonymous, and anger management. "He stated that in contrast to his prior efforts to hide his confusion, he now asks his peers questions to gain clarification." Appellant also reported being less defensive, and more open to listening to others. "He stated that he does not want to hurt people anymore." He indicated healthy, non-deviant masturbatory behaviors.

In his interview, appellant acknowledged an additional sexual assault for which he was not convicted. With regard to his sexual assault cycle, appellant reported the following:

> [Appellant] reported that he reviewed his cycle and revised it. He stated that he is attempting to memorize it so that he can access it when needed. He was then asked to present it and he stated that his build-up involved viewing his mother and father drinking and leaving him alone at home. He stated that he felt unloved, sad, angry, upset and afraid. His acting out involved drinking, being on the street, stealing cars, going to bars, talking about sex, and getting women into cars. He recalls kissing them and having sex with them. Despite recalling that all of the women were consensual, he reported that he includes this in his cycle because of his 1983 Aggravated Sexual Assault charge.

> His justification involved telling himself he didn't do anything wrong and she [the 1983 victim] should have ran.

Notwithstanding his progress, however, appellant did not acknowledge any current or past deviant arousal. Moreover, according to the doctor, his deviant arousal has not been examined enough in treatment to determine whether it had been "contained sufficiently because we're still learning about it." She said appellant had a difficult time complying with treatment recommendations, though she did not know whether to attribute this to his personality or cognitive difficulties. "Although he's been contained and does experience a mitigating effect from just the mere exposure to treatment and participation, he has not been meaningfully participating for very long at all."

At the time of his review, appellant had been in the TC for less than a month. Dr. Paolillo testified that this "was a great step for him," and a "meaningful gain" in light of his limitations. While still in the introductory stage, he was reportedly "adjusting well." Appellant was attending a process group that was accommodating for his cognitive needs, and his TC treatment team reported he was "showing notable motivation."

However, since the review, appellant has been removed from TC. Dr. Paolillo had limited knowledge of the circumstances, but testified that appellant was assigned a peer task, which led

to a negative interaction with a peer. Appellant reportedly became defensive, and the TC treatment team grew concerned that he was not taking responsibility, and was not receptive. Dr. Paolillo said that this behavior was "inconsistent with [her] experience of him." The team also indicated that he was "minimizing in regard to his history." Appellant asked to be removed from the TC, but Dr. Paolillo did not know the reason behind his request. The treatment team subsequently decided on its own to remove appellant from TC. Dr. Paolillo was uncertain whether appellant would need to reenter the TC, however. She said that appellant's cognitive limitations would make the TC more challenging for him than other residents. She was therefore "pondering" whether TC would be necessary for appellant's treatment prior to release.

The TPRC graded appellant on a Static-99R, a risk assessment tool for sex offenders. Based on a scale from zero (low risk) to six plus (high risk), appellant scored a six (high risk). He was also tested against the Psychopathy Checklist-Revised, 2nd Edition (PCL-R), to assess whether he fit the criteria for the "prototypical psychopath." Based on a cut-off score of 30 (meeting diagnostic criteria for psychopath), appellant scored a 20, meaning he falls in the moderate range and does not meet the threshold for construct of psychopathy.

As noted earlier, the TPRC with Dr. Paolillo diagnosed appellant with borderline intellectual functioning and alcohol dependence, in a controlled environment. He was also diagnosed with provisional paraphilia, not otherwise specified, non-consent, meaning "a chronic condition that is characterized by intense, sexually arousing fantasies, sexual urges, and/or behaviors involving sexual arousal to young adult females, who by virtue of force, are unable to consent." However, this diagnosis was "provisional" because appellant did not acknowledge any such arousal.

Finally, appellant was diagnosed with antisocial personality disorder, because he "exhibits a pervasive pattern of disregard for and violation of the rights of others." Underlying the diagnosis was a finding that appellant first exhibited antisocial behaviors between the ages of fifteen and eighteen. Moreover, the TPRC noted that "his personality structure is heavily based on poor impulse control, disrespect for the law, aggression, lack of remorse, reckless disregard for the wellbeing of others, and failure to conform to social norms with respect to lawful behaviors." Dr. Paolillo opined that appellant was "more antisocially driven than paraphilically driven at this point in time based on the information he's provided us."

Based on its assessment, the TPRC recommended that appellant remain in phase three of treatment, as he "remains highly likely to sexually recidivate." At the time of the review, appellant had only been in phase three of treatment for two years. Thus, according to Dr. Paolillo, his progress was a more recent development. She opined that, from this point on, appellant would be more amenable to the mitigating influences of treatment. Moreover, while appellant's age is not yet a factor in his risk assessment, it would be later. Finally, she opined that he was on the path to conditional discharge in the future "if he maintains his phase three and keeps moving forward[.]"

Dr. Zincone testified that he evaluated appellant prior to the hearing, and prepared a report on August 12, 2013. The report was written in the normal course of business. He relied on numerous sources, including four psychiatric interviews of appellant by the doctor, documents relating to appellant's convictions and other offenses, prison records, clinical certifications, psychological and psychiatric evaluations, TPRC reports, and STU treatment notes. The doctor confirmed that these sources were of the type normally relied upon by persons in his profession when making these kinds of assessments. He gave testimony consistent with his report, and reached his

opinions and conclusions with a reasonable degree of medical certainty.

Dr. Zincone first testified about appellant's sexual offense history, noting the inconsistencies between appellant's version of events and his sexual offending history. The doctor noted that appellant over-emphasized the influence of alcohol on his assaults. However, reports did not clearly indicate whether appellant was intoxicated when he committed all of his sexual offenses.

When Dr. Zincone asked appellant about his predicate offense, the sexual assault of a twelve-year-old girl, appellant said he was "still trying to figure out" why he raped her. When asked about a 1993 conviction for sexual assault, appellant said that the sex was consensual and not rape. As to a 1983 assault, appellant appeared to have a good memory of the details of his offense, up until the point of the actual rape, "where he indicated that he . . . did not . . . recall what had happened." The doctor clarified that appellant did not deny his crimes, "but stated that something must have happened because he got charged." Dr. Zincone said that these inconsistencies were the same in appellant's 2012 and 2013 interviews.

As to appellant's treatment progress, Dr. Zincone testified that appellant's attendance at process groups was consistent,

but that the quality of his participation was uneven, ranging from good to poor. The doctor noted that appellant had several institutional infractions in prison, but had improved while in the STU. By appellant's account, he is doing well in treatment. He also said that he did not want to leave TC, but the staff advised him that it would be in his best interest. In addition, when asked to rate his risk of re-offending on a scale of one to ten, ten being high risk, appellant rated himself a four or five. He also said that if he drinks, he could be unpredictable.

According to Dr. Zincone, appellant had poor insight into his alcohol abuse when he first arrived at STU, and did not comply with treatment recommendations. He has since gained some insight and is fairly active in substance abuse treatment at STU. However, as the doctor opined,

> His overall level of knowledge is fair. Looking at his substance abuse knowledge, he has difficulty putting the . . . 12 steps together although he indicates he's reading them every day. His understanding of relapse prevention was limited. When I saw him he gave very over simplified answers to high risk situations such as he just wouldn't drink or he wouldn't rape. He doesn't go any deeper than that at this point.
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> I gave him a scenario where there was a possibility that he would resume alcohol, have an alcohol relapse, and he had difficulty coming up with immediate

> interventions on how . . . he would handle that. And this is an individual that puts a lot of emphasis on his alcohol use, so that's a problem. He needs to continue to work on his substance abuse treatment.
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> He . . . is able to identify basic sexual assault cycle, but again that's not been the issue for [appellant], it's been the issue of him integrating it into his own dynamics, and talking about his arousal, and hos his arousal got him to the point of rape. That's been the difficult part for him.

The doctor further noted appellant's cognitive issues, and problems with his short term memory. He testified that appellant has problems recalling things in treatment, "but he's also worked through these issues, he's able to write things down, make lists, talk to other residents, and he actually does that so, . . . I think he's able to overcome these issues on his own."

Dr. Zincone found the same scores as Dr. Paolillo for appellant's Static-99R and PCL-R assessments. He also reached identical diagnoses. Dr. Zincone described the basis for his paraphilia diagnosis:

> [Appellant's] had three rapes; he's had a wide age span of . . . victims, 12, 27, an 29; . . . the reports of the rapes indicate that he . . . was aroused; he committed the crimes even through resistance of . . . the victims; he was on probation for the index crime, so supervision was not a deterrent for him even with the likelihood of him

> getting caught and having a more severe punishment.
>
> . . . [H]e had normal sexual partners through . . . some of these crimes and . . . still raped indicating he needed more to satisfy his arousal.

Dr. Zincone diagnosed antisocial personality disorder, in light of appellant's criminal history dating back to age fourteen, and his "reckless behavior, aggressiveness, assaultive behavior, [and] lack of remorse." He specifically disagreed with Dr. Paolillo's opinion that appellant's behavior was driven more by his antisocial personality disorder, and opined that paraphilia drives appellant's deviant arousal. He explained that antisocial personality disorder, when combined with paraphilia, would increase a person's risk to reoffend; and that the addition of alcohol abuse would further increase it. The doctor said that the conditions he diagnosed affected appellant emotionally, cognitively or volitionally, and did not spontaneously remit. He concluded that appellant was highly likely to reoffend.

Dr. Lorah testified that he had evaluated appellant prior to the hearing, and produced a report. The doctor had reviewed appellant's criminal institutional record as well. He testified that appellant had positively engaged in treatment over the past three years, as evidenced by his advancement in phases. The

doctor was "impressed" with appellant's understanding of his treatment. While the doctor agreed with the contention that appellant's knowledge of his treatment was "basic," he said that he had adapted his expectations in light of appellant's cognitive limitations. The doctor did not know the "specifics" of appellant's autobiography and relapse prevention work, but noted that appellant has written assignments, and seeks help from other residents. He opined that "basic" knowledge was sufficient in appellant's case.

Dr. Lorah testified that there were some concerns about appellant's intellectual functioning at TC, and his ability to make meaningful gains from the treatment there. He opined that appellant's cognitive limitations meant that he could only gain a concrete understanding of his offending, rather than an introspective one. He said that that was appropriate given appellant's limitations. However, he saw those limitations as the impetus for his removal from TC. Dr. Lorah thus concluded that appellant's rejoining TC would be inappropriate, as treatment providers would be better able to adapt to appellant's limitations in a non-TC setting. The doctor also acknowledged that the STU treatment that appellant is currently receiving has, in fact, been adapted to his limitations.

Dr. Lorah also testified that appellant recognized he had a "serious problem" with alcohol. He said that STU counseling has had "[a] significant impact on mitigating his substance abuse issues, because he's taken numerous modules, [and] identifies need for continued substance abuse treatment[.]" The doctor opined that appellant's most significant therapeutic need was in substance abuse treatment. He added that, "[o]bviously, there is some . . . ways to go on the sex offender specific treatment as well, but I think the majority of the work has been done or at least the majority of the work has been done in order to reduce his risk below the highly likely threshold."

Dr. Lorah also opined about alternative motives, besides deviant arousal, for committing sexual assault:

> I make a . . . differentiation between a willingness to rape and a wanting to rape. A wanting to rape would be much more pathological in my mind. It's where somebody would pursue a specific victim, set up circumstances to have that victim be alone, target a specific victim, and in terms of . . . willingness to rape, date rape situation where . . . two people have engaged in you know consumption of alcohol, there has . . . been some consensual sexual activity, some kissing and things like that, and then the woman most likely would say no, I don't want to do this anymore and the man would continue. That in my estimation is a much different situation and is less indicative of sexual pathology than the former case I have discussed.

The doctor emphasized that "wanting" to rape required some degree of preparation, but did not apply this to appellant's assault on the twelve-year-old girl who was alone in her home. In addition, he could only apply the "willingness" to rape or "date rape" characterization to appellant's 1993 offense, in which he was walking a woman home from a club. He also said that alcohol does not, by itself, lead a person to rape.

Dr. Lorah gave appellant a score of five on the Static-99R, within the moderate to high range. He said his score was lower because Dr. Zincone had inappropriately factored in one of appellant's charges for resisting arrest. He opined that appellant was no longer predisposed to commit acts of sexual violence, because of his age, treatment knowledge, and the passage of time between his last offense and the present.

Like the others, Dr. Lorah diagnosed appellant with alcohol dependence, and antisocial personality disorder. He diagnosed appellant with mild mental retardation, but provisionally, because he was not sure how strong appellant's adaptive functioning deficits are. He also said that appellant has borderline intellectual functioning.

He did not diagnose appellant with paraphilia. According to the doctor, paraphilia was not a commonly accepted diagnosis, was absent from the DSM-4TR, and rejected from inclusion in the

DSM-5. Moreover, he was uncertain whether appellant's behavior would satisfy the criteria, as he saw no evidence of recurrent intents, and sexual fantasies involving non-consenting partners, "regardless of his behavior over 20 years ago." He further noted that appellant had successfully completed the arousal polygraph, and so there was no deception indicated when he denied having continued sexual interest in non-consenting partners.

The doctor diagnosed appellant with "Encounter for mental health services for perpetrator of spouse of partner violence sexual." He explained that the condition referred to sexual aggression issues that are not easily explained by commonly accepted diagnoses, and for which sex offender treatment is needed. Despite its language, he applied the condition to appellant, though none of his victims were spouses or partners. Moreover, he said appellant's offending was more driven by a "personality characteristic" than sexual pathology.

Dr. Lorah ultimately recommended a conditional discharge for appellant, but with safeguards. The doctor opined that appellant was highly likely to comply with treatment recommendations in the community, that he would abstain from substance abuse, and would not commit sexual offenses.

At the close of the hearing, appellant's counsel argued for appellant's discharge. In support, he stated that appellant had not engaged in antisocial behaviors since 2004, and that he was performing well in treatment. Counsel argued that TC was unnecessary for appellant's treatment, that he had "some grasp" of sex offender specific treatment, and could articulate concrete interventions to reoffending. He argued further that appellant did not request to be removed from TC, but had undergone a "rough patch" in TC, and performed well afterward. Counsel also asked the court to credit Dr. Lorah's testimony that appellant was highly likely to comply with a conditional discharge plan.

The court found by clear and convincing evidence that appellant continued to satisfy the criteria for commitment under the SVPA. In support, the court set forth its reasoning on the record, first summarizing appellant's sexual and non-sexual criminal offenses. It further summarized the experts' testimony, regarding appellant's treatment progress, diagnoses, and actuarial scores. The court found both Dr. Paolillo and Dr. Zincone credible. As to Dr. Lorah, the court found that "[i]t doesn't make sense that he would diagnose an encounter for mental health services for perpetrator of spouse or partner violence," given that none of appellant's victims was a spouse

or a partner. However, the court found Dr. Lorah otherwise credible.

The court further concluded that appellant "continue[s] to suffer from [a] mental abnormality disorder, does not spontaneously remit Paraphilia NOS, and antisocial personality disorder. The paraphilia is the . . . thing that predisposed him to sexual violence." Finally, the court acknowledged that appellant "is making progress, he is aging out, and he's on a path for conditional discharge some time in the future, but not . . . now."

On appeal, appellant contends that he does not presently suffer from a mental abnormality that makes him highly likely to commit another sexual offense. He claims he has performed well and has made sufficient progress in treatment, despite his cognitive limitation. He believes that participation in the TC is inappropriate and unnecessary for his treatment, and that he is no longer highly likely to reoffend. Appellant asks to be granted a conditional discharge; and says he will comply with treatment recommendations if allowed back in the community.

Under the SVPA, the State may petition for the involuntary commitment of an offender after he has finished serving his sentence. N.J.S.A. 30.4-27.28. To this end, the State must present "clear and convincing evidence" that the offender 1)

"has been convicted, adjudicated delinquent or found not guilty by reason of insanity for commission of a sexually violent offense"; 2) "suffers from a mental abnormality or personality disorder"; and, as a result, 3) is "likely to engage in acts of sexual violence if not confined in a secure facility for control, care and treatment[.]" N.J.S.A. 30.4-27.26.

A "mental abnormality" is one "that affects a person's emotional, cognitive or volitional capacity in a manner that predisposes that person to commit acts of sexual violence." Ibid. One is likely to reoffend if he poses a danger to himself and others because of his present serious difficulty in controlling his dangerous sexual behavior. In re Commitment of W.Z., 173 N.J. 109, 132-33 (2002). After the initial commitment, appellant's continued commitment is subject to annual review. N.J.S.A. 30.4-27.35. At each review, the State must again prove by clear and convincing evidence that appellant continues to meet the criteria for commitment. N.J.S.A. 30.4-17.32.

"The scope of appellate review of a commitment determination is extremely narrow." In re Civil Commitment of R.F., 217 N.J. 152, 174 (2014) (quoting In re D.C., 146 N.J. 31, 58 (1996)) (internal quotations omitted). We give deference to the trial court's findings, as it has had opportunity to assess

witness testimony firsthand, and to develop a "feel" of the case. Ibid. (citing State v. Johnson, 42 N.J. 146, 161 (1964)). Moreover, we accord deference in light of the commitment judge's "expertise" in SVPA matters. Ibid.; In re Civil Commitment of T.J.N., 390 N.J. Super. 218, 226 (App. Div. 2007). We will not modify or reverse a commitment determination, "unless the record reveals a clear mistake." R.F., supra, 217 N.J. at 175 (quoting D.C., supra, 146 N.J. at 58) (internal quotation marks omitted). We are bound to uphold the judge's findings that are supported by "sufficient credible evidence" in the record. Ibid. (quoting Johnson, supra, 42 N.J. at 162) (internal quotation marks omitted).

Applying these standards and after carefully reviewing the record, we conclude that the judge's findings were supported by sufficient credible evidence in the record, his findings are entitled to our deference and we find no "clear mistake" in his determination. We therefore affirm for substantially the same reasons set forth by Judge Mulvihill in his oral decision of September 9, 2013.

Affirmed.

I hereby certify that the foregoing is a true copy of the original on file in my office.

CLERK OF THE APPELLATE DIVISION