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9 John Doe #3 and John Doe #4

10 **UNITED STATES DISTRICT COURT**
11 **NORTHERN DISTRICT OF CALIFORNIA**
12 **SAN FRANCISCO DIVISION**

13 JOHN DOE #1, an individual;
14 JOHN DOE #2, an individual;
15 JOHN DOE #3, an individual; and
16 JOHN DOE #4, an individual;

17 Plaintiffs,

18 vs.

19 JOHN KERRY, in his official
20 capacity as Secretary of State of the
21 United States; JEH JOHNSON, in his
22 official capacity as Secretary of
23 Homeland Security; LORETTA
24 LYNCH, in her official capacity as
25 Attorney General of the United
26 States; SARAH SALDANA, in her
27 official capacity as Assistant
28 Secretary of Immigration and
Customs Enforcement; R. GIL
KERLIKOWSKE, in his official
capacity as Commissioner of U.S.
Customs and Border Protection;
DAVID HARLOW, in his official
capacity as Acting Director of the
United States Marshals Service; and
DOES 1 to 20, inclusive,

Defendants.

CASE NO. 16-cv-00654-PJH

DECLARATION OF ASSOCIATION FOR
THE TREATMENT OF SEXUAL ABUSERS
IN SUPPORT OF PLAINTIFFS' REQUEST
FOR ORDER TO SHOW CAUSE RE
PRELIMINARY INJUNCTION

1 I, Michael H. Miner, declare as follows:

2 1. I currently serve as President of the Association for the Treatment of
3 Sexual Abusers (ATSA), an international organization dedicated to preventing sexual
4 abuse. ATSA promotes research, evidence-based practice, public policy and
5 community strategies that lead to the effective assessment, treatment, and
6 management of individuals who have sexually abused or are at risk to abuse.

7 2. The statements made below, except for biographical statements,
8 represent the official position of ATSA and have been reviewed by both the
9 Executive Director and Policy Chairman of that organization.

10 3. I was graduated with a Bachelor of Arts degree from Ohio University in
11 psychology in 1975.

12 4. I was graduated with a Master of Arts degree from Loyola Marymount
13 University in counseling psychology in 1977.

14 5. I was graduated with a Ph.D. in psychology from St. Louis University in
15 1984.

16 6. I am a licensed psychologist in the states of California and Minnesota. I
17 am also on the National Register of Health Service Psychologists and a Diplomate in
18 Psychology, American College of Forensic Examiners.

19 7. I am currently employed by the University of Minnesota, Department of
20 Family Medicine and Community Health, as a professor and research director of the
21 Program in Human Sexuality.

22 8. I am currently the Principal Investigator for a five-year, \$1.49 million
23 grant from the National Institute of Justice, "Evaluation of the Implementation of the
24 Sex Offender Treatment Intervention and Progress Scale." I have served as Principal
25 Investigator for nine additional state and federal grants, many of which addressed sex
26 offending issues.

1 9. I am an author of more than 70 peer-reviewed publications, including
2 “The Adam Walsh Act: An Examination of Sex Offender Risk Classification
3 Systems,” which was published in “Sexual Abuse: A Journal of Research and
4 Treatment” in February 2015.

5 10. I am also an editor or co-editor of three books regarding sex offender
6 treatment. In addition, I have contributed chapters regarding sex offenders and sex
7 offending to 10 additional books.

8 11. I am also the author or co-author of 15 reports, including “A multi-site
9 state recidivism study using Static-99R and Static-2002 risk scores and tier guidelines
10 from the Adam Walsh Act” which was funded by the National Institute of Justice and
11 completed in 2012.

12 12. A copy of my complete Curriculum Vitae is attached to this declaration
13 as Exhibit A.

14 13. The rate of re-offense for the group of individuals known as “sex
15 offenders” is the lowest rate of re-offense for any group of individuals convicted of a
16 crime with the exception of murderers. According to Meta analyses, the rate of re-
17 offense for “sex offenders” is, on average, approximately 14 percent, with a recent
18 study finding rates ranging from 6 % to 34% depending on risk level¹.

19 14. The rate of re-offense for “sex offenders” declines with advanced age.
20 That is, the older the “sex offender”, the less likely he is to commit a subsequent sex
21 offense.

22 15. In addition to age, re-offense risk decreases the longer that a “sex
23 offender” is free in the community without a subsequent sex crime arrest.

24 16. Dr. Karl Hanson is one of the world’s preeminent researchers regarding
25 re-offending and risk assessment for “sex offenders.” Dr. Hanson is also a former
26 ATSA board member and a current consultant on my ongoing research grant,

27 _____
28 ¹ Hanson, R.K., Thornton, D., Helmus, L.M. & Babchishin, K.M. (2015). What sexual recidivism rates are associated with Static 99R and Static 2002R scores? *Sexual Abuse*, ??, 1-35.

1 “Evaluation of the Implementation of the Sex Offender Treatment Intervention and
2 Progress Scale”, funded by the National Institute of Justice.

3 17. Dr. Hanson is one of the developers of the Static-99R, the most well-
4 researched and widely used an risk assessment tool worldwide, to determine an
5 individual “sex offender’s” relative risk of re-offense, with categories designating risk
6 as low, moderate low, moderate high, or high.

7 18. According to the results of extensive research conducted by Dr. Hanson,
8 an individual “sex offender” who has a low risk of re-offense is no more likely to
9 commit a subsequent sex offense than an individual who has never committed a sex
10 offense.²

11 19. Also, according to the results of Dr. Hanson’s extensive research, an
12 individual “sex offender” who has a moderate risk of re-offense and who has not
13 committed a new sex offense in 12.5 years is no more likely to commit a subsequent
14 sex offense than an individual who has never committed a sex offense.³

15 20. Further, according to the results of Dr. Hanson’s extensive research, an
16 individual “sex offender” who was deemed at release as high risk of re-offense and
17 who has not committed a new sex offense in 17 years is no more likely commit a
18 subsequent sex offense than an individual who has never committed a sex offense.⁴

19 21. There are multiple treatment options available to reduce the rate of re-
20 offense for “sex offenders”. The most effective treatment options are those that
21 adhere to principles that apply counseling and management strategies according to an
22 individual’s risks, criminogenic needs, and responsiveness to interventions, and
23 include cognitive-behavioral psychotherapeutic treatments and, sometimes,
24 medication.⁵

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² See Exhibit B, line C.

27 ³ See Exhibit B, line B.

28 ⁴ See Exhibit B, line A.

⁵ Hanson, RK, Bourgon, G., Helmus, L., & Hadgson, S. (2009). The principals of effective correctional treatment also apply to sex offenders: a meta-analysis. *Criminal Justice and Behavior*, 36, 865-891.

1 22. Meta-analyses indicate that appropriate psychotherapeutic and/or
2 pharmacologic interventions can result in a 25 to 30 percent reduction in the rate of
3 re-offense for “sex offenders”⁶.

4 23. Research conducted by the Minnesota Department of Corrections
5 indicates that intensive probation or parole supervision is effective in reducing rates
6 of re-offending in high risk “sex offenders”.

7 24. There is little evidence indicating that prevailing legislative responses to
8 sexual offending, such as residence restrictions, community notification, and
9 registration, are likely to reduce the likelihood of re-offense for most “sex offenders.”
10 Conversely, there are indications that many of these policies produce unintended
11 consequences such as unemployment, social isolation, and residential instability –
12 factors that may in fact increase risk of re-offense and decrease public safety.

13 25. The International Megan’s Law (IML) is based upon several
14 misconceptions and is too broad because it treats all registered sex offenders as
15 though they pose a high risk for future sexual crime or human trafficking. That is, the
16 law treats every “sex offender” as a high-risk “sex offender” and does not taken into
17 consideration factors that be correlated with recidivism. . In fact, empirically derived
18 methods for assessing risk are available and could be used in the implementation of
19 IML.

20 26. Further, IML treats individuals who committed their sex offenses as
21 juveniles in the same manner as those who offended as adults, despite clear research
22 demonstrating that juveniles pose a lower risk for re-offending.

23 27. The IML inflicts travel restrictions on registered persons and, potentially,
24 their families. “Sex offenders” with family abroad may be impeded in their ability to
25 maintain contact with relatives or to provide support for dependent family members.

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⁶ Schmucker, M. & Lösel, F. (2015). The effects of sexual offender treatment on recidivism: an international meta-analysis of sound quality evaluations. *Journal of Experimental Criminology*, published on-line, 19 August 2015.

1 Further, it restricts the right to travel, potentially interfering with educational
2 opportunities, business ventures, and employment options.

3 28. The unique identifier, required by the IML to be added to the passports
4 of some “sex offenders,” will falsely imply that all “sex offenders” pose a threat to
5 public safety. This requirement will also stigmatize individuals and expose them to
6 possible vigilante violence domestically and abroad.

7 29. Importantly, The IML fails to identify those who actually engage in
8 human sex trafficking because those individuals are more likely to be motivated by
9 financial incentives (rather than sexual deviance) and are more likely to be involved
10 in organized criminal activities than they are to be registered as “sex offenders.”

11 30. The IML incorrectly uses the terms “pedophile”, “child molester” and
12 “sexual predator” interchangeably. Each of those terms has a different definition as
13 explained below.

14 31. Pedophilia is a mental health diagnosis defined by the Diagnostic and
15 Statistical Manual of Mental Disorders, 5th Edition, as a pattern of exclusive or
16 primary attraction to *prepubescent* children. A person with Pedophilia may or may
17 not have touched a child inappropriately or been convicted of a sexual crime.

18 32. The phrase “child molester” is applied to individuals who have
19 inappropriately touched a child in a sexual manner. He may or may not have the
20 disorder of Pedophilia.

21 33. The phrase “sexual predator” is legal term with no clinical meaning.
22 While the term has been statutorily defined by some states to denote a limited sub-
23 class of high-risk “sex offenders” for purposes of registration, civil commitment,
24 lifetime supervision, and related provisions, these definitions have varied
25 considerably across states. These legal designations are generally reserved for
26 chronic repeat or violent offenders or those deemed to be at especially high risk of re-
27 offense, and do not apply to the vast majority of registered “sex offenders.”

28

1 34. The media has played a significant role in creating a “moral panic” about
2 anyone labeled a “sex offender”. This is largely due to their focus on tragic but
3 statistically improbable crimes such as sexually motivated abductions and murders of
4 children.

5 35. Media coverage and widespread access to information via the Internet
6 has led to the presumption of an increase in sexual assaults upon and murders of
7 children domestically or abroad. However, research evidence indicates that sexual
8 abuse has decreased in frequency over the last two decades.

9 36. While prevention of global human trafficking is an important public
10 safety initiative, the costs associated with IML are likely to be enormously
11 disproportionate to any potential protective benefit of the law. The law is likely to
12 impede the ability of many “sex offenders” to engage in productive and prosocial
13 work-related and family activities afforded to other criminal offenders who have
14 served their time and intend to positively reintegrate into society.

15
16 I declare under penalty of perjury of the laws of the United States that the foregoing is
17 true and correct.

18
19 Dated: February 19, 2016



Michael H. Miner, Ph.D.