Briefing for the Maryland Sexual Offenders Advisory Board:

Laws and Programs for the Special Civil Commitment of Sex Offenders

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Introduction

Twenty states, the District of Columbia, and the Federal jurisdictions have laws for the special civil commitment of sex offenders.[1] Targeting convicted offenders who have completed a criminal sentence but are found to have a "mental abnormality or personality disorder" that makes them sexually dangerous if released, these laws are based on but differ significantly from the laws found in every state for the psychiatric civil commitment of people with mental disorders.

Background: Civil Commitment, Criminal Commitment, and the First-Generation Sex Offender Commitment Statutes

To understand the recent popularity of laws for the special civil commitment of sex offenders and appreciate the variety of other measures states have taken to contain the risks sex offenders present, it is useful briefly to consider the evolution of civil and criminal commitment in the United States over the last 50 years.

Civil Commitment

Psychiatric civil commitment historically has followed a medical model in the United States. In most states, until the 1970s, an individual could be involuntarily admitted to a psychiatric hospital simply upon the certification of a physician that the

1 AZ, CA, DC, FL, IL, IA, KS, MA, MN, MO, NE, NH, NY, ND, NJ, PA, SC, TX, VA, WA, WI, Federal Jurisdictions

individual was "in need of treatment." Some states provided procedural protections for prospective patients, including court hearings and, in a few states, the right to a jury trial, but the standard for commitment—need for treatment—was nearly universal (P. Appelbaum, *Almost a Revolution: Mental Health Law and the Limits of Change,* 1994). Significant reform came only in the late 1960s and early 1970s, as part of the civil rights movement . Citing the sorry conditions that existed in many public institutions at that time and decrying the "massive deprivation of liberty" occasioned by commitment, critics challenged the authority of the state to commit someone simply on a belief that treatment would be beneficial. Heralding the "right to be different" (Kittree, 1971) and even challenging mental illness as a legitimate medical construct (Szasz, 1970), some called for abolition of commitment laws altogether. Courts and legislatures throughout the country took notice, and by the close of the 1970s, virtually every state had rewritten its civil commitment law. No longer was it enough that an individual would benefit from treatment. Now, to justify commitment, it would be necessary to show that, without treatment, an individual's mental disorder would make him or her "dangerous" to self or others.

By the 1980s, virtually every state's commitment law had been amended to require a showing of dangerousness. Today, people speak of the "dangerousness standard" for commitment as though the prevention of dangerousness were commitment's primary purpose. In fact, however, as before, treatment remains the essential aim of civil commitment. The dangerous requirement was added simply to constrain the state's authority to hospitalize people it believed needed treatment—"to insure that, among those individuals who might be candidates for treatment, only those whose mental condition placed them at significant risk of harm would be subject to commitment. By no means were these laws intended to *expand* the scope of commitment —to sweep up and institutionalize people who did not need treatment but who posed a threat to public safety. That was the business of the criminal justice system" (Fitch, WL, and Ortega, RJ, *Behavioral Science and the Law*, 2000).

Criminal Commitment

The criminal law has long provided for the confinement (criminal commitment) of dangerous offenders. The purpose of such confinement is four-fold: (1) to punish offenders, commensurate with the seriousness of their behavior and the degree of their culpability; (2) to incapacitate offenders, denying them the opportunity to reoffend; (3) to deter offenders and others from committing offenses in the future; and (4) to rehabilitate offenders so that they could safely re-enter the community. For most of the last century, rehabilitation was the predominate purpose of the criminal sentence (Von Hirsch, 1983). Offenders requiring confinement were committed to Departments of "Correction," where, in keeping with the "rehabilitative ideal," efforts were made to alter the offender's "underlying personality and to make him safe to be returned to society." (La Fond, 1992). Sentences were generally open-ended, or "indeterminate." An offender might be sentenced to a potentially lengthy period of

confinement but would be eligible at any time for an early release, on parole, if successfully rehabilitated.

It was in this spirit of rehabilitation that the nation's first statutes for the special civil commitment of sex offenders were enacted. Reflecting the view that "sex offenders were ill and that psychiatrists could cure them" (American Psychiatric Association (Fitch, WL), 1999, p. 13), these laws provided for hospitalization (for treatment) in lieu of a traditional criminal sentence.

Sex Offender Commitment: First Generation Statutes

Michigan and Illinois were the first states to enact statutes for the special civil commitment of sex offenders (in 1937-1938). Within two years, Minnesota, Ohio, Wisconsin, California, and Massachusetts had joined their ranks. By the 1950s, more than half the states had special sex offender commitment laws, variously called "sexual psychopath" laws, "sexually dangerous persons" acts, "mentally disordered sex offender" acts, and "defective delinquent" statutes. (Fitch, WL, and Hammen, D, *Protecting Society from Sexually Dangerous Offenders*, 2003). Minnesota's law was typical, targeting for commitment individuals with "conditions of emotional instability or impulsiveness of behavior, or lack of customary standards of good judgment, or failure to appreciate the consequences of his acts, or a combination of any such conditions, as to render such a person irresponsible for his conduct with respect to sexual matters and thereby dangerous to other persons" (Minn stat §26.10 (1941)).

The American Bar Association has observed that the popularity of these early sex offender commitment laws "rested on six assumptions: (1) there is a specific mental disability called sexual psychopathy, or defective delinquency; (2) persons suffering from such a disability are more likely to commit serious crimes, especially dangerous sex offenses, than normal criminals; (3) such persons are easily identified by mental health professionals; (4) the dangerousness of these offenders can be predicted by mental health professionals; (5) treatment is available for the condition; and (6) large numbers of persons afflicted with the designated disabilities can be cured." (American Bar Association, 1984, 1989, p. 457). In the 1970s, however, these assumptions came under attack. "The optimism of earlier decades that psychiatry held the cure to sexual psychopathy no longer shown so brightly." (American Psychiatric Association, 1999, p. 11). One court observed that "[n]on-criminal commitments of so-called dangerous persons have long served as preventive detention, but this function has been either excused or obscured by the promise that, while detained, the potential offender will be rehabilitated by treatment. Notoriously this promise of treatment has served only to bring an illusion of benevolence to what is essentially a warehousing operation for social misfits." (Cross V. Harris, 418 F2d10951107) D.C. Cir 1969)).

Calls for repeal were heard from the Group for the Advancement of Psychiatry (GAP, 1977), the President's Commission on Mental Health (1978), and the American Bar Association (1984, 1989). In its 1977 monograph, *Psychiatry and Sex Psychopath Legislation: the 30s to the 80s,* the GAP observed that the "broad definition of mental illness in sex psychopaths statutes allows almost any mental aberration for emotional disorder to qualify…. More frequently than not, mental illness is deduced primarily, if not solely from the commission of the sexually deviant act." The GAP concluded, "sex

psychopath and sexual offender statutes can best be described as approaches that have failed…. The notion is naïve and confusing that a hybrid amalgam of law and psychiatry can validly label a person a "sex psychopath" or "sex offender" and then treat him in a manner consistent with a guarantee of community safety. The mere assumption that such a heterogeneous legal classification could define treatability and make people more amenable to treatment is not only fallacious; it is startling. Our position is that the experiment was a form of well-intentioned but misguided intervention" (GAP, 1997, p. 843). The GAP report sounded the death knell for these laws; in the next ten years, more than half would be repealed and nearly all the rest fall into disuse (Brakel, et al, 1985, p. 740).

Disillusionment with laws for the special commitment of sex offenders came at a time of growing disillusionment generally with the criminal justice system's emphasis on rehabilitation. Nothing seemed to be working; crime rates were at record highs. Observers across the political spectrum called for change (Cornwall, 1998). Lawmakers responded, scrapping indeterminate sentencing laws and enacting in their place laws prescribing fixed or presumptive sentences that every offender would be required to serve in full. There would be no opportunity for early release. Parole was a thing of the past.

Although intended to "get tough on crime" and keep the "bad guys" locked up, in fact these reforms had the effect of accelerating the release of many of the criminal justice system's most dangerous offenders. The reason requires some explanation but is important to understand. Under indeterminate sentencing, an offender sentenced to incarceration received a term of years representing the maximum possible period of imprisonment. An offender could be required to serve the maximum sentence-- and those presenting the greatest risks to public safety generally were-- but most offenders were released much sooner, on parole. When states moved to determinate sentencing, however, sentence lengths were recalculated based on how long, on average, offenders had served historically (i.e., before release on parole). This recalculation was necessary in order to maintain prison populations at roughly existing levels. If every offender were required to serve the maximum sentence prescribed under indeterminate sentencing, prison populations would explode. The upshot of this reform was that most offenders—the large majority, who would have won early release under an indeterminate sentencing system—found themselves incarcerated for somewhat longer periods than before. But others—ironically the most dangerous offenders, who might never have won an early release on parole—were released much sooner. Among this group was a category of sex offenders the public believed to be at particularly high risk for recidivism, a category soon to be labeled "sexually violent predators."

Faced with these hard realities of determinate sentencing, states experimented with a variety of measures to prevent the premature release of dangerous sex offenders. Some simply ignored the impact on correctional beds and established longer sentences for all sexual crimes or "enhanced" sentences for repeat offenders.[2] Others returned to indeterminate sentencing for certain offense categories and tightened the requirements of parole for offenders who might qualify. Colorado's Lifetime Supervision of Sex Offenders Act authorized sentences of up to life in prison for serious offenders but provided an "intensive supervision parole program" for those who won release, including

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2 Partly as a result of states lengthening determinate sentences, the prison population nationally has grown sevenfold since 1972. DOJ

supervision by specially trained parole officers with small case loads, mandatory sex offender treatment, and monitoring with polygraphs and physiological measures (Colorado Sex Offender Lifetime Supervision Act of 1998, 16-13-805). These more restrictive sentencing laws, however, were applicable only to offenders who committed their crimes after the laws took effect. Constitutional protections (against double jeopardy and ex post facto lawmaking) prevented states from extending an offender's sentence after it had been served. For those already in the pipeline-- offenders sentenced to a fixed term-- retention under the jurisdiction of the criminal justice system would not be an option. For these offenders, states were forced to look to the civil law for remedies. And what they found there was psychiatric civil commitment--other than quarantine, the only mechanism for preventive detention outside the criminal law. But ordinary civil commitment would not do. As much as its focus may have turned to "dangerousness" over the years, civil commitment remained reserved for people with serious mental illnesses-- illnesses most dangerous sex offenders did not have. If civil commitment were to be the state's remedy for a failed sentencing system, a new kind of commitment law would have to be written.

Sexually Violent Predator Commitment: Second Generation Statutes

In 1987, Earl K. Schriner completed a ten-year sentence in a Washington State prison for abducting and assaulting two 16-year old girls. Prior to his release, officials sought to have Mr. Schriner civilly committed, noting that he "had hatched elaborate plans to maim or kill youngsters while waiting out the final months of his prison sentence" (Tacoma Morning News Tribune, May 23, 1989). He was held for evaluation but, at his commitment hearing 72 hours later, was found not to meet commitment criteria (Id.). Four months after his release, Schriner stabbed a boy with a knife. He pled guilty to a reduced charge of simple assault and received (and served) the determinate sentence of 90 days in jail. Shortly after his release from this sentence, he was arrested again, this time for abducting a ten-year old boy, tying him to a fencepost, and beating him (Id.). An attempted rape charge was dismissed in exchange for Schriner's agreement to plead guilty to attempted unlawful imprisonment. He served 67 days in jail. Five months after his release, Schriner abducted a seven-year old boy riding a bicycle in his Tacoma neighborhood, raped the boy orally and anally, and severed his penis. News coverage of the crime was extensive; community reaction was unprecedented. "The executive director of the State Sentencing Guidelines Commission stated that she had calls 'from people who indicated they had never made a phone call on a matter of public policy in their lives'" (Boerner, 1992, p. 534).

Less than a week after the crime, Washington's Governor established a task force to "review the current criminal justice system and the mental health civil involuntary commitment process to measure their effectiveness in confining persons who are not safe to be at large in the community" (Executive Order No. 89-04, Wash. St. Reg. 89-13-055, 1989). The task force's report, issued in November, 1989, included an ambitious legislative agenda for protecting the community from dangerous sex offenders. Warmly received by the Washington Legislature, the task force's legislative proposals were enacted into law in February 1990, as the Community Protection Act. Under the Act,

sentences for most sex crimes were increased and the nation's first sex offender registration requirement was established, providing a model for legislation in other states and for federal legislation (The Jacob Wetterling Act of 1991) imploring all states to enact sex offender registration laws. Finally, the Act established a new procedure for the special civil commitment of sex offenders leaving jail or prison (RCW §71.09.010 (1990)).

In a Preamble to the law, the Washington legislature explained why this new commitment procedure was necessary: "The Legislature finds that a small but extremely dangerous group of sexually violent predators exist that do not have a mental disease or defect that renders them appropriate for the existing Involuntary Treatment Act….In contrast to persons appropriate for [ordinary] commitment, sexually violent predators generally have antisocial personality features which are unamenable to existing mental illness treatment modalities….The Legislature further finds that the prognosis for curing sexually violent predators is poor, the treatment needs of this population are very long, and the treatment modalities for this population are very different from the traditional treatment modalities for people appropriate for commitment under the Involuntary Treatment Act" (RCW §71-09-010 (1990)).

Unlike its first-generation sex offender commitment law, repealed only 10 years earlier, Washington's new law made no provision for commitment as an alternative to imprisonment. In fact, it made no provision for treatment whatsoever until an offender had completed his or her sentence and was scheduled for release to the community. Commenting on laws like Washington's, the American Psychiatric Association has observed that "their primary purpose would appear to be incapacitative rather than therapeutic. No one has suggested that these laws reflect a renewed faith in the power of psychiatry to cure sex offenders" (APA, Dangerous Sex Offenders, 1999).

Washington's law provides for the indeterminate civil commitment of criminal offenders found to be "sexually violent predators" (a term coined by the Community Protection Act). The law defines "sexually violent predator" as "any person who has been convicted of or charged with a crime of sexual violence and who suffers from a mental abnormality or personality disorder which makes the person likely to engage in predatory acts of sexual violence if not confined in a secure facility" (RCWA 71.09.020 (16) (2003)). "Sexually violent offense" includes forceable rape, statutory rape, indecent liberties by forceable compulsion, indecent liberties or incest against a child under age 14, child molestation, and other crimes (including property crimes) determined to have been "sexually motivated" (RCWA 71.09.020 (15) (2003)). "Mental abnormality" is defined as "a congenital or acquired condition affecting the emotional or volitional capacity which predisposes the person to the commission of criminal sexual acts in a degree constituting such person a menace to the health and safety of others" (RCWA 71.09.020 (8) (2003)). "Personality disorder" is not defined in Washington law. "Predatory," under Washington law, is defined as "acts directed towards: (a) strangers; (b) individuals with whom a relationship has been established or promoted for the primary purpose of victimization; or (c) persons of casual acquaintance with whom no substantial personal relationship exists" (RCWA 71.09.020 (9) (2003)).

Although aimed primarily at convicted offenders completing a criminal sentence, Washington's law also may be used for the commitment of (1) criminal defendants found incompetent to stand trial or not guilty by reason of insanity of a sexually violent offense but not (or no longer) committable under applicable laws and (2) juveniles found delinquent for a sexually violent offense and about to be released from confinement in the juvenile justice system (RCWA 71.09.030 (2003)).

Individuals found to be sexually violent predators under the law are committed to a secure facility operated by Washington's Department of Social and Health Services. The period of commitment is indeterminate—"until such time as: (a) the person's condition has so changed that the person no longer meets the definition of a sexually violent predator; or (b) conditional release to a less restrictive alternative…is in the best interest of the person and conditions can be imposed that would adequately protect the community" (71.09.060 (2001)).[3]

Washington's law, the first of this new breed of post-sentence commitment law, has served as a model for legislation in other states. Laws in Kansas and Wisconsin (both enacted in 1994) were virtually carbon copies of Washington's law. Even today, most states' laws closely resemble Washington's. There are some notable differences, however:

[3] Section (b), providing for conditional release to a less restrictive alternative, did not appear in the statute as originally enacted but was added later in response to a court decision.

- Texas law provides only for outpatient commitment. It expressly forbids housing of committed offenders "for any period of time" in a mental health facility. The standard for commitment, however, is identical to that in the other states.

- In Pennsylvania, commitment applies only to juveniles "aging out" of the juvenile justice system (and therefore no longer subject to detention). Pennsylvania has no law for the special civil commitment of adult sex offenders leaving criminal justice confinement.

- Missouri law allows for the commitment of previously convicted individuals not currently in custody who have committed a "recent overt act" (one that creates a reasonable apprehension of sexually violent harm) and meet criteria of a sexually violent predator.

Among the most recent statutes for the special civil commitment of sex offenders is the federal "sexually dangerous persons" law, enacted in July 2006 as part of the Adam Walsh Child Safety and Protection Act. Targeted at offenders leaving confinement in the federal criminal justice system, the law closely resembles the states' sex offender commitment laws, with one big exception: no provision is made for a federal commitment facility. Rather, offenders found to be "sexually dangerous persons" under the law are committed to the custody of the United States Attorney General. The law directs the Attorney General to "release the person to the appropriate official of the State in which the person is domiciled or was tried if such State will assume responsibility for his custody, care, and treatment." The law goes on to provide that "the Attorney General shall make all reasonable efforts to cause such a State to assume such responsibility. If, notwithstanding such efforts, neither such State will assume such responsibility, the Attorney General shall place the person in a suitable facility, until a State will assume such responsibility or [the person no longer meets criteria for commitment.]" Note that nothing in the new law requires states to assume responsibility for federal committees presented by the Attorney General.

Current Statutes: Rates of Commitment and Release

Surveys conducted by the Forensic Division of the National Association of State Mental Health Program Directors (NASMHPD) in 2006 and by the Sex Offender Civil

Commitment Program Network (SOCCPN) in 2008 and 2009 show that there are at least 5,094 individuals confined in sex offender commitment facilities nationally. States with the largest patient populations include California (1045), Florida (670), Minnesota (565), New Jersey (402), Illinois (365); Wisconsin (349), and Massachusetts (317). Other states report the following numbers: 68 in Arizona; 74 in Iowa; 170 in Kansas; 147 in Missouri; an undetermined number in Nebraska; 2 in New Hampshire; 175 in New York; 60 in North Dakota; 24 in Pennsylvania; 90 in South Carolina; 0 in Texas (where only outpatient commitment is permitted); more than 200 in Virginia; and 285 in Washington State. The District of Columbia serves a population of 4-- offenders committed under a first generation commitment law that no longer is used for new commitments but is still on the books to provide authority for the retention of earlier committees. Note that DC has reported a population of 4 each year since NASMHPD began surveying these programs in 1997.

In some states, the law allows for the alternative of commitment to outpatient treatment in the community--a "less restrictive alternative" to confinement (or "LRA"). In most states, an individual committed to a facility may be transitioned to an LRA on "conditional release" (AKA "supervised release" or "transitional release") after some period of inpatient commitment. In many states, supervisory responsibilities for individuals on conditional release rest with the state's Department of Probation and Parole. Typical conditions of placement in an LRA include: compliance with treatment; leaving one's residence only with supervision; electronic monitoring; no use of drugs or alcohol; no access to internet pornography; and restricted access to "vulnerable populations" (Fitch, W.L., and Hammen, D., 2002). Offenders on supervised release in Wisconsin are restricted to their residence for the first year "except for outings that are under the direct supervision of a Department of Corrections employee and that are for employment purposes, religious purposes, or for caring for one's basic living needs" (personal communication from the former Director of Forensic Services for Wisconsin's state mental health authority).

The NASMHPD and SOCCPN surveys described earlier show that, nationally, 280 offenders are committed to an LRA: 59 in Arizona (in a residence on the grounds of the state's maximum security facility); 6 in California; 19 in Illinois; 6 in Iowa; 7 in Kansa; 18 in New Jersey; 139 in Texas (where all commitments are outpatient); 10 in Washington State; and 16 in Wisconsin. No one was committed to an LRA in DC, Florida, Massachussetts, Minnesota, Missouri, New Hampshire, North Dakota, Pennsylvania, South Carolina, Virginia, or the federal jurisdictions. The survey was unable to determine the number of offenders who had completed treatment and been discharged from commitment altogether. The New York Times, however, has reported that, nationally, 250 offenders have been released unconditionally in the years since Washington State's law was enacted 1990-- only about half having completed treatment, however; the rest were released "on legal or technical grounds unrelated to treatment" (M. Davey and A. Goodnough, "Doubts Rise as States Hold Sex Offenders After Prison," *New York Times,* March 4, 2007).

Current Statutes: Costs

Costs associated with implementing sex offender commitment laws include the cost of end-of-sentence reviews (to determine who among the large number of qualifying offenders leaving prison should be referred for consideration of commitment), the cost of mental health evaluations and risk assessments conducted prior to commitment hearings, legal costs (attorneys' fees, court costs, other litigation costs), the cost of inpatient care and treatment (including the cost of operating commitment facilities), the cost of services and monitoring for offenders on conditional release (typically including housing), and capital costs (i.e., construction or renovation of inpatient and community facilities). The 2006 NASMHPD survey of states with commitment laws found inpatient treatment costs (per patient, per year) ranging from $40,108 (in Massachusetts) to $237,000 (in the District of Columbia). In Minnesota, the state with the longest experience serving committed sex offenders, inpatient costs were estimated to be $120,000. Other states reported inpatient costs as follows: $97,502 in North Dakota; $107,000 in California; $ 300,000 in Pennsylvania (but expected to fall substantially as the new program's census grows); $41,267 in Kansas; $107,000 in Washington State (2005 costs); $127,750 in Wisconsin; $91,250 in South Carolina (2005 costs); $76,334 in Illinois (2005 costs); $92,500 in Arizona; $73,724 in Missouri, $65,000 in New Jersey; and $170,000 in Virginia. A more recent AP analysis found annual per capita costs of $175,000 in New York and $173,000 in California (Lohn, M, 2010).

The cost of serving an individual in the community is difficult to assess, as there have been relatively few outpatient commitment orders written to date and the needs of individuals placed in the community vary so widely. In Washington State alone, the range extends from $25,000 to more than $400,000 (Seling, M., 2002). Kansas reports that it spends about $100,000 annually for "transitional services" for SVPs in the community; Illinois reports an average of $80,000 for each of its five outpatients (2005 costs); Wisconsin reports an average of $40,000 for each of its sixteen; Virginia an average of $13,700 for each of its four; and California an average of $125,000 for each of its four. The other states either had no offenders under outpatient treatment or were unable to provide cost estimates.

Costs associated with the legal process are particularly difficult to determine. The former clinical director of the Center for Forensic Services in Washington State has estimated that court costs and "litigation costs" in his state average approximately $35,000 per patient per year (Hamilton, D., 2000). In response to a survey conducted in 1997, officials in Minnesota estimated that each commitment proceeding cost approximately $100,000, for attorneys and experts alone, not including other court costs (NASMHPD, 1997).

Diagnosis

One of the most pressing questions for mental health authorities charged with implementing laws for the special civil commitment of sex offenders is whether the people these laws take in have the kinds of mental disorders for which facility-level care and treatment are clinically indicated. A NASMHPD survey in 2002 showed the diagnoses of all patients committed in 14 of the 16 jurisdictions with a sex offender

commitment law in effect at that time.[4] The survey determined[5] the number and percentage of patients in each state with any of the following conditions: "serious mental illness (such as would be common among patients committed under ordinary civil commitment laws);" mental retardation; paraphilia (differentiated); and personality disorder (differentiated for antisocial personality disorder). Nationally, 12 percent of all committed SVPs were diagnosed with a serious mental illness. Four percent were diagnosed with mental retardation. Eighty-five percent carried a diagnosis of paraphilia, including 49 percent (of all committed patients) with pedophilia; 6 percent with masochism or sadism; 14 percent with exhibitionism, fetishism, frotteurism, or voyeurism; and 23 percent with paraphilia, NOS. Seventy-five percent of all committed SVPs carried a diagnosis of a personality disorder. Forty-eight percent (of all committed SVPs) had antisocial personality disorder (Fitch, W.L., New York Academy of Science, 2003).

Clearly, many committed SVPs carry more than one diagnosis. The 2002 survey, however, did not examine how different diagnoses cluster. Therefore, it is not known, for example, what percentage of individuals with pedophilia also carry a diagnosis of antisocial personality disorder. Citing a 1999 study by Raymond et al, Fagen et al recently reported that 60 percent of male pedophilic sex offenders also meet criteria for a personality disorder, "the chief among them being obsessive compulsive (25 percent), antisocial (22.5 percent), narcissistic (20%), and avoidant (20 percent)." (Fagen, P.J., et al, 2002, p. 2461). Although the prevalence of personality disorders (and particularly antisocial personality disorder) among pedophiles committed as SVPs is not known, the survey data and anecdotal evidence suggest it is higher than the prevalence Raymond et al found among sex offenders in general.

Professional Concerns

Since they first appeared in the early 1990s, laws for the special, post-sentence civil commitment of sex offenders have aroused serious concerns in the professional community. In 1994, with legislatures throughout the country considering sex offender commitment bills, the American Psychiatric Association established a Task Force to study these laws. In 1996, the Task Force released an interim report observing that the individuals these laws were designed to commit in many cases did not have the kinds of serious mental disorders for which inpatient psychiatric services were appropriate. The Task Force declared that these laws employed psychiatric commitment as a "pretext for extended confinement that would otherwise be impermissible" and, thus, served to "distort the traditional meanings of civil commitment, misallocate psychiatric facilities and resources, and constitute an abuse of psychiatry" (American Psychiatric Association, 1996, p. 106). Note that the APA had used this characterization, "abuse of psychiatry," only once before-- in describing psychiatry in the former Soviet Union. Three years after releasing its preliminary report, the APA published the Task Force's Final Report.

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4 Officials in Florida were unable to provide the requested information, and no one had yet been committed in Virginia, where the law's implementation date had been delayed until 2004.

5 In some states, the data provided represented the "best estimate" of the state official completing the survey.

Employing slightly less sensational language, the report concluded: "[S]exual Predator Commitment Laws represent a serious assault on the integrity of psychiatry…[B]y bending civil commitment to serve essentially non-medical purposes, sexual predator commitment statutes threaten to undermine the legitimacy of the medical model of commitment….[T]his represents an unacceptable misuse of psychiatry" (American Psychiatric Association, 1999, p. 173-174). Rejecting civil commitment, the APA recommended that states contain the risk of sex offender recidivism by "bring[ing] back indeterminate sentencing, at least for repeat sex offenders. By prescribing lengthy sentences (e.g., life)… but allowing for discretionary parole, the state could ensure the retention of inmates deemed to be at high risk, yet allow for the release of lower risk offenders, and it could do all this without the the pretext of treatment. Treatment, of course, might be available to offenders serving their sentences (and, indeed, release decision making might turn, in some cases, on an offender's response to treatment), but pretending that treatment is the *purpose* of confinement no longer would be necessary."

NASMHPD has taken a significant interest in these laws since 1997, conducting annual surveys to assess legislative activity in different states and to monitor implementation efforts and legal developments in states with these laws. NASMHPD's 1997 Position Statement, noted above, warned that laws for the special civil commitment of sex offenders threatened to "disrupt the state's ability to provide services for people with treatable psychiatric illnesses,…undermine the mission and integrity of the public mental health system,…divert scarce resources away from people who both need and desire treatment,…and endanger the safety of others in those facilities who have treatable psychiatric illnesses" (NASMHPD, 1997, p. ii). Recognizing that, despite this warning, legislation was likely to continue in many states, NASMHPD included in its statement the following "guidelines" for legislatures bent on enacting statutes of this kind:

(1) If enacted, sex offender commitment laws should be clearly distinct from ordinary civil commitment laws (to avoid any confusion of the two patient populations and, thus, minimize the stigma psychiatric patients might experience by their association with SVPs);
(2) SVPs should not be committable to facilities with mentally ill patients (for the protection of the patients);
(3) SVP facilities should be administered and funded outside the state mental health authority (to maintain the mission and integrity of the public mental health system and guard against the depletion of resources allocated for traditional mental health services);
(4) If state mental health authorities are given responsibility for treatment, they also should be given a role in determining committability, treatment strategies, and length of stay;
(5) Laws should be narrowly drawn to capture only those offenders most in need of inpatient care and treatment; and
(6) Treatment of SVPs should begin before their release from prison (NASMHPD, 1997, p. iii).

While subsequent legislation has accommodated some of NASMHPD's concerns, mental health agencies in states with these laws continue to have responsibility for

providing (and funding) care for committed offenders, and their influence over commitment and release decision-making remains limited.

Legal Challenges

Laws for the special civil commitment of sex offenders have been challenged on the ground that they allow commitment without a finding of mental illness —that a "mental abnormality" or "personality disorder" does not constitute the kind of mental disorder that justifies commitment to a mental health facility. At the same time, states have been sued for failing to provide meaningful services for committed offenders.

Kansas v. Hendricks: *Constitutionality of Special Commitment*

After conflicting decisions in the lower courts, the U.S. Supreme Court in *Kansas v. Hendricks* (1997) rejected the idea that civil commitment required a showing of mental illness (or any other condition recognized by organized psychiatry): "[W]e have never required State legislatures to adopt any particular nomenclature in drafting civil commitment statutes. Rather, we have traditionally left to legislators the task of defining terms of a medical nature that have legal significance." The Court also rejected challenges based on the constitutional prohibitions against double jeopardy and ex post facto laws (arguments that the law in effect punished offenders for past conduct for which they already had been convicted and served their time), determining that the law was civil in nature based on its legislative intent and therefore not punitive. The Court was unmoved by the fact that Mr. Hendricks, the patient in this case, had received "essentially no treatment during this period of commitment." The majority attributed that apparent shortcoming to the novelty of the treatment program, pointing out that treatment, after all, was a stated purpose of the commitment.

In a concurring opinion, however-- an opinion essential to the holding in this 5-4 decision-- Justice Kennedy made clear his view that the availability of treatment was prerequisite to the law's constitutionality. " If the object or purpose of the Kansas law had been to provide treatment but the treatment provisions were adopted as a sham or mere pretext, there would have been an indication of the forbidden purpose to punish." Justice Kennedy went on to question the legitimacy of "mental abnormality" as the predicate condition for commitment: "If it were shown that mental abnormality is too imprecise a a category to offer a solid basis for concluding that civil detention is justified, our precedence would not suffice to validate it…. In this case, the mental abnormality—pedophilia—is at least described in the DSM-IV."

In a dissenting opinion, Justice Breyer identified several aspects of the statute that made it appear more punitive than civil. In addition to the apparent lack of treatment for committed patients, he noted that the State's concerns about an offender's treatment needs were absent altogether prior to the offender's release from prison, suggesting that the real motivation for commitment was not to ensure treatment, but, rather, to ensure continued confinement. He also noted the State's failure to provide for alternative, less

restrictive forms of treatment, routinely available for individuals subject to ordinary civil commitment. [6]

Note that in its opinion in *Hendricks*, the Court wrote that "[t]he pre-commitment requirement of a "mental abnormality" or "personality disorder" [in the Kansas law] is consistent with the requirements of these other statutes that we have upheld in that it narrows the class of persons eligible for confinement to those who are *unable to control their dangerousness*" (emphasis added). Nothing in the Kansas statute, however, required a showing of lack of control. That said, Hendricks' testified at his commitment hearing that he was unable to control the urge to molest children and that "the only way he could keep from sexually abusing children in the future was "to die"" (*Kansas v. Hendricks*, p. 355). Suppose he had not given this testimony? Would his commitment still have withstood the Court's scrutiny? Hendricks was diagnosed with pedophilia. Would this diagnosis alone provide the basis for finding him unable to control his behavior? Did the Court mean to imply that all "mental abnormalities" or "personality disorders" render an individual unable to control their dangerousness? Or did it mean to suggest that commitment in every case requires specific evidence of such an inability? These questions lie at the heart of a subsequent Supreme Court case, *Kansas v. Crane*, 534 U.S. 407 (2002).

Kansas v. Crane: *Commitment Standard*

Like Leroy Hendrick*s*, Michael Crane was committed pursuant to the provisions of Kansas' sex offender commitment law. At the time he was committed, Crane had just completed a five-month sentence for lewd and lascivious behavior. At his commitment hearing, experts testified that he suffered from exhibitionism and antisocial personality disorder and that these conditions rendered him a sexually violent predator, at risk for future offenses. There was no testimony (or finding) that Crane was unable to control his dangerousness, but the trial court committed him nonetheless. Hearing his case on appeal, the Kansas Supreme Court overturned Crane's commitment, citing the state's failure to prove Crane's inability to control his dangerousness as required by the Court in *Hendricks*. "A fair reading of the majority opinion in Hendricks leads us to the inescapable conclusion that commitment under the Act is unconstitutional absent a finding that the defendant cannot control his dangerous behavior. To conclude otherwise would require that we ignore the plain language of the majority opinion in *Hendricks* (In re *Crane*, 269 Kan. 578, 585 (2000)).

Kansas appealed the State Court's decision, arguing that its rationale (that the state need prove individuals "completely unable to control their behavior") reflected a misreading of *Hendricks*. The U.S. Supreme Court accepted the case for review and, in a decision announced in 2002, agreed with Kansas that "*Hendricks* set forth no requirement of total or complete lack of control" (*Kansas v. Crane,* p. 411). The Court, however, declared that some "lack of control" analysis was required.

> "We do not agree with the state…insofar as it seeks to claim that the Constitution permits commitment of the type of dangerous

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6 Note that Kansas has since added a provision for commitment to a less restrictive alternative.

> sexual offender considered in *Hendricks* without any lack of control determination….[T]here must be proof of serious difficulty in controlling behavior. And this, when viewed in light of such features of the case as the nature of the psychiatric diagnosis, and the severity of mental abnormality itself, must be sufficient to distinguish the dangerous sexual offender whose serious mental illness, abnormality, or disorder, subjects him to civil commitment from the dangerous but typical recidivist convicted in an ordinary case" (*Kansas v. Crane,* p. 412).

The Court observed that 40-60 percent of male prison inmates have antisocial personality disorder and suggested that a law that would allow these inmates to be kept confined (after serving their sentences) under the guise of civil commitment might invite commitment to be used as "a mechanism for retribution or general deterrence—functions properly those of criminal law, not civil commitment" (*Kansas v. Crane,* p. 412).

Unresolved by the Court's opinion in *Crane* is the question whether diagnosis alone may establish "lack of control." Does the Court's lack of control requirement simply represent an effort to distinguish individuals with a serious enough mental condition to warrant commitment, or does it stand as an independent criterion that must be established in every case? Must individuals who have schizophrenia (and are dangerous) also be shown to have serious difficulty controlling their behavior in order to be committed? If so, are ordinary civil commitment laws, none of which require evidence of impaired behavioral control (apart from their requirement that dangerousness be due to a mental disorder) constitutionally suspect in light of *Crane*?

In distinguishing Hendricks' (valid) commitment from Crane's, the Supreme Court described pedophilia as a "serious disorder," "a critical distinguishing feature [of which is] a special and serious lack of ability to control behavior" (*Kansas v. Crane,* p. 412).[7] The 2002 Forensic Division Survey discussed above found that nearly half of all committed sex offenders have pedophilia. Are their commitments validated by *Crane*, or, in the absence of specific proof of impaired behavioral control, are they suspect? Finally, what about those individuals with "less serious" diagnoses? Seventy-five percent of all committed SVPs have a personality disorder. Nearly 50 percent have anti-social personality disorder. If an individual suffers from a disorder like pedophilia (which carries with it some impairment in behavioral control) but also suffers from anti-social personality disorder (which the Court suggested may not adequately distinguish offenders suitable for commitment from those "convicted in an ordinary case") , must there be a determination which disorder accounts for the offender's propensity to offend (or "serious difficulty controlling behavior")? And if it is the latter, will commitment be permissible? Or would commitment under these circumstances amount to "a mechanism for retribution or general deterrence?" All of these are important questions that the Supreme Court has yet to take up.[8] In the meantime, many states have amended their

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7 Note that the Court also recognized Hendricks' admissions (that he could not control his urge to molest children) as evidence of his inability to control his behavior.

8 Note that the Washington Supreme Court has ruled that where commitment may be based on either a "mental abnormality" or a "personality disorder," due process does not require a jury to indicate from which disorder the individual suffers; the two may operate independently or work in conjunction. "Thus, because

commitment laws in accordance with *Crane* to require a finding of "serious difficulty controlling behavior." Whether this additional requirement has had any effect on commitment practices is unclear.

Seling v. Young: *Services and Conditions of Confinement*

The Supreme Court to date has heard only one other sex offender commitment case, *Seling v Young* (531 U.S. 250 (2001), a case with particularly important implications for mental health program directors. Andre Young was among the first sex offenders committed (in 1990) under Washington's new sexual predator commitment law. A litigious soul, Young spent the next 11 years in and out of court challenging his commitment. Finally, in 2001, his case reached the U.S. Supreme Court .

The issue before the Court in Young's case was whether Washington's sex offender commitment law should be held unconstitutional not *on its face* (the Court's opinion in *Hendricks* having effectively precluded that argument) but, rather, *as it was applied* in his case. Young argued that his confinement at the state's Special Commitment Center was "too restrictive, that the conditions [were] incompatible with treatment, and that the system [was] designed to result in indefinite confinement." Therefore, he insisted, his confinement was incompatible with the law's stated purpose of treatment and, in effect, amounted to a term of punishment, in violation the Double Jeopardy and Ex Post Facto Clauses of the U. S. Constitution.

The Court, however, denied Young's claim, on the ground that as-applied challenges "would prove unworkable." The Court noted that treatment facilities, such as the one where Young was held, had changing conditions that made it difficult for federal courts to assess their constitutionality. The result was that, even if Young was receiving de facto punishment in the Center, the Court was in no position to provide the relief Young sought. Rather, the court suggested, Young's remedy lay elsewhere.

Prior to the Court's ruling in Young's case, the federal district court in Washington had found the conditions of confinement at the state's Special Commitment Center (SCC) to be inadequate and issued what became a long-standing injunction against the Center. To remedy deficiencies, the court ordered Washington to (1) hire competent therapists, (2) rectify the lack of trust and rapport between staff and residents, (3) implement a treatment program that met prevailing standards, (4) develop treatment plans for all residents, and (5) hire a psychologist or psychiatrist with sex offender treatment expertise to supervise the clinical staff (*Turay v. Seling,* 108 F. Supp. 2d 1148 (2000)). The Supreme Court in *Seling v. Young* cited these civil actions as the primary recourse for sex offenders objecting to the conditions of their confinement. "It is for the Washington courts to determine whether the Center is operating in accordance with state law and provide a remedy," Justice O'Connor wrote in her majority opinion. In addition,

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a sexually violent predator may suffer from both defects simultaneously, the mental illnesses are not repugnant to each other and may inhere in the same transaction" (*In re the Detention of Halgren,* 156 Wash.2d 795, 132 P.3d 714 (2006)). If, however, one of the disorders provides an insufficient basis for commitment (as the U.S. Supreme Court in *Crane* suggested anti-social personality disorder would), then it may be necessary for a jury to specify the applicable disorder,

she noted, confined sex offenders might have causes of action under federal civil rights law, 42 U.S.C. § 1983.

Implications for Policy and Programs

The Court's decision in *Young* makes clear that states with these laws must offer their patients some level of care and treatment in a therapeutic environment, lest they face lawsuits claiming denial of civil rights (Fitch, 2006). *Turay v. Seling* had produced rulings from both state and federal courts in Washington finding inadequacies in the state's treatment program. In 1998, 15 residents in Washington's SCC sought damages, and the State agreed to pay each $10,000 as well as $250,000 in lawyers' fees. Orders issued in 1998 and 1999 called for further improvement at the SCC. In a 1999 evidentiary hearing, the State conceded that it still had not met professional standards as required under the Constitution. Later that year, the *Turay* court found the State and the SCC guilty of "foot-dragging which had continued for an unconscionable time." The court admonished the State for a litany of "failures:" failure to provide sufficient staff training; failure to provide individualized treatment programs; failure to make adequate provisions for participation of the residents' families in treatment; failure to distinguish the facility from the state prison; failure to improve the treatment environment by providing for resident grievances and vocational training; failure to institute more oversight; and failure to take "all reasonable steps to bring a constitutionally adequate program into reality rather than merely describing it on paper."

After years of litigation, on March 23, 2007, the federal district court dissolved the *Turay* injunction, noting that "the defendants have worked long and hard to meet the constitutional requirements identified by this Court, and there is no longer any basis for the Court's continued oversight." The lesson in Washington's experience, however, is clear: states with laws for the special commitment of sex offenders must provide meaningful services, and they must provide these services in a therapeutic environment. Failure to do so might not threaten the constitutionality of a state's law, but it almost certainly will become a lightening rod for patient litigation.

Practical Considerations

This section of the paper presents observations made by mental health professionals, researchers, and attorneys from several states with sex offender commitment programs during a two-day meeting held at the National Association of State Mental Health Program Directors in 2007. Participants were encouraged to speak frankly.

Services in Prison

The meeting participants were unanimous in their opinion that if treatment is going to be provided for sex offenders, it should begin while the offender is serving his or her sentence in prison, not reserved for such time as the defendant is about to be released. Ideally, the group suggested, sentences for sex offenders should be indeterminate (i.e., potentially long-term but with the possibility for early release on parole), both to encourage offenders to participate in treatment (in hopes of winning early release) and to provide officials with the authority to retain offenders whose risks remain high. It was reported that some sentenced offenders in states with post-sentence commitment laws are reluctant to participate in prison-based treatment for fear that disclosures they make there might be used against them during end-of-sentence commitment proceedings.

Recidivism Rates

It was the sense of the group that the public (and policy-makers) over-estimate sex offender recidivism rates--that most people believe sex offenders in general re-offend at far higher rates than non-sex offenders. Data collected by the Department of Justice, however, suggest just the opposite, showing that non-sex offenders in fact are 50% more likely than sex offenders to be arrested for a new criminal offense (68% of non-sex offenders arrested within 3 years of release from prison versus 43% of sex offenders, generally). More importantly, the offenses for which released sex offenders are re-arrested very rarely are sex offenses (5.3% arrested for a sex offense versus 38% arrested for a non-sex offense). That said, released sex offenders are significantly more likely to be arrested for a sex offense than released non-sex offenders (1.3% of non-sex offenders rearrested versus 5.3% of released sex offenders, generally). It is important to note that these statistics represent arrest rates, which may not accurately reflect the rates at which sex offenders (or other offenders) re-offend.

One meeting participant noted that sex offense rates are significantly lower than they were 20 years ago. Citing studies by Finklehor, he offered several possible explanations: (1) the country's population has aged (and sex offenses, like other crimes, are committed disproportionately by men in their teens and twenties); (2) the population has become more obese, with increasing numbers suffering from diabetes (which tends to be associated with decreased libido and sexual functioning); (3) sex offending behavior is seen as more repugnant and socially unacceptable than in the past, and offenders may have a greater fear of identification and prosecution; (4) parents are more protective of their children, at least with respect to risks associated with sexual molestation; and (5) fewer young adults today than in previous years were the victims of sexual and child abuse in their youth, reducing their risk to commit sexual assaults (D. Finklehor, 2004). Because rates of sexual re-offense have dropped so significantly, developers of the Static

99, an actuarial instrument used to assess the risk of sexual recidivism, have had to re-norm the instrument (Helms, L, Hanson, R, and Thornton, D, 2009).

Anticipating Bed Need

Everyone at the meeting noted that their states, when preparing to implement sex offender commitment laws, significantly underestimated the number of offenders who would be committed. California, for example, watched beds at its Atascadero State Hospital fill to capacity with sex offenders before finally constructing a new (1500 bed) facility exclusively for this population. In Kansas, unanticipated growth in the population of committed sex offenders led to a Legislative Audit which concluded that "[u]nless Kansas is willing to accept a higher level of risk of re-offense, few options exist to curb the growth of the program" (Performance Audit Report, 2005). Options the auditors suggested included reducing the number of sex offenders who are eligible for commitment, allowing sex offenders whose risk levels have dropped to be released, providing treatment to sex offenders while they are in prison, establishing a community containment model for offenders in the transition phase of commitment, and transferring medically frail offenders to nursing homes.

In many states, authorities have established "filing considerations" to guide authorities responsible for deciding whom to petition for commitment. Designed to identify offenders who not only are at highest risk but also are clinically most appropriate, filing considerations can do much to regulate commitment rates. In Washington State, the Association of Prosecuting Attorneys promulgated filing considerations "calling for a petition only if:

- a qualified mental health professional has determined that the offender "(a) currently suffers from the requisite mental abnormality or personality disorder and (b) because of that mental condition is likely to engage in predatory acts of sexual violence"
- the offender has a "provable pattern of prior predatory acts" (in practice, at least three prior acts are required)
- the offender was not paroled for his or her most recent offense
- all other civil commitment and/or criminal proceedings have been exhausted
- the victim and/or victim's family has been consulted and their willingness to testify has been considered" (Sappington, 1998, in Fitch, 2003).

Filing considerations, however, are not immutable or resistant to public pressures. After a study in Washington State showed a 59 percent criminal arrest rate (during a 5-70 month follow-up) for referred sex offenders for whom no petition was filed, the filing rate in Washington jumped in one year from 35 percent (of offenders referred) to 84 percent. (NASMHPD/HSRI, 1999, pp. 22-23).

Impact on Mental Health Resources

A discussion about the impact of these special commitment laws on the availability of resources for people with more serious mental disorders in public mental health systems failed to reach a consensus. In some states, it appears, budgets for the development and operation of sex offender programs are provided separately from those funding other mental health services. There were reports, however, that bed availability had been adversely affected in some states with these laws. In California, as noted above, until the state constructed its new 1500-bed sex offender facility in Coalinga, committed offenders had displaced nearly all the psychiatric patients at Atascadero State Hospital. In Wisconsin, commitments reportedly have temporarily displaced some mentally ill correctional inmates from beds in a secure hospital operated for correctional inmates. Finally, everyone recognized that regardless of how discretely agency budgets are maintained, these new offender commitment programs are costly to the states (with costs increasing each year as the committed population grows) and naturally have an impact on the amount of funding available for other state services.

Patients' Rights

Participants noted that patients committed under these special commitment laws presented behavioral issues that were significantly different from those seen in patients served in ordinary inpatient psychiatric settings. The incidence of instrumental violence (violence not the product of a mental illness) is a particular problem that distinguishes this population. The group felt strongly that patients' rights regulations written for psychiatric facilities must be modified for use in these special commitment facilities. Some states' commitment programs are operated jointly by the state mental health authority and the state corrections authority (typically with mental health providing clinical care and corrections providing security services). All these programs, the participants suggested—whether operated by Departments of Correction or Departments of Mental Health, should be seen as distinctly different, with features of both mental health and corrections; the conditions of treatment should be regulated accordingly.

Amendments to Statutes

It was noted that legislative changes made in the years following the enactment of sex offender commitment laws often make these laws more restrictive, further frustrating states' efforts to move offenders through treatment and back to the community. In Wisconsin, for example, the standard of proof for commitment and retention was changed recently from "substantial probability" (that the offender will engage in acts of sexual violence) to "more likely than not." Also, the opportunity for placement on supervised release, originally available at the time of commitment, was

made unavailable until after an offender had spent 18 months in confinement. Finally, there have been increasing restrictions on supervised release in Wisconsin, including a provision for what amounts to "house arrest" during an offender's first year in the community.

Obstacles to Release

Committed sex offenders present with very complex problems; few ever reach a level of safety that is assured. Even if treatment has been successful and a patient's risk has been reduced, say, from 55% to 25%, the question arises, is 1 chance in 4 low enough? Can the program explain to the press its decision to release such a patient if things go awry? One participant observed: "If you have this law and you let someone out, there's going to be trouble; if you have this law and you don't let someone out, there's going to be trouble." Another suggested that the threshold for release should be the level of risk presented by sex offenders completing criminal sentences who are not committed. If the state chooses not to commit these individuals, how can it justify retaining someone else whose threat to public safety is no greater?

Another significant obstacle to release in many cases is the difficulty programs have finding housing and other supportive services for offenders in the community. Not only is the public slow to embrace these new neighbors (and quick to organize in opposition), many states have onerous statutory restrictions on where registered sex offenders may live (e.g, not within 2,000 feet of any school or day care center in Iowa). In some states, entire communities may be off limits. Siting community-based transitional release facilities presents special difficulties, forcing some states to consider locations so secluded that meaningful community reintegration is unrealistic. The siting of inpatient commitment facilities presents similar challenges. Too often, only remote locations are available, complicating efforts to recruit professional staff.

Staff Recruitment and Retention

Staff recruitment and retention is a big problem for all of these programs. The patient population can be difficult to work with, especially those with high levels of psychopathy. Many patients are litigious and complain or file grievances incessantly. Staff often are named in lawsuits and sometimes are sued in their individual capacities. Some patients employ their psychopathic "charm" to curry the affections of naïve young staff members. Staff burn-out can be high. In addition, patient progress in treatment can be slow, frustrating providers who are accustomed to seeing more rapid recovery. Given these challenges, the workgroup participants felt that states must consider paying a differential rate for providers working in these facilities.

Alternatives to Commitment

It is important to note that while many states have enacted laws for the special civil commitment of sex offenders, most have not, particularly states, like Maryland, that never repealed indeterminate sentencing. Sentencing reform has been the preferred remedy in most states-- either longer sentences for convicted offenders or a return to indeterminate sentencing (where it had been repealed), with enhanced parole for released offenders (e.g., Colorado's Lifetime Supervision of Sex Offender's Act, discussed above).

Several states have established interagency committees to study the problem and offer solutions. After an extensive examination of all the options, Connecticut's "Committee to Study Sexually Violent Persons" flatly rejected commitment in favor of longer sentences, longer and more closely supervised probation and parole, improved reporting of juveniles' predatory sexual behavior, presentence evaluations of convicted sex offenders to inform sentencing and release determinations, and increased availability of treatment for offenders serving sentences (Report of the Committee to Study Sexually Violent Persons,1999).

Previous Maryland Study of Dangerous Sex Offenders

In 2001, Maryland's Department of Public Safety and Correctional Services and Department of Health and Mental Hygiene established a joint departmental task force to examine best practices and to consider legislative initiatives for managing dangerous sex offenders in the state. The task force consisted of representatives of both departments, the Office of the Attorney General, the Governor's Office of Crime Control and Prevention, the Maryland Chiefs of Police, the Maryland Sheriff's Association, the Office of the Public Defender, the Maryland State's Attorney's Association, the Family Violence Council, the National Alliance for the Mentally Ill, and other agencies. The final report of the task force, released December 3, 2001, contains the following recommendation:

> Civil commitment following incarceration is currently available in Maryland under Health-General Article, §10-632, with respect to a person who: (1) has a mental disorder; (2) needs inpatient care or treatment; (3) presents a danger to the life or safety of himself/herself or of others; and (4) is not amenable to a less restrictive form of intervention that is effective. Legislation that would extend the civil commitment to a sex offender who does *not* have a mental disorder, who does *not* need impatient care, or who does *not* present a danger to self or others is not recommended. It is believed that the availability of longer sentences of up to life imprisonment, more intensive supervision, longer supervision, and effective programs in the community represent a better alternative for an offender who does not otherwise meet civil commitment criteria.