The Civil Commitment of Sex Offenders

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Science is being placed at the core of the debate about whether sex offender commitment laws are a legitimate exercise of the state's civil authority or are illegitimate preventive detention. What mental illnesses or conditions are sufficient to meet the mental abnormality requirement? What is the relationship between mental condition and the proclivity for future violence? Such scientific questions can serve as screens to cover fundamental social and legal problems.

U.S. society has struggled with the question of what to do with sex offenders. Between 1930 and 1960, a number of states passed "sexual psychopath laws" that offered indefinite hospitalization and treatment in lieu of incarceration for offenders who committed repetitive sexual crimes. When treatment was not sufficiently effective, and when retribution became a more primary goal than rehabilitation, these statutes were repealed or fell into disuse. Sex offenders were then given very long sentences with the opportunity for earlier release if they were deemed safe by parole boards. This era of so-called "indeterminate sentencing" was replaced in the 1980s by the present era of "determinate sentencing." The mandatory sentence now is based on the average time offenders used to spend in prison for a given offense under the old indeterminate sentencing system.

One consequence of this policy change in criminal justice has been that offenders had to be released at the end of a relatively brief fixed sentence, and a number of them inevitably repeated some particularly heinous crimes. The legislature of the state of Washington reacted to this by passing the first of the "sexual predator" statutes in 1990. Over the next 3 years, several states passed similar legislation or revived their old sexual psychopath statutes. These new statutes permitted state officials, under civil law, to commit offenders who were considered dangerous if, at the end of their sentence, they met the criteria of a "sexual predator." In order to do so, offenders had to have a "mental abnormality" that would lead to the commission of further crimes. The definition of "mental abnormality" that is sufficient to meet the legal standard included many disorders that had not been used as a basis for civil commitment for many years. This abnormality can be defined so broadly as to include antisocial personality traits, such as lack of empathy for others or absence of conscience, that could make the offenders likely to repeat their past crimes. If these criteria are met, the person could be confined indefinitely as a "patient" in a psychiatric hospital until it is "safe" to permit that person's return to the community.

Because the legal and psychiatric professions had recommended the repeal of the remaining sexual psychopath statutes 10 to 20 years ago, these "predator" statutes came as something of a surprise (*1*, *2*). The past 30 years had seen a narrowing of the criteria for civil commitment of the mentally ill by both state statutes and professional guidelines. In addition, the civil commitment of criminal offenders from prisons to hospitals had been made more difficult by the Supreme Court and by state statutes (*3*). The sexual predator statutes were quickly challenged in the courts, and the State Supreme Court of Washington upheld the constitutionality of its statute in 1993 (*4*). Three years later, the Kansas Supreme Court said an almost identical statute was unconstitutional. In an opinion announced on 23 June 1997, the U.S. Supreme Court reversed the decision of the Kansas court, ruling that civil confinement of sex offenders beyond their prison terms does not violate the Constitution's double jeopardy prohibition or its ban on ex post facto lawmaking. Hospitalization can be based on remote past behavior coupled with some "mental abnormality" or "personality disorder" that makes an individual likely to engage in predatory behavior.

In the decision *Kansas* v. *Hendricks* (*5*), a 5-to-4 majority of the Court upheld a statutory scheme that permits the hospitalization of sex offenders who have been found to be "sexually violent predators" after, and only after, they have served their entire criminal sentence. This was found constitutionally permissible because the confinement was deemed civil rather than criminal and because treatment was the goal, even though the legislature conceded in a preface to the statute that sex offenders largely were not amenable to treatment. Even the dissenting justices agreed that the statute would be constitutional as long as treatment was provided, particularly if treatment were available before the expiration of the criminal sentence.

The public was generally pleased with the result because it protected them from someone like Hendricks [a pedophile who said that the only way he could honestly guarantee that he would not repeat his crime would be to die (*6*)]. Many other legislatures are currently considering such proposals. It is a politically popular position, and only a few law professors, the American Psychiatric Association, and the *New York Times* have publicly stated that the Court had it wrong.

So what is wrong with confining these obviously dangerous people in mental hospitals? Some of the concerns of the medical profession, which ultimately have implications for the public, are the following:

1) The decision broadly redefines sexual criminal behavior as a mental illness for the purpose of allowing continued preventive detention—an unacceptable medicalization of deviance. These individuals have been found competent to proceed with the legal process and criminally responsible for their behavior. Waiting until the end of their sentence to raise a finding of a mental abnormality that can be so vaguely defined and then confining them in a maximum security hospital seems a pretext for ensuring their continued confinement. By statutory definition, these laws are designed to prevent future crimes.

2) The legislature's main purpose, in spite of the Supreme Court's interpretation, is preventive detention and not treatment. The Kansas statute states that "sexually violent predators generally have antisocial personality features which are unamenable to existing mental illness treatment modalities" (*7*).

In addition to pedophiles, these statutes target rapists, the vast majority of whom do not have any mental disorder other than antisocial personality disorder (*8*). The essential feature of this disorder is a pervasive pattern of disregard for, and violation of, the rights of others that begins in childhood or early adolescence and continues into adulthood. These patterns represent long-standing traits that are not specific to sexual activity but reflect a willingness to engage in a wide variety of general antisocial behaviors. There are no effective treatments available for changing such deep-seated character traits. Studies have shown that one-third to one-half of all inmates in prison fit the criteria for antisocial personality disorder.

Treatment for some paraphilic (*9*) sexual offenders has become more promising, in spite of the fact that good recidivism studies proving effectiveness are lacking. The current state of treatment for pedophilia and

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other paraphilias recommends a combination of cognitive behavioral and pharmacological approaches (*10*). The cognitive approaches are designed to undercut some of the rationalizations that many pedophiles use to justify their behavior (such as "this is an expression of love and affection" or "the child is consenting unless they specifically say no"). Pharmacological agents may be used as well, including anti-androgens or anti-depressants such as Prozac that decrease the intensity of the sexual drive (*11*). As with addictions, treatment is more likely to be effective if the person wants to stop. From the public viewpoint, only a relapse rate of zero is acceptable, with the practical burden falling on the offender to show that he is safe; thus, release of pedophiles will be very difficult even with a "good" response to treatment.

3) A diagnosis of a mental disorder does not provide definitive information about the capacity for volitional choice. The Court in its majority opinion ran roughshod over prior legal jurisprudence as well as any scientific data in concluding that Hendricks lacked volitional control. Justice Thomas, writing for the majority, stated that "Hendricks even conceded that, when he becomes 'stressed out' he cannot 'control the urge' to molest children. This admitted lack of volitional control, coupled with the prediction of future dangerousness, adequately distinguishes Hendricks from other dangerous persons who are perhaps more properly dealt with exclusively through criminal proceedings."

The Court's easy acceptance of the lack of volitional control bears little relation to the Court's earlier careful review of another impulse or addictive disorder, that is, whether to hold chronic alcoholics responsible for public drunkenness (*12*). In that case, the Court acknowledged that alcoholism was a disease but struggled with and ultimately rejected the concept that alcoholism "destroys the afflicted person's will power to resist the constant, excessive consumption of alcohol." Acknowledging the distinction between the relative "loss of control" once an individual has begun to drink and the "ability to abstain from drinking in the first place," the Court was not willing to conclude the total loss of control that Justice Thomas accords to Hendricks. Thurgood Marshall, writing for the majority in *Powell* v. *Texas* (*12*), noted that "If Leroy Powell cannot be convicted of public intoxication, it is difficult to see how a state can convict an individual for murder, if that individual, while exhibiting normal behavior in all other respects, suffers from a 'compulsion' to kill, which is an 'exceedingly strong influence,' but 'not completely overpowering.' "

In the *Hendricks* case, the question of voluntariness of the original behaviors was never disputed at trial, and he was found criminally responsible as will be the majority of offenders affected by these statutes. The *Diagnostic and Statistical Manual of Mental Disorders—Fourth Edition*, which provides the standard definitions of mental conditions for mental health professionals, is careful in its language to describe the impulse disorders as a "failure to control" rather than an "inability to control." There is no scientific basis for measuring a person's capacity for self-control or for quantifying any impairment of that capacity. There is also no a priori reason to think that "abnormal" pedophilic impulses (for example) are more difficult to control than "normal" adult heterosexual ones (for example). This logic makes it likely that the mere repetition of an offense becomes the measure of the ability to control. This is an adequate justification for imposing longer sentences in the criminal justice system. It is not a scientific measure of the capacity to control.

New commitment laws had to be created for sex offenders for at least two reasons. (i) A definition of mental abnormalities that encompassed both rapists and child molesters had to be broader than is usually acceptable in civil commitment cases. (ii) Standard civil commitment requires recent dangerous behavior and precludes the use of behavior that occurred many years before to justify the proposed commitment.

4) Conservative estimates are that 10% of sex offenders will meet criteria for being sexual predators, which will put an inappropriate burden on the health care system. If public mental health systems must bear the cost of serving this population, the result will be significantly reduced resources for persons with serious treatment needs. Treatment for this group requires maximum-security treatment facilities and cannot be accomplished in the usual hospital settings. Annual cost estimates range from $60,000 to $130,000 per patient. These do not include the costs for the commitment proceedings (attorneys and experts) or for any needed construction of facilities. It is three to four times more expensive to provide hospitalization than to give longer prison sentences. The challenge for the mental health professions is to continue to inform legislatures and courts that they believe it is inappropriate to transform hospitals into prisons at great expense and thereby to decrease services to the already underserved population of the severely mentally ill.

With the focus on "predator" commitment statutes, there has been a lack of attention to treatment programs in correctional settings. Offenders who may be treatable—those with paraphilias or substance abuse problems that may contribute to criminal behavior—are not receiving needed care. To delay such treatment is costly and wrong. Such programs can be implemented through a variety of legal models, including indeterminate sentencing and conditions of parole.

5) Such broad-based civil commitment statutes are an attempt to deal with changes in the criminal justice system that now force the release of felons who generally could have been given much longer sentences, and thus are a misuse of psychiatry. (Hendricks could have been given several life sentences for his past activity but only received 5 to 20 years at his last sentencing.) The effect is to stigmatize persons with true mental illness and discredit the systems for their care.

An amicus brief from the Menninger Foundation that ignored long-standing American Psychiatric Association policy on civil commitment supported a broad use of mental abnormality and allowed the Court to say that psychiatric opinion was divided. Framing the issue as a scientific dispute absolves the Court from articulating a principled justification for prolonged confinement of these offenders. In looking at whether antisocial personality disorder provided a sufficient basis for commitment, some of the lower courts were satisfied to reduce the question to whether it was a disorder recognized by psychiatry rather than looking at whether or not its characteristics represented a type of serious mental disorder justifying inpatient psychiatric services. Science should not be the central question but rather whether society can justify a social control scheme for sex offenders.

References and Notes

1. American Bar Association, Criminal Justice Mental Health Standards, Commentary to Standard 7-8.1, at 457 (1989).
2. Group for the Advancement of Psychiatry, *Psychiatry and Sex Psychopath Legislation: The 30's to the 80's* (Brunner/Mazel, New York, 1977).
3. *Baxstrom* v. *Herold*, 383 U.S. 188 (1966); *Jackson* v. *Indiana*, 406 U.S. 715 (1972); see the symposium on defective delinquents and the Patuxent Institution in *Bull. Am. Acad. Psychiatry Law* **5**, 116 (1977).
4. In re Young, 857 P. 2d 989 (WASH. 1993).
5. *Kansas* v. *Hendricks*, 117 S. Ct. 2072 (1997).
6. *ibid.*, p. 2079.
7. Kansas Statutes Annotated 59-29a01.
8. C. Adler, *Crim. Justice Behav.* **11**, 157 (1984).
9. The paraphilias are a group of disorders characterized by recurrent intense sexual urges and fantasies. Those affected suffer clinically significant distress or impairment of social, occupational, or other areas of functioning associated with these urges or with acting on them. See *APA Diagnostic and Statistical Manual of Mental Disorders—Fourth Edition* (American Psychiatric Association, Washington, DC, 1994), pp. 522–525.
10. W. Pithers and G. Cumming, in *The Sex Offender—Corrections, Treatment and Legal Practice*, B. Schwartz and H. Cellini, Eds. (Civic Research Institute, Kingston, NJ, 1995), pp. 20-1–20-32.
11. J. Bradford, *Rev. Psychiatry* **14**, 755 (1995).
12. *Powell* v. *Texas*, 88 S. Ct. 2145 (1968).