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# SEXUALLY DANGEROUS PREDATORS AND POST-PRISON COMMITMENT LAWS

*Saul J. Faerstein, M.D.\**

## I. INTRODUCTION

The laws and standards we are discussing here today were written by legislators and appellate judges, most of whom are attorneys. Ultimately, however, it is mental health practitioners who have to make commitment and treatment decisions under these laws. To do so requires that they understand the laws and be able to provide the treatment required by these laws. Attorneys may be concerned with whether these laws are constitutional and whether they reflect valid social policy. From the perspective of the psychiatrist, it is necessary to consider whether these laws make sense medically and whether their mandates can be carried out by mental health practitioners.

*Baxstrom v. Herold* created a requirement that post-prison commitments meet specified civil commitment standards.<sup>1</sup> These include the presence of a mental disorder and the finding of danger to self, danger to others, and grave disability.<sup>2</sup> *Barefoot v. Estelle* established that psychiatrists may predict with an acceptable degree of reliability that a particular criminal will commit other crimes in the future and so represent a danger to the community.<sup>3</sup> *Foucha v. Louisiana* set a standard that there be a mental illness and the finding of dangerousness in order to commit.<sup>4</sup> The problem for mental health professionals was defining "mental disorder" and defining the criteria for "dangerousness."

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1. See 383 U.S. 107, 115 (1966).

2. See *id.* at 114-15.

3. See 463 U.S. 880, 896 (1983).

4. See 504 U.S. 71, 86 (1992).

II. *KANSAS V. HENDRICKS*<sup>5</sup>

Kansas law provides for civil commitment of persons who, due to a “mental abnormality” or a “personality disorder,” are “likely to engage in the predatory acts of sexual violence.”<sup>6</sup> Leroy Hendricks had a long history of sexually molesting children. Diagnosed with pedophilia,<sup>7</sup> he continued to harbor sexual desires for children and was unable to “control the urge” to molest children” when “stressed out.”<sup>8</sup> At the commitment hearing, the jury determined that Hendricks was a sexually violent predator.<sup>9</sup> The trial court found that pedophilia was a “mental abnormality” under the statute and Hendricks was committed to the state hospital.<sup>10</sup>

On appeal, the Kansas State Supreme Court invalidated the statute on the ground that a finding of a “mental abnormality” did not satisfy the “substantive” due process requirement that involuntary civil commitment must be predicated on a “mental illness” finding.<sup>11</sup> The United States Supreme Court heard the case on appeal in December 1996 and ruled in June 1997.<sup>12</sup> They held that the Act’s definition of “mental abnormality” satisfies substantive due process requirements.<sup>13</sup> The Court ruled that “people who are unable to control their behavior and who thereby pose a danger to the public health and safety” can be involuntarily committed, provided that the confinement takes place pursuant to proper procedures and evidentiary standards.<sup>14</sup> The Court, referring to previous holdings, held such standards to be the presence of a “mental illness” and the presence of “dangerousness.”<sup>15</sup> The Kansas law required both a “mental abnormality,” or a “personality disorder,”—which the Supreme Court found met the test of a “mental illness”—and a state of “dangerousness.”<sup>16</sup> The Court left to the states the task of defining terms of a medical nature that have legal significance.<sup>17</sup>

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5. 117 S. Ct. 2072 (1997).

6. KAN. STAT. ANN. § 59-29a02 (1995 & Supp. 1997).

7. See AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 527-28 (4th ed. 1994).

8. *Hendricks*, 117 S. Ct. at 2078.

9. See *id.* at 2079.

10. See *id.*

11. *Id.*

12. See *id.* at 2072.

13. See *id.* at 2079.

14. See *id.* at 2080.

15. *Id.*

16. *Id.*

17. See *id.* at 2081.

The Court found "that the Act does not establish criminal proceedings," and that involuntary commitment under it is not punishment.<sup>18</sup> According to the Court, the intent of the Act is not punitive<sup>19</sup> because it lacks the two primary elements of criminal punishment: retribution<sup>20</sup> and deterrence.<sup>21</sup> The right to restrain dangerously mentally ill persons was historically regarded as a legitimate non-punitive objective.<sup>22</sup> The purpose of the Act was found to be rehabilitation or treatment,<sup>23</sup> and the indefinite confinement would end as soon as the mental abnormality would no longer cause the offender to be a threat to others.<sup>24</sup> But what did the Court say about the obligation to provide treatment? It ruled that the Act is not necessarily punitive if it fails to offer treatment where treatment for a condition is not possible, or if treatment, though possible, is merely an ancillary, rather than an overriding, state concern.<sup>25</sup> Thus, treatment need not be provided at all and the Act would still conform to a legislative intent that it be rehabilitation. Incredibly, this would mean that warehousing equals rehabilitation.

What did the Court mean by stating that treatment for a condition might not "be possible?" Does this refer to monetary limitations, personnel shortages, and institutional constraints? Or might we infer that the Court considers that certain mental abnormalities are not treatable? This issue, glossed over in the *Hendricks* opinion, may well be the most difficult issue in the post-criminal commitment debate.

### III. THE PROBLEM OF DEFINITIONS

The *Hendricks* case spurred a debate as to whether a mental abnormality was a mental illness. Forensic psychiatrists have debated for years about the terms mental illness, mental disease, and mental defect. Is the Diagnostic and Statistical Manual (DSM)<sup>26</sup> the arbiter

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18. *Id.* at 2085.

19. *See id.*

20. *See id.* at 2082. The Court found that the Act "does not affix culpability for prior criminal conduct" nor does it "make a criminal conviction a prerequisite for commitment." *Id.*

21. *See id.* According to the Court, persons with "a 'mental abnormality' or 'personality disorder' . . . are . . . unlikely to be deterred by the threat of confinement." *Id.*

22. *See id.* at 2083.

23. *See id.*

24. *See id.*

25. *See id.* at 2084.

26. AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL

of whether a condition is a mental disease, disorder or defect? Why is Antisocial Personality Disorder not considered a mental disorder for the purpose of a not guilty by reason of insanity acquittal, but acceptable for the mental abnormality part of a post-criminal commitment standard which leads to a loss of liberty?

Labeling a condition as a disease or disorder to some extent involves a value judgment.<sup>27</sup> Before DSM III,<sup>28</sup> homosexuality was considered a mental disorder. It was removed from the DSM in part as a political act of American psychiatry. It is still unclear whether a sexual attraction to children or other alteration of sexual object choice is determined by biology or by early life experience. In either case, once this drive is determined, it cannot be psychologically erased, even with the exercise of will power.<sup>29</sup>

#### IV. PREDICTION OF DANGEROUSNESS

How do you determine that a committed patient is no longer dangerous? There is no objective standard to make that determination the way one can use specific criteria to make the diagnosis of a mental illness. "Dangerousness" is not itself a mental disorder. Rather, it is a social state that may be determined by the presence of a mental disorder, as well as other social variables. When it comes time to consider the release of an individual determined to be dangerous, one's past history of violent or dangerous conduct will still be part of the database, but there will also be a period of time in confinement with a totally different set of variables. While in confinement, it is nearly impossible to measure dangerousness. The prison or hospital setting is not an environment which replicates real society. For example, there is the absence of potential sexual victims when housed apart—women and children—there is the constant visible presence of controls—guards or doctors—and there is an absence of the pressures of life outside the walls—earning a living, paying bills—which may increase frustration and decrease impulse controls.

How do you ever know when you have reached the point of "nondangerousness" of the inmate or patient? The classic studies of

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MANUAL OF MENTAL DISORDERS (4th ed. 1994).

27. See Fred S. Berlin, *Ethical Use of Psychiatric Diagnosis*, 13 *PSYCHIATRIC ANNALS* 321, 321-31 (1983).

28. AMERICAN PSYCHIATRIC ASSOCIATION, *DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS* (3d ed. 1987).

29. See Fred S. Berlin, *The Paraphilias and Depo-Provera: Some Medical, Ethical and Legal Considerations*, 17 *BULL. AM. ACAD. PSYCHIATRY & L.* 233, 233-39 (1989).

John Monahan differentiated short-term predictions from long-term predictions.<sup>30</sup> These studies also defined the contexts and factors which effect the reliability of such predictions.<sup>31</sup> Applying Monahan's criteria, is it really possible to determine that a sex offender is a danger to society at the end of a long period of incarceration, and then to make a further prediction that the sex offender will be a danger for a significant period in the future?

#### V. THE CALIFORNIA SEXUALLY VIOLENT PREDATOR LAW

The California Sexually Violent Predator Law,<sup>32</sup> passed in 1995 and implemented on January 1, 1996, allowed for the civil commitment of sexual offenders released by the California Department of Corrections (CDC).<sup>33</sup> The procedure requires both a consensus by the examining doctors that the individual is still dangerous and the safeguard of a jury trial, which must reach a unanimous verdict that the individual is a "Severely Violent Predator."<sup>34</sup> While you can lead these offenders to treatment, you cannot make them undergo treatment. Under the law, amenability to treatment is not required. The offenders need not recognize their problems, they need not participate in the treatment program, and the treatment need not be successful.<sup>35</sup>

In addition to requiring that the offender meet the legal criteria of having committed certain specified offenses, the offender must have a "diagnosed mental disorder."<sup>36</sup> The disorder is defined as a "congenital or acquired condition affecting the emotional or volitional capacity that predisposes the person to the commission of criminal sexual acts in a degree constituting the person a menace to the health and safety of others."<sup>37</sup> This definition was modeled on a Washington state statute<sup>38</sup> which allowed inclusion of both Axis I and Axis II disorders.<sup>39</sup> Thus, almost any diagnosis in the DSM-IV,

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30. See JOHN MONAHAN, *THE CLINICAL PREDICTION OF VIOLENT BEHAVIOR* 14-15 (1981).

31. *Id.*

32. CAL. WELF. & INST. CODE § 6600 et seq. (West Supp. 1998).

33. See *id.* § 6600(a).

34. See *People v. Hedge*, 65 Cal. Rptr. 2d 693, 697 (Cal. Ct. App. 1997).

35. CAL. WELF. & INST. CODE § 6606(b).

36. *Id.* § 6600(c).

37. *Id.*

38. See WASH. REV. CODE ANN. § 71.09.020(2) (West 1997 & Supp. 1998).

39. Axis I and Axis II are classifications used to group disorders together. See AMERICAN PSYCHIATRIC ASSOCIATION, *DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS* 25-27 (4th ed. 1994).

except V Codes,<sup>40</sup> could be used to qualify offenders for commitment.

## VI. TREATMENT

In 1975 Alan Stone proposed a set of criteria for involuntary hospitalization based on a need for treatment rather than on dangerousness.<sup>41</sup> A more recent study concluded that (1) assessments of treatability should be seen as more practically relevant to dispositional decisions than assessments of criminal responsibility, and (2) improving the effectiveness of treatment is a better approach to the problem of dangerousness than attempting to improve predictive methods.<sup>42</sup>

Whether the aberration in sexual offenders is a biological or a psychological problem, the only way to alter the pattern of sexual drive is through professional treatment. Without treatment, incarceration, or even warehousing in a hospital setting, will not have an impact. Are there treatments available for sexual offenders and are there studies to show whether or not they are effective? Are organic treatments more effective than psychological treatments?

Treatment might prove to be more effective in the post-conviction stage, when guilt or innocence is not at issue. Sex offenders were found to be more defensive and in greater denial in the early treatment stages, especially when the legal consequences were greater.<sup>43</sup> Only in later treatment were they found to move from an acknowledgement of minimal deviant behavior to an admission of recurrent behavior, and later, if at all, to provide a detailed description about fantasies and urges.<sup>44</sup>

## VII. ORGANIC TREATMENTS

Several pharmacological treatments have been researched and used in the treatment of sex offenders. The first, Depo-Provera (medroxyprogesterone)—a synthetic progesterone that decreases plasma testosterone and consequently the sexual libido—has been

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40. V Codes denote no mental illness. *See id.* at 4.

41. *See* ALAN STONE, MENTAL HEALTH AND LAW: A SYSTEM IN TRANSITION (DHEW Publication No. ADM 75-176, 1975).

42. *See* Vernon L. Quinsey, *Assessments of the Treatability of Forensic Patients*, 6 BEHAV. SCI. & L. 443, 447-49 (1988).

43. *See* Robert M. Wettstein, *A Psychiatric Perspective on Washington's Sexually Violent Predators Statute*, 15 U. PUGET SOUND L. REV. 597, 617 (1992).

44. *See* Sheldon Travin, M.D., *Sex Offenders: Diagnostic Assessment, Treatment, and Related Issues*, in PRINCIPLES AND PRACTICE OF FORENSIC PSYCHIATRY 531-32 (Richard Rosner ed. 1994).

called "a sexual appetite suppressant."<sup>45</sup> It is an injectable steroid which has been tested and used for the past thirty years to treat paraphilic disorders. It is given by weekly injection, which makes it very easy to document its administration, and it can be monitored with a simple blood test of testosterone levels. Moreover, it is not expensive, which makes it available to public institutions. Lowering the strength of the sexual drive will not change the sexual object choice, but it will make it easier to control the behavioral response to the drive. It will help free the mind of obsessional cravings and ruminations about unacceptable forms of sexual behavior.

Another biological treatment is the use of anti-obsessive medications. Since most sex offenders tend to act out in repetitive and predictable patterns, their behavior resembles the behavior of obsessive-compulsive disorders. If one could reduce the frequency and intensity of the obsessive sexual thoughts, then one might reduce the sexual acting out which follows. In fact, it has been shown that Buspirone, a serotonergic drug with anticonvulsive properties, has been effective in treating sex offenders.<sup>46</sup> Other medications may prove equally as effective.

Other studies have found that a variety of phenothiazines, such as Mellaril, and antidepressants including Prozac have been effective with treating paraphilic disorders.<sup>47</sup>

#### VIII. PSYCHOLOGICAL TREATMENTS

Psychological treatment of sexual disorders has been extensively utilized for both inpatient and outpatient treatment. This approach includes both behavioral and psychodynamic treatments. Although both individual and group therapy are used, it is clear that the economic limitations of individual treatment favor the latter therapy. There is no evidence that any one school or methodology can effectively change sexual object choice, even if that choice were psychologically determined.

Cognitive and behavioral therapy has also been found to have some effectiveness in the population of sex offenders. These techniques have expanded since the 1970s to include programs to modify deviant and appropriate arousal, provide sex education, enhance self-esteem and social skills, reduce hostility and anger, control alco-

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45. Berlin, *supra* note 29, at 235.

46. H. J. Pearson et al., *Treatment of a Compulsive Paraphilic with Buspirone*, 5 ANNALS OF SEX RES. 239, 239-46 (1992).

47. See Travin, *supra* note 44, at 531-32.

hol abuse, and teach offenders to use their leisure time more constructively. The development and application of cognitive-behavioral therapy programs by G.G. Abel were directed at the distortions offenders have in their views of themselves, the behavior and feelings of their victims, and the means by which such distortions might be modified.<sup>48</sup> Treatment is also directed at enhancing offenders' empathy for their victims and improving intimacy skills.

Because there is a significant relapse rate even among treated sex offenders, some of these approaches have been incorporated into relapse prevention, a new treatment method which has had some success in the addictions. This treatment involves recognizing high risk situations and developing effective coping responses. The approach developed at the Vermont Treatment Program for Sexual Aggressors involves identifying and altering both internal self-management skills and external factors affecting behaviors.<sup>49</sup> Most researchers agree that "the treatment approach for any individual patient should ideally involve varying combinations of these treatments."<sup>50</sup>

Psychological treatments are labor-intensive and require skilled, trained, and competent therapists working long hours over long periods of time. The economic realities suggest that such resources are only in limited availability in correctional institutions and state hospitals.

#### IX. VOLUNTARY AND INVOLUNTARY TREATMENT

Most therapists find that voluntary, motivated patients do better than involuntary patients in achieving treatment aims. The population we consider here today is the involuntary group. Is it not a myth that treatment is voluntary when we limit the options available to post-conviction patients?

What factors are likely to improve compliance among these patients in treatment? Are they likely to continue taking medications which reduce feelings and behaviors that have been experienced with pleasure? Patients with seizure disorders generally take anti-seizure medications because the cessation of seizures is a positive experience. But some bipolar patients stop taking lithium because they do not want to lose manic episodes which may be experienced as exciting,

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48. See Gene G. Abel et al., *An Integrated Treatment Program for Rapists*, in *CLINICAL ASPECTS OF THE RAPIST* 161-214 (R.T. Rada ed. 1978).

49. See Lael Montgomery, *Sex Offenders in the Community: Colorado's New Standards and Guidelines—Part I*, *COLO. LAW.*, Dec. 1996, at 47, 48.

50. Travin, *supra* note 44, at 531.

productive, empowering, and enjoyable. Do sexual predators experience their deviant sexual behavior as enjoyable and exciting? If so, they are more likely to avoid taking medications voluntarily or complying with treatment.

#### X. FACTORS COMPLICATING TREATMENT

The problem of substance abuse further complicates the return of sex offenders to society. One study showed that 50% of offenders were intoxicated at the time of their most recent offense, and that there were drug and alcohol abuse problems in 60% of these men.<sup>51</sup> Clearly, there is a greater opportunity to abuse drugs and alcohol following release into the community than during the period of inpatient treatment when dangerousness is being assessed.

While only a relatively small percentage of sex offenders are psychopathic, 7.5% of child molesters and 12.2% of rapists according to one study,<sup>52</sup> the role of personality disorder may further complicate the efforts to treat offenders and alter long standing patterns of thinking and behavior. V.L. Quinsey and his associates found that Hare's Revised Psychopathy checklist had merit as a predictor of recidivism among sex offenders.<sup>53</sup>

Some studies suggest that sex offenders may have multiple paraphilias.<sup>54</sup> If sex offenders are polymorphously perverse, this would demand a different approach to assessment and treatment than is currently employed, complicating and lengthening treatment, and making it even more difficult to determine the point at which they would no longer be considered dangerous as a result of psychopathology.

Studies of hospitalized sex offenders have found that there are significant deficits in social skills among rapists<sup>55</sup> and child molesters<sup>56</sup>

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51. See W.L. Marshall, *Assessment, Treatment and Theorizing about Sex Offenders: Developments During the Past Twenty Years and Future Directions*, 23 CRIM. JUST. & BEHAV. 162, 176 (1996) (citing M.M. CHRISTIE ET AL., A DESCRIPTIVE STUDY OF INCARCERATED RAPISTS AND PEDOPHILES (1979)).

52. See *id.* (citing R.C. Serin et al., *Psychopathy and Deviant Sexual Arousal in Incarcerated Sexual Offenders*, 9 J. INTERPERSONAL VIOLENCE 3, 3-11 (1994)).

53. See *id.* (citing Vernon L. Quinsey et al., *Psychopathy, sexual deviance and recidivism among sex offenders released from a maximum security institution*, in PENETANGUISHENE RESEARCH REPORT 7(1) (1990)).

54. See Gene G. Abel and Joanne L. Rouleau, *The Nature and Extent of Sexual Assault*, in HANDBOOK OF SEXUAL ASSAULT: ISSUES, THEORIES AND TREATMENT OF THE OFFENDER 9-21 (Marshall et al. eds., 1990).

55. See David N. Lipton et al., *Heterosocial Perceptions in Rapists*, 55 J. CONSULTING & CLINICAL PSYCHOL. 17, 17-21 (1987).

56. See Zindel V. Segal & William L. Marshall, *Discrepancies Between Self-*

which could be directly related to inappropriate social behavior and sexually offending conduct. Rapists misconstrued women's cues in social situations. Child molesters construed children as non-dominant and easy to relate to, while viewing adults as overbearing and threatening.<sup>57</sup> Some studies have found higher levels of hostility toward women among rapists, exhibitionists, and non-familial child molesters compared to non-offender controls.<sup>58</sup>

How do you address these issues and change life-long patterns in individuals who are less than well-motivated to change? Many sex offenders have grown up under circumstances that have eroded their self-esteem, confidence and trust in others. Those who emerge from prison and face treatment in hospitals or outpatient settings, the population we consider here today, have been typically treated with contempt and further abuse while incarcerated, raising the threshold for engagement in therapy. These offenders are found to have high levels of denial and minimization, and limited psychological insight. They are found to be deficient in empathy toward their victims.<sup>59</sup>

## XI. CONCLUSIONS

The decision to use psychiatric hospitalization to extend the incarceration of sex offenders by post-conviction commitment for the protection of society is grounded in a belief that psychiatrists can predict future danger. Although courts have granted psychiatrists this power, psychiatrists continue to debate whether they have the ability to make such predictions accurately and effectively.

The decision to move sex offenders from prison settings to hospital settings at the end of their prison terms has been driven by the social policy that sex offenders should be removed from society for as long as they pose a danger. Placing them in hospitals can be morally justified only if the hospitals can provide treatment. Otherwise, hospitals are no more than prisons by another name.

There are many problems in treating sex offenders and many questions about the most productive treatment approaches. Current research indicates that progress is being made in identifying effective

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*efficacy Predictions and Actual Performance in a Population of Rapists and Child Molesters*, 10 COGNITIVE THERAPY RES. 363, 363-76 (1986).

57. See Kevin Howells, *Some Meanings of Children for Pedophiles*, in LOVE AND ATTRACTION 524-25 (Mark Cook & Glenn Wilson eds., 1978).

58. See Bonnie T. Seidman et al., *An Examination of Intimacy and Loneliness in Sex Offenders*, 9 J. INTERPERSONAL VIOLENCE 518, 524-26 (1994).

59. See Marshall, *supra* note 51, at 182-84.

treatments for sex offenders.<sup>60</sup> The choices society makes in implementing such treatments may be decided by the limited resources available, but ultimately it should be outcome studies that determine treatment choices.

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60. *See id.* at 187-90.

