

Civil Commitment: Dubious Solution to a Serious Problem?

This presentation to the Sex Offender Recidivism Commission (SORC) was intended to give a cursory overview of the history of civil commitment laws for sex offenders in the USA in general and in Massachusetts in particular, to summarize the current status of such laws, and to discuss the pros and cons of this sex offender specific legislative initiative.

Brief History of Civil Commitment in the US and Massachusetts

Civil commitment laws for sex offenders have been enacted in two temporal waves. Both waves have been precipitated by salient, high profile sex offender cases that caught the attention of the press, who publicized the incidents and sparked a public outrage and demand for legislative action. The first wave started in the 1930s in California, Illinois, Michigan, and Minnesota, and at its height in the early 1960s there were sexual predator commitment laws in 26 states and the District of Columbia. Supported by a belief in the efficacy of psychotherapeutic interventions for sex offenders, this first wave created treatment centers that were alternatives to incarceration. These commitment laws were established under the *parens patriae* power to protect others from the violence of mentally ill persons. A current residual in commitment laws still requires that sex offenders must suffer from a “mental abnormality or personality disorder” that predisposes them to commit future acts of sexual violence.

This first wave waned in the 1960s and 1970s because of the growing conviction that sex offenders were not mentally ill, that treatment was ineffective, and that treatment centers for sex offenders were costly to maintain. There was a shift to determinative sentencing of sex offenders. The disapprobation with treatment coincided with the growing, now discredited “nothing works era” in criminology in general (Andrews & Bonta, 2006; Martinson, 1974).

In response to a widely publicized case of an offender who sexually molested and killed two young boys shortly after being released from prison, Massachusetts passed its first sexually violent persons (SVP) law (in MA this law is commonly called the sexually dangerous persons law [SDP], but for consistency with the general literature SVP will be used here) and subsequently established the Massachusetts Treatment Center (MTC) in Bridgewater in 1959. This law was abolished in 1990 after a commission appointed by Governor Dukakis determined that the SVP law did not enhance public safety. During the 21-year tenure of the first enactment of this law in Massachusetts 5000 convicted sex offenders were referred for evaluation as SVPs in Massachusetts; 1900 of these were considered to have probable cause and were transferred to MTC for a 60-day evaluation. Of the 1900, 570 were committed from day to life, and 1330 were released back to prison.

In the same year that Massachusetts repealed its first SVP legislation, a high profile sexual crime in the state of Washington precipitated the beginning of the second national wave of sex offender civil commitment legislation. Currently, 20 states and the District of Columbia have SVP commitment statutes. It was estimated that in 2010 alone these states spent \$500 million to detain 5200 offenders (“Sex Offender Confinement,” 2010). In Minnesota it was recently determined that the per diem cost for each committed sex offender is \$344 or \$125,560 annually (Herbart, 2015, personal communication). Although there are substantial differences among the states in their SVP statutes, the criteria for commitment typically require (a) a history of sexual violence; (b) current mental disorder or abnormality; (c) likelihood of future sexual crimes; and (d) a link between the first two elements and the third (*Kansas v. Hendricks*, 1997). Because the mental “disorder” required in SVP legislation is not the gravely disabling type (e.g., psychosis) used to support traditional civil commitment (Mercado, Schopp, & Bornstein, 2005),

and because the laws do not require proof of *imminent* danger (Jackson & Richards, 2007), the criteria for SVP commitment are looser and more open to interpretation than the traditional civil commitment of the mentally ill.

In 1999 Massachusetts reestablished its SVP law. Since then it has been roughly estimated (generalized approximately from data from the Massachusetts District Attorney's Association [2010] and MTC records) that 20,270 offenders have been referred to the District Attorneys; 1095 were transferred to MTC for full evaluation; and of those transferred 251 were committed to MTC and 844 were released. Since 1999, 122 committed offenders have been released to the community as no longer sexually dangerous. The commitment process in Massachusetts involves multiple steps: (a) referral to the District Attorneys (DA); (b) filing of an SVP petition and transfer to MTC (5% of DA referrals); (c) determination of probable cause (75% of SVP petitions); (d) trial for SVP (41% of SVP petitions); and (e) determination of SVP (22% of SVP petitions and approximately 1.2% of DA referrals).

Pros and Cons of Civil Commitment

The use of civil commitment of sex offenders as a strategy for enhancing public safety has generated considerable debate in both clinical and legal circles (Douard, 2007; Janus & Prentky, 2003). Proponents see SVP commitment as an essential tool for incapacitating the highest risk subgroup of sex offenders, and some argue that it is a means to provide recidivism-reducing treatment interventions that would not be available in general prison settings. It is a solution that has "intuitive simplicity," if it were truly possible to identify with little error the most serious offenders. Assuming high predictive potency of assessment instruments, most court decisions in response to challenges (often involving due process, ex-post facto, and double jeopardy clauses) have upheld the constitutionality of SVP statutes.

On the other hand, opponents raise a number of scientific, practical, legal, and philosophical objections to the strategy. Included among their criticisms are: (1) The clinical criteria for commitment have been defined by legislative bodies rather than by researchers and clinical scientists who study both criminal prediction and psychopathology. The mental “disorders” typically used in the commitment process (e.g., paraphilias, personality disorders, impulse disorders) have been found to be dimensional, not categorical, and the empirical bases for traditional cutoffs are limited or non-existent (e.g., Paraphilia, OSDP, nonconsent; Knight, 2010; Knight, Sims-Knight, & Guay, 2013). The links of specific mental disorders to the prediction of sexual coercion or its frequency are often tentative at best. (2) The available projected likelihoods for sexual recidivism are vague, often lower than popularly believed, and often sample-specific (Helmas, Hanson, Thornton, Babchishin, & Harris, 2012). For instance, the 2 to 25 year follow-up recidivism rate of *highest* category in Static 99R (6 or greater) for those committed to MTC in the first SVP wave was 34.9% (Knight & Thornton, 2007). Yet, the Supreme Court approval of civil commitment was predicated on the ability of actuarials to identify offenders with almost certain probabilities of recidivism. (3) Although the predictive potency of current empirical actuarials is adequate for differentiating among offenders for treatment and management, they are inadequate to the task of indeterminate commitment, even if done under optimal conditions (i.e., they are mechanically applied), because of the high cost of false positives and the low base rate of SVP (Knight, 2003). (4) Optimal practice for predicting recidivism (direct mechanical application of actuarials without clinical adjustment) is not implemented in SVP hearings. Adjustments by clinical evaluators inevitably yield lower predictive accuracy (Hanson & Morton-Bourgon, 2009). (5) The treatment of committed offenders is compromised, because offenders cannot demonstrate they have learned from past

transgressions so that they can be judged fit for release unless they participate in treatment, but participation in treatment can lead to self-incrimination. Moreover, within the confines of incarceration it is difficult to judge improvement.

As we have seen the commitment strategy is very expensive, and because it ultimately involves so few committed offenders, it has little impact on the overall frequency of sexual coercion in the state. Consequently, it represents a substantial allocation of resources for an apparently small benefit. There are cheaper alternatives that do not rely on the dubious strategy of incarcerating someone on the basis of what we predict he might do. These include—(a) SVP status hearings at criminal sentencing to increase sentences and mandate treatment; (b) lifetime probation (e.g., Arizona); (c) an outpatient commitment program with careful community monitoring and therapeutic management (e.g., Texas, but there have been problems with this particular implementation); and (d) the circles of support strategy successfully implemented by Robin Wilson in Florida (McWhinnie & Wilson, 2005).

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