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Sexually Violent Predators: Is there an Ethical Obligation to Ensure they Receive Mental Health Services

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SEXUALLY VIOLENT PREDATORS: IS THERE AN ETHICAL OBLIGATION TO ENSURE THEY RECEIVE MENTAL HEALTH SERVICES?

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I. INTRODUCTION

Derrick S[1] is a victim of a broken system even though he is a sexually violent predator. He was a member of a gang, forced to participate in gang rape in order to stay in the gang and fit into the street lifestyle. At the time he was only seventeen but already had a string of violent crimes as part of his record. He was sentenced to thirty years in prison and on the day he was released, was transferred to a facility that houses sexually violent predators and has remained at the facility for nearly thirteen years. Derrick S. actively tries to seek mental health treatment in order to complete the steps on the road to recovery but remains stuck in the facility. A number of factors work against him: the stigma that is attached to the label of sex offender, lack of treatment, and a lack of focus within the academy on issues of bioethics as they relate to mental health law. These three shortcomings create a situation in which sex offenders could be committed indefinitely with little if any treatment in a broken system with few people advocating on their behalf for changes in the system and greater access to the mental health services that these men desperately need.

In this paper I will examine the mental health services individuals committed under sexually violent predator (SVP) statutes receive during their commitment. In order to evaluate those services and how we view the adequacy of the mental health services these men receive, Part One will look at the O'Connor v. Donaldson[2] case which set the standard for what could be

[1] Name has been changed, as this individual is currently involved in a call action lawsuit seeking to improve mental health treatment at the SVP facility in New Jersey.
[2] O'Connor v. Donaldson, 422 U.S. 563, 563 (1975).

called "traditional" civil commitment[3]. For a point of comparison, Part Two will focus on the history of SVP acts and highlight the different types of mental health programs that exist in the country. Part Three will examine how the field of bioethics has largely shied away from mental illness due to the conflicting nature of autonomy and protectionism. Part Four will delve into how bioethics should be tackling the issue of mental health and mental illness and highlight how bioethics should evaluate the state and mental health services received by those men[4] committed under SVP statutes. This final section will also highlight critiques of the SVP statute and treatment paradigm, taking into account arguments against treatment such as societal protection and funding issues. This section concludes that with the expansion of the power[5] to commit these individuals, we are ethically obligated to provide mental health services that seek to treat the diseases that afflict these individuals.

II. History of Traditional Civil Commitment

The power to commit someone against his will to an institution for the treatment of a mental disorder is based on two main principles of Western legal tradition: *parens patriae* (the theory that the sovereign acts in the best interests of subjects who are unable to act for themselves[6]) and the state's police power.[7] Involuntary civil commitment is the process by which

[3] Traditional in this context refers to commitment in a state against an individuals will when that individual is found to be mentally ill and to be a danger to themselves or others. This is in contrast to an SVP act which hinges on a criminal conviction of a sex offense.

[4] In the state of New Jersey all the individuals that have been committed to the treatment facility in Avenel, NJ have all been male. Additionally, according to *Biennial Report Regarding the Council on Sex Offender Treatment September 1, 2008 – August 31, 2010*, all 175 SVPs were male.

[5] US v. Comstock held that a federal statute allowing a district court to order the civil commitment, beyond the date the prisoner would otherwise be released, of a sexually dangerous federal prisoner was constitutional under the Necessary and Proper Clause. *United States v. Comstock*, 130 S. Ct. 1949 (176), (2010). This creates an a federal system of commitment of sexually violent predators in addition to state statutes.

[6] Robert I. Simon, M.D., Clinical Psychiatry and the Law 1,158 (2d ed. 1992).

an individual may be committed to an inpatient mental health facility against his will by a judge, usually upon a showing that the individual is dangerous to himself or others, (police power). Alternatively, the state's *parens patriae* authority is derived from English law, which, at the time of the settling of the American colonies, gave the King, as sovereign, the responsibility for the care and custody[8] of "all persons who had lost their intellects and become incompetent to take care of themselves."[9] Together these two theories create a legal process that is controlled by state statute and affords considerable due process protection[10] to the individual in question. For example, in order for the state to commit someone under the police power theory of commitment, the state must show by at least clear and convincing evidence[11] that the individual suffers from a mental illness and is dangerous to himself or others.[12]

One of the first cases to deal with the constitutionality of the civil commitment process was O'Connor v. Donaldson, decided in 1975.[13] The Donaldson case was an action against the superintendent of a mental hospital and others for allegedly wrongfully confining the plaintiff for fifteen years. The Supreme Court held for the first time that "a State cannot constitutionally confine without more a non-dangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends."[14] The

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[7] Veronica J. Manahan, *When Our System of Involuntary Civil Commitment Fails Individuals with Mental Illness: Russell Weston and the Case for Effective Monitoring and Medication Delivery Mechanisms,* 28 Law & Psychol Rev. 1,1 (2004).
[8] Thomas K. Zander, *Civil Commitment without Psychosis: the Law's Reliance on the Weakest Links in Psychodiagnosis*, 1 Journal of Sexual Offender Civil Commitment: Sci & L., 1, 17-82 (2005).
[9] *Developments in the Law: Civil Commitment of the Mentally Ill* ,87 Harv. L. Rev. 1190. 88, (1974).
[10] *Id.* at 88
[11] *Addington v. Texas*, 441 U.S. 418, 425 (1979)
[12] Manahan, *supra* n.7 at 4.
[13] *O'Connor v. Donaldson*, 422 U.S. 563, 563(1975).
[14] Donaldson 422 U.S. at 576.

evidence showed that Donaldson's confinement was a simple regime of enforced custodial care, not a program designed to alleviate or cure his supposed illness.[15] The Court stated that even if Donaldson's original confinement was founded upon a constitutionally adequate basis, it could not constitutionally continue after that basis no longer existed because due process required the state to do more.[16] Essentially the court was pointing out that if the reason for civil commitment was for Donaldson to receive treatment and he received the treatment curing him of his original illness that was reason for confinement, his confinement was no longer constitutional because he could not be labeled mentally disordered. In fact, in the Donaldson case, the evidence at trial showed that "testimony at the trial demonstrated, without contradiction, that Donaldson had posed no danger to others during his long confinement, or indeed at any point in his life."[17] The decision in Donaldson established that the only constitutionally recognized grounds for involuntary commitment are preventing injury to the public, ensuring the mentally ill person's own survival or safety, or alleviating or curing the mental illness.[18] The court was very careful to say that there was no constitutional right to treatment while committed.[19]

This paper will not address the advisability of involuntary civil commitment. The goal of this paper is to highlight the stigma of sexual deviance associated with individuals confined under an SVP act for indefinite commitment, lack of treatment, and a void in bioethical understanding of mental health issues. However, when the traditional civil commitment system is utilized appropriately, such that an ill and dangerous individual is committed to an institution

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[15] *Id* at, 569.
[16] *Jackson v. Indiana*, 406 U.S. 715, 738 (1972)
[17] *Donaldson*, 422 U.S. at 568,
[18] Donald H. J. Hermann, *Barriers to Providing Effective Treatment: A Critique of Revisions in Procedural, Substantive, and Dispositional Criteria in Involuntary Civil Commitment*, 39 Vand. L. Rev. 83, 87 (1986).

[19] *Donaldson*, 422 U.S. at 581, 584.

with adequate facilities and treatment options, the individual and public benefits from the protection afforded by that environment and treatment.[20] By committing an individual who has a mental illness and treating him with effective medication under its power of *parens patriae* and police power, the state is able to ensure that the individual is receiving helpful treatment, fulfilling the goals of our civil commitment system.[21] This should also be the goal of forced institutionalization under an SVP statute: to ensure the safety of the community while effectively treating the committed individual[22] in hopes of eliminating or controlling the reason for their commitment to allow them to reenter society safely. On one hand the goal of civil commitment is to keep the individual and society safe. This goal creates tension with the proposed dual purpose of commitment (public safety and receiving treatment). These competing goals make the reality of receiving effective treatment dim.

Nevertheless, the Supreme Court has addressed the constitutionally required treatment standard. The standard for treatment of civilly committed individuals once they are institutionalized was elucidated in Youngberg v. Romeo.[23] In Youngberg, the Court held that the proper standard for determining whether a state adequately had protected the rights of those

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[20] Manahan, supra n.7 at 7.
[21] *Id.*

[22] Although treatment does not eliminate sexual crime, research supports the view that treatment can decrease the likelihood of future sex offenses and protect potential victims. However, given the limitations in scientific knowledge and accuracy of outcome data, as well as the potential high human costs of prognostic uncertainty, any commitment to a social project substituting treatment for imprisonment of sexual aggressors must be accompanied by vigorous research. Grossman, *Are Sex Offenders Treatable? A Research Overview* ,Psychiatric Services 1999. *See also*, Olver, M. E., & Wong, S. P. (2009). *Therapeutic Responses of Psychopathic Sexual Offenders: Treatment Attrition, Therapeutic Change, and Long-Term Recidivism*. 77 J. Consult. Clin. Psychol. 328-336 (2009) ("Overall, the results suggest that given appropriate treatment interventions, sex offenders with significant psychopathic traits can be retained in an institutional treatment program and those showing therapeutic improvement can reduce their risk for both sexual and violent recidivism").
[23] *Youngberg v. Romeo*, 457 U.S. 307,307 (1982).

civilly committed was whether the medical professionals at the facility in fact had exercised professional judgment where the individual was committed.[24] The Court found that qualified professional judgment was entitled to a presumption of correctness and that liability could be imposed only when a treatment decision represented such a substantial departure from accepted professional judgment as to demonstrate that the decision had not been based on professional judgment.[25] The Court left the decision regarding what constituted accepted professional judgment largely to the discretion of medical professionals and medical authorities, because courts, judges, and juries are not in a position to second guess experts on matters on which they are better informed.[26] While the Court has recognized a range of procedural requirements that protect the civil liberty interests of persons subject to civil commitment, it has also increasingly given recognition to treatment and clinical rights of persons involuntarily committed to mental health facilities.[27] On the other hand, many legislatures and courts have focused only on the civil liberty interests of persons subject to involuntary civil commitment,[28] leaving the treatment concerns to meet the minimum standards set out in Youngberg, creating competing goals for civil commitment across state lines.

A major concern coming out of the court decisions and legislation regarding traditional civil commitment is that those individuals that are seriously mentally ill may not be meeting the commitment threshold (i.e. posing an imminent danger to the community) and are too mentally

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[24] *Id.* at 307.
[25] *Id.*
[26] *Id.*
[27] s*ee generally* Monahan, Three Lingering Issues in Patient Rights, in PSYCHIATRIC PATIENT RIGHTS AND PATIENT ADVOCACY: ISSUES AND EVIDENCE 264-65 (B. Bloom & S. Asher eds. 1982) (examining the differences both in nature and success in advocacy of procedural and treatment rights)
[28] Hermann *supra* n. 18 at 106.

ill to recognize that they need to consent to treatment.[29] The Court has emphasized that civil committees such as in the case of Youngberg v. Romeo, where Romeo was neither charged with nor convicted of a crime, are entitled to more considerate treatment and conditions of confinement than criminals whose conditions of confinement are designed to punish.[30] This creates a treatment dichotomy in which who that may have committed crimes because of their mental illness do not receive the same treatment as those individuals that have been found to be a danger to themselves or the community before their actions resulted in criminal sanctions.[31] This is the inherent problem that those committed under SVP statutes face. Some have committed morally reprehensible crimes and some like Derrick S., are sympathetic characters that while having a criminal conviction, are subjected to a broken system.[32] They are individuals that need access to mental health service yet do not appear to be receiving treatment with the end goal of improving their mental health to be reintegrated into society. Some would say that the language in Youngberg strongly suggests that there is no broad constitutional right to treatment for persons

[29]David T. Simpson, Jr., Note, *Involuntary Civil Commitment: The Dangerousness Standard and Its Problems*, 63 N.C. L. Rev. 241, 241 (1984).

[30] Eric S. Janus & Wayne A. Logan, *Substantive Due Process and the Involuntary Confinement of Sexually Violent Predators*, 35 Conn. L. Rev. 319, 343 (2003).

[31] The Kansas Supreme Court in Kansas v. Hendricks recognized that, whereas civil commitment under Kansas's general civil commitment law for the mentally ill comported with the U.S. Supreme Court's reasoning in *Foucha* by requiring evidence of "mental illness," *Kansas v. Hendrick*, 521 U.S. 346,358 (1997): the KSVPA departed from *Foucha* by allowing civil commitment based not on mental illness but rather on "antisocial personality features which are unamenable to existing mental illness treatment modalities", Zander, *supra n. 8.*

[32] Derrik committed his sexual crime when he was a minor, the testing that can allow an individual to be labeled treated with a low recidivism rate considers such factors as living in the same home as a lover for at least two year (see Static –99R code form), considering that he was a minor he was unable to meet this requirement and get a 1 instead of a 0 for this category. The higher point value indicated on the Static 99 means a higher potential for reoffense.

involuntarily confined as dangerous and mentally impaired, at least where no acceptable treatment exists or where they cannot be successfully treated for their afflictions.[33]

This treatment dichotomy can bee seen in the Supreme Court's decision in Foucha v. Louisiana.[34] Terry Foucha was found guilty by reason of mental insanity and was civilly committed to a facility.[35] Doctors at the state facility had found that Foucha had an antisocial personality disorder, a condition that is not a mental disease and is untreatable. The state Supreme Court found that under Louisiana's statutory scheme confinement of an insanity acquittee based on dangerousness alone was allowed.[36] In reversing Louisiana's supreme court, the United States Supreme Court reversed and ruled that potential dangerousness was not a justification to retain a person found not guilty by reason of insanity if no mental illness was present. The Court also held that, as a matter of due process, he was entitled to release when he had recovered his sanity or was no longer dangerous.[37] This would mean that the court does not envision indefinite commitment under traditional civil commitment and that at least part of the goal of civil commitment is to treat the mental illness since dangerousness was not enough to keep Foucha committed. Individuals committed under SVP acts can be committed for "mental abnormalities," one of which is anti-social personality disorder, which is "notoriously difficult to treat"[38] and is "essentially a way of being."[39] The definition of antisocial personality disorder highlights that the reason for which a sexually violent predator faces indefinite commitment is

[33] Janus & Logan, *supra* n. 30 at 384.
[34] *Foucha v. Louisiana*, 504 U.S. 71, 71 (1992).
[35] *Id.*
[36] *Id.*
[37] *Id.*
[38] Mayo Clinic, Antisocial Personality Disorder, *available at* accessed 11\19\12, *http://www.mayoclinic.com/health/antisocial-personality-disorder/DS00829/DSECTION=treatments-and-drugs.* (last accessed Nov. 19, 2012).
[39] *Id.*

because of the aspect of dangerousness. This suggests that states with SVP acts are not interested in treating mental illness\conditions but instead focus on what may happen upon release.[40] The section below will clearly show that SVP statutes have a primarily to protect the public and not to treat the committed individuals. States refer to SVPs as "the worst of the worst,"[41] and presenting dangers and risks to the community.[42] The dual purpose of public protection and treatment is not a reality.

II HISTORY AND VARIATIONS OF SVP ACTS IN THE US

In the United States there are 20 states that have adopted SVP statutes in addition to the federal government.[43] As of 2006, when only 17 states possessed SVP laws, over 4,500 individuals had been committed under their provisions with only 494 offenders having been released once they were confined.[44] This created a release rate of just under 11 percent of the

[40] In *State v. Randall*, the ability to hold someone on dangerousness alone was upheld however, ultimately, the court held that an insanity *acquittee* may be held in an institution as long as he/she is still dangerous, to the extent the time does not exceed the maximum time that could have been imposed if the *acquittee* had been sentenced to prison. State v. *Randall*, 532 N.W.2d at 94,94 (Wis. 2d 1995) *see also* David L. Shaprio, *Ethical Dilemmas for the Mental Health Professional*: *Issues Raised by Recent Supreme Court Decisions* 34 Cal. W. L. Rev. 1 (1997). This is clearly different in the context of SVPs who are held after they have completed a full prison sentence for their crimes.

[41] "The worst of the worst" is the term used to describe Sexually Violent Predators by Riverside County, California District Attorney Rod Pacheco. Keith Matheny, *Areas Fear Predators' Releases,* USA Today, Mar. 4, 2010, at 3A (outlining difficulties surrounding supervised release of sexually violent predators).

[42] Kan. Stat. Ann. § 59-29a01 (1994); N.Y. MHY Law § 10.01 (2009); Wash. Rev. Code § 71.09.010 (1992).

[43]Dan Krauss, John McCabe & Joel Lieberman *Dangerously Misunderstood: Representative Jurors' Reactions to Expert Testimony on Future Dangerousness in Sexually Violent Predator Trial*, Psychology, Public Policy, and Law, July 25, 2011, at 1, *available at* http://www.cgu.edu/pdffiles/sbos/krauss_dangerously_misunderstood.pdf

[44]Kathy Gookin *Comparison of State Laws Authorizing Involuntary Commitment of Sexually Violent Predators* Washington State Institute for Public Policy Aug. 2007, at 1, *available at* http://www.wsipp.wa.gov/rptfiles/07-08-1101.pdf

committed population.[45] Civil rights lawyers have argued, several states have held that SVP statutes are an unconstitutional form of preventive detention, double jeopardy, and/or punishment without due process. Two cases[46] made it to the US Supreme Court and, despite amicus briefs from the American Psychological Association in opposition, the Court has twice accepted the constitutionality of the SVP statutes.[47]

One of the first of these SVP laws to be enacted and reviewed by the Supreme Court was enacted by Kansas.[48] LeRoy Hendricks, who had been convicted and sentenced for sexually molesting children, challenged this statue in 1996.[49] Hendricks challenged the Kansas SVP statute on grounds of due process. In Kansas v. Hendricks,[50] the Supreme Court, Justice Thomas delivering the opinion of the court, held that: the Act's definition of "mental abnormality" satisfied substantive due process requirements for civil commitment, the Act did not establish "criminal" proceedings, and involuntary confinement pursuant to Act was not punitive, thus precluding finding of any double jeopardy or *ex post facto* violation.[51]

With the constitutionality of the Kansas SVP statute being upheld, similar acts have been enacted in 19 other states.[52] The programs in these states, however, are not identical, this analysis concerns itself with the programs in Kansas, Texas, California, and New Jersey.

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[45] This number was arrived at using data from the previous sentence, comparing the release of 494 individuals in comparison to 4500 individuals committed under SVP statutes. The actual number is 10.978%.

[46] This refers to Kansas v. Hendricks and Kansas v. Crane. Kansas v. Crane, further affirmed the constitutionality of the SVP laws, and allowed a broader interpretation of volitional control than Hendricks, by clarifying that complete inability to control behavior is not required (Kansas v. Crane, 534 US 407 (2002).

[47] Frances, Allen, and Shoba Sreenivasan. *Sexually Violent Predator Statutes: The Clinical/Legal Interface.* Psychiatric Times 25.14 (2008).

[48] Zander, *supra* n. 8 at 22.

[49] *Id.*

[50] Kansas v. Hendricks, 521 U.S. at 350.

[51] *Id.*

[52] Kraus, *supra*, note 4.

Although the predominant motivation for SVP commitment laws is incapacitation, states uniformly promise treatment as an ancillary purpose. Indeed, it is this "treatment" purpose that marks the high-security, long-term incapacitation characteristic of SVP regimes as non-punitive, and insulates them from constitutional challenge. Yet, in practice, the promised treatment most often goes unredeemed. [53] These four states highlight the differences that have arisen in the formulation of SVP treatment programs. These differences are due in part to the deference given to the states in the formulation of their SVP statutes and from the Supreme Court decision in Hendricks set forth an imprecise constitutional standard on treatment.[54]

A. THE KANSAS STATUTE

In Kansas, a Sexually Violent Predator (SVP) is a sex offender who has a mental abnormality or personality disorder and a charge or conviction for a sexually violent offense.[55] SVPs are different than other sex offenders because they are at a higher risk to re-offend if their mental abnormality or personality disorder is left untreated.[56] In Kansas an individual committed under the SVP act is housed at Larned State Hospital.[57] There are seven steps of the treatment program including five inpatient and two outpatient phases.[58] There is no time limit for completion of each phase.[59] The offender must meet the predetermined requirements of the phase to advance.[60] Since the program's genesis 16 years ago,[61]only two people have earned final

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[53]Janus, *supra* note 30 at 321.
[54] Zander, *supra* note 8 at 24.
[55] Kansas Dept. Of Corrections, January 2011, *available at* http://www.doc.ks.gov/victimservices/brochures/SVP%20Brochure%20Jan%202011.pub.pdf.
[56] *Id.*
[57] *Id.*
[58] Kansa Dept. of Corrections. *supra* n. 55
[59] *Id.*
[60] *Id.*
[61] As of November 2010.

release, according to state records, 16 people earned conditional release or were released by a state judge for other reasons and 15 others died in the program.[62]

Compared with the other states examined here,[63] the Kansas model is relatively straightforward. This is because the Kansas program for custody and treatment is more heavily dependent on the Department of Corrections for its day-to-day operations[64] than any of the six programs.[65] As a practical matter, the treatment program, located within the Larned Correctional Mental Health Facility, relies on the DOC for facility security, food, transportation, and medical care – virtually everything with the exception of delivery of the treatment program.[66]

B. THE TEXAS STATUTE

In Texas, the SVP statute was deemed needed because the existing involuntary commitment provisions of Subtitle C, Title 7,[67] were inadequate to address the risk of repeated predatory behavior that sexually violent predators pose to society. The legislature further found that treatment modalities for sexually violent predators are different from the traditional treatment modalities for persons appropriate for involuntary commitment. Thus, the legislature found that a civil commitment procedure for the long-term supervision and treatment of sexually

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[62] Larry Seward, *Is the Kansas Program treating sexual predators or making them worse?,* Kansas City Action News Article, Nov. 3, 2010, *available at* http://www.kshb.com/dpp/news/crime/is-ks-program-treating-or-perverting-sexual-predators#ixzz2AiQVb94Y

[63] Analysis relied on is by Andrew Harris and his report cited below

[64] Andrew Harris, *A Prospective Analysis of Sexually Violent Predator Civil Commitment Policies*, (Doctoral Dissertation), Robert F. Wagner School of Public Justice, New York, NY, Sept. 2003

[65] The six programs reviewed in the study were Wisconsin, Kansas, California, Florida, Washington, Minnesota.

[66] Harris. *supra* n. 64 .

[67] Tex. Health & Safety Code Ann. §§ 574.001-.203(1999).

violent predators was necessary and in the interest of the state. [68] Unlike all of the other states that have SVP acts, Texas' program is focused exclusively on the use of outpatient treatment and supervision as an alternative to the route of inpatient commitment.[69] The individual is held until trial on the petition for civil commitment. There is no probable cause hearing built into the Texas scheme,[70] because the statute does not anticipate detaining the respondent in an inpatient facility. Thus, the basic loss of liberty inherent in a typical inpatient commitment is not present.[71] In this sense, the Texas statute is at the forefront of developments in this area of the law nationally and provides another option for those states considering the enactment of laws for civil commitment of sexually violent predators.[72]

Compared to the release of individuals that are committed under the Kansas program, the treatment and release of individuals under the Texas program is much higher. As of October 1, 2011, there were 224 sexually violent predators that have been committed under Health & Safety Code Chapter 841.[73] Of the 224 that were committed, 125 reside in the community and 99 are awaiting release from the Texas Department of Criminal Justice into the treatment program. [74] Furthermore, the Texas law has attempted to develop an effective balance in the area of the civil commitment of the sexually violent predator. Outpatient supervision and treatment in all practical terms can lend itself to greater actual psychotherapeutic intervention and some

[68] Tex. Health & Safety Code Ann., § 841 (1999).
[69] Rahn Bailey, *The Civil Commitment of Sexually Violent Predators: A Unique Texas Approach*, 30 J. Am. Acad. Psychiatry Law,525, 525–32 (2002).
[70] Tex. Health & Safety Code, *supra*, n. 68.
[71] Bailey, *supra*, n. 69 at 526.
[72] *Id*.
[73] Texas Civil Commitment-Outpatient Sexually Violent Predator Treatment Program (OSVPTP) Health & Safety Code, Chapter 841, *available at* http://www.ovsom.texas.gov/docs/Texas-Civil-Commitment-OutpatientSVP.pdf.
[74] Texas Civil Commitment, *supra* n. 73.

psychiatrists question the validity and effectiveness of treatment during incarceration.[75] These higher release rates tend to show that the Texas program's course of treatment affords the committed individual a greater access to mental health services that actually could aid in treating the conditions that caused these individuals to offend in the first place and to prevent re-offense. The statistics from Texas have shown that as of October 1, 2011, none of the SVPs committed to the program have been charged with or convicted of a new sexual crime,[76]which represents a 0 percent sexual recidivism rate.[77]

C. THE CALIFORNIA STATUTE

Involuntary commitment of sexual offenders to state hospitals in California dates back to the early 20th century.[78] The "sexual psychopath laws" were indeterminate criminal sentences that allowed for commitment to state psychiatric hospitals for as long as the individual was deemed a threat to society.[79] The purpose was to help sexual offenders by curing them in a shorter time than they would serve in prisons, and to protect society against release of sexual offenders who had not been cured within the maximum incarceration sentence.[80] In California, the Sexual Psychopath Law was replaced in favor of the Mentally Disordered Sexual Offender (MDSO) Law[81] in 1944, with the MDSO law being repealed in January 1982. [82]

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[75] Bailey, *supra* n. 69, 53.
[76] This is not to say that there were not instances of the individuals re-offending, 38% percent, 68 SVPs, have committed a non-sexual offense and been returned to prison.
[77] Texas Civil Commitment, *supra* n. 73.
[78] Deidre M D'Orazio et al., *The California Sexually Violent Predator Statute: History, Description & Areas for Improvement*, Cal. Coalition on Sexual Offending, Jan. 2009, at 5, *available at* http://ccoso.org/papers/CCOSO%20SVP%20Paper.pdf
[79] *Id.*
[80] *Id*. D'Orazio, *supra*¸ n. 78; *see also*, *Dangerous Sexual Offenders: A Task Force Report of the American Psychiatric Association* (1st ed. 1999).
[81] The MDSO statute provided for the diversion from prison to forensic state psychiatric hospitals of those individuals whose sexual crimes were deemed to be due to a mental disorder. The treatment goal was to reduce risk to such an extent that the individual was felt to be safe for

Developing out of this attention to a subgroup of criminals, the California Legislature passed the SVP Act as a component of the Welfare and Institutions Code[83] to address the concern expressed in the preamble of the legislation; specifically, according to the state, "a small but extremely dangerous (number of) sexually violent predators exist."[84] California's SVP statute was closely modeled after that of the first state to enact an SVP statute, Washington state (1990). Persons committed as SVPs have been previously convicted of specified sex offenses against one or more victims and have been determined to have a diagnosed mental disorder that makes it likely that they will engage in sexually violent predatory behavior upon release into the community.[85] Unlike all of the other statutes, except for Texas, which only has an outpatient program, an SVP in California cannot be held for more than two years, unless a subsequent extended commitment is obtained from the court by the granting of a new petition for commitment.[86]

In terms of treatment, California again differs slightly from other state statutes as the statute focuses on treating the prevalence of re-offense as oppose to curing the sexual offender.[87] The program focuses around this relapse prevention idea and focuses on "offense specific" treatment components; that is, treatment components will be geared toward the identification and

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release. *See generally* Sturgeon, V. H. & Taylor, J., Report of a 5-year Follow-up Study of Mentally Disordered Sexual Offenders Released From Atascadero State Hospital in 1973Crim. Justice Journal, 4, 31-74 (1980). California's statutes have generally acknowledged the dangerousness of these individuals but sought to provide treatment in order to reduce recidivism rates.

[82]D'Orazio, *supra*, n. 78 at 7.

[83] Cal. Welf. & Inst. Code§ 6600 (1995).

[84] *Id.*

[85] California Department of State Hospitals, *http://www.dsh.ca.gov/forensics/FAQs.asp* (last accessed Nov. 19, 2012); *see also* Cal. Welf. & Inst. Code § 6601 (1995). Note another differing criteria for commitment as compared to other states in this paper is that in California the SVP statute only applies to those individuals that are already confined to state prison

[86] California Department of State Hospitals, *supra* n. 85

[87] *Id.*

modification of risk factors for sexual offending.[88] Like other states with SVP statues, California utilizes a phase system.[89] There are four inpatient phases; each with specific requirements and phase five is an outpatient supervised patient reintegration program. [90] Compared to the release rates in Kansas and the zero percent recidivism rate of the Texas program, California's results seem to fall somewhere in the middle. Since the program's genesis, 95 of the 558 total committed SVPs have earned final release.[91] This is above the national average (11 percent), accounting for a release rate of just over 17 percent.[92] There has been no study specifically on the 95 individuals that have been reintegrated into society. However, there was a study regarding the treatment model that is employed in California. The Sexual Offender Treatment and Evaluation Project[93] looked at the relapse prevention model that is currently incorporated into California's SVP treatment program. [94] A positive treatment effect was revealed when the treatment groups were separated into two groups, those who "got it"[95] and those who were assessed to have failed to meet the treatment objectives.[96] The "got it" group had recidivism rates 50 percent less than those assessed to have not met the treatment program objectives.[97] These results[98] are not

[88] *Id.*
[89] D'Orazio, *supra* n. 78 at 31.
[90] *Id.* See also, California Department of State Hospitals, *supra* n. 85
[91] *Id.*
[92] Gookin, *supra*, n. 43; *see also* D'Orazio, *supra*, n. 77 at 2 (comparing the individuals that are currently committed as of 2009 to individuals released as of 2009).
[93] The Sex Offender Treatment and Evaluation Project is a six-year clinical research program specifically mandated by the California State Legislature
[94] D'Orazi *supra* n. 78 at 11.
[95] Referring to individuals that were able to meet treatment objectives
[96] Marques, et al., Effects of a Relapse Prevention program on Sexual Recidivism: Final Results from California's Sexual Offender Treatment and Evaluation Project, 17 Sexual Abuse: A Journal of Research and Treatment, 179-107 (2005)
[97] *Id.*
[98] The highest group to recidivate sexually or violently was the treatment drop-out group, those who volunteered and were assigned to the treatment group who dropped out of treatment before 1 year. The sexual re-offense rate for the treatment dropout group was 35.7%. This suggests to

dispositive but in combination with the results of the Texas outpatient treatment program, tend to show that a relapse prevention model and outpatient program where individuals can work through phases and are not committed for indefinite amounts of time can have positive effects on recidivism rates. Focusing the treatment program on relapse prevention and outpatient programs where the SVP is exposed to real life triggers has had a positive correlation on recidivism rates and should be taken into account when reviewing the mental health services provided to the individual subject to the SVP statute.

D. THE NEW JERSEY STATUTE

The statue in New Jersey, The Sexually Violent Predator Act,[99] defines a sexually violent predator as an individual who has been convicted of a sexually violent offense and suffers from a mental abnormality or personality disorder that makes the person likely to engage in acts of sexual violence if not confined in a secure facility for control, care and treatment.[100] To qualify as a SVP, an individual need not suffer from "mental illness," as defined for purposes of general civil commitment[101] instead, he must have a mental abnormality or personality disorder that may or may not constitute "mental illness," coupled with a criminal conviction or finding of legal insanity or trial incompetence.[102] The origins of the New Jersey statute come from its traditional

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me that it would be likely that those that were committed to mandatory treatment for at least two years would be less likely to reoffend, serving the dual purpose of providing mental health services to the individual and protection to the public.

[99] N.J.S.A. 30:4-27.24-.3838 (1999).

[100] N.J.S.A. 30:4-27.26. (1999).

[101] N.J.S.A.. 30:4-27.2.r (1999).

[102] John Cornwell, John Jacobi, and Philip Witt, Ph.D., *The New Jersey Sexually Violent Predator Act: Analysis and Recommendations for the Treatment of Sexual Offenders in New Jersey*, 24 Seton Hall Legis. J. 1, 5 (1999).

civil commitment statute that was expanded[103] in 1994 and upheld after In the Matter of D.C.[104] In affirming the commitment, the New Jersey Supreme Court found that the new definition of mental illness was clearly intended to apply to released sexual offenders like D.C. who needed to be involuntarily detained for public safety.[105]

It is through the Department of Health Services that the committed individuals under the statute in New Jersey receive treatment at the Sexual Treatment Unit (STU). The treatment provided in the New Jersey facility follows the relapse prevention model, with phase designations.[106] In order to regain his liberty,[107] even conditionally, the ex-offender must establish that he has been successfully treated for the mental abnormality or personality disorder that was the basis for his confinement to the STU.[108] The primary mental health treatment provided to committees is a form of group therapy administered in "process groups," supplemented by psycho-educational "modules" devoted to topics such as victim empathy, relapse prevention, and arousal reconditioning.[109]

Recent data show that from 1999 through the end of March 2012, only 69 of the 580 men committed to the STU (less than 12 percent) were discharged to the community, in most cases subject to stringent conditions including parole supervision and community-based therapy. This release rate falls just below the national average and it appears from the data that the majority of

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[103] *See* 1994 N.J. Sess. Law Serv. 542, 542 (West). The definition was expanded to encompass individuals that had an impaired capacity to control behavior based on a substantial disturbance of perception or orientation.
[104] *See In the Matter of D.C.*, 146 N.J. 31, 48 (1996)
[105] *Id*. at 55.
[106] Cornwall, *supra* n. 102 at 15.
[107] All of the individuals committed under NJ's statue have been men, as of August 2012. Research on file with Seton Hall Center for Social Justice, Civil Rights and Constitutional Law Clinic. *see also* Alves v. Main, Memo in Support of Joint Motion for Settlement Approval.
[108] Alves v. Merril Main, Memo in support of joint motion for settlement approval, August 6th 2012.
[109] *Id.*

the men that were released did not sexually reoffend as they would have been transferred back to the facility.[110] These numbers may seem encouraging and along the lines of the result seen in Texas's with regard to recidivism rates however, more than half of the men that were released to the community were committed within the first three years that the facility was open.[111] It was only after between ten and 13 years they were able to receive enough therapy to receive a phase designation for four or five and gains final release.[112]

The treatment provided under the New Jersey statute appears to be more extensive than in Kansas but the numbers of release and recidivism seem to suggest that it is less effective[113] than the treatment received in California and Texas. What one can take away from the review of these statutes is that they provide a wide array of treatment, both effective and ineffective. More than one statue's primary goal and seemingly only goal is protection of the public. The reality of treatment is overlooked if it means these individuals will not be released, preventing them from ever reoffending.

III. THE CURRENT STATE OF BIOETHICS AND MENTAL ILLNESS

The revolutionary import of bioethics was to shift moral agency away from physicians to patients, and to introduce moral perspectives from outside of medicine.[114] In recent years there has been little focus on how bioethical principles should be used to intervene into mental health

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[110] Data on file with author and Seton Hall Law CSJ. Note that the number of men that were ultimately released does include men that were recommitted after an initial release, involved themselves in the treatment program and were again released to society.
[111] *Id*; As well as Declaration of Barbra Moses in Alves v. Main August 6th 2012.
[112] *Id*. (Stating that the most reliable method to discharge from the STU is treatment).
[113] The class action, Alves v. Main, sought to create a better and more comprehensive treatment program in order to meet the minimum standards as set out in Youngberg v. Romero. The settlement sought to provide more detailed and individualized treatment, a greater amount of therapy, and a better ration of treatment providers to those committed to the facility.
[114] J. Nelson, *Bioethics and the Marginalization of Mental Illness*, J. Soc. Christ. Ethics, 1,179 (2003).

services,[115] in particular there has been virtually no attention given to the ethical implications of the lack of treatment given to the individuals convicted under SVP statutes. While mental illness is not completely missing from the public discussions, literature, and texts of bioethics, it tends to be marginalized much as mental health is in relation to physical health care.[116]

One scholar suggests that the reasons that ethical issues associated with mental illness have generally been neglected in literature and texts of the discipline of bioethics centers around three main issues: changes in the delivery system of mental health services, conflicting ethical theories, and finally the stigma that is associated with mental illness. [117]

The delivery of mental health services was dramatically changed after World War II and continued through the 1970s, with the deinstitutionalization of persons with mental illness and the introduction of community-based outpatient treatment.[118] The deinstitutionalization was driven in part by court rulings and in part by emergence of the community mental health movement, which challenged the therapeutic efficacy of hospitalization in the process of treatment and recovery from mental illness and the emergence of mental health advocacy groups.[119] Deinstitutionalization changed the preeminent model of delivery services into a community based treatment approach that involves a number of different medical services provided by a variety of medical professionals.[120] It is this movement toward a community-based model that has left bioethics without a seat at the table. Bioethics moved from the fringes of the

[115] *Id.*
[116] M*ental Heath: A Report of the Surgeon General* (Washington, DC: Department of Health and Human Services, 1999), chap. 1.
[117] Nelson, *supra* n. 114 at 179.
[118] *Id.*
[119] *Id.*
[120] *Id.*

academic world to the forefront by pursuing institution-based opportunities.[121] With the movement away from treating mental health services in these types of institutions, bioethicists do not have a platform to comment on the state of mental illness.

The second contributing factor to the lack of scholarship on the ethics of mental illness is the conflicting ethical principles that could be applied in this area. The conflict largely centers around the positive and negative implications of applying a paternalistic approach and relying on autonomy. Autonomy is commonly understood to be the principle that independent actions and choices of the individual should not be constrained by others.[122] Paternalism on the other hand, in particular medical paternalism, is the interference with the autonomy of patients for their own clinical benefit, and was an accepted ethical norm in the history of Western medical ethics and was widespread in clinical practice.[123]

Due to the nature of mental illness and the potential for diminished decision-making capacity, autonomy tends to become a contentious issue, rather than ta worthwhile principle in bioethical discussions.[124] The emphasis that autonomy places on rational decision making as the necessary and sufficient condition for autonomous moral action becomes a conceptual barrier to engagement with the wider range of issues facing the mentally ill because many argue they are often not rational individuals.[125] It can be argued that the coercive treatment of psychiatric patients only seemingly conflicts with considerations of autonomy, namely in all cases where

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[121] *Id.*
[122] Barry Furrow et al., Bioethics: Health Care Law and Ethics, 1,3 (6th ed. 2008).
[123] Laurence B. McCullough, *Was Bioethics Founded On Historical And Conceptual Mistakes About Medical Paternalism?,* Bioethics 25.2 1,66-74 (2011).
[124] Nelson, *supra* n. 114 at 179.
[125] *Id.*

patients are not capable of making autonomous decisions[126] however, given the paternalistic nature of the commitment statutes being discussed, it is clear that society's goal is inherently paternalistic. Accordingly there are occasions when people should be treated paternalistically in the interest of others and if it means that the paternalistic intervention could make the individual better: allowing him or her to make autonomous choices.[127] The tension between these two approaches creates a divide where bioethicists do not have a unified voice to speak on the issue.

Compounding the issue of autonomy versus paternalism is the stigma that is often associated with mental illness and the public response. Even with the evolution of other theories of bioethics (feminism, caustrity, narrative) there has not been an increased amenability to the study of mental illness from a bioethics framework.[128]People with mental illness are often seen by the general public as lazy, as individuals that can help themselves yet do not do so.[129] Stigma is also a contributing factor in the chronic underfunding of public mental health services and in the disparities of coverage in private insurance plans.[130] The stigma attaches most directly to persons with mental illness, but there is a wider stigmatizing effect on people who are associated with persons with mental illness.[131] This stigma presents the final barrier that bioethics must overcome in order to become more engaged in the discussion of mental illness. As the scholar Janet Nelson aptly puts it "mental illness, despite the many recent advances in scientific understanding and medical treatment, retains about it the musty and unpleasant aura of the asylum—and no one, from bioethicists to the mentally ill themselves, cares to visit that place if it can be

[126] M Jostrand & G Helgesson,, *Coercive Treatment and Autonomy in Psychiatry* 22 Bioethics, 2, 113-120 (2008).
[127] Jostrand, *supra*, n. 126.
[128] Nelson, *supra*, n. 114 at 179
[129] *Id.*
[130] *Id.*
[131] *Id*.

avoided."[132]

IV. BIOETHICS, MENTAL ILLNESS, AND THE SVP TREATMENT PARADIGM

In order for bioethics to become engaged in mental health issues it must first overcome the stigma that is involved in treating societally unpopular individuals.[133] Bioethics is a field that answers difficult and often unpopular questions, looking at the rights, obligations, privileges and relationships of people.[134] To start to overcome the stigma that is associated with mental illness, bioethics can begin by looking at mental illness through the lens of public health and health disparity prevalent in developing countries. This acts as a way for bioethicists to begin a dialogue, a key step to overcoming the stigma of treating the mentally ill and discussing their conditions. Traditionally speaking, bioethicists tend to focus their attention on those areas where they can demonstrate how to exercise virtue.[135] The mentally ill are a group that suffers and their suffering often goes unnoticed, this is an area where bioethics and bioethicist have made a difference in the past and clearly fits the model for discussion.[136]

By overcoming the stigma and asserting its presence in the filed of mental illness, bioethicists can develop a new understanding of autonomy that can greatly benefit the mentally ill. Autonomy should move away from the focus on the rational aspect of the definition and

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[132] Id.

[133] This becomes especially important in the context of treating mentally ill SVPs because there is evidence to suggest that once a state has opened Pandora's box by adopting an SVP Program, efforts to limit the growth of such programs will be met with fierce public opposition. *See.* Eric S. Janus, *Closing Pandora's Box: Sexual Predators and the Politics of Sexual Violence*, 34 Seton Hall L. Rev. 1233, 1250 (2004).

[134] Furrow *supra* n. 122 at 4.

[135] Larry R. Churchill, Are We Professionals? A Critical Look at the Social Role of Bioethicists, *Daedulus* 128, no. 4 (fall 1999): 253f

[136] Nelson, supra n. 114 at 179 ; *see also* Larry R. Churchill, *Are We Professionals? A Critical Look at the Social Role of Bioethicists,* Daedulus 128, no. 4:253f. (Fall 1999).

instead seek to empower[137] the individual with the power to be educated about and make choices regarding their own mental health treatment. This concept includes certain positive rights such as having decision-making power, access to information and resources, and a range of options from which to make choices and a continuous conversation about those choices. [138]

Even those people with severe mental illnesses, including some people who are experiencing active psychotic episodes, are not so impaired that they are incapable of understanding a proposed medical treatment.[139] They might refuse treatment for their psychotic symptoms on the basis of unlikely or even obviously false belief that they are not ill.[140] Such beliefs do not necessarily make them incapable of comprehending the proposed treatment.[141] Providing that through discussion a severely mentally ill person can have an understanding of the consequences of refusing treatment, this furthers the ultimate goal of promoting autonomous decisions. This new understanding of autonomy helps to ensure that someone who refuses treatment does so because refusing treatment is consistent with his own goals and desires. Provided that the individual is not a danger to himself or others, his mental

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[137] Judi Chamberlin, *A Working Definition of Empowerment*, Psychiatric Rehabilitation Journal, Spring 1997, *available at* http://www.bu.edu/cpr/resources/articles/1997/chamberlin1997.pdf.
[138] Nelson, Bioethics and the Marginalization of Mental Illness, Journal of the Society of Christian Ethics, 179 (2003).
[139] *See* Elyn R. Saks & Dilip V. Jeste, *Capacity to Consent to or Refuse Treatment and/or Research: Theoretical Considerations,* 24 Behav. Sci. & L. 411, 426 (2006) ("It is clear ... that many mentally ill people--indeed, many seriously mentally ill people--are not incompetent on most measures of incompetency."); *see also* William T. Carpenter, Jr. et al., *Decisional Capacity for Informed Consent in Schizophrenia Research,* 57 Archives Gen. Psychiatry 533, 533 (2000) ("Studies of the capacity of schizophrenic patients to make decisions regarding their treatment demonstrate that ... numerous people with schizophrenia, even when acutely ill, perform no worse than many members of the general population.").
[140] Dora W. Klein, *When Coercion Lacks Care: Competency to Make Medical Treatment Decisions and Parens Patriae Civil Commitments,* 45 U. Mich. J.L. Reform 561, 563 (2012).
[141] *Id*.

illness should not prevent him from deciding what course of treatment, if any, he wishes to pursue.

Bioethics should look to areas where it can become involved in a way that has been successful in the past. Bioethics took a firm stance in the early years of mental illness treatment because of the harsh methods used in institutional facilities, the lack of consent of the patients housed in those facilities and the overall mistreatment that institutionalized patients had to deal with in the early years of mental health treatment.[142] Following this model would mean that a bioethicist would sit on the board of facility that treats the mentally ill or would be allowed access to that facility in order to make ethical determinations. The civil commitment process creates a place where bioethicist can follow a model that works. In particular the bioethicist could look at the treatment of an underserved (although unpopular population) of sex offenders. Examining the treatment and the facilities where SVP are committed would allow bioethicists to focus on the suffering inherent in being committed in a system that requires an individual to move through treatment modules. In order to move through those phases or treatment modules they have to have treatment, yet, the treatment they receive is sub-standard and they become trapped in this seemingly never ending cycle.

A commitment facility would provide fertile ground to further the discussion on the ethical treatment of committed SVPs. Given that the dual purpose for commitment under SVP statutes is community protection and to aid the individual, providing adequate mental health services will allow both goals to be accomplished. Treating these individuals of their mental afflictions reduces the risk to the community and serves the goals of paternalism. While the goals of

[142] Nelson, *supra* n. 114 at 3. In particular the early focus of bioethics in the institutional setting was regarding the involuntary and arbitrary commitment of persons to mental hospitals and the egregious use of invasive psychosurgery and electroconvulsive therapy (ECT).

paternalism may not have the best interest of the patient in mind, they do have the interest of society at large. Allowing this balance between SVP treatment and public safety is essential to instituting a new treatment model. [143] When a real tragedy occurs, the media and politicians will interpret the tragedy as a failure to use the SVP tool broadly enough. Moves will be made to broaden the SVP net.[144] The public needs assurances that allowing for variations in treatment will not put themselves or their children at risk and a bioethicist needs room to encourage changes to the treatment system, making the balancing of these competing goals paramount to ensuring that SVP acts are not broadened and treatment does not suffer.

While there are arguments that treatment will not work for sex offenders, as noted previously in this paper, there is not conclusive evidence on either side[145] and the effectiveness of treatment is highly controversial.[146] However, research generally indicates that rehabilitative programs can help sex offenders control their impulses and reduce their likelihood of reoffending.[147] Specifically, studies indicate that the recidivism rate for sex offenders receiving treatment was nineteen percent, compared to a twenty-seven percent rate for non-treated sex offenders.[148] For some particular sexual afflictions (paraphilia and pedophilia) there

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[143] *See generally*, Eric S. Janus, *Closing Pandora's Box: Sexual Predators and the Politics of Sexual Violence*, 34 Seton Hall L. Rev. 1233, 1250 (2004). SVP laws entail a logic that pushes our thinking and approach to sexual violence ever further off balance and demands increasing investment in their strategies. Like Pandora's box, these new laws, which seemed attractive at first, now seem excessive, but cannot, given the political context in which they exist, be abandoned or limited.

[144] Id.

[145] Discussion *supra* n. 22

[146] *See* Linda S. Grossman et al., *Are Sex Offenders Treatable*? *A Research Overview*, 50 Psychiatric Services 349, 349-50 (1999) (noting widespread skepticism regarding the efficacy of sex offender treatment, as well as the difficulty in assessing whether treatment actually works).

[147]Douglas C. Maloney, *Lies, Damn Lies, and Polygraphs: The Problematic Role of Polygraphs in Post Conviction Sex Offender Treatment (PCSOT),* 84 Temp. L. Rev. 903 (2012).

[148] Grossman *supra n. 145.* at 357.

is evidence that a relapse prevention model can reduce rates for recidivism.[149] This would provide a place where bioethics can encourage change. Under the theory of autonomy, if an individual is being placed in a facility under the guise of receiving treatment, they should be allowed to have access to therapy for those afflictions if there is evidence that it will help. These individuals should not be placed in a system that becomes punitive because research on sexual deviance is not complete. Bioethicists should promote the theory of non-malfeasance, to do no further harm to the committed populations.

There will inevitably be those individuals who refuse treatment. Under the current system in place in many states, this refusal may because certain treatment programs require that offenders recount their sexual offenses, which in turn leads treatment providers, the judicial system, and the public to believe that the offenders continue to contemplate sexually violent acts and are still dangerous.[150] It could become the bioethicist role to advocate for the committed SVP that engaging in therapy should not result in a punitive outcomes because treatment appears to be at least minimally effective, encouraging treatment achieves the statutory and constitutional aims of protecting society and caring for mentally ill persons.[151] Allowing a committed SVP who would otherwise refuse treatment due to fear of additional criminal sentencing or a longer stay in an SVP facility to choose an outpatient treatment method or treatment with a certain amount of privacy protection[152] would likely increase treatment participation. Appealing to the SVP

[149] Marques, et al., *supra* n. 96.
[150] Jeslyn A. Miller, *Sex Offender Civil Commitment: The Treatment Paradox*, 98 Cal. L. Rev. 2093, 2118 (2010)

[151] *Id*. at 2122.
[152] Meg S. Kaplan, et al., *The Impact of Parolees' Perception of Confidentiality of Their Self-Reported Sex Crimes*, 3 Sexual Abuse: J. Res. & Treatment 293 (1990) Discussing the correlation between confidentiality and a willingness to talk about sexual crimes.

committee as an autonomous decision maker instead of a criminal heightens the likelihood of the SVP committee choosing treatment.

Finally, there would likely be arguments against providing treatment because it costs too much. However, the Texas program proves that treatment can prevent recidivism and the cost per individual in the Texas program is 17,000, which is 77,000 less than the national average.[153] The cost of the SVP system is not only witnessed in providing care in an institutionalized atmosphere, but is evidenced in budget cuts in certain states. These budget cuts, in an attempt to protect the public by keeping SVPs from reentering society have come at a high price. Some states have taken measures like reducing the number of probation officers and cutting funds to domestic violence and sexual violence prevention programs.[154] As more and more resources pour into SVP programs, the distortion in policy and resource allocation will become more and more severe. Society will suffer because of the resource drain, and victims will suffer as more resources are drawn away from programs that address the great bulk of sexual violence in the community.[155]

The cost of providing treatment can be defended under bioethical principles regarding access to healthcare, beneficence, and a sense of justice. If SVP statues want to have provisions regarding treatment of the individual then they should have to subscribe to a duty of fairness and

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[153] Gookin, *supra* n. 43 at 5. The cost for the Texas program is 17, 391 per individual while the national average is 94, 017 per individual.

[154] In 2004, California spent more than $78 million to lock up 535 predators, while at the same time providing "no substantial sex offender treatment for the seventeen thousand sex offenders in its prisons." Eric S. Janus, *Failure to Protect: America's Sexual Violent Predator Laws and the Rise of the Preventive State* 1, 115 (2006). Similarly, in 2004, Minnesota spent $26 million to lock up 235 predators. That same year, pecuniary problems forced the state to propose cutting 137 of its 778 police officers and actually to eliminate 100 probation officer positions despite rising caseloads, and it cut its funding for domestic violence and sexual violence prevention programs by $3.6 million per year. Tamara Rice Lave, *Controlling Sexually Violent Predators: Continued Incarceration at What Cost*? 14 New Crim. L. Rev. 213 Spring (2011).

[155] Janus *supra* n. 133 at 1250

give to each committed SVP that treatment that the individual deserves. By creating an outpatient program, which will cost lest than institutionalization, focus can be on individual triggers and therapy. This then allows states that are considering budget cuts in other areas to continue to employ corrections officers and provide funding to sexual violence prevention programs. This cost shifting then becomes mutually beneficial: allowing each state to treat the afflicted SVP while cutting its budget and potentially seeing the zero percent recidivism Texas has seen using this out-patient approach.

Conclusion

Bioethics should focus on individuals committed under SVP statutes in order to draw awareness to the lack of treatment they receive. Treatment should be improved and varied in these programs, as it would lead to lower cost and likely a lower rate of recidivism. Following the Texas model would allow for patient autonomy while still serving the interest of the state by protecting citizens. Allowing a new understanding of autonomy to take root would likely greatly advance the conditions within SVP facilities and make great steps toward allowing both the mentally ill and sexually violent predators to choose and receive treatment to become productive members of society.