REPORT

THE NEW JERSEY SEXUALLY VIOLENT PREDATOR ACT: ANALYSIS AND RECOMMENDATIONS FOR THE TREATMENT OF SEXUAL OFFENDERS IN NEW JERSEY*

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* Editor's Note: This is a reprint of the report as originally submitted to various individuals and agencies within New Jersey government. Editorial changes have been kept to a minimum as to maintain the integrity of the report as originally submitted.

I. Preface

The treatment of violent sex offenders raises vexing questions for legislative, judicial and therapeutic authorities. Few offenses induce a more powerful visceral reaction, and, when these crimes are committed by persons with a history of such conduct, policy makers search for appropriately lawful means of response. Incapacitation of persons identified as sexually violent predators has been the increasingly common response of state legislatures. Beginning in 1990 with the Washington Sexually Violent Predator Act, state after state has implemented mechanisms for identifying persons suffering from a mental disorder that would make them more likely to engage in predatory acts of sexual violence, and permitting for their civil commitment on that basis. In 1997, the United States Supreme Court upheld Kansas' version of this statute, affirming that states are empowered to civilly commit persons with a mental abnormality rendering them likely to engage in predatory sexual violence.[1]

The Court's imprimatur spurred more states to enact similar statutes. New Jersey did so in the year following the Court's opinion, and the Governor signed the New Jersey Sexually Violent Predator Act in August 1998.[2] New Jersey officials in several Departments will face significant challenges in implementing this Act. This report was submitted to the Governor of New Jersey, leaders of the New Jersey Legislature, and the Commissioners of the New Jersey Department of Human Services and the New Jersey

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1 *See generally* Kansas v. Hendricks, 117 S. Ct. 2052 (1997).

2 *See* N.J. STAT. ANN. § 30:4-27 (West 1999).

Department of Corrections on June 9, 1999, two months prior to the effective date of the Act. The report comprises the analysis and recommendations for implementation of the Act by the Institute of Law & Mental Health, housed at Seton Hall Law School in Newark, New Jersey.

The report is divided into four sections. The first explains the features of the New Jersey Sexually Violent Predator Act and other statutes currently in place in New Jersey that provide treatment to sex offenders.[3] It also identifies the parameters of the rights to treatment and to refuse treatment for individuals involuntarily detained in psychiatric facilities.[4] The second section outlines important considerations relevant to the implementation of the Act, such as the pathology of sexual predators, findings of current research addressing sex offender treatment, and the experience of other jurisdictions where similar statutes are in force.[5] The third section applies this information in evaluating the current efforts to treat sexual predators in New Jersey.[6] The final section concludes with concrete recommendations in the area of treatment, housing, and staffing for the appropriate implementation of the Act.[7] The focus of these recommendations is on the new Act, but they also address closely related, existing treatment programs for other civilly committed or criminally incarcerated sex offenders in New Jersey.

II. Introduction

A. Setting the Stage

In 1989, in the State of Washington, convicted sex offender Earl Shriner raped a seven-year-old boy, severed his penis and left the boy to die. State officials had previously attempted to civilly

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3 *See infra* Part II.
4 *See infra* Part III.
5 *See infra* Part IV.
6 *See infra* Part V.
7 *See infra* Part VI.

commit Shriner to a psychiatric hospital upon his release from prison in 1987, but their efforts proved unsuccessful, the court finding that Shriner did not satisfy the requirements of present mental illness and dangerousness. In response to this tragedy, the state legislature enacted, in January 1990, the Washington Sexually Violent Predator Act which permitted the post-incarceration civil commitment of sex offenders who suffered from a mental disorder which made them likely to engage in predatory acts of sexual violence. Many other states, including Wisconsin, Kansas, Iowa, California, Arizona and Minnesota, followed suit over the next several years, enacting statutes identical or substantially similar to Washington's.

After the Kansas Supreme Court declared its sexual predator commitment law unconstitutional on due process grounds, the state attorney general filed an appeal with the U.S. Supreme Court, which agreed to hear the case in 1996. In 1997, the Court issued its opinion in *Kansas v. Hendricks*[8] upholding the Kansas Sexually Violent Predator Act.[9] In so doing, the Court affirmed states' authority to civilly commit individuals convicted of, or charged with, a sexually violent offense upon proof, beyond a reasonable doubt, that such individuals suffer from a mental abnormality or personality disorder which makes them likely to engage in acts of "predatory sexual violence."[10] Since the *Hendricks* decision was handed down, a number of states have enacted or are in the process of enacting sexual predator commitment statutes patterned after the Washington/Kansas model.[11] New Jersey is among them, enacting its Sexually Violent Predator Act in August 1998.[12] The law took effect in August 1999.

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8 117 S. Ct. 2052 (1997).

9 *See* KAN. STAT. ANN. § 59-29a01, *et seq.* (Supp. 1996).

10 *See id.* § 59-29a02(a).

11 By September 1999, sexual predator commitment laws will be in effect in 13 states.

12 N.J. STAT. ANN. § 30:4-27 (West 1999).

B. The Civil Commitment of Sexually Violent Predators in New Jersey

The Sexually Violent Predator (SVP) Act provides for two separate procedures by which a sex offender may be subject to involuntary civil commitment in New Jersey. We will describe each, starting with the new Act.

1. New Jersey's Sexually Violent Predator Act

Under the SVP Act, a sexually violent predator is a person who has:

> (1) been convicted, adjudicated delinquent or found not guilty by reason of insanity for commission of a sexually violent offense, or has been charged with a sexually violent offense but found to be incompetent to stand trial, and (2) 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.[13]

Thus, to qualify as a SVP, an individual need not suffer from "mental illness," as defined for purposes of general civil commitment under N.J.STAT. ANN. 30:4-27.2.r;[14] 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.

When it appears that an individual may fall within the Act's classification of a SVP, any agency that has custody or care of that individual may notify the state within ninety days of a possible release from a prison or care facility or adjustment of that

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[13] N.J. STAT. ANN. § 30:4-27.26.b. Sexually violent offenses include the following: aggravated sexual assault; sexual assault; aggravated criminal sexual contact; kidnapping while endangering the welfare of a child by engaging in sexual conduct; criminal sexual contact; felony murder, if the underlying crime is sexual assault; an attempt to commit any of these enumerated offenses; or a criminal offense with substantially the same elements as any offense enumerated above, entered or imposed under the laws of the United States, this State or another state; or any offense for which the court makes a specific finding on the record that, based on the circumstances of the case, the person's offense should be considered a sexually violent offense. *See id.*

[14] *See infra* Part IB2.

individual's status in a care facility.[15] Upon the state's motion, the court shall review all relevant information concerning the status of the individual to determine if there is probable cause to hold a full hearing on the issue of whether he is a sexually violent predator.[16] If the court finds that there is probable cause to hold the individual over for a hearing, the individual must, at all times, remain in the state's custody until that hearing is held.[17] At the hearing, the individual is entitled to counsel and to present evidence and cross-examine witnesses.[18] The state bears the burden of establishing by clear and convincing evidence that the individual in question is a sexually violent predator and should be involuntarily committed to a care facility for treatment of his mental disorder.[19]

2. General Civil Commitment

Even prior to the enactment of the Sexually Violent Predator Act, state officials were able to move for the involuntary detention of sexual predators under the procedures governing the involuntary civil commitment of all individuals believed to be mentally ill and dangerous to themselves, others, or property.[20] Under this civil commitment statute, a psychiatric care facility or hospital can initiate proceedings against an individual.[21] Once the court receives all of the relevant information concerning the individual's mental state, it will decide if there is probable cause to hold a hearing.[22] The patient is entitled to counsel and may introduce evidence and cross-examine witnesses.[23] The court must find that the patient is mentally ill and dangerous by clear and convincing evidence.[24] If the court so finds, commitment is ordered.

In 1994, the New Jersey Legislature broadened the statutory definition of mental illness and, in doing so, specified that the presence of psychosis was not necessary to a finding of present

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15 *See* N.J. STAT. ANN. § 30:4-27.27.
16 *See id.* § 30:4-27.28.
17 *See id.*
18 *See id.* § 30:4-27.31.
19 *See id.* § 30:4-27.30.
20 *See id.* § 30:4-27.2.r.
21 *See* N.J. STAT. ANN. § 30:4-27.10.
22 *See id.*
23 *See id.* § 30:4-27.14.
24 *See id.* § 30:4-27.15.

mental illness.[25] The Legislature deemed its actions a curative function to clarify the existing definition.[26] With the clarification of the definition, individuals can be committed based on an "impaired capacity to control behavior based on a 'substantial disturbance' of perception or orientation."[27]

In 1996, the New Jersey Supreme Court upheld the Legislature's clarification in *In the Matter of D.C.*[28] In that case, the state had civilly committed a convicted rapist who, while non-psychotic, was deemed incapable of controlling his behavior and thus was mentally ill under the Legislature's expanded definition. 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.[29] Thus, *In the Matter of D.C.* established that, under the broader definition of mental illness introduced in 1994, the state could obtain involuntary psychiatric commitment of sexual predators under existing statutory provisions, even where the predator did not suffer from "traditional" (*i.e.* major) mental illness.

C. *The Criminal Commitment of Sex Offenders in New Jersey*

New Jersey's Department of Corrections also provides for the care and treatment of sex offenders serving criminal sentences. This process is completely separate from that pertaining to involuntary civil commitment. Under N.J. STAT. ANN. § 2C:47-1, an individual found guilty of committing a sexually violent crime can be sentenced to serve his term of imprisonment at the New Jersey Adult

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25 *See* 1994 N.J. Sess. Law Serv. 542, 542 (West).

26 *See* In the Matter of D.C., 146 N.J. 31, 48, 679 A.2d 634, 643 (1996).

27 "Mental illness" means a current, substantial disturbance of thought, mood, perception or orientation that significantly impairs judgment, capacity to control behavior or capacity to recognize reality, but does not include simple alcohol intoxication, transitory reaction to drug ingestion, organic brain syndrome or developmental disability unless it results in the severity of impairment described herein. N.J. STAT. ANN. §30:4-27.2.r (West 1999).

28 *See In re D.C.*, 146 N.J. at 48.

29 *See id.* at 55.

Diagnostic Treatment Center (ADTC) in Avenel.[30] Sentencing to the ADTC results "if the court finds that the offender's conduct was characterized by a pattern of repetitive, compulsive behavior and the offender is amenable to sex offender treatment and is willing to participate in such treatment."[31] Of course, because the individuals residing at the ADTC are inmates, their detention is criminal in nature, in contrast to the civil commitment described previously. Also, amenability and willingness to participate in treatment are required only for inmates housed at the ADTC, *i.e.*, not for civilly committed sex offenders.

III. Treatment Rights of Involuntarily Committed Patients

Once an SVP properly has been committed to an institution pursuant to one of the procedures described above, various forms of treatment may become available to him. His rights with respect to receiving or refusing that treatment are defined by reference to two bodies of federal and state law. Under one body of law, the committee has an affirmative, if limited, right to treatment. Under another, he has an affirmative, if limited, right to refuse unwanted treatment.

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30 *See* N.J. STAT. ANN. § 2C:47-1. The statute states that:

> [w]henever a person is convicted of the offense of aggravated sexual assault, sexual assault, aggravated criminal sexual contact, kidnapping pursuant to paragraph (2) of subsection c. of N.J. STAT. ANN. § 2C:13-1, endangering the welfare of a child by engaging in sexual conduct which would impair or debauch the morals of the child pursuant to subsection a. of N.J. STAT. ANN. § 2C:24-4, endangering the welfare of a child pursuant to paragraph (4) of subsection b. of N.J. STAT. ANN. § 2C:24-4, or an attempt to commit any such crime, the judge shall order the Department of Corrections to complete a psychological examination of the offender, except the judge shall not require a psychological examination.

Id.

31 *Id.* § 2C:47-3. Prior to involuntary civil commitment, the defendant in *In the Matter of D.C.* served his sentence for rape at the ADTC. *See supra* text accompanying notes 26-27.

A. *Right to Treatment*

The Eighth and Fourteenth Amendments to the United States Constitution guarantee to incarcerated and involuntarily committed persons at least a minimal level of medical and psychiatric care. Incarcerated persons are entitled to be free from the denial of care that rises to the level of deliberate indifference to their serious medical needs.[32] This standard applies to mental health as well as medical care.[33] Similarly, patients committed under the traditional dangerousness standard have been found to be entitled to some "minimally adequate treatment" of their mental illness.[34] While the Supreme Court appeared to endorse the notion that states are empowered to commit SVPs for reasons primarily related to incapacitation, it also suggested that the denial of care for a *treatable* condition might evidence a criminal, rather than civil purpose for commitment.[35]

These constitutional standards are eclipsed in New Jersey, however, where the rights of incarcerated and civilly committed persons to mental health services are more specifically set out elsewhere. A recent Settlement Agreement incorporates a description of a broad array of psychological services available to persons incarcerated in state prisons.[36] And, by statute, New Jersey creates an entitlement to "medical care and other professional services in accordance with accepted standards" for all mentally ill persons.[37] Finally, the New Jersey Sexually Violent Predator Act requires the Division of Mental Health Services in the Department of Human Services to provide or arrange treatment "appropriately tailored to address the specific needs of sexually violent predators."[38]

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32 *See* Estelle v. Gamble, 429 U.S. 97, 104 (1976); *see also* Vance v. Peters, 97 F.3d 987, 991 (7th Cir. 1996).

33 *See* Smith v. Jenkins, 919 F.2d 90 (8th Cir. 1990).

34 *See generally* Youngberg v. Romeo, 457 U.S. 307, 322 (1982).

35 *See* Kansas v. Hendricks, 117 S. Ct. at 2085.

36 *See* C.F. v. Terhune, Civ. No. 96-1840 (AET), Settlement Agreement executed 5/12/99 and 5/13/99, Appendix B.

37 N.J. STAT. ANN. § 30:4-24.1. New Jersey's statutory definition of mental illness is quite broad, and would appear to include persons found to be SVPs. *See* N.J. STAT. ANN. § 30:4-27.2.r.

38 *See id.* § 30:4-27.34.b.

B. *Right to Refuse Treatment*

It is clear, then, that involuntarily committed SVPs have a right to treatment. Under some circumstances, however, they have a right to *refuse to accept* that treatment. The right to refuse treatment under federal and state law is often framed by reference to Justice Cardozo's famous dictum that "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages."[39] This dictum has come to be incorporated in civil law as the doctrine of informed consent, by which physicians are required to disclose all information material to a reasonably prudent patient in the course of obtaining consent for medical[40] or pharmacological[41] treatment. For involuntary committees, however, these rights are necessarily limited, although not extinguished, by virtue of their institutional status.

Involuntary committees in New Jersey retain a broad array of civil rights.[42] The rights include freedom from "unnecessary or excessive medication" and physical restraint, and to privacy and dignity.[43] Unlike voluntary committees, however, involuntary committees have no *statutory* right to refuse treatment.[44] Their rights to refuse treatment are, however, recognized as a matter of constitutional law. The United States Supreme Court, in reviewing state policies permitting the forced treatment of involuntary committees and prisoners, has assumed the existence of a liberty interest in refusing treatment.[45] The institutionalized individual's exercise of this liberty interest is constrained by the existence of significant state interests in enforcing treatment—often the interest in avoiding self-inflicted harm to the inmate or harm to others.

In cases where a treating physician's professional judgment

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39 In re Conroy, 98 N.J. 321, 346 (1985) (quoting Scholendorff v. Society of New York Hospital, 105 N.E. 92, 93 (1914)).

40 *See* Largey v. Rothman, 540 A.2d 504 (N.J. 1986).

41 *See* Niemiera v. Schneider, 114 N.J. 550, 562-63 (1989).

42 *See* N.J. STAT. ANN. § 30:4-24.2.a.

43 *See id.* §§ 30:4-24.2.d(3).

44 *See id.* § 30:4-24.2.d(1).

45 *See* Washington v. Harper, 494 U.S. 210 (1990); *see also* Mills v. Rogers, 457 U.S. 291 (1982).

determines that forced treatment is necessary to prevent a committee's creating a danger to himself or others, the right to avoid treatment is overcome.[46] The proper balance of the individual's right to refuse treatment against the state's important goals in other situations is fact specific, and the process by which the significance of the competing claims is determined must permit a full consideration of the effects of treatment, the interests of the committee, and the policies of the state that favor treatment.[47]

IV. Implementing New Jersey's Sexually Violent Predator Act

A. The Pathology of Sexual Predators

Sexual predators, in particular, those whose pathology is so extreme as to require civil commitment, are difficult to characterize. They are as varied a population as any other clinical group. Researchers have unsuccessfully searched for decades attempting to find a personality style common to sex offenders.[48] The heterogeneity of this population, therefore, requires a flexible treatment approach. Although, as will be seen in our review of treatment programs below, certain core components can be identified. Different offenders will require more of one component, while others will require more of another component.

Perhaps the most comprehensive, empirically validated method of classifying sex offenders has been developed by Knight and Prentky.[49] Knight and Prentky developed classification systems for both child molesters and rapists and subjected their taxonomy systems to empirical validation, resulting in three revisions of each system before sufficient validity was obtained. The rapists, those

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46 *See* Rennie v. Klein, 720 F.2d 266, 269-70 (3d Cir. 1983).

47 *See id.*; *see also* United States v. Watson, 893 F.2d 970 (8th Cir. 1990).

48 *See* Quinsey, V.L., Harris, G.T., Rice, M.E., & Cormier, C.A., VIOLENT OFFENDERS: APPRAISING AND MANAGING RISK 127, 127 (Am. Psychol. Ass'n 1998).

49 *See* Knight, R.A. & Prentky, R.A., *Classifying Sexual Offenders: The Development and Corroboration of Taxonomic Models*, HANDBOOK OF SEXUAL ASSAULT: ISSUES, THEORIES, AND TREATMENT OF THE OFFENDERS 23, 23-52 (1990).

who have forcibly sexually assaulted adults, usually women, can be classified by their level of social competence, presence or absence of chronic anger (either generally or specifically towards women), and the presence or absence of sadistic sexual fantasies. The child molesters can be classified by their level of sexual fixation (i.e., the degree to which their sexual fantasies and preferences focus on children), the extent of their social contact with children, their social competence, the meaning of their contact with children (that is, among those child molesters with extensive contact with children, whether their contact was purely exploitive in intent or whether the child molester established a relationship with the children), and the presence or absence of both sadistic sexual fantasies and victim harm. One can see by the complexity of this taxonomy system that two offenders may commit the same offense, for example, aggressively sexually assaulting, and yet have different motivations, one having performed the act out of anger while another as an expression of sadistic sexual fantasies. Consequently, treatment must be tailored to the needs of the particular offender.

The etiology of sexual offending, in particular, is poorly understood. There is no consensually accepted theory of how sex offenders acquire their illegal sexual behavior and interest patterns.[50] The two most prevalent etiological theories are behavioral and biological.[51] Behavioral theories focus on conditioning of deviant sexual arousal (typically through pairing deviant fantasies with sexual arousal through masturbation, childhood sexual trauma, or both), distorted cognitions that justify sexual offending, and inadequate interpersonal skills, particularly with regard to maintaining adult emotionally intimate relationships. Behavioral theories suggest that sexual arousal to deviant sexual stimuli, typically as assessed in the laboratory through penile plethysmography, is associated with increased performance of the deviant sexual behavior to which the individual is aroused. This seemingly plausible hypothesis has been best supported among child molesters who molest children outside their own families[52] and has

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50 *See* Becker, J.V. & Murphy, W.D., *What We Know and Do Not Know About Assessing and Treating Sex Offenders*, 4 PSYCHOL., PUBL. POL'Y, & L. 116, 116-37 (1998).

51 Similarly, the two most common treatment modalities are also behavioral and biological.

52 *See* Marshall, W.L., *Pedophilia: Psychopathology and Theory*, SEXUAL

been less supported, although still to a statistically significant degree, among rapists.[53] Certainly those individuals found to be the most dangerous to the community have been found, not surprisingly, to have high levels of both sexual deviance and criminality.[54] As one authoritative work puts it: "Offenders who are both psychopathic and sexually deviant are most likely to recidivate. Thus, two classes of variables predict sex offending: measures of antisociality (which also predict violent reoffending among both sex offenders and non-sex offenders) and sexual deviance (which predicts primarily sexual reoffending)."[55]

Biological theories have focused on the role of male sex hormones and, recently, neurotransmitters in affecting sexual arousal and interest.[56] Much of the evidence for the role of hormones and neurotransmitters in sex offenses does not come from chemical analyses of the blood of sex offenders. In fact, the results of such studies have been inconclusive, with some studies showing sex offenders to have abnormal hormone or neurotransmitter levels and other studies showing no such relationship.[57] Rather, biological mediation of sex offenses has been inferred from the positive effect of antiandrogen and antidepressant treatment of sex offenders and non-sex offender paraphilics.[58] As one authority notes: "At present,

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DEVIANCE: THEORY, ASSESSMENT, & TREATMENT 332, 332-55 (1997).

53 *See* Hudson, S.M. & Ward, T., *Rape: Psychopathology and Theory,* SEXUAL DEVIANCE: THEORY, ASSESSMENT, & TREATMENT 152, 152-174 (1997). Also, for a review generally supporting the ability of phallometric findings to differentiate rapists from non-rapists, see Quinsey, V.L., *supra* note 48, at 124.

54 *See* Serin, R.C., Malcolm, P.B., Khanna, A., & Barbaree, H.E., *Psychopathy and Deviant Sexual Arousal in Incarcerated Sexual Offenders,* 9 J. OF INTERPERSONAL VIOLENCE 3, 3-11 (1994).

55 Quinsey, *supra* note 48, at 142.

56 *See* Bradford, J., *Medical Interventions in Sexual Deviance,* SEXUAL DEVIANCE: THEORY, ASSESSMENT, & TREATMENT 449, 449-64 (1997).

57 *See* Grubin, D. & Mason, D., *Medical Models of Sexual Deviance,* SEXUAL DEVIANCE: THEORY, ASSESSMENT, & TREATMENT 434, 440 (1997).

58 *See* Bradford, *supra* note 56; Kafka, M.P., *Successful Antidepressant Treatment of Nonparaphilic Sexual Addictions and Paraphilias in Men,* 52 J. OF CLINICAL PSYCHIATRY 60, 60-65 (1991); *see also* Kafka, M.P. & Prentky, R.A., *Fluoxetine Treatment of Nonparaphilic Sexual Addictions and Paraphilias in Men,* 53 J. OF CLINICAL PSYCHIATRY 351, 351-58 (1992); Kafka, M.P., *Sertraline Pharmacotherapy for Paraphilias and Paraphilia-related Disorders: An Open Trial,* 6 ANNALS OF CLINICAL PSYCHIATRY 189, 189-95 (1994).; Kafka, M.P., *Current Concepts in the Drug Treatment of Paraphilias and Paraphilia-related Disorders,* 3 CNS DRUGS 9, 9-21 (1995) [hereinafter *Current Concepts*].

there is no single unifying theory to adequately explain the pathogenesis of sexual impulse disorders."[59] However, the presumed mechanism of action of antiandrogen drugs is to reduce serum testosterone levels, thereby reducing sexual drive, both deviant and normal.[60] The presumed mechanism for serotonergic antidepressants is that because serotonin is believed to inhibit human sexual behavior, raising levels of serotonin decreases sexual impulsivity.[61]

Although sex offenders are a diverse group, certain common features are present in civilly committed offenders. These offenders are the highest risk offenders, so one would anticipate that as a group they would be higher on the negative attributes measured on various risk assessment scales, and such has been found to be the case. In New Jersey, for example, a recent study found that sex offenders, probationers, state prison inmates, Adult Diagnostic and Treatment Center inmates, and civilly committed sex offenders had average risk scores on the New Jersey's sex offender risk assessment scale, the Registrant Risk Assessment Scale (RRAS), of 38, 53, 60, and 62 points respectively.[62] In this study, civilly committed sex offenders tended to have committed the most serious offenses, to have the longest histories of sexual offending, and (particularly among the rapists) to have the highest levels of general criminality. A statistical analysis of the properties of the RRAS indicates that two major factors account for much of its predictive power: sexual deviance and criminality. These two factors have been found repeatedly in studies of sex offender populations, with rapists typically being higher on criminality (much like a general prison population) and child molesters being higher on sexual deviance.[63] These two areas must be carefully assessed and addressed in treatment.

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59 Kafka, *Current Concepts, supra* note 58, at 12.

60 *See id.*

61 *See id.*

62 *See* Ferguson, G.E., Eidelson, R.J., & Witt, P.H., *New Jersey's Sex Offender Risk Assessment Scale: Preliminary Validity Data*, 26 J. OF PSYCHIATRY AND L. 327, 327-51 (1998).

63 We are speaking in broad terms here; as noted previously, one must be careful to assess each sex offender individually, since they are diverse.

B. Lessons from the Research Literature

There are, as of this date, no published studies on treatment effectiveness for SVPs committed in various jurisdictions; no jurisdiction has yet funded an outcome study, which, even if funded, would require years of follow-up to determine whether any reduction in recidivism resulted from such treatment. Consequently, SVP treatment programs have been based on what has been accepted as standard treatment for other incarcerated, inpatient, or outpatient sex offenders.

Treatment programs for sex offenders in general have two major content types: psychological and pharmacological. Current pharmacologic treatment for sex offenders involves two major classes of drugs: antiandrogens and antidepressants of the selective serotonin reuptake inhibitor family (SSRIs). Considerable research has been done on antiandrogens, including double-blind, placebo controlled studies.[64] These drugs either block production or uptake of androgens, the male sex hormones. In so doing, they lower levels of sexual urges, deviant and normal. Although they do not have a specific effect on just deviant urges, since they lower normal urges as well, they have been used either instead of, or in addition to, cognitive-behavioral treatment.

Reductions in plasma testosterone are associated with lower levels of sexual fantasies, decreased spermatogenesis, and decreased sexual urges.[65] Some authorities believe that antiandrogen treatment is the treatment of choice for more severe offenders, with such offenders needing to be on these hormonal agents indefinitely. Others believe that hormonal treatment can be tapered as the patient progresses in psychologically oriented treatments. The most common antiandrogen used in the United States is medroxyprogesterone acetate, usually in its fat soluble, injectable form and commonly referred to by its trade name, Depo Provera, while a more recently used antiandrogen in the U.S. is leuprolide (Lupron).[66]

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64 An excellent summary is available in Bradford, J., *Medical Interventions in Sexual Deviance*, SEXUAL DEVIANCE THEORY ASSESSMENT & TREATMENT 449, 449-64 (1997).

65 *See* Bradford, *supra* note 56.

66 Depo Provera was developed and is still clinically indicated for use as a birth

In recent years, SSRIs have also been used to lower sexual drive. Although SSRIs have no known effect on testosterone levels, they have been widely known to have the side effect of lowering sexual drive in a normal population taking them, and this side effect can be beneficial with a sex-offending population. Additionally, some SSRIs have recently been approved for use with obsessive-compulsive disorder. Although few sex offenders are diagnosed with obsessive-compulsive disorder, those sex offenders with high levels of compulsivity share some characteristics with obsessive-compulsives, particularly the struggle to control strong urges and the cognitive preoccupation with those urges. Hence, it is a reasonable assumption that SSRIs will assist at least some sex offenders in controlling their urges. Although no double-blind controlled studies have yet been published on the use of SSRIs with sex offenders, numerous supportive case studies and anecdotal articles have been published.[67] The most thoroughly researched of the SSRIs is fluoxetine (Prozac), although a variety of other serotonergic antidepressants have been used as well.[68]

A recent survey of North American treatment programs found that the psychological component of most long-term inpatient or incarcerated population treatment programs today follows a cognitive-behavioral/relapse prevention model.[69] Such a model, originating with Alan Marlatt in addictions treatment programs,[70]

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control agent. Leuprolide (Lupron), also a true antiandrogen, was developed to treat prostatic carcinoma, endometriosis, and precocious puberty. The use of antiandrogens to lower sexual drive in sex offenders is an off-label use; no specific FDA approval exists for treating sex offenders with these hormonal agents. Nonetheless, the use of antiandrogen drugs is not uncommon among biologically oriented practitioners, and the use of various drugs for off-label uses is itself common when research supports such use. For a review of the studies supporting antiandrogen use in sex offenders, see Bradford, *supra* note 57.

67 For a detailed review of the literature, see Kafka, *Current Concepts*, *supra* note 59, and Bradford, *supra* note 56.

68 Kafka, *supra* note 58, at 13 table 2.

69 A recent survey of North American sex offender treatment programs found that a cognitive-behavioral/ relapse prevention model is the modal approach to this population. *See* Freeman-Longo, R.E., Bird, S., Stevenson, W.F., & Fiske, J.A., 1994 NATIONWIDE SURVEY OF TREATMENT PROGRAMS AND MODELS SERVING ABUSE-REACTIVE CHILDREN AND ADOLESCENT AND ADULT SEX OFFENDERS (1994); *see also* Witt, P.H., Rambus, E., & Bosley, T., *Current Developments in Psychotherapy for Child Molesters*, 11 SEXUAL AND MARITAL THERAPY 173, 173-85 (1996).

70 *See* RELAPSE PREVENTION: MAINTENANCE STRATEGIES IN THE TREATMENT OF ADDICTIVE BEHAVIORS (Marlatt, G.A. & Gordon, J.R. eds. 1985).

has in recent years been applied to a variety of disorders, including sex offending.[71] The relapse prevention theory posits that when many patients enter treatment, they are abstinent from their problem behavior. Over time, however, some patients follow an identifiable sequence that eventually leads to relapse. This sequence passes through seemingly unimportant decisions that lead the patient into high-risk situations, which in turn draw out of the patient maladaptive coping responses that lead to eventual relapse. Relapse prevention treatment, then, involves educating the patient about the steps leading from abstinence to relapse and assisting the patient to acquire the skills to prevent relapse. Much of this treatment has an educational tone, involving classes, lessons, and practices sessions for skills. The wealth of psychoeducational modules used in current sex offender treatment programs comes from this tradition.

A recent authoritative work by William Marshall and his colleagues reviews institutional treatment programs around the world, including North America, Europe, and New Zealand.[72] Certain similarities exist among the institutional programs, regardless of whether these programs are conducted in prisons or in secure psychiatric facilities.[73] First, many of the institutional programs have phases, or stages, through which the patient progresses. These stages involve two characteristics: increasing levels of responsibility and increasing complexity of therapeutic tasks (with a gradual shift toward development of a discharge plan as potential discharge nears). Both features of these stages are based on reasonable principles. Almost all secure facilities have a system by which patients or inmates acquire increasing levels of responsibility as they behave well. Increasing complexity of tasks as

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71 Perhaps the most prominent proponent of this model for sex offenders has been William Pithers, a prior student of Alan Marlatt's. *See* Pithers, W.D., *Relapse Prevention with Sexual Aggressors*, HANDBOOK OF SEXUAL ASSAULT 343, 343-61 (1990).

73 *See* SOURCEBOOK OF TREATMENT PROGRAMS FOR SEXUAL OFFENDERS (Marshall, W.L., Fernandez, Y.M., Hudson, S.M., & Ward T. eds. 1998).

73 Although a relapse prevention model is used by most institutional programs, within this model there is considerable latitude for individualizing a treatment plan, which is important given the heterogeneity of sex offenders; that is, treatment programs must be flexible, allowing each patient's program to be tailored to his specific deficits and difficulties. By way of example, a rapist whose assessment reveals that anger and a generally antisocial, criminal lifestyle motivated his offenses would not be suitable for antiandrogen treatment, whereas a rapist whose assessment revealed strong sadistic sexual fantasies that led to his offenses might well be suitable for such treatment.

one masters simpler tasks is how most complex skills are acquired. For example, the following is a summary of the stages of the Ontario penitentiaries' program:[74]

Stage 1: Developing compliance and motivation for behavior change

Objective A: Acceptance of responsibility for sex crimes; reatment targets include denial, minimization, and cognitive distortions

Objective B: Becoming aware of victim harm and developing empathy

Stage 2: Achieving behavior change

Objective C: Chains of behavior; developing an awareness of the antecedents and precursors to their sexual crimes.

Objective D: Developing a relapse prevention plan

Objective E: Eliminating deviant sexual arousal

Objective F: Finding community supports and resources

Stage 3: Implementation of the relapse prevention plan

Objective G: Going straight; preventing re-offense while developing a prosocial life in the community

Almost all of the treatment in the institutional programs reviewed in the Marshall study is provided in groups, not individually. Some programs separate groups into a core therapy group, whose therapist acts as a case manager for the inmate, and separate psychoeducational modules.[75] A common set of psychoeducational modules is shared by most programs reviewed. The following is a list of modules in the Kia Marama program in

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[74] *See* Barbaree, H.E., Peacock, E.J., Cortoni, F., Marshall, W.L., & Seto, M., *Ontario Penitentiaries' Program*, SOURCEBOOK OF TREATMENT PROGRAMS FOR SEXUAL OFFENDERS 59, 66 table 5.2 (1998).

[75] However, this structure is not universal. Washington, for example, incorporates the content of psychoeducation modules into the core therapy group, believing that the primary therapist can best tailor the treatment to each inmate's needs. *See* RELAPSE PREVENTION: MAINTENANCE STRATEGIES IN THE TREATMENT OF ADDICTIVE BEHAVIORS 1, 3-16 (Marlatt, G.A. & Gordon, J.R. eds. 1985)(citing Gordon, A. & Hover, G., *The Twin Rivers Sex Offender Treatment Program*).

New Zealand:[76]

Assessment
Norm building
Understanding your offending
Arousal reconditioning
Victim impact and empathy
Mood management
Relationship skills
Relapse prevention
Reassessment

Increasing victim empathy, developing relapse prevention skills, acquiring interpersonal skills, managing negative emotions, and decreasing deviant sexual arousal are common elements of almost all programs reviewed.

Some of the institutional programs make an effort to involve security staff. The most common method of involvement is in monitoring. That is, security staff provide feedback on how the sex offender is adjusting in the institution. Security officers may be appointed a particular treatment group to monitor or a particular housing unit or work area to monitor, depending on the organization of the institution. In this way, security officers provide valuable information on the inmates' functioning outside of the treatment group. Having security officers monitor and report on inmates' behavior is also a function reasonably consistent with the security officers' role of maintaining a safe, secure environment, thus preventing any conflict of roles that hamper the security officers' effectiveness.

One often debated topic is whether sex offender treatment works. Unfortunately, this debate is frequently heated and polarized. One difficulty lies in the incompleteness of the data. It is difficult to conduct outcome studies on sex offender treatment. Some relapses go undetected. Moreover, it is difficult to conduct controlled trials on sex offender treatment, since a no-treatment control group is viewed as unethical by many practitioners. Finally, to conduct prospective studies to determine whether treatment reduces recidivism one must wait decades to determine which offenders recommit sex crimes many years after treatment.

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[76] *See id.* at 17-28, table 2.1.

Nonetheless, recent reviews indicate that while treatment cannot eliminate future sex offending, treatment can reduce recidivism, perhaps up to 30%.[77]

C. *Lessons from Other Jurisdictions*

In completing this project, we visited the Minnesota Sexual Psychopathic Personality Treatment Center in Moose Lake, Minnesota. This secure, free-standing facility is operated by the Minnesota Department of Human Services and houses the Minnesota Sex Offender Program (MSOP). It houses patients civilly committed under two separate Minnesota statutes, one for sexually dangerous persons (SDPs) and another for sexual psychopathic personalities (SPPs). We chose this facility by virtue of its reputation, among clinical and legal experts in the field, as one of the finest of its kind in the country. We also reviewed documents describing the California Sex Offender Treatment Program (SOTEP), located at the Atascadero State Hospital in Atascadero, California. SOTEP is a treatment program run by the California Department of Mental Health at an existing psychiatric hospital for civilly committed sex offenders. In addition, we interviewed various state officials responsible for providing treatment and security to civilly committed sex offenders in a variety of jurisdictions, including California, Wisconsin, Washington, and Arizona.

All of the treatment programs reviewed share many of the characteristics noted in our review of literature above. First, pharmacologic intervention, where used, consists either of the administration of antiandrogens or SSRIs. That being said, the prescription of such medication is more the exception than the rule in the jurisdictions surveyed; typically, no more than ten percent of the sex offender population received either form of drug therapy to reduce sexual urges or impulsivity. A reluctance to use

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[77] *See* Schwartz, B.K. & Cellini, H.R., *The Sex Offender: Corrections, Treatment, and Legal Practice*, KINGSTON, N.J.: CIVIC RESEARCH INSTITUTE 4-1 through 4-19 (1995) [hereinafter *The Sex Offender*]; Prentky, R. & Burgess, A.W., *Rehabilitation of Child Molesters: A Cost-Benefit Analysis*, 60 AM. J. OF ORTHOPSYCHIATRY 108, 108-17 (1992); Marshall, W.L & Pithers, W., *A Reconsideration of Treatment Outcome with Sex Offenders*, 21 CRIM. JUST. & BEHAV. 10, 10-27 (1994); Hall, G.C.N., *Sexual Offender Recidivism Revisited: A Meta-Analysis of Recent Treatment Studies*, 63 J. OF CONSULTING AND CLINICAL PSYCHOL. 802, 802-09 (1995).

pharmacologic agents more widely is attributed in part to the unpleasant side effects of the medication, especially the antiandrogens, as well as ethical considerations concerning patient compliance.

Turning, then, to psychological interventions, we would first note that, consistent with standard practice, almost all treatment is conducted in groups. Treatment programs justify this reliance on group treatment both clinically and financially. Simply put, it is less expensive to provide treatment in groups than individually. Additionally, sex offender treatment involves assisting the offenders to change how they relate to others, and this is most efficiently accomplished in treatment groups, where their interactions can be observed and where they can be given immediate and direct feedback on their behavior. Such work occurs in what are referred to as core treatment groups, *i.e.*, long-term, relatively unstructured groups run by the resident's primary therapist. The psychoeducational modules can also be effectively taught in a group format. Although there have been no empirical studies comparing group and individual treatment of sex offenders, group treatment has become the usual and customary practice in the field.[78]

In addition, all of the programs reviewed follow a stage, or phase, model in which residents obtain increasing levels of responsibility and focus on increasingly complex therapeutic tasks as they progress in treatment. These stages, as discussed above in our review of the literature, begin with simple therapeutic tasks and progress to more complex tasks. The assumption behind the phase model is that patients need to receive program information in increasingly complex ways, beginning with the most simple presentation. Only after a patient has mastered the tasks at one phase can he progress to the next. Further, increasing levels of personal responsibility are granted at each successive phase.

While there are minor differences among the models used in the jurisdictions reviewed, they are basically similar in form and

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78 This is not to say that individual therapy is nonexistent in sex offender treatment programs. Officials from the State of Washington, for example, report that each committed sex offender receives one to two hours per week of individual therapy to address issues specific to him which are inappropriate for group discussion. Wisconsin also incorporates individual therapy, albeit to a lesser degree. Minnesota, on the other hand, uses individual therapy on a more *ad hoc* basis, where the treatment team deems such intervention necessary to address disruptive behavior.

structure. To illustrate the features of these models, we will begin with Minnesota's program which contains four stages: introduction; evaluation; active inpatient treatment; and transition into the community. Patients entering Minnesota's Sex Offender Treatment Program (MSOP) are placed in the introductory stage after a brief evaluation. At this time, they receive orientation materials and are introduced to the basic treatment concepts and procedures, including common motivators for sex offending and typical victim experiences. They are also taught the journal process, and instructed on a self-monitoring and record-keeping procedure which they will use throughout the more advanced treatment phases.

After completing this introduction, a patient proceeds to the evaluation phase, where he receives evaluations by a variety of disciplines, including nursing, medical, psychiatric, psychological, educational, vocational, chemical abuse, social work, and recreational. The psychological evaluation includes a number of objective personality assessment instruments, such as the MMPI-2, as well as instruments that focus on sex-offense-specific characteristics, such as empathy and sexual compulsivity. A brief screening IQ test is also administered.

Once the treatment team has completed its evaluation, an individualized treatment plan is developed for each resident and a report is filed for the court indicating whether the staff believes that the resident meets the criteria for commitment. Within this active inpatient treatment stage, there are four distinct phases. In the first phase, the treatment team endeavors to break through the patient's denial and minimization, introduce him to the group process, address anger management, provide basic sex education, and introduce him to the relapse prevention model. It is possible to complete Phase I in one trimester.

Phase two focuses on helping the patient to develop insight into his personal sexual abuse cycle. Before progressing to phase three, the patient must meet phase two goals for at least two trimesters. To complete phase three, the patient must demonstrate insights acquired in previous phases through demonstrable behavior change. Progression to phase four requires meeting the goals of phase three for at least two trimesters. Phase four involves planning for the transition stage. It is possible to complete phase four in one trimester. Transition residents can earn staff-supervised, off-grounds privileges, and then unsupervised on-grounds privileges in small

increments. After several months of successful adaptation, residents can be considered for unsupervised off-grounds privileges if approved by an external review board. All residents are closely monitored during this stage through call-in times, weekly urinalysis, mileage logs, timesheet checks, random phone calls, and monitoring polygraphs. A minimum of thirty-two weeks of successful, unsupervised, off-grounds privileges must be achieved before conditional discharge is considered.[79] In the MSOP, the resident receives formal written evaluations at the end of every trimester, with written feedback at the trimester's midpoint to provide him with early notification of his progress. At the end-of-trimester meeting, the resident receives both written and oral feedback and is advised of areas for further work.

The MSOP involves non-treatment staff in the treatment program. Twice weekly, the clinical staff on each housing unit meets with recreation supervision, work supervision, and security staff to review the patients' behavior. A detailed behavioral summary for each patient is compiled, and this summary is used as a foundation for giving the patient periodic progress reports. These biweekly behavioral summaries serve two purposes. First, they allow the non-clinical staff, particularly housing unit security staff, to participate actively in treatment. Their input is valued and considered in making treatment decisions. One traditional problem in secure treatment facilities is conflict between the security and treatment staff, since each group sees its purpose differently. Treatment staff believes it is there to help the patients, while security staff believes it is there to restrain and perhaps punish the patients. All too often, these diverging directions cause internal conflict. By consciously including security staff in treatment, even if primarily for monitoring patients, this divergence is reduced. Second, these biweekly behavioral summaries serve to anchor the periodic patient progress reports. The detailed biweekly reports are written and stored in the patients' files, providing the evidence on which periodic feedback is based, rather than relying on the vagaries of the clinical staff's memory.

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[79] MSOP has two residents in the transition program with one approaching conditional discharge. Electronic mail communication from, Anita Schlank, Ph.D., MSOP Clinical Director to Prof. Kip Cornwell (Apr. 9, 1999) (on file with the author).

The California program at Atascadero State Hospital has both treatment and security staff also employed by California's Department of Mental Health. Craig Nelson, Ph.D., the program's Clinical Director stated that:

> [s]ecurity in our program is provided by Hospital Peace Officers (HPO's) who work for the Department of Mental Health. They have full peace officer status, including the ability to make an arrest. They provide perimeter security as well as security functions within the institution. They work well with the clinical staff and some have previously been psychiatric technicians. They have the freedom to write in the clinical record if necessary (although this seldom occurs).[80]

He does not report any systematic use of security staff in resident feedback sessions, as does the MSOP. The California SVP program at Atascadero State Hospital has a series of five phases, similar to the MSOP:[81]

Phase One (Treatment Readiness): This is an educational component designed to prepare offenders to take an active role in their treatment. Topics include an introduction to the following: (1) overview of treatment; (2) review of the SVP law; (3) understanding mental disorders; (4) victim awareness; (5) relapse prevention; and (6) cognitive distortions.

Phase Two (Skills Acquisition): This phase marks a shift from education and preparation to personal therapy. To advance to this phase, the offender must: (1) acknowledge committing past sexual offenses and express a desire to reduce risk of re-offending; (2) be willing to discuss past offenses; (3) agree to participate in required assessment procedures; and (4) conduct himself appropriately in

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80 *Id.*

81 *See* Craig Nelson, Ph.D., CALIFORNIA SEX OFFENDER COMMITMENT PROGRAM OVERVIEW. Craig Nelson, Ph.D., the program's Clinical Director reports:

> Progress through the phases is very individualistic. Some patients take less than a month to get through the first phase, others have taken years. Some patients may take only 3 months to get through the second phase (although most are taking 6-9 months or longer). No patients have entered into the fourth phase yet, so it is hard to say the typical progress in Phase III. Phase III is designed to take longer than the other phases, though.

Id.

group. The offender begins to apply relapse prevention principles to his specific case, identifying personal risk factors and proposing relapse prevention plans. The offender completes an assignment known as the Decision Matrix, which emphasizes the consequences of either offending or abstaining from illicit sexual behavior. The offender's cognitive distortions that allowed him to victimize others are examined. In addition to a core therapy group, the offender is assigned to special skill-building groups on human sexuality and interpersonal relationships.

Phase Three (Skills Integration): In this phase, offenders begin to integrate the skills they learned during phase two. To enter phase three, the offender must: (1) accept the commitment not to re-offend; (2) understand that the goal of treatment is to manage and control his deviant behavior (as opposed to believing he will be cured); (3) complete all assessment procedures; (4) complete the behavior chain and decision matrix assignments; (5) recognize and correct cognitive distortions that led him to sexually victimize; and (6) complete phase two specialty groups. The goal of this phase is to have offenders practice their relapse prevention skills to the point of being over-learned, strong habits. They also begin keeping logs and journals, which are regularly reviewed in group to help identify high-risk thinking and behavior. During phase three, the offender may be assigned to specialty groups that focus on sexual arousal modification, family relationships, or family and couples counseling sessions.

Phase Four (Discharge Readiness): During phase four, the treatment team assists the offender in developing a discharge plan, which includes developing an aftercare plan. In the core group, the offender completes a detailed maintenance manual that he will use to maintain the treatment gains upon discharge. In-depth release planning incorporates conditions of community treatment, supervision, living circumstances, employment, and safe community activities.

Phase Five (Conditional Release): The final phase is administered in California by the offender's county of commitment. Major tasks involve ensuring that the offender successfully implements his discharge plan and that services are coordinated with his county of commitment.

One can see obvious similarities between Minnesota's and California's phase models. Both begin the active treatment

component with educational material regarding general sex- offense-related issues and basic therapy skills acquisition. Both progress through a series of stages in which the resident gradually learns to apply the more general content to himself and his life. Both eventually shift focus toward developing relapse prevention and discharge plans, working to coordinate the resident's transition into the community.

Both the California and the Minnesota programs place residents in a core treatment group whose therapist acts as their case manager. The therapist places the resident in adjunctive treatment modules that focus on specific aspects of the resident's emotional problems. Following is the list of adjunctive treatments available in the Minnesota program, each module being one trimester:[82]

(1) Relapse prevention series (seven modules on identifying risk factors, coping effectively, developing behavior contracts, cultivating support networks, and discharge planning)
(2) Sex education series (two modules on sexual anatomy, diseases, and sexual development and arousal)
(3) Interpersonal relations series (six modules including communications skills, gender roles, and emotional intimacy)
(4) Family relationships series (four modules including family of origin issues and domestic violence)
(5) Victim empathy series (two modules on intellectual and emotional aspects of victim empathy)
(6) Personal victimization series (two modules focusing on one's own abuse, if present)
(7) Chemical abuse series (four modules focusing on assessment, 12 step model, and chemical abuse relapse prevention)
(8) Self-management series (two modules focusing on stress and anger management)
(9) Behavior therapy series (two modules focusing on sexual reconditioning)

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82 *See id.*

(10) Miscellaneous modules (seven modules on a variety of additional issues, such as self-esteem, cultural diversity, health and wellness, and transition planning)

Treatment modules in the California program are quite similar to those in Minnesota's program. One can see again, that the modules in both programs generally conform to what we found to be standard in our review of the institutional program literature.

Assessment of a resident's needs upon intake, progress through treatment, and readiness for discharge is critically important. Some programs use psychological testing to assess a patient's progress. Minnesota's program, for instance, includes an extensive battery of psychological tests in its first phase, the evaluation phase, prior to the beginning of active treatment. Minnesota administers a wide range of instruments, including general personality tests (such as the MMPI-2), focused instruments (such as rape cognitions scales), psychopathy measures (such as the Hare PCL-R), and cognitive tests (such as the Stroop Neuropsychological Screening Test). These tests assist in designing an individualized treatment plan.

Minnesota uses two physiologic assessment methods to determine readiness for transition to the community: the Abel Assessment for Sexual Interest, commonly referred to as the Abel Screen, and a polygraph examination. The Abel Screen was developed by Gene Abel, M.D., as an alternative to phallometry, in light of the controversy, in some jurisdictions, over phallometry and its associated use of explicit erotic stimuli. On the Abel Screen, the patient views fully clothed (but suggestive) stimuli, and his viewing time to each stimulus is monitored. The viewing time is thought to be a measure of sexual interest. The Abel Screen has become increasingly popular among sex offender treatment professionals, although published experimental data so far have only come from Abel's lab.[83]

The polygraph has also become an increasingly popular tool in risk assessment. "Monitoring polygraphs" are conducted to insure that the patient is fully disclosing his deviant sexual interests and behavior. Such polygraphs are particularly useful when considering

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83 For relatively positive review, see Krueger, R.B., Bradford, J. M, & Glancy, G.D., *Report from the Committee on Sex Offenders: The Abel Assessment for Sexual Interest: A Brief Description*, 26 J. OF AM. ACAD. OF PSYCHIATRY & THE L. 277, 277-80 (1998).

to release a patient to the community and in following and supervising that patient in the community, since those are the times at which a clear picture of the patient's interests and behavior are most critical.

V. *The Treatment Program for Sexual Predators in New Jersey*

Having surveyed how treatment is being conducted in other jurisdictions, we can now examine New Jersey's treatment program for criminally and civilly committed sexual predators to determine its conformity to generally accepted standards and methodology. We will begin with the treatment program at the ADTC. As discussed earlier, the ADTC is a free-standing sex offender treatment center run by the N.J. Department of Corrections (DOC) for incarcerated, repetitive-compulsive sex offenders. While its security is provided by the DOC, its treatment program is run by a private contractor, Public Safety Concepts, whose supervisory staff is located in Massachusetts. While not an SVP facility, in the sense that no patients there are civilly committed, its population has been incarcerated under a special statute designed to identify the more deviant sex offenders for placement. Its population also has many similarities to at least some civilly committed sex offenders from other jurisdictions. We reviewed documents from and made a site visit at the ADTC.

A. Features of the ADTC Treatment Program

In August 1996, the treatment program at the ADTC was privatized, and the program underwent dramatic changes. A difficult transition period ensued in which treatment staff turnover was high and little treatment occurred while new treatment staff were being recruited, hired, and trained. The treatment program at the ADTC has since stabilized, and we will describe its current operation.

The ADTC has one clinical administrator (a licensed psychologist with no direct treatment responsibilities), two psychiatrists, five licensed psychologists, and fifteen licensed clinical social workers. The psychiatrists provide psychotropic medication but do not run any treatment groups. Each psychologist directs a treatment team of three to four licensed clinical social workers. These treatment teams maintain a stable caseload, providing treatment and evaluations to a set group of residents for the duration of the residents' incarceration at the ADTC.

Like Minnesota and California, the ADTC uses a treatment phase system, consisting of five levels.[84] In Level I, patients receive basic information regarding sex offending in a structured, didactic format, acquire the skills needed for more advanced treatment, are socialized into therapeutic norms, and complete two workbooks written by the program director, Barbara Schwartz, Ph.D.[85] Typical chapters in these workbooks involve looking at one's deviance, understanding deviant sexual arousal, examining one's cognitive distortions, and examining one's emotions, among others. The patients must successfully complete written assignments and tests prior to graduating to the second treatment phase. Level I can be completed in six months.

In Level II, patients continue completing the structured workbook, begin applying the general knowledge acquired in Level I to their own life history, develop acknowledgement of guilt and responsibility, and participate in victim empathy exercises. Level II can be completed in three to five months. The average length of time to complete both Levels I and II combined is one year.

Level III attempts to achieve comprehensive cognitive mastery of material in earlier levels, including summarizing and paraphrasing material learned in the psychoeducational modules. Patients begin to participate in core treatment group (as opposed to merely structured, didactic groups) and take beginning modules on relapse prevention, victim empathy, and clear thinking. The time frame of Level III is open, depending on the patient's progress;

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84 Adapted from ADTC program description, April 24, 1998. Levels are based loosely on Barbara Schwartz's, the program director's, writings in Schwartz & Cellini, *The Sex Offender, supra* note 77, part 2.

85 *See* Schwartz, B.K. & Canfield, G.M.S., CIVIC RESEARCH INSTITUTE, KINGSTON, N.J.: FACING THE SHADOW (1996); *see also* Schwartz, B.K., *Understanding Sexual Assault*, PUBLIC SAFETY CONCEPTS (1995).

however, the average length of time to complete this level is one year.

Level IV introduces more advanced psychoeducational modules and includes the development of a relapse prevention plan. Patients work towards accepting full responsibility for their past and present behavior. Level IV lasts from eighteen to twenty-four months and may include therapeutic community involvement, such as limited housing unit self-government.

Level V, which is currently under development, contains a maintenance program for those inmates who have completed previous levels but remain incarcerated. This program may include therapeutic community involvement, such as limited self-government, monthly group meetings, and tutoring or similar activities at the ADTC. Level V continues until resident's release into the community.

The ADTC program staff has devised treatment goals for each stage of treatment. Each goal—for example, denial and victim empathy—has been decomposed into its components, and these components placed on a rating form. While no studies have been done to examine the operating characteristics of these rating forms, their use is a step in the right direction by making therapist ratings more stable and reproducible. The ADTC's psychoeducational components are consistent with those offered in other treatment programs. Following are the psychoeducational offerings at the ATDC, which are reasonably representative (all modules are a trimester):[86]

(1) Anger Management: Develop ability to identify and cope with anger.
(2) Arousal Reconditioning: Eliminate or decrease deviant sexual arousal and develop arousal to appropriate partners and behavior.
(3) Clear Thinking: Enhance problem-solving skills and cognitive coping strategies.
(4) Personal Victimization: Increase awareness of how one's own victimization relates to sex offending dynamics.

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86 These modules are based loosely on Barbara Schwartz's, the program director's, writings in *The Sex Offender*, supra note 77, at 13-3, 13-9.

(5) Relapse Prevention 1: Gain an understanding of the deviant sexual cycle as it applies to that particular inmate.
(6) Relapse Prevention 2: Learn and understand the types of interventions sex offenders can use in the context of their deviant cycle.
(7) Relapse Prevention 3: Apply knowledge and strategies learned in Relapse Prevention 1 and 2 through role plays; modify relapse prevention plan based on these experiences.
(8) Relationship Group: Increase understanding of healthy patterns of relating to others and develop skills to do so.
(9) Sex Education: Learn about sexual functioning of adult males and females and correct any misconceptions.
(10) Social Skills Training: Improve on/develop the skills necessary (i.e. assertiveness) to interact appropriately in a variety of interpersonal situations.
(11) Stress Management: Identify stressors and signs of stress; develop strategies for managing stress appropriately and effectively.
(12) Victim Empathy: Develop an affective understanding of the impact of sex offending on victims and their families and develop the capacity to empathize.

The ADTC has a multistep release process for the residents. There are two possible release paths. In the first path, when a resident has completed Level IV, his therapist can recommend him for parole. The patient is then reviewed by the treatment staff. In an effort to ensure objectivity, those treatment staff members who review the resident are not those on his treatment team. If the resident passes the treatment panel staffing, he is referred to the Special Classification Review Board (SCRB), an outside board of members appointed by the N.J. Commissioner of Corrections. If the resident passes the SCRB, he is referred to the N.J. State Parole Board, which has the final paroling authority.

As the result of a legal settlement, a second path to the SCRB now exists. Even if not recommended by the treatment staff for parole, an inmate receives an interview with the SCRB when he serves one-fourth of his sentence (unless he has a period of parole ineligibility imposed). The SCRB considers these automatic referrals and can in turn send such residents on to the State Parole Board for final parole consideration, although most residents

reaching the SCRB in this manner are referred back to the staff for further treatment.

B. Critiquing the ADTC Treatment Program

The design of the treatment program at the ADTC appears to fall within usual and customary practice. There is, on paper, a therapeutic level system with explicit, written criteria for progression from one level to the next. Residents are to be given regular, detailed feedback on their progress. This system conforms to the programs we have reviewed, both in our site visits and our literature review. One strength of the ADTC system is its clear, detailed rating forms for resident progress.

ADTC's treatment model is relapse prevention/cognitive-behavioral. This form of treatment is also consistent with current accepted practice in the field. The specific psychoeducational modules sample a wide range of areas, covering the standard topics used by other treatment programs for this population. Although we did not observe any treatment or psychoeducational sessions, we did review the treatment manuals and workbooks. These written materials were thorough and appropriate for the topics covered and the population.

Two levels of incentive, short-term and long-term, are useful in motivating residents to do the hard work necessary in treatment. Incentives and rewards also allow the institution's administration to exercise control over the patients. Short-term incentives can include permission to purchase various goods, see movies, participate in additional recreational, and have more freedom of movement within the institution.

The ADTC, through its therapeutic level system and parallel security level system, is designed to employ a reasonable set of internal, short-term incentives. As the system is designed, residents can progress in treatment, behave well in the institution and gain both increased social rewards from the treatment staff in the form of good evaluations and increased minor privileges in the institution through a decrease in their security level.

The ADTC falls short, however, in its ability to provide a long-term incentive—that is, conditional discharge, or parole—to residents. No inmate has been paroled from the ADTC for over one

year, and although the treatment staff has residents progressing through the treatment levels and approaching parole readiness, the N.J. State Parole Board has not approved an ADTC resident's parole in recent memory.[87] It has been reported that the N.J. State Parole Board refuses to come to the ADTC, not even making a pretense of holding hearings.

The staffing balance at the ADTC is reasonable. The ADTC employs two psychiatrists for its roughly 800 residents, which is adequate in light of the paucity of patients receiving psychotropic or other pharmacological intervention. The bulk of the clinical staff at the ADTC is made up of licensed psychologists and clinical social workers who conduct the therapeutic groups which are the central feature of the psychological treatment program.[88]

One concern we have about the ADTC is its dual chain of command. Treatment staff are employed by a private contracting firm whose administrative staff is in Massachusetts. The remainder of the institutional staff—including administrative, security, and support staff—are state employees who report to the ADTC's superintendent. This awkward arrangement sometimes leads to cumbersome negotiations in which requests from the ADTC's administration must proceed to the private contracting firm's administrators in Massachusetts, only then to be transmitted to supervising treatment staff in the ADTC. Although our impression is that all staff involved are making a good faith effort to cooperate, the cumbersome nature of this arrangement can lead to inefficiency and misunderstandings.

We are also concerned about housing at the ADTC. Originally built for 175 residents in individual rooms, and expanded over the years, the ADTC now houses approximately 800 residents, many in dormitories. In some cases, these dormitories were carved out of recreation areas. Only 150 residents remain housed in individual

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87 Following are the number of ADTC residents paroled during the past four years: 0 in 1999; 0 in 1998; 4 in 1997; 4 in 1996; and 3 in 1995. *See* Statistics compiled by Jeanette Ferro, Supervisor, Classification Department, ADTC (Apr. 10, 1999).

88 After privatization, many unlicensed treatment staff, who had been working at the ADTC as state employees due to its exempt nature, were let go. The treatment component of the ADTC, now being private, lost its exemption from professional licensing requirements for treatment staff. A few unlicensed treatment staff remain and run selected psychoeducational modules deemed not to constitute psychological treatment.

rooms; approximately half of the ADTC's 800 residents are housed in thirty-person dorms. In our opinion, the ADTC is overcrowded. Crowding increases resident stress as well as the potential for aggressive interactions among residents and between residents and staff.

The ADTC has no research staff. Our impression is that research is seen as an expendable luxury in the state institutions. This lack of research staff support leads to the unfortunate situation in which the ADTC is criticized for having no research to support the effectiveness of its treatment program, but is given no staff to conduct research that would allow the question of effectiveness to be addressed. We recommend that research support staff be included in the ADTC's budget or that research staff already present in central locations—for example, the Administrative Office of the Courts—be directed to conduct research on the ADTC's treatment program.

The ADTC's release process is conservative, involving multiple reviews of the residents by both in-house staff and external review panels. We believe this multistep process to be appropriate. A careful, detailed analysis of a resident's readiness for discharge best protects the community.

We have two concerns, however, about the ADTC's release process. The first, discussed previously, concerns the unavailability of release as a realistic prospect at present for patients, as demonstrated by the refusal of the Parole Board even to come to ADTC for hearings. This removal of even the possibility of release results, we believe, in a disincentive for patients to engage meaningfully in treatment.

Second, the ADTC does not use any of the physiologic assessment technologies now available and in use by some of the best programs. The critical area for assessment upon release is whether deviant sexual interest is still present. Sexual interest and arousal can be assessed directly through either penile plethysmography or the Abel Screen. Sexual interest can also be assessed through constructing questions on this topic and administering a polygraph on these questions.

With respect to the physiologic assessment methodology, we acknowledge that there are problems with each. The Abel Screen is supported primarily by research out of its developer's laboratory; little or no replication data has been published in the literature.

Phallometry, typically involving having the resident listen to or view erotic stimuli while having a penile transducer attached to him, is intrusive. Moreover, even the possession and use of deviant sexually explicit stimuli, particularly those involving children, present ethical and legal questions. The polygraph, although it receives overwhelming support in the sex offender treatment community,[89] has little empirical data to support its use with sex offenders.

These problems do not lead us, however, to recommend against the use of the above instruments. With respect to the polygraph, in particular, sex offender treatment providers almost uniformly report that monitoring sex offenders with periodic polygraphs results in increased levels of self-disclosure of deviant sexual interest and behavior, allowing the offender to be more accurately assessed by the clinician.

C. *Current Treatment for Sex Offenders Not Housed at the ADTC*

As discussed earlier in this report, mentally disordered sex offenders who are not serving a criminal sentence are eligible for involuntary civil commitment under the state's general civil commitment provisions, even if they do not suffer from a major mental illness, provided the state demonstrates by clear and convincing evidence that they suffer from a mental disorder characterized by an "impaired capacity to control behavior based on a 'substantial disturbance' of perception or orientation."[90] Once committed under this provision, an individual is first sent to the Ann Klein Forensic Psychiatric Center (FPC) in West Trenton for evaluation.[91] Since 1994, the FPC has received 187 committed sex offenders, twenty-six of whom currently reside in the facility. The majority have been relocated to the state's non-forensic psychiatric hospitals.

In both the FPC and the non-forensic psychiatric hospitals, civilly committed sex offenders receive treatment similar to that

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89 The correspondence on the Internet list server run by the Association for the Treatment of Sexual Abusers overwhelmingly supports the use of the polygraph to monitor truthfulness of sex offenders in treatment.

90 N.J. STAT. ANN. § 30:4-27.

91 We reviewed documents and made a site visit to the forensic center.

provided to the other psychiatric patients, *e.g.* group and individual psychotherapy, recreation therapy, substance abuse counseling, and life skills training. They also receive psychotropic medication as needed for any comorbid disorder, such as depression or psychosis, although, as discussed earlier, mentally disordered sex offenders rarely suffer from major psychiatric illness.

Unfortunately, the state's psychiatric hospitals have no treatment staff experienced or trained in treating sex offenders, and there is no sex-offender-specific treatment programming, as exists in other jurisdictions and at ADTC. Nowhere in the state's psychiatric hospital system will one find any components of the generally accepted sex offender treatment protocol reviewed previously. There is no trained or experienced staff in the state psychiatric hospitals where these commitment cases reside, and there are no programs specific to the needs of these patients, aside from a minority of patients receiving psychotropic medication, antiandrogens or SSRIs. Not surprisingly, the psychiatric hospitals do not want to accept sex offender cases, viewing them as beyond their training and experience and seeing them as potentially disruptive to the hospital's therapeutic milieu. In short, New Jersey presently lacks any coherent treatment for civilly committed sex offenders.

VI. Recommendations for Implementation of the New Jersey Sexually Violent Predator Act

I. Creation of Model Treatment Program: Our review of the above programs and our survey of the research literature have left us with some guiding principles we hope can be applied in creating a model sex offender treatment program in New Jersey. This program should contain the following features:

(A) Phases: This program should include a series of phases through which a patient progresses, gradually increasing incomplexity and responsibility. Initial phases should primarily

involve education and later phases should contain individualized treatment and community responsibility. Not every patient, of course, would progress through all phases. Some deniers, for example remain at earlier phases due to their failure to satisfy criteria for progression.[92]

(B) Psychoeducational Modules: All programs would include very much the same (or similar) psychoeducational treatment modules. These modules, detailed above, should follow the standard cognitive-behavioral/relapse prevention treatment models supported in the literature and currently in place, in large part, in jurisdictions such as Minnesota and California.

(C) Pharmacologic Intervention: As discussed earlier, antiandrogens and SSRIs are not prescribed routinely to mentally disordered sex offenders in the jurisdictions surveyed. Nonetheless, for more extreme cases—and extreme cases, by definition, are likely to be more common among commitment cases—use of antiandrogens to enforce chemical castration may be necessary.

II. Compatibility of Treatment Programs: Because a significant portion of individuals committed under the SVP Act are likely to have come from the ADTC, the SVP facility and the ADTC should have compatible treatment programs. This same treatment should be made available to mentally disordered sex offenders detained under the general civil commitment statute who currently receive little to no sex-offender-specific intervention, whether they are housed within the SVP facility or in some other state psychiatric hospital. We further recommend, in this regard, that the latter be relocated in the SVP facility to avoid costly, and unnecessary, duplication of treatment programs.

III. Staff Training: Staff training and supervision are critically important. In the SVP program, most new staff will be relatively inexperienced in sex-offender-specific treatment, since a large pool of experienced sex offender treatment professionals does not exist in the state outside of the ADTC. Consequently, local and regional experts should be enlisted to train the staff on the basic procedures related to providing services to this population. If the new SVP

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92 Recent work indicates that if deniers are presented a program of victim empathy and relapse prevention, a significant percentage will acknowledge their offenses, thus making them amenable for more advanced treatment. *See* Schlank, A.M. & Shaw, T., *Treating Sexual Offenders who Deny Their Guilt: A Pilot Study*, 8 SEXUAL ABUSE: A JOURNAL OF RESEARCH AND TREATMENT 17, 17-24 (1996).

facility is geographically proximal to the ADTC, new SVP staff should consider co-leading treatment groups with experienced ADTC staff as a means of quickly learning the necessary skills. Financial support should be provided to insure ongoing staff training. An SVP population is among the most challenging, so it is in the state's best interest to have staff maintained at a high level of skill.[93]

IV. The Role of Security Personnel: The SVP facility should include lay staff in the treatment program to the extent feasible. One lesson from Minnesota and other programs discussed in the literature[94] is that lay personnel can effectively assist in treatment if properly selected, trained, and supervised. The benefits of including security staff in monitoring the treatment progress of the patients are twofold. First, security staff are used as allies, rather than treated as adversaries, as too often happens in secure institutions. Second, a valuable source of information on patient behavior on the housing unit is gained, a source that would otherwise be unavailable. The most appropriate form of security staff involvement is monitoring and structured feedback, since an observation function presents no role conflict for security staff. If security personnel are to perform such functions, however, it is critical that they be properly trained by clinical staff employed by the Department of Human Services so that these security officers are familiar with the salient features of the treatment program and their proper role within it.

V. Staffing Requirements: Presently, one treatment team per 50 residents is planned, with each treatment team consisting of: one psychiatrist; three psychologists, two of whom are doctoral level;[95] one program coordinator; one clinical nurse-specialist; one secretary; one administrative analyst; one medical records staff member; and 12 rehabilitation staff members, including allied disciplines such as occupational and rehabilitation therapy.[96] This

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93 *See* Marshall, *supra* note 76.

94 *See* Marshall, *supra* note 76.

95 The third psychologist is to be masters level. Given that the treatment program will be provided by a state department (rather than a private contracting firm, as is the ADTC's), the SVP facility would be exempt from licensing requirements. Therefore, it would be able to use masters level, presumably unlicensed, psychologists. Whether this use of unlicensed personnel is wise, even if legally permitted, is a different issue, about which we have our doubts, given the potentially difficult, dangerous, and litigious nature of the patient population.

96 Interview with John Main, CEO, Ann Klein Forensic Center (Feb. 22, 1999).

distribution reflects greater reliance on psychiatrists than is customary at similar facilities in other jurisdictions, due, in all likelihood, to the requirement in the New Jersey SVP Act that a psychiatrist sign the commitment certificate. We consider this increased number of psychiatrists both needlessly costly and ill advised. The treatment of sex offenders in North America is a specialty whose experts, with rare exception, are psychologists. Unlike traditional commitments, where the patients have major mental disorders requiring psychiatric medication and medical management, SVP commitments involve psychological risk assessments. Psychologists have for the most part created the risk assessment instruments. Although nothing in a psychiatrist's training would preclude him or her from acquiring the necessary knowledge and skills, this is not a specialty that has attracted large numbers of psychiatrists. Moreover, because few SVP patients require psychotropic medication, even if one assumes an increased number of patients taking antiandrogens or SSRIs, a large complement of physicians is not therapeutically necessary. For the foregoing reasons, we recommend that the state consider revising its staffing requirements to include fewer psychiatrists and more psychologists and licensed clinical social workers.[97]

Staffing at the MSOP and similar programs involves having senior psychologists run treatment teams composed of social workers and less experienced psychologists. This staffing model seems reasonable and is the one we recommend for the SVP facility. Each treatment team could be composed of one psychologist and three to four social workers, and each team could be responsible for 110 to 140 residents, assuming each social worker had a caseload of 30 residents while the supervising psychologist had a caseload of 20 residents. The SVP facility of 300 residents could then easily be staffed with three treatment teams.

VI. Chain of Command: We are concerned about the new SVP facility's dual chain of command, with the DOC corrections officers reporting through one administrator to the superintendent of the ADTC and the treatment staff reporting through another administrator to the CEO of the Anne Klein Forensic Center. We see this dual chain of command as an invitation for friction and divergence between the two staffs, rather than for the cooperation

97 The ADTC, by comparison, has two psychiatrists for 800 residents.

necessary to run an effective treatment program. The dual chain of command at the SVP facility in many ways reflects the traditional conflict in industry as to whether to structure organizations by function or by product.[98] In the SVP facility, the choice has been to structure the organization by function. That is, the Department of Corrections has traditionally provided the service of security, and it does so here; the Department of Human Services has traditionally provided the service of mental health treatment, and it does so here. The vast majority of jurisdictions that have implemented similar SVP statutes have chosen *not* to use DOC officers to provide internal security choosing instead to assign responsibility for the hiring and training of security personnel to the Department of Human Services, or its equivalent, to reflect the distinction between incarceration and civil commitment. We consider this approach taken by the majority of jurisdictions to be optimal. A far less favorable alternative would use DOC personnel to provide security.

If this option is chosen, we would recommend the following: (1) that the DOC officers providing security within the SVP facility complete a mandatory training course, conducted by DHS personnel, describing the use of non-aggressive intervention; (2) that there be regularly scheduled meetings between the CEOs of the ADTC and the Ann Klein Forensic Center, perhaps facilitated by a third party at some level above them in the state's organizational hierarchy; and (3) that there be regular multidisciplinary staff meetings within the SVP facility, including members of both the security staff administration and the treatment staff administration.

These provisions will promote cooperation at intermediate levels within each chain of command. In addition, as discussed previously, security staff should be included in the treatment process through monitoring and providing feedback regarding residents. This will help to ensure, to as great a degree as possible, that the security and treatment staff pursue similar objectives.

VII. Risk Assessment: Particularly as the time for discharge nears,[99] the most sophisticated assessment methods should be used.

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[98] *See* Walker, A.H. & Lorsch, J.W., *Organizational Choice: Product vs. Function*, HARVARD BUS. REV. 129, 129-38 (Nov.-Dec. 1968).

[99] This assumes the obvious; that is, at some time in the future, residents will be conditionally discharged from either the ADTC or the SVP facility. It is difficult to imagine that such residents will be kept incarcerated or civilly committed for their lifetimes, given the almost certainly successful constitutional challenges to such

If possible, these methods should include physiologic measures of sexual behavior and interests, such as the Abel Screen and the polygraph. The stakes upon discharge are high for society, and the use of the most sophisticated, difficult-to-fake methods reduces error.

VIII. Research Support: We encourage the legislature to adequately fund the SVP facility with regard to research support. The ADTC has been criticized for the lack of empirical support to establish the effectiveness of its treatment program. Yet, it has no funding for staff to conduct the very research that would establish effectiveness. We do not want to see this situation develop at the SVP facility. Perhaps the necessary research could be undertaken pursuant to a well-designed study funded by an interested independent research foundation.

IX. Capital Construction: We encourage the legislature to adequately fund capital construction. The ADTC now houses 800 residents, most in large dormitories, some of which have been carved out of recreation areas. Adequate funds should be set aside to allow living conditions at the SVP facility most conducive to rehabilitation, and least likely to contribute to overcrowding, with its associated problems. The Minnesota program has, in many ways, an ideal facility, with a central common area for residents to socialize, access to which must be earned through good behavior. Such common areas for recreation—physical or otherwise—are important to the smooth functioning of an institution, and such areas are typically the first to go when housing needs in an institution outstrip available bed space.

VII. Authors' Biographies

John Kip Cornwell

Professor Cornwell received his A.B., with honors, from Harvard University, his M.Phil. in International Relations from Cambridge University, and his J.D. from Yale Law School where he was an editor of the *Yale Law Journal*. He clerked for the

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indefinite detention.

Honorable Mariana R. Pfaelzer of the U.S. District Court, Central District of California, and the Honorable Dorothy W. Nelson of the U.S. Court of Appeals for the Ninth Circuit.

From 1990 to 1994, he was a trial attorney in the Civil Rights Division of the U.S. Department of Justice specializing in institutional reform litigation and employment discrimination. He joined the Seton Hall faculty in 1994 and teaches Criminal Law, Criminal Procedure and Employment Law. Professor Cornwell is also the Director of the Institute of Law and Mental Health, established in 1998 by a grant from the New Jersey legislature. The Institute is housed at Seton Hall University School of Law.

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John Jacobi is a Professor of Law and Associate Director of both the Institute of Law & Mental Health and the Seton Hall School of Law Health Law & Policy Program. He teaches a variety of health law courses, including Managed Care, Health Care Fraud and Mental Health Law. He received a B.A. *summa cum laude* from the State University College of New York at Buffalo and a J.D. *magna cum laude* graduate of Harvard Law School, after which he served as law clerk to the Hon. Anne E. Thompson, U.S. District Court for New Jersey.

Before coming to Seton Hall, he served as Assistant to the Commissioner in the New Jersey Department of the Public Advocate, and as a fellow in the Gibbons Fellowship in Public Interest and Constitutional Law. He publishes and lectures on issues related to mental health law, disability discrimination, health care finance and access to health care for the poor and disabled.

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