

The Right to Community Treatment for Mentally Disordered Sex Offenders

*John Kip Cornwell**

PART I: OUTLINING THE PROBLEM

In 1990, Earl Shriner, a released pedophile, raped a seven-year-old boy, severed the boy's penis, and left him to die.¹ The public outrage that followed this horrific incident in Tacoma, Washington led to the passage of that state's Sexually Violent Predator ("SVP") law. The law provides for post-incarceration psychiatric commitment of sex offenders who suffer from a "mental abnormality or personality disorder" that makes them sexually dangerous.² State officials deemed the legislation necessary to protect the public against individuals like Shriner whom they had been unable to detain under the state's involuntary psychiatric commitment standard following release from prison.³ Legislators believed that the adoption of a standard that specifically targeted sexual dangerousness while incorporating ambiguous mental impairment language would facilitate sex-offender commitment.

They were right. In the first twelve years of enforcement, 164 individuals were committed under the law.⁴ But Washington is not alone. Fifteen states and the District of Columbia have enacted SVP statutes patterned closely on Washington's.⁵ As of the spring of 2002, some 2,229 individuals—virtually all of them male—were civilly

* Professor, Seton Hall University School of Law. Thanks to my research assistant, Kevin McDonough, for his assistance in preparing this Article.

¹ Roxanne Lieb, *State Policy Perspectives on Sexual Predator Laws*, in PROTECTING SOCIETY FROM SEXUALLY DANGEROUS OFFENDERS: LAW, JUSTICE, AND THERAPY 41, 43 (Bruce J. Winick & John Q. La Fond eds., 2003) [hereinafter PROTECTING SOCIETY].

² WASH. REV. CODE ANN. § 71.09.020 (West 2004).

³ Gary Gleb, *Washington's Sexually Violent Predator Law: The Need to Bar Unreliable Psychiatric Predictions of Dangerousness from Civil Commitment Proceedings*, 39 UCLA L. REV. 213, 237 (1991).

⁴ W. Lawrence Fitch, *Sexual Offenders in the United States: Legislative and Police Concerns*, 989 ANNALS N.Y. ACAD. SCI. 489, 492 (2003).

⁵ Eric S. Janus & Wayne A. Logan, *Substantive Due Process and the Involuntary Confinement of Sexually Violent Predators*, 35 CONN. L. REV. 319, 321 n.7 (2003).

detained or committed nationally as sexually violent predators.⁶

Commentators have debated both the constitutionality of these statutes and their merit as a matter of public policy.⁷ Whatever their pros and cons, the Supreme Court's vindication of this approach to managing the risks posed by mentally-disordered sex offenders in *Kansas v. Hendricks*⁸ presages the continuation of the practice for the foreseeable future. As such, our attention must now focus on the issues of statutory implementation⁹ and release from confinement. The latter is especially critical. While state and local prosecutors have been very successful in securing commitments, detainees have been profoundly unsuccessful in gaining releases. For example, in the State of Washington, fewer than ten civilly-committed SVPs have been granted conditional release from institutional confinement due, in large part, to the refusal of state officials to recommend discharge in any form.¹⁰ Likewise, in Minnesota, only one patient gained conditional discharge over a twenty-year period under that state's SVP and sexual psychopath commitment statutes.¹¹

This intransigence on the part of state officials with respect to release must ultimately give way, however, if SVP commitment is to remain constitutionally viable. In *Hendricks*, where the Justices split five to four on the issue of whether Kansas's SVP law was unconstitutionally punitive, Justice Kennedy recognized the statute's potential to convert civil detention into "confinement for life."¹² To

⁶ Lieb, *supra* note 1, at 45.

⁷ See Alexander D. Brooks, *The Constitutionality and Morality of Civilly Committing Violent Sexual Predators*, 15 U. PUGET SOUND L. REV. 709, 751-54 (1992); John Q. La Fond, *Washington's Sexually Violent Predator Law: A Deliberate Misuse of the Therapeutic State for Social Control*, 15 U. PUGET SOUND L. REV. 655, 691-701 (1992). Compare Bruce J. Winick, *Sexually Violent Predator Laws and Registration and Community Notification Laws: Policy Analysis*, 4 PSYCHOL. PUB. POL'Y & L. 505 (1998) (urging, as a matter of constitutional law, stricter limits on the use of involuntary civil commitment), and Janus & Logan, *supra* note 5 (positing that statutes which authorize confinement beyond what is a reasonable time for the accomplishment of treatment goals contravene the doctrine of substantive due process), with John Kip Cornwell, *Protection and Treatment: The Permissible Civil Detention of Sexual Predators*, 53 WASH. & LEE L. REV. 1293 (1996) (arguing that sexual predator legislation is constitutional).

⁸ 521 U.S. 346 (1997).

⁹ See John Kip Cornwell et al., *The New Jersey Sexually Violent Predator Act: Analysis and Recommendations for the Treatment of Sexual Offenders in New Jersey*, 24 SETON HALL LEGIS. J. 1, 36-41 (1999).

¹⁰ Bruce J. Winick et al., *Outpatient Commitment's Next Frontier*, 9 PSYCHOL. PUB. POL'Y & L. 159, 172 (2003). See generally Sarah Duran, *Expert Faults McNeil Plan for Sex Predators*, THE NEWS TRIBUNE (Tacoma, Wash.), July 10, 2001, at A1.

¹¹ Eric S. Janus, *Preventing Sexual Violence: Setting Principled Constitutional Boundaries on Sex Offender Commitments*, 72 IND. L.J. 157, 205-06 (1996).

¹² *Hendricks*, 521 U.S. at 372 (Kennedy, J., concurring).

this end, his concurrence warned state officials not to use the civil system “to impose punishment after the State makes an improvident plea bargain on the criminal side”;¹³ while incapacitation is a legitimate objective of psychiatric hospitalization, deterrence and retribution are not.

The indefinite detention of all those committed as SVPs would promote the conflation of civil and criminal incapacitation of which Justice Kennedy warns. Recognizing, perhaps, the untenability of this result, some jurisdictions have begun to release SVPs into the community in greater numbers. For example, whereas only forty-nine SVPs had gained release by the year 2000,¹⁴ sixty-nine were released by 2002—an increase of over forty percent.¹⁵

As these numbers increase, the need for community-based treatment will grow as well. This eventuality will create a significant problem because of the critical shortage of clinicians qualified to treat this unique patient population.¹⁶ Indeed, given the difficulty jurisdictions have had in securing resources to hire and train psychologists and social workers to staff their inpatient programs, it is hard to imagine how burgeoning outpatient needs will be satisfied. For example, at the time of his initial SVP commitment, Leroy Hendricks was receiving treatment that was non-existent at worst and “meager”¹⁷ at best. Even ten months later, the facility’s clinical director testified that SVPs were receiving essentially no treatment and that the program was woefully understaffed.¹⁸

The State of Washington has encountered similar problems in implementing its SVP statute. In 1994, a superior court judge found that the state’s Special Commitment Center (“SCC”) for SVPs was failing to provide constitutionally adequate treatment based, inter alia, on the “[I]ack of sufficient staff trained, experienced and certified in [the] treatment of sex offenders.”¹⁹ That same year, a federal court also found the treatment program to be constitutionally

¹³ *Id.* at 373 (Kennedy, J., concurring).

¹⁴ John Q. La Fond, *The Costs of Enacting a Sexual Predator Law and Recommendations for Keeping Them from Skyrocketing*, in PROTECTING SOCIETY, *supra* note 1, at 288.

¹⁵ Fitch, *supra* note 4, at 492.

¹⁶ See Robert M. Wettstein, *A Psychiatric Perspective on Washington’s Sexually Violent Predator Statute*, 15 U. PUGET SOUND L. REV. 597, 624 (1992).

¹⁷ *Hendricks*, 521 U.S. at 367.

¹⁸ *Id.* at 392-93 (Breyer, J., dissenting).

¹⁹ Orders on Motions to Dismiss Because of Unconstitutional Conditions of Confinement at 4, *In re Detention of Pedersen*, 93-2-09933-9 (King Co. Supr. Ct. Mar. 7, 1995).

inadequate.²⁰ The court entered an injunction requiring improvements in a host of areas, including staffing, in order to bring the SCC into constitutional compliance.²¹ Five years later, however, the SCC remained non-compliant principally because of the state's failure to allocate sufficient resources for necessities such as staffing and training.²² Only after an order of contempt was entered against the state in November 1999, which assessed significant monetary penalties for each day the SCC remained non-compliant, did the state allocate the resources necessary to provide adequate staffing and treatment.²³

The problems associated with resource availability for inpatient treatment are even more pronounced in the outpatient context. Consider, for example, the situation in New Jersey. New Jersey is relatively unusual in that it has a separate correctional facility in Avenel for repetitive and compulsive sex offenders.²⁴ Inmates housed at this facility receive therapy throughout their period of incarceration. Those who are civilly committed as sexually violent predators at the end of their sentences, whether or not they had served their time at Avenel,²⁵ would also receive therapy at state

²⁰ Order and Injunction, *Turay v. Weston*, No. C91-664WD, U.S. Dist. Court, W.D. Wash., June 3, 1994.

²¹ *Id.*

²² *Turay v. Seling*, 108 F. Supp. 2d 1148, 1152-53 (W.D. Wash. 2000).

²³ *Id.* at 1154, 1160.

²⁴ See N.J. STAT. ANN. § 2C:47-1 (West Supp. 2004), which states:
[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 if the offender is to be sentenced to a term of life imprisonment without eligibility for parole. The examination shall include a determination of whether the offender's conduct was characterized by a pattern of repetitive compulsive behavior and, if it was, a further determination of the offender's amenability to sex offender treatment and willingness to participate in such treatment. The court's order shall contain a determination of the offender's legal settlement in accordance with subdivision D of article 3 of chapter 4 of Title 30 of the Revised Statutes.

²⁵ That is, not all sex offenders are separately housed at Avenel. Some are excluded because they do not meet the "repetitive and compulsive" standard; others are ineligible because, while they satisfy these criteria, they refuse to engage in treatment and thus must remain in the general prison population.

expense. Once released into the community from either criminal or civil detention, however, state-sponsored treatment is available only at the correctional facility in Avenel.

Parolees who are unable to access those services are seriously disadvantaged. They may look to the state's network of community mental health centers, but very few have expertise in sex-offender therapy and many will not accept sex offenders as clients. Conversely, paroled sex offenders may attempt to locate qualified therapists on their own, but, even if successful, the cost will ultimately prove prohibitive to many. At present, a federal grant funds aftercare services at selected district parole offices for sex offenders whom the court has ordered to participate in Community Supervision for Life;²⁶ thus, at least some released sex offenders who cannot access Avenel have treatment options available to them. The grant expires, however, in December 2004.

As the foregoing illustrates, even in New Jersey, which is among the most proactive states with respect to providing sex-offender treatment, individuals released from SVP commitment have no guarantee of continued access to therapeutic intervention. Ironically, because individuals released from SVP commitment are less likely than paroled sex offenders to be subject to Community Supervision for Life, they would be far less likely, as a group, to benefit from the treatment services provided through the federal grant. As mentioned above, even if released SVPs manage to find treatment providers on their own, their ability to pay for these services long term is questionable. Of course, the converse is equally true. In areas far from Avenel and the state's urban centers, SVPs are likely to find it difficult to find clinicians qualified to treat them, whether or not they can pay for those services.

For the time being, these problems are speculative since no one has yet been released from SVP commitment in New Jersey, other than by court order. In other jurisdictions, where SVPs have been conditionally discharged, treatment policies vary. In Wisconsin, for example, the state does pay for (and require) outpatient treatment.²⁷ In Minnesota, by contrast, the state will pay for Depo-Provera, an antiandrogen medication, but not for group or individual psychotherapy.²⁸ As time passes, and SVPs are released in greater

²⁶ See *State v. L.P.*, 800 A.2d 207, 209 (N.J. Super. Ct. App. Div. 2002) (affirming a sentence that included community supervision for life).

²⁷ See WIS. STAT. ANN. §§ 980.08(5), 980.12(1) (West 2004).

²⁸ Interview with Dr. Anita Schlank, Former Clinical Director, Minnesota Sex Offender Treatment Program, Moose Lake, Minn.

numbers, current policies introduce the alarming notion that mentally disordered sex offenders may be released into the community without necessary therapeutic supports. The specter of relapse is troubling not only for the individual but for ordinary citizens as well, as they must confront the risk to public safety occasioned by this eventuality.

I believe that this result is not only undesirable from a policy perspective, it offends federal constitutional principles. Due to the unique nature of SVP commitment, and the representations states have made to justify it, substantive due process requires state-sponsored outpatient treatment for all those who gain release. This argument does not presuppose a right to post-release treatment for civilly committed individuals, nor does it address directly the right of the state to detain sex offenders without treatment in a non-psychiatric facility—though I would consider such a practice to raise serious constitutional questions. My focus is squarely on the treatment rights upon release of individuals civilly committed as sexually violent predators under statutory schemes similar to the Kansas statute addressed by the U.S. Supreme Court in *Kansas v. Hendricks*.

PART II: THE RIGHT TO INPATIENT TREATMENT

A. *The Scope of the Right to Treatment*

A right to community treatment would be illogical if there were not a pre-existing right to treatment while housed inpatient. Thus, we must first explore the parameters of inpatient treatment requirements. While the U.S. Supreme Court has never squarely addressed the right to treatment, the Justices have noted on several occasions that the nature of psychiatric detention must be tailored to its purpose.²⁹ This mandate would not be met, in the case of sexual predators, if they were confined in a psychiatric hospital without treatment addressing the mental abnormality that makes them sexually dangerous.

Contrarians may point to Justice Thomas's embrace in *Hendricks* of civil incapacitation as a legitimate goal of civil detention.³⁰ This fact does not suggest, however, that a failure to provide suitable treatment over time would be acceptable as a matter of substantive due process. On the contrary, Justice Thomas noted that confining

²⁹ See, e.g., *Foucha v. Louisiana*, 504 U.S. 71, 87-88 (1992) (O'Connor, J., concurring); *Jackson v. Indiana*, 406 U.S. 715, 738 (1972).

³⁰ *Hendricks*, 521 U.S. at 365-66.

SVPs to an institution “expressly designed to provide psychiatric care and treatment” clearly “satisfied *its obligation to provide available treatment*.”³¹ This choice of words is informative, because the statutory language, relied on elsewhere in the opinion,³² nowhere references the phrase “available treatment.” It would seem, therefore, that the majority is promoting a freestanding duty of state officials towards those whom they choose to confine in mental health facilities.

Moreover, Justice Kennedy warned that, while lifelong detention may be the “practical effect” of SVP commitment, if it is the statute’s very *intention*, the confinement it prescribes is indistinguishable from criminal incarceration and is therefore impermissible.³³ A contrary purpose is demonstrated most persuasively by the provision of treatment. In this regard, the “presently available treatment” standard referenced by the *Hendricks* majority has significant roots. For example, in the seminal case of *Rouse v. Cameron*,³⁴ the District of Columbia Court of Appeals held that, to justify psychiatric detention, a state must endeavor to provide treatment that is “adequate in light of present knowledge.”³⁵ To demonstrate that they are fulfilling this obligation in good faith, state officials must monitor a patient’s status by making “initial and periodic inquiries” to facilitate the creation of a therapeutic program “suitable to his particular needs.”³⁶

Rouse v. Cameron provides a ready framework for interpreting the treatment standard forwarded in *Hendricks*. Its emphasis on patients’ needs and the development of individualized treatment programs precludes long-term reliance on non-specific treatments, such as “milieu” therapy, that may not prove beneficial. *Rouse* is also consistent with *Youngberg v. Romeo*,³⁷ the Supreme Court’s leading right-to-treatment case. There, in the context of institutionalized mentally retarded individuals, the Justices required not only that treatment be made available, but also that it be “minimally adequate . . . to ensure safety and freedom from undue restraint.”³⁸ The Court added that lower courts should bestow “presumptive validity” to the

³¹ *Id.* at 368 n.4 (emphasis added).

³² *Id.* at 367.

³³ *Id.* at 372-73 (Kennedy, J., concurring).

³⁴ 373 F.2d 451 (D.C. Cir. 1966).

³⁵ *Id.* at 456.

³⁶ *Id.*; see also *Mahoney v. Lensink*, 569 A.2d 518, 527 (Conn. 1990) (stating that “meaningful” treatment requires individualized effort to help each patient by “formulating, administering and monitoring a ‘specialized treatment plan’”).

³⁷ 457 U.S. 307 (1981).

³⁸ *Id.* at 319.

judgments of “qualified professionals” in this regard.³⁹ In determining whether the exercise of professional judgment was proper in a given case, *Youngberg* accommodates the use of certain factors, including periodic patient re-evaluation and the development of individualized treatment programs.⁴⁰ Incorporating these considerations serves not to usurp medical judgment, but rather ‘to ensure that professionals . . . apply their knowledge and skills’ in determining the sufficiency of the state’s treatment efforts.⁴¹

In sum, the foregoing uncovers that individuals who are involuntarily committed to psychiatric hospitals have, at a minimum, a right to presently available treatment, reasonably tailored to the their disorder(s), and informed by professional judgment. While a necessary precondition to any subsequent right to community-based treatment, this entitlement to inpatient treatment does not incorporate such a right in and of itself, in light of the lesser liberty infringement associated with conditional release. I believe, however, that SVPs who are conditionally discharged from civil confinement do, in fact, have such a right. As I will explain in the next section, this right derives from a fusion of the justification proffered by state officials in committing SVPs initially and the theoretical underpinnings of the right-to-treatment case law.

B. The Theoretical Underpinnings of the Right to Treatment

Having examined the potential scope of a right to treatment, we must now consider its historical foundations. Among the various theories that courts and commentators have forwarded to justify a right to treatment, two have particular relevance in the case of SVPs.⁴² The first straightforwardly relies on the statutory guarantee of treatment. For example, in *Rouse v. Camaron*, the Court of Appeals for the District of Columbia cited language in the federal 1964

³⁹ *Id.* at 322-23.

⁴⁰ *See, e.g.,* Janet D. v. Carros, 362 A.2d 1060 (Pa. Super. Ct. 1976).

⁴¹ *Youngberg v. Romeo*, 457 U.S. 307, 317, 319-20 (1982). For a fuller discussion of these issues, see John Kip Cornwell, *Understanding the Role of the Police and Parens Patriae Powers in Involuntary Civil Commitment*, 4 PSYCHOL. PUB. POL’Y & L. 377, 408-12 (1998).

⁴² A third theory relies on the state’s authority as parens patriae to provide care and treatment for those citizens who are unable to care for themselves. Accordingly, due process requires treatment when citizens are deprived of liberty “upon the altruistic theory that the confinement is for humane therapeutic reasons.” *Wyatt v. Stickney*, 325 F. Supp. 781, 785 (D. Ala. 1971). Because the civil confinement of sexual predators is based overwhelmingly on the state’s police power authority to protect its citizens rather than its beneficent parens patriae powers, this theory has little relevance in this context.

Hospitalization of the Mentally Ill Act specifying “[a] person hospitalized in a public hospital for a mental illness shall, during his hospitalization, be entitled to medical and psychiatric care and treatment.”⁴³ Likewise, in *Welsch v. Likins*,⁴⁴ the district court derived a treatment mandate from statutory authority permitting state officials to hospitalize involuntarily any “mentally deficient” individual who “requires treatment or supervision for his own good or the public welfare.”⁴⁵ Since hospitals were defined in the statute as places “equipped to provide care and treatment,” when state officials choose to place citizens in hospitals against their will, those citizens have a right to receive treatment.⁴⁶

The SVP statutes also reference treatment, as this prototypical provision from the State of Washington illustrates:

The legislature finds that a small but extremely dangerous group of sexually violent predators exist who do not have a mental disease or defect that renders them appropriate for the existing involuntary treatment act . . . which is intended to be a short-term civil commitment system that is primarily designed to provide short-term treatment to individuals with serious mental disorders and then return them to the community. [By] contrast, sexually violent predators generally have personality disorders and/or mental abnormalities which are unamenable to existing mental illness treatment modalities and those conditions render them likely to engage in sexually violent behavior. The legislature further finds that sex offenders’ likelihood of engaging in repeat acts of predatory sexual violence is high The legislature further finds that the prognosis for curing sexually violent offenders is poor, the treatment needs of this population are very long term, and the treatment modalities for this population are very different than the traditional treatment modalities for people appropriate for commitment under the involuntary treatment act.⁴⁷

In *Hendricks*, the U.S. Supreme Court acknowledged that Kansas’s SVP law, which is fundamentally similar to Washington’s, obligates state officials to provide treatment.⁴⁸ It does not matter that the primary purpose of these laws is to separate those committed under them from society. Even if treatment is merely an “ancillary” goal,

⁴³ *Rouse*, 373 F.2d at 453.

⁴⁴ 373 F. Supp. 487 (D. Minn. 1974).

⁴⁵ *Id.* at 500 (quoting MINN. STAT. ANN. § 253A.02 subd. 5).

⁴⁶ *Id.* (quoting MINN. STAT. ANN. § 253A.02 subd. 8).

⁴⁷ WASH. REV. CODE ANN. § 71.09.010 (West 2004); *see also* 1995 Ariz. Sess. Laws § 10; CAL. WELF. & INST. CODE § 6606 (West 2004).

⁴⁸ *Hendricks*, 521 U.S. at 367.

having declared that the state will provide it, it cannot fail to do so.⁴⁹

A second justification for a right to treatment, known as the quid pro quo theory,⁵⁰ posits that the state must give individuals who are involuntarily civilly committed something in exchange for their loss of liberty.⁵¹ If the restraint on freedom is based on a need for treatment, the quid pro quo is the provision of that treatment. It does not matter if treatment is not the primary motivation for detention; even if the deprivation of liberty is based only in part on the promise of treatment, the representation is sufficient to force the state's hand.⁵²

PART III: LOCATING A RIGHT TO POST-RELEASE COMMUNITY TREATMENT FOR SVPS

While the foregoing identifies a right to presently available treatment for civilly committed SVPS based on a statutory guarantee and a quid pro quo theory, these considerations do not suggest that SVPS have any right to state-sponsored treatment once they are discharged into the community. State constitutions may provide certain community-treatment rights for mentally ill individuals.⁵³ There may also be some entitlement to community-based services based on state statutes. These provisions are likely, however, to provide only short-term treatment⁵⁴ and to face practical challenges based on funding shortages.⁵⁵

A. *Statutory and Quid Pro Quo Imperatives*

Significantly, no court has yet to embrace any federal

⁴⁹ *Id.*

⁵⁰ See, e.g., Susan Stefan, *Leaving Civil Rights to the Experts: From Deference to Abdication Under the Professional Judgment Standard*, 102 YALE L.J. 639, 687-88 (1992).

⁵¹ See, e.g., Gary W. v. Louisiana, 427 F. Supp. 1209, 1216 (E.D. La. 1976) (holding that where an individual is confined against his will for reason other than commission of criminal offense, the state must provide a benefit in exchange for loss of liberty), *aff'd on other grounds*, 601 F.2d 240 (5th Cir. 1979); see also Donaldson v. O'Connor, 493 F.2d 507, 522 (5th Cir. 1974) (stating that outside the criminal context, "there must be a quid pro quo extended by the government to justify confinement"), *vacated and remanded on other grounds*, 422 U.S. 563 (1975).

⁵² See *Youngberg*, 457 U.S. at 326 (Blackmun, J., concurring).

⁵³ Anthony B. Klapper, Comment, *Finding a Right in State Constitutions for Community Treatment of the Mentally Ill*, 142 U. PA. L. REV. 739 (1993).

⁵⁴ See, e.g., MONT. CODE ANN. § 53-21-185 (1991) (obligating state mental health department "to provide adequate transitional treatment and care for all patients released after a period of involuntary confinement").

⁵⁵ Klapper, *supra* note 53, at 816.

constitutional obligation to provide treatment once discharged from institutional confinement. I believe, however, that such a right does exist for individuals committed under modern SVP statutes. This obligation derives principally from the legislative “findings” highlighted above. Those findings specify that SVPs subject to civil commitment: (1) are extremely sexually dangerous; (2) are likely to reoffend; and (3) have “very long-term” treatment needs that are different from those of other individuals subject to involuntary psychiatric detention.⁵⁶ Because SVPs typically do not have a mental disorder sufficient to qualify them for commitment under pre-existing standards for involuntary psychiatric detention, “special” laws are necessary and should be specifically tailored to SVPs’ unique mental impairment and the resulting dangers it produces.⁵⁷

Drawing a distinction between SVPs and other psychiatric patients makes sense. Many of the latter have mental illnesses that, based on pharmacological advances, do not require long-term confinement. Accordingly, involuntary psychiatric commitment is ordinarily intended “to provide short-term treatment to individuals with serious mental disorders and then return them to the community.”⁵⁸ Once in the community, these individuals can receive follow-up services through the network of clinical providers available privately or through community mental health centers.

SVPs, however, are very differently situated. Unlike other psychiatric patients, their mental “abnormalities”⁵⁹ require *specialized, long-term* treatment.⁶⁰ The goal of treatment for this “small group of extremely dangerous”⁶¹ mentally disordered sex offenders is not to “cure” them; indeed, the state has acknowledged that these individuals have little chance of being “cured” of their disorders.⁶² Instead, treatment is designed to achieve a degree of recovery sufficient to allow them to re-enter the community.

Since discharged SVPs are not “cured,” it would be unrealistic at best, and disingenuous at worst, to expect that they would be able to

⁵⁶ See *supra* text accompanying note 47.

⁵⁷ Not all SVP statutes explicitly contain the legislative findings referenced above. However, the statutes are fundamentally similar in all significant respects in terms of content, sentiment and intent; all provide for treatment; and all are patterned after the Washington statute which did contain such findings. Thus, it is appropriate to give the findings full force when construing SVP statutes.

⁵⁸ WASH. REV. CODE ANN. § 71.09.010 (West 2004).

⁵⁹ *Id.*

⁶⁰ *Id.*

⁶¹ *Id.*

⁶² *Id.*

sustain their progress without therapeutic reinforcement. As the discussion in Part I indicated, however, the willingness to provide this treatment varies widely among the states.⁶³ This problem is compounded when SVPs relocate to areas away from urban centers where clinicians experienced in providing sex-offender therapy are in especially short supply or, when services are available but released SVPs cannot afford them.

It is my belief that states are obligated, as a matter of constitutional due process, to provide these services to discharged SVPs. States cannot justify their authority to confine SVPs in a psychiatric facility indefinitely to address their unique, long-term treatment needs and then refuse, upon conditional release, to provide the very treatment that they have acknowledged is necessary to allow them to gain their freedom. The state would be effectively saying: "You have a special condition that makes you dangerous and, because of it, we are going to confine you for a long time during which you will be treated to reduce that risk. At the point at which your therapy has succeeded such that you can begin to re-integrate into the community, we can stop providing treatment so that you can regress and return to inpatient hospitalization for another indefinite period."

In addition to contravening the state's statutory guarantee, this result would also violate *quid pro quo* principles. The state would, on the one hand, justify the restraint on liberty by the need for ongoing, long-term treatment to restore it and, on the other hand, take that treatment away the moment its success became manifest. As Judge Becker of the U.S. Court of Appeals for the Third Circuit noted, "due process dictates that the benefit to which the civilly committed are entitled is the habilitation to enable them to leave their commitment."⁶⁴ By denying SVPs the right to state-sponsored, outpatient treatment, the state would be nullifying this entitlement.

This is not only unjust, it invokes the kind of animus that Justice Kennedy warned of in *Hendricks*. There, the Justice noted, that when civil confinement becomes a mechanism for retribution or general deterrence, it loses its constitutional moorings. The problem is not that committed SVPs face potentially life-long commitment;⁶⁵ the difficulty lies, instead, with structuring a civil commitment system to promote that result.

⁶³ See *supra* notes 24-28 and accompanying text.

⁶⁴ *Clark v. Cohen*, 794 F.2d 79, 94 (3d Cir. 1986) (Becker, J., concurring).

⁶⁵ *Hendricks*, 521 U.S. at 372 (Kennedy, J., concurring).

B. *The Role of Treatment Efficacy*

Critics may argue against my position on the ground that treatment is insufficiently effective to obligate the state to provide it upon conditional release. Indeed, treatment efficacy remains a controversial topic among commentators and researchers.⁶⁶ Arguably, the most comprehensive review of the psychological treatment for sex offenders is that conducted by the Collaborative Outcome Data Project Committee. In 2002, the project's first report positively associated treatment with reductions in both sexual and general recidivism.⁶⁷ In four to five years of follow-up, sexual recidivism in the treatment group was ten percent versus seventeen percent in the non-treatment group. Additionally, general recidivism was at thirty-two percent for those receiving treatment versus fifty-one percent for the untreated.⁶⁸ The significance of these findings has been challenged, however, based on alleged flaws in the research design, including: (1) that the comparison groups were not comparable, and (2) that the evidence was contaminated by the inclusion in the comparison groups of higher-risk offenders who would have refused or quit treatment if they had had the choice.

Fortunately, it is not necessary to resolve this ongoing debate about treatment efficacy to vindicate a constitutional right to community treatment because the states have chosen, in their legislative findings, to declare that treatment is necessary to reduce the risks of recidivism posed by this population. By denying treatment upon release, the states would, by their own admission, be setting SVPs up for failure and recommitment. In addition, by denying SVPs the proverbial "benefit of the bargain," the state would extinguish the possibility of SVPs living in a less restrictive setting

⁶⁶ Compare Robin Fretwell Wilson, *Cradles of Abuse: Evaluating the Danger Posed by a Sexually Predatory Parent to the Victim's Siblings*, 51 EMORY L.J. 241, 298-99 (2002) (arguing that treatment can lower the risk of future offenses and courts should take into account an offender's participation in treatment), and James A. Billings & Crystal L. Bulges, *Maine's Sex Offender Registration and Notification Act: Wise or Wicked?*, 52 ME. L. REV. 175, 243-45 (2000) (highlighting flaws in research techniques that measure treatment efficacy, but concluding that "[t]reatment is also integral to sex offense solutions"), with R. Karl Hanson, *What Do We Know About Sex Offender Risk Management?*, 4 PSYCHOL. PUB. POL'Y & L. 50, 68 (1998) (noting that research regarding whether SVPs benefit from treatment is inconclusive), and Kirk Heilbrun et al., *Sexual Offending: Linking Assessment, Intervention, and Decision Making*, 4 PSYCHOL. PUB. POL'Y & L. 138, 169 (1998) (concluding that "[p]rogress in treatment is not a powerful risk-reduction indicator").

⁶⁷ R. Karl Hanson et al., *First Report of the Collaborative Outcome Data Project on the Effectiveness of Psychological Treatment for Sex Offenders*, 14 SEXUAL ABUSE: J. RES. & TREATMENT 169 (2002).

⁶⁸ *Id.*

than that of the institution, a result which raises distinct constitutional concerns. In litigation over Washington's SVP statute, a federal judge has held that providing for community transition to a less restrictive setting is a vital and necessary part of professional minimum standards. "Without LRAs [least restrictive alternatives]," the court commented, "the constitutional requirement of treatment leading, if successful, to cure and release cannot fully be met."⁶⁹

C. *Advocating Affirmative Rights*

Another potential criticism of my proposal is that it impermissibly imposes on the states affirmative obligations where the state does not assume full custody and control over the individuals to whom services are provided. In *DeShaney v. Winnebago County Department of Social Services*,⁷⁰ the U.S. Supreme Court held that the state has no constitutional duty to protect a child from his parent after receiving reports of possible abuse. In reaching this conclusion, the Court noted that "[a]lthough the liberty protected by the Due Process Clause affords protection against unwarranted government interference, it does not confer an entitlement to government aid as may be necessary to realize all the advantages of that freedom."⁷¹

The context of *DeShaney* is distinguishable, however, from that with which this Article is concerned. Most significantly, *DeShaney* dealt with purely private conduct; the deprivation of liberty to which the complainant was subjected was not created by the state, nor was the minor in state custody when the violence occurred. By contrast, even when SVPs are no longer confined institutionally, the state still restrains their freedom substantially. Common conditions of discharge include, for example, mandatory supervision when outside the residence, electronic monitoring, no drug or alcohol use, no access to pornography, and restricted access to "vulnerable" populations.⁷² Thus, the state impedes the liberty of sexual offenders, but does offer, in exchange, treatment to allow targeted SVPs to gain freedom. By creating this interest in treatment as part of the commitment process, states should not be permitted to abandon it by removing some restrictions on liberty.⁷³

⁶⁹ Turay v. Selig, 108 F. Supp. 2d 1148, 1156 (W.D. Wash. 2000).

⁷⁰ 489 U.S. 189 (1989).

⁷¹ *Id.* at 196 (quoting Harris v. McCrae, 448 U.S. 297, 317-18 (1980)).

⁷² Fitch, *supra* note 4, at 492.

⁷³ *Cf.* Cleveland Bd. of Educ. v. Loudermill, 470 U.S. 532 (1985) (holding that creating constitutionally protected property interest obligates the state to support that interest adequately).

Moreover, *DeShaney* itself recognizes that affirmative duties of care may exist in certain circumstances where individuals face less than total deprivation of liberty. The Court opined that if state officials had removed Joshua DeShaney from his home and placed him in a foster home run by “its agents,” the situation might be “sufficiently analogous to incarceration or institutionalization to give rise to an affirmative duty to protect.”⁷⁴ Like foster care, community placement of an SVP is less restrictive than institutional care, though the state imposes conditions and retains substantial oversight that permits restoration of institutional custody if the situation warrants. Thus, in both instances, this exercise of state authority and control is sufficient to give rise to affirmative obligations on the part of the state to provide care and treatment.⁷⁵

D. Equal Protection

Because the community treatment rights that I am advocating would apply only to SVPs discharged from civil commitment, some might argue that the rights of other individuals discharged from involuntary psychiatric detention are violated under the Equal Protection Clause of the Fourteenth Amendment. To evaluate this claim, it is first necessary to identify the appropriate level of scrutiny. This task is challenging, since the U.S. Supreme Court has not spoken with clarity about the standard of review it applies in cases involving involuntary commitment classifications.

Early cases seemed to require only that these classifications be rationally or reasonably related to legitimate government interests.⁷⁶ However, the 1992 case of *Foucha v. Louisiana*⁷⁷ suggested greater scrutiny, mandating that the state provide a “particularly convincing reason” for continuing to commit insanity acquittees who had

⁷⁴ *DeShaney*, 489 U.S. at 201 n.9.

⁷⁵ See *Hasenfus v. LaJeunesse*, 175 F.3d 68 (1st Cir. 1999) (stating that public school officials may have affirmative duties to render aid to school children under the Due Process Clause); accord *Freeman v. Ferguson*, 911 F.2d 52 (8th Cir. 1990); cf. *Dwares v. New York*, 985 F.2d 94 (2d Cir. 1994) (positing that affirmative duties may arise in the absence of state custody where state actors play a part in the liberty deprivation).

⁷⁶ See, e.g., *Jones v. United States*, 463 U.S. 354, 364 (1983) (concluding that it was not “unreasonable” for Congress to provide for the “automatic” commitment of a defendant found not guilty by reason of insanity); *Jackson v. Indiana*, 604 U.S. 715, 729 (1972) (requiring a “reasonable justification” for involuntary commitment classification); *Baxstrom v. Herold*, 383 U.S. 107, 114 (1966) (stating that “classification of patients for involuntary commitment . . . may not be wholly arbitrary”).

⁷⁷ 504 U.S. 71 (1992).

regained mental health. The Court's two most recent decisions, both concerning Kansas's SVP law, do not explicitly reference any particular standard of review. In *Hendricks*, the Court stated simply that involuntary civil commitment statutes that "narrow[] the class of persons eligible for confinement to those who are unable to control their dangerousness" are constitutional.⁷⁸ Five years later, *Kansas v. Crane*⁷⁹ specified that proof of a "serious difficulty in controlling behavior" is an essential requirement of substantive due process.⁸⁰

By mandating proof of a volitional impairment not specified in the Kansas statute, *Hendricks* and *Crane* suggest a level of scrutiny higher than the rational basis test, which would have required upholding the statute as written. In addition, because the stigmatizing effect of mental illness undermines respect and dignity and promotes social isolation,⁸¹ I have repeatedly advocated for heightened scrutiny in evaluating classifications affecting involuntary civil commitment.⁸²

That being said, I believe that there is a "particularly convincing reason" or "exceedingly persuasive justification"⁸³ for treating SVPs differently from other individuals discharged from involuntary psychiatric detention with respect to community treatment. As discussed above, individuals committed as SVPs have treatment needs that are distinct from those of other patients in terms of modality and duration, a fact which states have acknowledged in enacting this legislation. Moreover, because the failure to provide necessary treatment carries specific risks to public safety that are unique and deeply troubling, the state may use different procedures to guard against those risks.

E. *Alternative Approaches to Sex Offender Commitment*

Because the constitutional right to community treatment that I

⁷⁸ *Hendricks*, 521 U.S. at 359.

⁷⁹ 534 U.S. 407 (2002).

⁸⁰ *Id.* at 413.

⁸¹ L.J. Skinner et al., *Generalizability and Specificity of the Stigma Associated with the Mental Illness Label: A Reconsideration Twenty-five Years Later*, 23 J. COMMUNITY PSYCHOL. 3 (1995).

⁸² See, e.g., John Kip Cornwell, *Confining Mentally Disordered "Super Criminals": A Realignment of Rights in the Nineties*, 33 HOUS. L. REV. 651, 677-89 (1996); John Kip Cornwell, *Sex Offenders and the Supreme Court: The Significance and Limits of Kansas v. Hendricks*, in PROTECTING SOCIETY, *supra* note 1, at 197 (2003); John Kip Cornwell & Raymond Deeney, *Exposing the Myths Surrounding Preventive Outpatient Commitment for Individuals with Chronic Mental Illness*, 9 PSYCHOL. PUB. POL'Y & L. 209 (2003).

⁸³ *United States v. Virginia*, 518 U.S. 515, 529 (1996) (defining heightened scrutiny standard in context of gender-based discrimination).

am vindicating relies on legislative findings specific to SVP commitment laws, the entitlement to such services would not necessarily apply to discharge from other systems of civil detention. Should we worry, therefore, that states will create alternative means of civilly confining SVPs to avoid providing community treatment upon release?

The experience in New Jersey is instructive in this regard. In 1994, New Jersey declared that certain sex offenders “suffer from mental illness which renders them dangerous to others.”⁸⁴ The legislature then facilitated their detention under the *existing* civil commitment law by redefining mental illness as “a current, substantial disturbance of thought, mood, perception or orientation which significantly impairs judgment, *capacity to control* behavior or capacity to recognize reality”⁸⁵ This “clarification” of the state’s mental illness standard was subsequently held constitutional by the state supreme court in a case brought by a sex offender detained under it.⁸⁶ In so finding, the justices also overturned the decision of the appellate court that the petitioner was insufficiently mentally ill to warrant ongoing detention. Medical testimony concluding that he suffered from an antisocial personality disorder and had fantasies of sexual sadism were adequate to support the trial court’s order for continued psychiatric detention.⁸⁷

The foregoing suggests that states need not resort to novel commitment standards to manage mentally disordered SVPs. It is curious, therefore, that more have not chosen to alter their existing commitment standards, instead of creating a new, controversial commitment formula. Faced, for example, with a definition of mental illness similar to that of the unamended New Jersey statute, Wisconsin⁸⁸ chose to enact a separate SVP statute, patterned after Washington’s, rather than altering the definition of mental illness to achieve the same result.

Wisconsin’s reluctance may reflect a tension between the nature and purposes of “ordinary” psychiatric commitment and that

⁸⁴ Act of Oct. 31, 1994, ch. 134, § 1(a), 1994 N.J. Sess. Law Serv. 542, 542 (West).

⁸⁵ N.J. STAT. ANN. § 30:4-27.2(r) (West 1994) (emphasis added to denote amended language).

⁸⁶ *In re D.C.*, 679 A.2d 634 (N.J. 1996).

⁸⁷ *Id.* at 649.

⁸⁸ WIS. STAT. ANN. § 51.01(13b) (West 1987) (“‘Mental illness,’ for purposes of involuntary commitment, means a substantial disorder of thought, mood, perception orientation, or memory which grossly impairs judgment, behavior, capacity to recognize reality, or ability to meet the ordinary demands of life, but does not include alcoholism.”).

provided under SVP statutes. Normally, the state's civil commitment authority is based on its *parens patriae* power to "provid[e] care to its citizens who are unable because of emotional disorders to care for themselves" and its police power "to protect the community from the dangerous tendencies of those who are mentally ill."⁸⁹ Because the commitment of SVPs is primarily—some would say exclusively—an exercise of states' police power,⁹⁰ the "profile" of committed SVPs differs markedly from that of most psychiatric inpatients in that the former do not typically suffer from mental disorders that pose a danger to themselves or impair their ability to live day-to-day in a community setting. In addition, whereas involuntary commitment is designed to be short-term,⁹¹ the treatment needs of the SVP population are necessarily long-term.⁹²

Because of these differences, attempting to force mentally disordered sex offenders into pre-existing commitment schemes which do not naturally fit seems unwise. To that end, notwithstanding the above-referenced expansion of its mental illness standard, New Jersey enacted a *Hendricks*-style SVP statute in 1998.⁹³ The law was urged by the Task Force for the Review of the Treatment of the Criminally Insane created by then-Governor Christine Todd Whitman in 1996.⁹⁴ When the task force invited me to meet with them to discuss *Kansas v. Hendricks* and its implications for the care and management of sexual predators, I inquired as to why New Jersey would need an SVP statute in light of the changes made to accommodate sex offender commitment in its existing civil commitment statute. Those who responded opined that offenders committed under the expanded mental illness standard were gaining release too easily because judges and/or psychiatrists did not consider them sufficiently mentally ill to justify indefinite detention. Thus, special standards and procedures were necessary to identify more specifically the particular dangers and disorders presented by mentally disordered sex offenders.

These remarks illustrate the difficulty in managing SVPs within the traditional civil commitment framework. It is for this reason, perhaps, that states have not favored this approach and New Jersey

⁸⁹ *Addington v. Texas*, 441 U.S. 418, 426 (1979).

⁹⁰ Cornwell, *supra* note 41, at 403; Eric S. Janus, *Hendricks and the Moral Terrain of Police Power Commitment*, 4 *PSYCHOL. PUB. POL'Y & L.* 297, 302 (1998).

⁹¹ See *supra* text accompanying note 47.

⁹² *Id.*

⁹³ Cornwell et al., *supra* note 9, at 2.

⁹⁴ Report of the Task Force for the Review of the Treatment of the Criminally Insane 3 (Oct. 1997) (unpublished report, on file with author).

abandoned it. Parenthetically, inasmuch as those who promoted adopting an SVP law in New Jersey were motivated by the desire to lengthen the duration of civil detention for sex offenders, they should be pleased with the results. According to a survey conducted in the summer of 2002, New Jersey had an inpatient SVP population of 223 with only two gaining release in the first three years the statute went into effect.⁹⁵

CONCLUSION

Prior to the 1990s, the psychiatric commitment of sex offenders was largely moribund. Statutes that existed were little enforced, and new initiatives were not on the horizon.⁹⁶ The *Shriner* case, and others like it,⁹⁷ changed all this. They ushered in a new wave of legislation that allowed mentally disordered sex offenders to be committed at the expiration of their criminal sentences based on mental impairments otherwise insufficient for involuntary detention. As these laws proliferated in the 1990s, the legal debate focused on the constitutionality of this novel approach to sex-offender containment. To this end, the U.S. Supreme Court considered challenges based on SVP laws three times between 1997 and 2002.⁹⁸ Thus, in 2004, we have a much clearer picture of the constitutional landscape with respect to SVP commitment than we did a few years ago.

Because the Court has all but foreclosed challenges based on the Ex Post Facto and Double Jeopardy Clauses, our focus must now be on whether the implementation of these laws satisfies due process, ever mindful of Justice Kennedy's admonition that "[i]f . . . civil confinement were to become a mechanism for retribution or general deterrence . . . [the Court's] precedents would not suffice to validate it."⁹⁹ Persistent refusal on the part of state officials to afford release would provide persuasive evidence of this impermissible purpose, but simply allowing discharge is not enough. Because SVPs have unique, long-term treatment needs which state officials acknowledged as a

⁹⁵ Fitch, *supra* note 4, at 492.

⁹⁶ Cornwell, *supra* note 7, at 1297; Gleb, *supra* note 3, at 215.

⁹⁷ See, e.g., Kelly A. McCaffrey, Comment, *The Civil Commitment of Sexually Violent Predators in Kansas: A Modern Law for Modern Times*, 42 U. KAN. L. REV. 887, 887 (1994) (discussing the rape and murder of Stephanie Schmidt by a released sex offender that inspired the passage of the Kansas SVP law).

⁹⁸ *Kansas v. Crane*, 534 U.S. 407 (2002); *Seling v. Young*, 531 U.S. 250 (2001) (hearing claim that SVP statute violated ex post facto and double jeopardy clauses requires proof that law is punitive "on its face" rather than as applied in practice); *Kansas v. Hendricks*, 521 U.S. 346 (1997).

⁹⁹ *Hendricks*, 521 U.S. at 373 (Kennedy, J., concurring).

basis for confinement and affirmatively obligated themselves to treat, the state must continue to provide that treatment in the community in fulfillment of their statutory guarantee and corresponding constitutional mandate.

Some discharged SVPs may already be receiving state-sponsored treatment; others may not. Some may be able to find qualified sex-offender therapists on their own; others may not. Some may be able to pay for such treatment; others may not. By recognizing the obligation of state officials to provide therapeutic services to *all* SVPs discharged into the community from civil commitment, the opportunity to retain their freedom will be equally available to all.