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Sex Offender Civil Commitment: The Treatment Paradox

Jeslyn A. Miller[†]

Twenty-one states and the federal government have civil commitment schemes that provide for the further confinement of sex offenders after they have completed their prison sentences. These schemes survive constitutional scrutiny on the grounds that they are not a second prison sentence, but rather serve the non-criminal ends of protecting society and helping treat violent sex offenders. The underlying legislation confirms the treatment objective by elaborating statutory guidelines for treatment programs.

This Comment argues that treatment—although guaranteed by statute, legislative findings, case law, and the constitution—is an empty promise. Indeed, participation in treatment harms the very offender that it purports to help. This treatment paradox arises because successful treatment and relapse prevention require that an offender discuss his sexual fantasies and past transgressions; yet, unprotected by privilege or confidentiality, these cathartic admissions are utilized in civil commitment proceedings to secure further confinement. Because the prosecution heavily relies on treatment records to show that the offender continues to suffer from a mental abnormality and because the completion of treatment does not favorably impact an offender's chance of release, offenders often elect to forgo treatment. This treatment disincentive effectively denies offenders the opportunity to heal and to obtain release from commitment through treatment, an opportunity envisioned by statute and by the civil commitment scheme's constitutional underpinnings.

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This Comment traces the history of sex offender civil commitment and investigates the treatment paradox through the lens of law and psychiatry. To conclude, I suggest statutory remedies that could transform the promise of treatment into a reality.

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INTRODUCTION

Violence, including sexual violence, is usually controlled through *criminal* prosecution, conviction, and punishment. However, in recent years, states have increasingly turned to a *civil* system of confinement for the most dangerous sex offenders. Laws prescribing civil commitment for sexually violent predators identify those persons convicted of sexual offenses who are the most likely to recidivate and provide a mechanism whereby, upon completion of their criminal sentences, they can be isolated until they are no longer a threat to society. Despite the extreme deprivation of liberty that accompanies forced confinement,¹ the Supreme Court has deemed

1. See, e.g., *Addington v. Texas*, 441 U. S. 418, 425 (1979) (“This Court repeatedly has recognized that civil commitment for any purpose constitutes a significant deprivation of liberty

these commitment statutes *civil*, and not punitive or *criminal*, in nature.² Because of this designation, sex offender commitment processes need not afford the procedural safeguards guaranteed in criminal proceedings, including the Fifth Amendment right against self-incrimination, the Sixth Amendment rights to jury trial and to assistance of counsel, and the requirement of proof beyond a reasonable doubt.³

Civil commitment programs represent a delicate balance between society's interest in protecting the public, on one hand, and the confined individual's interest in liberty, on the other.⁴ This Comment focuses on one aspect of that balance: treatment. I argue that persons in state commitment facilities have a statutory and constitutional right to treatment.⁵ Because civil commitment schemes circumvent the strict procedural constraints of the criminal justice system, treatment is one of the few guarantees afforded to involuntarily committed sex offenders. However, a sex offender's full and candid participation in treatment is limited by the reality that all treatment records are discoverable. Unhindered by the right against self-incrimination and the psychotherapist-patient privilege, the government can introduce treatment records at the initial commitment trial and at all subsequent release hearings.⁶ Moreover, experts disproportionately rely on treatment records in their determination of mental abnormality and future dangerousness—the two central criteria for commitment.⁷

This commitment scheme confronts sex offenders with a Catch-22: without participating in treatment, offenders cannot demonstrate that they have learned from past transgressions and are fit for release; yet by participating in treatment—which requires admission of guilt, polygraph testing, sexual history documentation, dream logs, and victim letters—the offenders incriminate themselves.⁸ This Catch-22 has larger, systemic implications. At the point that treatment is “mere pretext,” serving more to propagate evidence for the prosecution than to provide a legitimate opportunity for rehabilitation, civil

that requires due process protection.”); BRUCE J. WINICK, CIVIL COMMITMENT: A THERAPEUTIC JURISPRUDENCE MODEL 1–2 (2005) (explaining that civil commitment may entail a greater curtailment of liberty than penal incarceration because, in addition to the forced detention found in both systems, involuntary commitment requires intrusive treatment and imposes a “severe stigma” that produces continued social and occupational disabilities long after discharge).

2. See, e.g., *Kansas v. Crane*, 534 U.S. 407 (2002); *Kansas v. Hendricks*, 521 U.S. 346 (1997).

3. See *United States v. Ward*, 448 U.S. 242, 248 (1980).

4. See, e.g., Edward P. Ra, Comment, *The Civil Confinement of Sexual Predators: A Delicate Balance*, 22 ST. JOHN'S J. LEGAL COMMENT. 335, 337, 364 (2007); N.Y. MENTAL HYG. LAW § 10.01 (McKinney 2010) (describing protection of the public and treatment of the offender as dual aims of New York's civil commitment system).

5. See *infra* Part II.

6. For a discussion of psychotherapist-patient privilege and civil commitments, see *infra* notes 90–92 and accompanying text.

7. See *infra* Part III.B.

8. I am grateful to Tamara Lave for discussing this point with me.

commitment becomes constitutionally problematic.⁹ Treatment-less commitment rings deceptively punitive, rendering the system subject to ex post facto and double jeopardy challenges.¹⁰

This Comment discusses the implications of discoverable treatment records by juxtaposing the statutory and constitutional promise of treatment with the reality of the commitment process. Part I provides a background to civil commitment statutes, including relevant history and general criticism. Part II examines the “promise of treatment,” concluding that state statutes and the federal constitution guarantee care and treatment for involuntarily committed persons. Part III discusses the “reality of treatment,” examining how the prosecution’s reliance on treatment records discourages offenders from meaningful participation in treatment and discussing the critique that sexually violent predators are not treatable. In Part IV, I search for a solution that will allow experts and fact-finders to make informed decisions as to the dangerousness of sex offenders and yet will incentivize offenders’ treatment, rehabilitation, and eventual transition back to society. I conclude that courts are extremely deferential to the legislature’s stated objectives and, hence, few constitutional or state-prescribed remedies exist by which individuals can challenge their classification as sexually violent predators or their treatment options. Hence, it is up to state legislatures to craft sound policies that provide real treatment options and incentivize participation in treatment.

I.

CIVIL COMMITMENT STATUTES: HISTORY AND CRITICISM

There is a long history of sex offender civil commitment in the United States. As early as 1911, state legislation defined violent sex offenders as “defective delinquents” and “criminal psychopaths.”¹¹ Laws for the special commitment of sex offenders first appeared in the 1930s, paralleling the development of medical explanations for criminal behavior and the desire to emphasize “treatment goals over punishment.”¹² By 1960, twenty-six states and the District of Columbia had special statutes authorizing civil commitment for persons who courts determined to be “sexual psychopaths.”¹³ Unlike modern

9. See, e.g., *Kansas v. Hendricks*, 521 U.S. 346, 371 (1997) (Kennedy, J., concurring) (“If the object or purpose of the Kansas [sex offender civil commitment] law had been to provide treatment but the treatment provisions were adopted as a sham or mere pretext, there would have been an indication of the forbidden purpose to punish.”).

10. See, e.g., *id.*

11. Jason A. Cantone, *Rational Enough to Punish, But Too Irrational to Release: The Integrity of Sex Offender Civil Commitment*, 57 *DRAKE L. REV.* 693, 696 (2009).

12. See Samuel Jan Brakel & James L. Cavanaugh, Jr., *Of Psychopaths and Pendulums: Legal and Psychiatric Treatment of Sex Offenders in the United States*, 30 *N.M. L. REV.* 69, 71 (2000). Michigan was one of the first states to pass sex offender civil commitment legislation in 1937. Mich. Comp. Laws § 780.501–.509 (1937) (repealed 1968).

13. Raquel Blacher, Comment, *Historical Perspective of the “Sex Psychopath” Statute: From the Revolutionary Era to the Present Federal Crime Bill*, 46 *MERCER L. REV.* 889, 903

sexually violent predator commitment programs that take effect after the completion of a sex offender's criminal sentence, psychopath commitments served as an alternative to criminal sentencing.¹⁴ In the 1970s, sexual psychopath laws fell out of favor due to empirical evidence that violent sex offenders were not responding to treatment,¹⁵ a shift toward determinative sentencing,¹⁶ and court decisions that held that certain features of the laws infringed offenders' civil liberties.¹⁷ For example, one circuit court concluded that because indefinite commitment under the sexual psychopath laws was "justifiable only upon a theory of therapeutic treatment," the lack of adequate treatment destroyed any valid basis for distinguishing sexual psychopath committees from other prisoners in order to subject them to indeterminate commitment.¹⁸

In 1990, Washington became the first state to enact a new form of civil commitment law in what Eric Janus classifies as the "second wave" of sex offender commitment schemes.¹⁹ Inspired by high-profile crimes and public outrage,²⁰ these second-generation laws operated as an extension to already

(1995); see also Karl M. Bowman, *Review of Sex Legislation and the Control of Sex Offenders in the United States of America*, INT'L REV. OF CRIMINAL POL'Y, July 1953, at 20–39 (1953) (explaining that various terms were used to describe the targeted group of sex offenders, including "psychopathic offenders" and, most typically, "sexual psychopaths").

14. Blacher, *supra* note 13, at 905; John Q. La Fond, *The Costs of Enacting a Sexual Predator Law*, 4 PSYCHOL. PUB. POL'Y & L. 468, 470–71 (1998).

15. See Blacher, *supra* note 13, at 906 (stating that various factors led to the treatment's decline, including "the recognition that not all violent sexual offenders were likely to respond to the same type of therapy; the growing awareness that sex offenders were not mentally ill," and "the lack of proven treatment methods to reduce recidivism rates"). A number of influential reports, including those of the Group for the Advancement of Psychiatry and the American Bar Association's Criminal Justice Mental Health Standards, recommended the repeal of special statutes for mentally disordered offenders. See GROUP FOR THE ADVANCEMENT OF PSYCHIATRY, PSYCHIATRY AND SEX PSYCHOPATH LEGISLATION: THE '30S TO THE '80S 942, 935 (1977) (characterizing sex psychopath statutes as an "experiment [that] has failed" because they provided neither effective treatment nor the incarceration of truly dangerous individuals and recommending the repeal of sex psychopath legislation).

16. See Aman Ahluwalia, *Civil Commitment of Sexually Violent Predators: The Search for a Limiting Principle*, 4 CARDOZO PUB. L. POL'Y & ETHICS J. 489, 489 (2006); Cantone, *supra* note 11, at 697.

17. Case law converted sexual psychopath laws into something inherently criminal. See, e.g., *Specht v. Patterson*, 386 U.S. 605, 609–11 (1967) (holding that due process in commitment hearings requires assistance of counsel, the right to confront and to cross-examine adverse witnesses, the right to present one's own witnesses and evidence, and a final decision sufficiently articulated to permit meaningful review on appeal); *United States ex rel. Stachulak v. Coughlin*, 520 F.2d 931, 935 (7th Cir. 1975) (finding that individuals committed under the Illinois Sexually Dangerous Persons Act suffer a "grievous loss" and that, in addition to statutory rights to a hearing, jury trial, and counsel, a defendant is entitled to the right to confront and to cross-examine witnesses, the right against self-incrimination, the right to speedy trial, and a reasonable-doubt standard of proof) (citations omitted).

18. *Millard v. Cameron*, 373 F.2d 468, 472–73 (D.C. Cir. 1966).

19. ERIC S. JANUS, *FAILURE TO PROTECT: AMERICA'S SEXUAL VIOLENT PREDATOR LAWS AND THE RISE OF THE PREVENTATIVE STATE* 22–23 (2006).

20. For example, Washington's civil commitment law responded to public outcry over the

lengthened prison sentences and allowed states to keep offenders who had served their full prison sentences in protective custody for as long as they were deemed dangerous. Today, twenty states²¹ and the federal government²² have involuntary commitment statutes aimed at “sexually violent predators.”²³ Although state-to-state variation exists in the exact language of these laws, most states define a “sexually violent predator” as a person (1) who has been convicted of or charged with a sexually violent offense and (2) who suffers from a mental abnormality or personality disorder (3) that makes the person likely to engage in acts of sexual violence.²⁴ As of 2006, more than 4,500 individuals were confined nationwide pursuant to sexually violent predator laws.²⁵

rape, mutilation, and killing of a seven-year-old boy by a mentally retarded man who had professed the intent to molest children if released from prison, and the kidnapping and murder of a young woman by an inmate who the state mental hospital considered “too dangerous to handle.” ROXANNE LIEB, WASHINGTON’S SEXUALLY VIOLENT PREDATOR LAW: LEGISLATIVE HISTORY AND COMPARISONS WITH OTHER STATES 1 (1996), <http://www.wsipp.wa.gov/rptfiles/WAsexlaw.pdf>. New Jersey enacted its civil commitment legislation following community outrage over the release of Donald Chapman, who had served twelve years for the abduction and rape of a twenty-three-year-old female and had expressed the intent to continue committing sexually motivated offenses against women and children upon release. Claudine M. Leone, *New Jersey Assembly Bill 155—A Bill Allowing the Civil Commitment of Violent Sex Offenders After the Completion of a Criminal Sentence*, 18 SETON HALL LEGIS. J. 890, 890–96 (1994).

21. ARIZ. REV. STAT. ANN. §§ 36-3701–3717 (2007); CAL. WELF. & INST. CODE §§ 6600–6609.3 (West 2010); FLA. STAT. §§ 394.910–394.932 (2010); 725 ILL. COMP. STAT. 205/1.01–205/12 (2010); IOWA CODE § 229A (2002); KAN. STAT. ANN. §§ 59-29a01-22 (2008); MASS. GEN. LAWS ch. 123A §§ 1–16 (2010); MINN. STAT. § 253B (2010); MO. REV. STAT. §§ 632.480–.513 (2008); NEB. REV. STAT. §§ 71-1201–1226 (2006); N.H. REV. STAT. § 135-E (2010); N.J. STAT. ANN. §§ 30:4-27.26–.38 (West 2010); N.Y. MENTAL HYG. LAW § 10.01 (McKinney 2010); N.D. CENT. CODE §§ 25-03.3-01–.3-44 (2009); 42 PA. CONS. STAT. §§ 6401-09 (2010); S.C. CODE ANN. §§ 44-48-10-170 (2009); TEX. HEALTH & SAFETY CODE ANN. §§ 841.001–007 (Vernon 2009); VA. CODE ANN. §§ 37.2-900–921 (2010); WASH. REV. CODE §§ 71.09.010–903 (2010); WIS. STAT. §§ 980.01–14 (2010).

22. 18 U.S.C. § 4248 (2006). The Supreme Court recently upheld this federal civil commitment statute—which authorizes the Department of Justice to detain a mentally ill, sexually dangerous federal prisoner beyond the date the prisoner would otherwise be released—as a constitutional exercise of congressional power under the Necessary and Proper Clause. *United States v. Comstock*, 130 S. Ct. 1949 (2010). The *Comstock* opinion expressly declined to address whether § 4248 or its application denied equal protection, procedural or substantive due process, or any other constitutional rights. *Id.* at 1956, 1965.

23. While “Sexually Violent Predator” or “SVP” is the most common designation for civilly committed offenders, Massachusetts and Wisconsin use “Sexually Dangerous Person,” North Dakota uses “Sexually Dangerous Individual,” and Arizona and Illinois use “Sexually Violent Person;” Minnesota has two designations under their law—“Sexually Dangerous Person” and “Sexual Psychopathic Personality.” ADAM H. DEMING, SEX OFFENDER CIVIL COMMITMENT PROGRAM DEMOGRAPHICS AND CHARACTERISTICS (2006), available at <http://www.soccpn.org/docs/soccpdemochar.pdf>.

24. Holly A. Miller, Amy E. Amenta & Mary Alice Conroy, *Sexually Violent Predator Evaluations: Empirical Evidence, Strategies for Professionals, and Research Directions*, L. & HUMAN BEHAV., Feb. 2005, at 29, 31–35 (providing a comparison of state laws).

25. WASH. STATE INST. FOR PUB. POLICY, COMPARISON OF STATE LAWS AUTHORIZING INVOLUNTARY COMMITMENT OF SEXUALLY VIOLENT PREDATORS: 2006 UPDATE, REVISED 1 (2007) [hereinafter WSIPP], available at <http://www.wsipp.wa.gov/pub.asp?docid=07-08-1101>.

Criticisms of modern sex offender civil commitment schemes are wide-ranging and include constitutional challenges;²⁶ arguments that such schemes have excessive cost;²⁷ concerns that the statutory criteria for sexually violent predator determinations set too low a threshold;²⁸ and fairness concerns that the commitment process is driven by political decisionmaking²⁹ and uses actuarial

26. Critics argue that civil commitment programs inappropriately blur the line between punishment and civil commitment in violation of the constitutional prohibitions against double jeopardy and ex post facto punishments. See, e.g., Peter C. Pfaffenroth, *The Need for Coherence: State's Civil Commitment of Sex Offenders in the Wake of Kansas v. Crane*, 55 STAN. L. REV. 2229, 2259–62 (2003). For a discussion of constitutional concerns in the context of civil commitment, see *infra* Part II.B.

27. See Monica Davey & Abby Goodnough, *Doubts Rise as States Hold Sex Offenders After Prison*, N.Y. TIMES, Mar. 4, 2007, at A1 (stating that civil commitment programs, on average, cost taxpayers four times more than keeping the offenders in prison). Costs include treatment, security and supervision, direct care, health care, contracted services, legal services, psychological examinations, transportation, and administrative overhead. In 2006, more than \$454.7 million was budgeted nationwide for civil commitment programs, and the average yearly cost across states was \$94,017 per resident in a commitment center as opposed to \$25,994 per Department of Corrections (DOC) inmate. WSIPP, *supra* note 25, at 5. California's cost of civil commitment was the highest: \$166,000 per sexually violent predator resident per year. *Id.* at 5. State commitment centers are also costly to build. For example, California's Coalinga State Hospital, constructed in 2005 to house California's sexually violent predator population, cost approximately \$388 million. Press Release, Cal. Dep't of Mental Health, Coalinga State Hospital Facts (2005), available at http://www.dmh.ca.gov/News/Press_Releases/docs/2005/dedication/CSH%20Facts.pdf. Further, critics opine that civil commitment programs divert resources that would otherwise fund prevention programs and probation departments to the highly visible but extremely rare incidents of sexual violence. See, e.g., JANUS, *supra* note 19, at 2–4.

28. For example, the past sexually violent offense requirement encompasses persons charged with just *one* crime of sexual violence; persons charged with sexual offenses as juveniles; and, in some states, persons charged with sexual conduct that does not involve any physical contact with another person, such as “living off or sharing earnings of a minor prostitute,” MASS. GEN. LAWS ch. 123A, § 1; possession of child pornography, *id.*; stalking via mail or telephone, MINN. STAT. § 253B.02(7)(b); or attempted offenses, N.H. REV. STAT. § 135-E:2(XI)(f); S.C. CODE ANN. § 44-48-30(2)(n); WIS. STAT. § 980.01(6)(c). South Carolina includes as a sexually violent offense the acts of incest or “buggery” (anal penetration), even when with a consenting adult. S.C. CODE ANN. § 44-48-30(2)(i)–(j). The mental abnormality requirement includes antisocial personality disorder, which “is extremely common in prisons with prevalence rates as high as 40–60% among the male sentenced population.” P. Moran, *The Epidemiology of Antisocial Personality Disorder*, 34 SOC. PSYCHIATRY & PSYCHIATRIC EPIDEMIOLOGY 231, 234 (1999); see also Rudolph Alexander, Jr., *Civil Commitment of Sex Offenders to Mental Institutions: Should the Standard Be Based on Serious Mental Illness or Mental Disorder?*, 11 J. HEALTH & SOC. POL'Y 67 (2000) (arguing that civil commitment should not include personality disorders, which many sex offenders suffer from, in the same category as major mental illness). And the risk of future dangerous determination is based on actuarial comparisons to other sexually violent predators; these actuarial tools are only 71 percent accurate, undercalculate the decrease in risk with advancing age, and do not take into account the link between an individual's mental illness and the risk of recidivism as constitutionally required. Tamara Rice Lave, *Controlling the Offender: Sex, Mental Illness, and the Static 99* (November 2006) (unpublished manuscript, on file with author).

29. Eric S. Janus, *Closing Pandora's Box: Sexual Predators and the Politics of Sexual Violence*, 34 SETON HALL L. REV. 1233, 1233–50 (2004) (discussing the effect of politics and public uproar against crimes of sexual violence and how that outcry fuels the expansion of sexually violent predator programs); Larry Oakes, *The New Life Sentence: OK'd for Transfer, but*

methods that “accentuate the prejudices and biases that are built into the penal code and into criminal law enforcement.”³⁰

Despite such strong criticisms, the U.S. Supreme Court has upheld sex offender civil commitment statutes as constitutional. The Supreme Court addressed the constitutionality of modern civil commitment statutes in the 1997 case *Kansas v. Hendricks*.³¹ The case addressed the civil commitment of Leroy Hendricks, who had a forty-year string of convictions and prison sentences for molesting at least twelve children, including his own stepdaughter and stepson.³² By a 5 to 4 margin, the Supreme Court upheld the Kansas Sexually Violent Predator Act against substantive due process, double jeopardy, and ex post facto challenges.³³

Although *Hendricks* was a close decision, many states responded by enacting their own sexually violent predator legislation.³⁴ These commitment statutes, and the underlying constitutional jurisprudence set forth in *Hendricks*, provide the framework for the promise of treatment, discussed in Part II.

II.

THE PROMISE OF TREATMENT

This Comment argues that treatment is a critical component of sexually violent predator statutes for two reasons: treatment is a statutory requirement, enforceable through state causes of action; and treatment is a constitutional requirement, subject to due process, ex post facto, and double jeopardy challenges.

A. Treatment as a Statutory Requirement

All states with civil commitment programs provide treatment for persons confined as sexually violent predators.³⁵ This provision of treatment validates

Going Nowhere, STAR TRIB., June 11, 2008, at A1 (noting that Minnesota has a political appointee making release decisions, that the sexually violent predator population has grown exponentially, and that “[b]ecause no one can guarantee an offender won’t rape or molest again, the safest course . . . has been to keep offenders locked up regardless of how their treatment has progressed”).

30. BERNARD E. HARCOURT, *AGAINST PREDICTION: PROFILING, POLICING, AND PUNISHING IN AN ACTUARIAL AGE* 190 (2007).

31. 521 U.S. 346 (1997).

32. *Id.* at 354–55. Hendricks conceded that he “can’t control the urge” to molest children when he “get[s] stressed out” and that the only sure way he could keep from sexually abusing children in the future was “to die.” *Id.*

33. *Id.* at 371. For an extended discussion of the *Hendricks* decision, see *infra* Part II.B.

34. To avoid additional constitutional challenge, state commitment programs typically mimic the Washington/Kansas model that was upheld as constitutional in *Hendricks*. Grant H. Morris, *The Evil That Men Do: Perverting Justice to Punish Perverts*, 2000 U. ILL. L. REV. 1199, 1204 (2000).

35. See MARCUS NIETO, *COMMUNITY TREATMENT AND SUPERVISION OF SEX OFFENDERS: HOW IT’S DONE ACROSS THE COUNTRY AND IN CALIFORNIA* 11–12 (2004), available at <http://www.library.ca.gov/crb/04/12/04-012.pdf>.

the *parens patriae* and general police power under which states enact civil commitment legislation and provides the necessary benchmark by which states can determine whether an individual is fit for release.

State statutes universally emphasize treatment for offenders and protection of society as joint aims of civil commitment.³⁶ These dual aims reflect the two powers—*parens patriae* and general police power—under which states implement their civil commitment programs.³⁷ Under the *parens patriae* power, states protect and provide services for individuals, such as mentally ill offenders who are unable to take care of themselves.³⁸ Under the police power, states can civilly commit dangerous persons to protect the public.³⁹

According to state legislative findings, sexually violent predators have behavioral abnormalities that render them unamenable to “traditional mental illness treatment modalities.”⁴⁰ Thus, unlike mentally ill persons serviced by existing involuntary commitment procedures,⁴¹ violent sex offenders require a separate commitment process to address their long-term treatment needs as well as the elevated threat they pose to society.⁴² Because “the prognosis for rehabilitating sexually violent predators in a prison setting is poor,”⁴³ states intend an independent system of confinement with unique treatment modalities.

Most state statutes detail treatment either as a “right” belonging to the committed offender⁴⁴ or as a duty of the state.⁴⁵ Many states couch their commitment programs in terms of treatment. For example, the Massachusetts “Care, Treatment and Rehabilitation of Sexually Dangerous Persons” provision commits sexually dangerous persons to a “treatment center.”⁴⁶ Minnesota’s “Commitment and Treatment Act” includes notification of “the right to obtain

36. *E.g.*, N.Y. MENTAL HYG. LAW § 10.01; *see also In re Detention of Darling*, 712 N.W.2d 98, 100 (Iowa 2006) (noting that one goal of the Iowa civil commitment statute is treatment of the sexually violent predator).

37. *See, e.g.*, *United States v. Comstock*, 551 F.3d 274, 278 (4th Cir. 2009), *overruled by* 130 S. Ct. 1949 (2010) (challenging the federal civil commitment scheme on the grounds that the federal government, unlike states, has no general police or *parens patriae* power).

38. *See, e.g.*, *Addington v. Texas*, 441 U.S. 418, 426 (1979).

39. *Id.*

40. TEX. HEALTH & SAFETY CODE ANN. § 841.001; *see also* IOWA CODE § 229A.1; FLA. STAT. § 394.910; KAN. STAT. ANN. § 59-29a01; N.H. REV. STAT. § 135-E:1; N.Y. MENTAL HYG. LAW § 10.01; S.C. CODE ANN. § 394.910; WASH. REV. CODE § 71.09.010.

41. Every state has a statute for the civil commitment of individuals with mental illness. These laws usually provide short-term treatment for individuals suffering from severe psychiatric illness where the persons’ symptoms put them at imminent risk of serious physical harm.

42. *E.g.*, FLA. STAT. § 394.910; S.C. CODE ANN. § 44-48-20.

43. FLA. STAT. § 394.910; N.H. REV. STAT. § 135-E:1.

44. *See* MINN. STAT. § 253B.03(7); WASH. REV. CODE § 71.09.080(2).

45. *See* 42 PA. CONS. STAT. ANN. § 6406(c) (2010) (listing treatment as a “duty” and requiring that the Department of Public Welfare “develop policies and procedures for providing individualized treatment and discharge plans based on clinical guidelines and professional standards in the fields of sexual offender treatment and mental health”); *see also* CAL. WELF. & INST. CODE § 6606(a); N.Y. MENTAL HYG. LAW § 10.01(f).

46. MASS. GEN. LAWS ch. 123A.

treatment and services voluntarily.”⁴⁷ Statutes either require treatment⁴⁸ or provide voluntary treatment.⁴⁹ Finally, treatment programs vary in structure, with some states providing no statutory guidelines for the treatment program,⁵⁰ and other states expressly requiring individualized treatment plans⁵¹ or periodic progress reports from qualified treatment providers.⁵²

Treatment is also central to a state’s statutory scheme in that it signals a potential end to commitment. Each state provides annual or biennial reviews for committed persons.⁵³ These reviews are essential to the constitutionality of the commitment process because states cannot, consistent with due process, civilly detain persons “absent a determination in civil commitment proceedings of current mental illness and dangerousness.”⁵⁴ As such, most statutes allow committed persons to petition the court for conditional release if their mental condition or personality disorder has changed such that they are no longer likely to engage in predatory acts of sexual violence.⁵⁵ However, while successful treatment can provide the impetus for release, states impose no obligation to achieve treatment success for unwilling or untreatable offenders.⁵⁶

47. MINN. STAT. § 253B.03(10)(2).

48. 42 PA. CONS. STAT. § 6404; TEX. HEALTH & SAFETY CODE ANN. § 841.082(a)(4).

49. See MINN. STAT. § 253B.04 (stating that voluntary admission is preferred over involuntary commitment and treatment); NEB. REV. STAT. § 71-1202 (providing that it is the “public policy” of the state that dangerous sex offenders obtain voluntary treatment, but that if “voluntary treatment is not obtained, such persons shall be subject to involuntary custody and treatment”).

50. See, e.g., S.C. CODE ANN. § 44-48-170 (stating only that the treatment program must comply with constitutional requirements).

51. See, e.g., NEB. REV. STAT. § 71-1215–1216; 42 PA. CONS. STAT. § 6406; TEX. HEALTH & SAFETY CODE ANN. § 841.083(a); see also MINN. STAT. § 253B.045 (requiring that treatment providers take “reasonable measures to assure proper care and treatment of a [committed] person”).

52. See, e.g., ARIZ. REV. STAT. ANN. § 36-3701(F) (requiring monthly reports for offenders on conditional release to a less restrictive alternative); MASS. GEN. LAWS ch. 123A, § 16 (requiring annual reports describing the treatments offered); NEB. REV. STAT. § 71-1215–16 (requiring reports regarding the individual’s progress in treatment every ninety days for the first year and every six months thereafter); N.Y. MENTAL HYG. LAW § 10.11(b)(2) (requiring treatment reports every four months).

53. See, e.g., KAN. STAT. ANN. § 59-29a08 (requiring a current examination of the committed person’s mental condition once per year); TEX. HEALTH & SAFETY CODE ANN. § 841.102 (providing for biennial review); WIS. STAT. § 980.08(1) (allowing a review of confinement after twelve months).

54. *Foucha v. Louisiana*, 504 U.S. 71, 72 (1992); see *id.* at 79 (holding that, as a matter of due process, insanity acquittee is entitled to release when he has recovered his sanity or is no longer dangerous even if he continues to have an untreatable antisocial personality disorder); *id.* at 88 (O’Connor, J., concurring) (“I think it clear that acquittees could not be confined as mental patients absent some medical justification for doing so; in such a case the necessary connection between the nature and purposes of confinement would be absent.”).

55. See, e.g., CAL. WELF. & INST. CODE § 6605; IOWA CODE § 229A.7(5)(b); TEX. HEALTH & SAFETY CODE ANN. § 841.103(c). Some states allow release to a “less restrictive alternative” treatment program. See, e.g., ARIZ. REV. STAT. ANN. § 36-3707(B); IOWA CODE § 229A.8A (2); WASH. REV. CODE § 71.09.092.

56. See *In re Detention of Darling*, 712 N.W.2d 98, 101 (Iowa 2006) (“Chapter 229A does

States that fail to provide adequate treatment are subject to state-law causes of action.⁵⁷ However, courts have hesitated to pronounce a robust right to treatment given a lack of statutory guidance. For example, the Supreme Court of Iowa held that the “statutory right to treatment” was satisfied as long as “an individualized treatment program would be offered to [the committed person] in an attempt to improve his ability to control his deviant behaviors.”⁵⁸

In sum, although not expressly pronounced as a statutory “right” in most jurisdictions, treatment is a required part of every civil commitment program. Successful treatment promises to sex offenders an opportunity for release from commitment. Moreover, the statutory requirement of treatment is closely tied to the schemes’ constitutionality: without the nonpunitive aim of treatment, commitment would constitute additional penal incarceration in violation of substantive due process and the double jeopardy and ex post facto clauses of the Constitution.

B. Treatment as a Constitutional Right

In addition to the statutory requirement of treatment, I argue that treatment is a constitutional right for involuntarily committed persons. Although the Supreme Court has never confirmed a constitutional right to treatment,⁵⁹ the right for individuals to participate meaningfully in treatment is implicit in the involuntary (implicating substantive due process concerns) and purportedly civil (implicating ex post facto and double jeopardy concerns) nature of the civil commitment system.⁶⁰ This Section addresses the interplay of treatment

not require that the treatment will ultimately be successful as a prerequisite for commitment.”); see also CAL. WELF. & INST. CODE § 6606(b) (“Treatment does not mean that treatment be successful . . . nor does it mean that the person must recognize his or her problem and willingly participate.”).

57. *Seling v. Young*, 531 U.S. 250, 265 (2001) (explaining that where the commitment law gives committed persons the right to adequate care and individualized treatment, it is for the state courts to determine whether the commitment centers are operating in accordance with state law and to provide a remedy).

58. *In re Detention of Betsworth*, 711 N.W.2d 280, 289 (Iowa 2006).

59. See *Hubbart v. Superior Court*, 969 P.2d 584, 602 (Cal. 1999) (finding that language in *Hendricks* “strongly suggests that there is no broad constitutional right of treatment for persons involuntarily confined as dangerous and mentally impaired, at least where no acceptable treatment exist[s] or where they cannot be successfully treated for their afflictions” (internal quotation marks omitted)). Cf. Elizabeth A. Weeks, Note, *The Newly Found “Compassion” for Sexually Violent Predators: Civil Commitment and the Right to Treatment in the Wake of Kansas v. Hendricks*, 32 GA. L. REV. 1261 (1998) (analyzing lower court decisions—including *Rouse v. Cameron*, 373 F.2d 451, 455–56 (D.C. Cir. 1966), *Wyatt v. Aderholt*, 503 F.2d 1305, 1306 (5th Cir. 1975), and *Cameron v. Walsh*, No. 95-10904, 1996 U.S. Dist. LEXIS 11691 (D. Mass. July 23, 1996)—that held civilly committed individuals have a constitutional right to treatment).

60. See Cantone, *supra* note 11, at 705; Pfaffenroth, *supra* note 26, at 2261; Douglas G. Smith, *The Constitutionality of Civil Commitment and the Requirement of Adequate Treatment*, 49 B.C. L. REV. 1383, 1384 (2008); see also David DePugh, *The Right to Treatment for Involuntarily Committed Sex Offenders in the Wake of Kansas v. Hendricks*, 17 BUFF. PUB. INT. L.J. 71, 82–84 (1998–1999) (espousing an Eighth Amendment cruel-and-unusual-punishment rationale for a right to treatment, based on *Robinson v. California*, 370 U.S. 660 (1962), and *Estelle v. Gamble*, 429

and substantive due process, ex post facto, and double jeopardy challenges to the civil commitment process. Ascertaining the constitutional boundary of a treatment right is particularly important because certain state statutes defer to this constitutional floor.⁶¹

As a matter of substantive due process, involuntary commitment severely curtails individual rights and, thus, is allowed only in “certain narrow circumstances.”⁶² The Court has found that civil detentions meet the requirements of substantive due process as long as the nature and duration of commitment bears some relationship to the objectives of confinement.⁶³ With regard to the statutory definition of a sexually violent predator, *Kansas v. Hendricks* held that civil commitment statutes satisfy substantive due process requirements where, as in the Kansas Sexually Violent Predator Act, they couple proof of dangerousness with the proof of some additional factor, such as a “mental illness” or “mental abnormality.”⁶⁴ With regard to treatment once an offender is committed, the Supreme Court has held that because an institutionalized person is wholly dependent on the state, the state has a “duty to provide certain services and care.”⁶⁵ Nonetheless, the Court grants the state “considerable discretion in determining the nature and scope of its responsibilities.”⁶⁶

In addition to substantive due process challenges, civil commitment schemes, which provide fewer procedural protections than mandated by the

U.S. 97 (1976)).

61. See, e.g., FLA. STAT. § 394.922 (“The long-term control, care, and treatment of a person committed under this part must conform to constitutional requirements.”); IOWA CODE § 229A.9 (same); N.H. REV. STAT. 135-E16 (same); S.C. CODE ANN. § 44-48-170 (same).

62. *Kansas v. Hendricks*, 521 U.S. 346, 357 (1997) (providing that, although freedom from restraint is at the core of the liberty interest protected by the Due Process Clause from arbitrary government action, in “certain narrow circumstances” states can civilly detain people who pose a danger to public health and safety because they are unable to control their behavior).

63. See, e.g., *Foucha v. Louisiana*, 504 U.S. 71, 80 (1992) (finding that continued civil confinement of an insanity acquittee became unconstitutional where the state could no longer show by clear and convincing evidence that the individual was both mentally ill and dangerous); *Jackson v. Indiana*, 406 U.S. 715, 738 (1972) (finding that the state was entitled to hold a person for being incompetent to stand trial only long enough to determine if he could be cured and become competent, otherwise the state was required to afford the protections constitutionally required in a civil commitment proceeding).

64. *Hendricks*, 521 U.S. at 358. In *Kansas v. Crane*, the Court clarified the *Hendricks* constitutional standard by requiring “proof of serious difficulty in controlling behavior” to commit a sexually violent predator civilly. 534 U.S. 407, 413 (2002).

65. *Youngberg v. Romeo*, 457 U.S. 307, 317 (1982) (holding that a severely mentally retarded person had a due process right to “training” minimally necessary to ensure his safety and freedom from shackling while institutionalized against his will); see also *Polite v. Liberty Behavioral Health Care, Inc.*, No. 2:07-cv-158, 2009 WL 2242626, at *4 (M.D. Fla. July 27, 2009) (“Contrary to the defendant’s argument that civil detainees at the FCCC do not have a federally protected right to treatment, the Fourteenth Amendment most certainly requires a State provide ‘minimally adequate or reasonable training’ to those involuntarily committed, civil detainees.” (quoting *Youngberg*, 457 U.S. at 319)).

66. *Youngberg*, 457 U.S. at 317.

criminal system, are subject to double jeopardy and ex post facto challenges alleging that they are not truly civil but rather a “camouflaged form of punishment.”⁶⁷

As a preliminary matter, criminal and civil laws serve different purposes and have different procedural requirements.⁶⁸ Criminal laws are retroactive in nature: they aim to punish for past acts and serve the goals of retribution, incapacitation, and deterrence.⁶⁹ Civil schemes are prospective in nature: they seek to prevent future harm and serve the civil goals of incapacitation and treatment.⁷⁰ Due to the deprivation of liberty involved, the criminal system requires unique procedural protections—the Fifth Amendment right against self-incrimination and double jeopardy; the Sixth Amendment right to trial by jury, to confront witnesses, and to the assistance of counsel; and a heightened burden of proof compared to that in civil proceedings.⁷¹

In determining the civil or criminal nature of commitment, the Supreme Court has given deference to a state legislature’s professed intent.⁷² For example, in *Allen v. Illinois*, the Court upheld an Illinois commitment as “essentially civil in nature” where the statute required the state to provide “care and treatment for persons adjudged sexually dangerous . . . in a facility set aside to provide psychiatric care”⁷³ and the record did not demonstrate that individuals—who could apply for release and would be discharged if found to be no longer dangerous—had been “confined under conditions incompatible with the State’s asserted interest in treatment.”⁷⁴

In *Kansas v. Hendricks*, the Court similarly deferred to legislative intent in finding that the Kansas commitment statute did not violate the Constitution’s double jeopardy provision or ban on ex post facto lawmaking.⁷⁵ The Court heavily relied on the Kansas legislature’s characterization of commitment as “civil” and its placement of the commitment statute within the probate code rather than the criminal code.⁷⁶ The *Hendricks* Court found that, because

67. See Todd M. Grossman, Comment, *Kansas v. Hendricks: The Diminishing Role of Treatment in the Involuntary Civil Confinement of Sexually Dangerous Persons*, 33 NEW ENG. L. REV. 475, 478 (1999).

68. *Ra*, *supra* note 4, at 350.

69. See *Allen v. Illinois*, 478 U.S. 364, 370 (1986); see also Grossman, *supra* note 67, at 477–78.

70. See *Allen*, 478 U.S. at 371 (explaining that if a law does not try to prevent past misdeeds, it is not criminal in nature); see also Grossman, *supra* note 67, at 478.

71. U.S. CONST. amends. V, VI.

72. See *Smith v. Doe*, 538 U.S. 84, 92 (2003) (stating that since the Court normally defers to the legislature’s stated intent, only the “clearest proof” will suffice to override legislative intent and prove the law punitive in nature); *Kansas v. Hendricks*, 521 U.S. 346, 361 (1997); *Allen*, 478 U.S. at 368.

73. *Allen*, 478 U.S. at 369 (quoting Illinois Sexually Dangerous Persons Act, ILL. REV. STAT. ch. 38, ¶ 105-8 (1985)) (internal quotations and punctuation omitted).

74. *Id.* at 373.

75. 521 U.S. 346 (1997).

76. *Id.* at 360–61.

nothing on the face of the statute suggested that the Kansas legislature sought to create anything other than a civil commitment scheme, the respondent (Hendricks) had to provide “the clearest proof” that the scheme was “so punitive in purpose or effect as to negate the State’s intention to deem it civil.”⁷⁷ The Court concluded that Hendricks failed to satisfy this heavy burden because neither the affirmative restraint nor the potentially infinite duration of commitment evinced a punitive purpose.⁷⁸

As a part of its analysis, the *Hendricks* Court found that a failure to offer legitimate treatment did not render the civil commitment statute punitive where treatment for a condition was not possible or where treatment was merely an ancillary, rather than an overriding, state concern.⁷⁹ The Court pointed out that Hendricks was the first person committed under the Kansas Act and that the state did not have all of its treatment procedures in place.⁸⁰ In the opinion of many observers, this aspect of the *Hendricks* decision eroded sex offenders’ right to treatment by signaling that civil commitment laws are constitutional as long as they provide some degree of treatment, even if treatment is not provided in every case or is not the primary goal of the commitment.⁸¹

Justice Kennedy, as the swing vote, wrote a short concurrence emphasizing that treatment underlies the civil nature of involuntary confinement and that treatment must be more than “mere pretext”:

77. *Id.* at 361 (quoting *United States v. Ward*, 448 U.S. 242, 248–49 (1980)) (internal quotations omitted). As a threshold matter, the Court explained that the civil commitment statute did not implicate retribution or deterrence, the two primary objectives of criminal punishment. *Id.* at 361–62. The statute’s purpose was not retributive because it did not affix culpability for prior criminal conduct (rather, prosecutors introduced past criminal history to support a finding of mental abnormality or dangerousness); it did not make criminal conviction a prerequisite for commitment; and it lacked a scienter requirement, an important element in distinguishing between criminal and civil statutes. *Id.* at 362. Nor did the statute operate as a deterrent because the threat of confinement was unlikely to deter individuals who suffer from mental abnormalities that prevent them from controlling their behavior. *Id.* at 362–63.

78. According to the Court, affirmative restraint did not evince punitive intent because the affirmative restraint of mentally ill and dangerous persons had been historically regarded as a legitimate nonpunitive objective. *Id.* at 363. Moreover, the potentially infinite duration of confinement corresponded with the purpose of holding a person until his mental abnormality no longer caused him to be a threat to others and did not implicate any punitive objective. *Id.* at 363–64.

79. *Id.* at 365–66.

80. *Id.* at 367–68.

81. See Steven I. Friedland, *On Treatment, Punishment, and the Civil Commitment of Sex Offenders*, 70 U. COLO. L. REV. 73, 112 (1989) (“[T]he Court no longer had to examine the circumstances of a commitment to determine whether the law met the treatment minimum; it could now simply look at the face of the law.”); Erich H. Gaston, *Kansas v. Hendricks: The Court’s Unworkable Constitutional Standards and Flawed Analysis Threaten Freedom*, 2 QUINNIPIAC HEALTH L.J. 227, 251 (1999) (“A particular danger is that *Hendricks* implies that treatment has little if any bearing on whether a state’s decision to civilly commit a person comports with due process.”); Grossman, *supra* note 67, at 503 (“[A]fter the *Hendricks* decision, courts are now free to apply a much more lenient standard than that which was previously required to satisfy due process.”).

A law enacted after commission of the offense and which punishes the offense by extending the term of confinement is a textbook example of an *ex post facto* law. If the object or purpose of the Kansas law had been to provide treatment but the treatment provisions were adopted as a sham or mere pretext, there would have been an indication of the forbidden purpose to punish.⁸²

The *Hendricks* dissent went further, suggesting that a civil scheme that requires treatment yet systematically denies access to treatment violates both substantive due process and the Constitution's *ex post facto* clause.⁸³ According to Justice Breyer, if Kansas's law were truly civil, the legislature would be seeking to help individuals overcome their mental abnormalities, at least insofar as treatment for the abnormality existed and was potentially helpful.⁸⁴

Thus, the provision of treatment is essential to the constitutionality of the civil commitment scheme. Yet, despite the importance of treatment, the Supreme Court has whittled away the offender's ability to challenge treatment conditions.⁸⁵ In *Seling v. Young*, the petitioner-committee maintained that the conditions at Washington State's commitment center were incompatible with the treatment required by the state's civil commitment statute.⁸⁶ Reversing the Ninth Circuit's opinion, the *Young* Court explained that the petitioner could not challenge the statute as applied to his particular case because, if courts allowed such individual challenges, they could never conclusively determine whether a particular scheme on its face was punitive in violation of the double jeopardy and *ex post facto* clauses.⁸⁷ The Court underscored that, although barred from as-applied challenges, petitioners could challenge the conditions and treatment regime at the commitment center through other means: a state cause of action if the treatment center failed to fulfill its statutory duty, a § 1983 civil rights action alleging unconstitutional deprivations in the conditions of confinement,

82. *Hendricks*, 521 U.S. at 371 (Kennedy, J., concurring).

83. *Id.* at 378 (Breyer, J., dissenting). Breyer concluded that the Kansas scheme, which conceded *Hendricks*'s condition was treatable but delayed such treatment until *Hendricks* completed his prison term—so that further incapacitation was therefore necessary—and provided only inadequate treatment thereafter, was not tailored “to fit the nonpunitive civil aim of treatment.” *See id.* at 396 (Breyer, J., dissenting).

84. *Id.* at 382–83.

85. *Seling v. Young*, 531 U.S. 250 (2001).

86. *Id.* at 260.

87. *Id.* at 263; *see also id.* at 263–64 (“Permitting respondent's as-applied challenge would invite an end run around the Washington Supreme Court's decision that the Act is civil in circumstances where a direct attack on that decision is not before this Court.”). In the *Young* dissent, Justice Stevens argued that courts should consider conditions of confinement in as-applied challenges in order to gain “full knowledge of the effects of the statute.” *Id.* at 277 (Stevens, J., dissenting). According to Stevens, if *Young*'s allegations—concerning both the absence of treatment and the starkly punitive character of the conditions of his confinement—were correct, the statute should have been characterized as a criminal law for federal constitutional purposes. *Id.*

or a facial challenge to the statute.⁸⁸ In sum, substantive due process requires that the nature of commitment, including treatment, bear some relationship to the objectives of the commitment. Ex post facto and double jeopardy prohibitions are implicated where a lack of treatment renders a purportedly civil scheme unconstitutionally punitive. Yet, the constitutional right to treatment is limited in scope due to the deference courts grant to the legislature's stated intent and to the *Young* decision that restricted the avenues available for individuals to challenge their commitments.

Because civil commitment schemes cannot, under statute and the Constitution, hold sex offenders once treatment renders them no longer dangerous or no longer in possession of a mental abnormality,⁸⁹ it would seem that treatment is a gateway to release. Yet, as Part III observes, treatment fails to open gateways because few, if any, sexually violent predators are ever released from commitment. Even more shockingly, treatment ostensibly closes gateways because prosecutors use treatment records to create the proof necessary for continued confinement.

III.

THE REALITY OF TREATMENT

In practice, states provide inadequate treatment services and make it exceedingly difficult for committed persons to obtain release from civil commitment. Rather than enable the offender to overcome his sexual deviancy, treatment often engenders further confinement by providing the prosecution with incriminating records.

The disclosure of treatment records in civil commitment proceedings violates neither the doctrine of privilege nor the defendant's constitutional right to privacy. Courts and statutes provide several justifications for overriding the psychotherapist-patient privilege and for admitting treatment-related testimony as relevant evidence in civil commitment proceedings. First, some courts have found that a psychotherapist-patient privilege never attaches in sex offender treatment because medical examinations are not intended to be confidential.⁹⁰

88. *Id.* at 265–67. The Court referred to a pending § 1983 action that would address the conditions of confinement at the Washington facility. *Id.* at 265–66. The Court noted:

The [Special Commitment] Center operates under an injunction that requires it to adopt and implement a plan for training and hiring competent sex offender therapists; to improve relations between residents and treatment providers; to implement a treatment program for residents containing elements required by prevailing professional standards; to develop individual treatment programs; and to provide a psychologist or psychiatrist expert in the diagnosis and treatment of sex offenders to supervise the staff.

Id. at 266.

89. *Foucha v. Louisiana*, 504 U.S. 71, 79 (1992) (holding that the continued detention of an insanity acquittee is “improper absent a determination in civil commitment proceedings of current mental illness and dangerousness”).

90. *See, e.g., People v. Martinez*, 105 Cal. Rptr. 2d 841 (Ct. App. 2001); Appeal in Pima

Second, some courts hold that, while the privilege attaches, testimony of sex offenders' therapists falls within an exception for communications relevant to proceedings to compel hospitalization for mental illness.⁹¹ This also applies to involuntary treatment.⁹² Finally, many civil commitment statutes expressly override the statutory privilege, if applicable, by specifying that all relevant evidence is admissible.⁹³

In addition to the inapplicability of state privilege, offenders do not have a constitutionally protected expectation of privacy in their treatment records. In the case of civil commitment—where the need to protect the public is great and the disclosure limited—the governmental interest in obtaining information outweighs the individual's privacy interest.⁹⁴ Moreover, sexually violent predator evaluations fall within two established exceptions to the confidentiality of medical communications: the exception for public health and safety, and the exception for communications made to a physician for a potential adversary's purpose rather than for curative treatment.⁹⁵

Thus, unprotected by privilege or privacy, treatment records and treatment-provider testimony constitute admissible evidence in civil commitment proceedings. This Part discusses the use of discoverable treatment records at each stage of the civil commitment process, the ensuing treatment disincentive, and the societal effect of the treatment disincentive.

A. Treatment Records Play a Critical Role in Civil Commitment Hearings

Prosecutors, experts, and fact-finders consider sex-offender treatment records at nearly every step of the sex offender civil commitment process, a consistent practice among states.⁹⁶ The assessment process usually begins six to

Cnty. Mental Health Case, 721 P.2d 142, 144 (Ariz. Ct. App. 1986).

91. See, e.g., *Trovillo v. State*, 953 So. 2d 637 (Fla. Dist. Ct. App. 2007); *People v. Dist. Court, Cnty. of Adams*, 797 P.2d 1259 (Colo. 1990).

92. See *In re Deville*, 610 So. 2d 1070 (La. Ct. App. 1992) (finding physician-patient privilege did not apply to bar admission of mental patient's medical records and oral testimony of treating physician in judicial commitment proceeding where the court ordered continued confinement and treatment of the patient).

93. See, e.g., MASS. GEN. LAWS ch. 123A, § 9:

Evidence of the person's juvenile and adult court and probation records, psychiatric and psychological records, the department of correction's updated annual progress report of the petition, . . . and any other evidence that tends to indicate that he is a sexually dangerous person shall be admissible in a hearing under this section.

See also N.H. REV. STAT. § 135-E:10(I); S.C. CODE ANN. § 44-48-140; *In re Civil Commitment of A.H.B.*, 898 A.2d 1027 (N.J. Super. Ct. App. Div. 2006); *Albertson v. Super. Court*, 107 Cal. Rptr. 2d 381 (Ct. App. 2001) (addressing updated evaluations in CAL. WELF. & INST. CODE § 6603(c)).

94. *Seaton v. Mayberg*, 610 F.3d 530, 534-35 (9th Cir. 2010).

95. *Id.*

96. Jill S. Levenson & John W. Morin, *Factors Predicting Selection of Sexually Violent Predators for Civil Commitment*, 50 INT'L J. OFFENDER THERAPY & COMP. CRIMINOLOGY 609, 610 (2006).

twelve months prior to an offender's release from prison. The responsible department screens incarcerated sex offenders for risk factors and refers inmates who appear to be most dangerous for a face-to-face expert evaluation by a licensed psychologist or psychiatrist.⁹⁷ Following the expert evaluation, a prosecutor reviews the files of those individuals assessed to meet the criteria for commitment and determines if sufficient evidence exists to file a petition for a probable cause hearing.⁹⁸ If the court finds probable cause, the offender receives a trial, at which a judge or jury determines whether the offender meets the criteria for a "sexually violent predator."⁹⁹

In most states, committed individuals are confined indefinitely with yearly evaluations until they are no longer considered dangerous to the community.¹⁰⁰ The majority of states require that sexually violent predators serve their commitment time in secure inpatient facilities. Arizona, Illinois, and Minnesota hospitalize some sexually violent predators when necessary but emphasize community treatment programs.¹⁰¹ Texas is the only state that conditionally releases sexually violent predators to outpatient treatment, where they are subject to polygraphs, penile plethysmograph,¹⁰² and global positioning system (GPS) monitoring, and are under the supervision of a case manager.¹⁰³

Expert evaluations play a critical role in the sex offender civil commitment process. Not only do expert psychologists conduct the initial evaluation, but they also testify at trial regarding two of the three statutory requirements for sexually-violent-predator commitments: the respondent's alleged mental disorder and the likelihood he will engage in future acts of sexually harmful conduct.¹⁰⁴ The final element—a past sexually violent offense—is usually not contested at trial because each state has formulated statutes that list which acts constitute sexually violent offenses and, typically, the screening committee only refers offenders who have been convicted of such offenses to the commitment process.¹⁰⁵

97. *Id.*

98. *Id.*

99. *Id.*

100. *Id.*; NIETO, *supra* note 35, at 3–4, 7–8; ROXANNE LIEB & SCOTT MATSON, SEXUAL PREDATOR COMMITMENT LAWS IN THE UNITED STATES: 1998 UPDATE 4–9 (1998), available at http://www.wsipp.wa.gov/rptfiles/sexcomm_98.pdf (detailing variation between states).

101. NIETO, *supra* note 35, at 3.

102. The penile plethysmograph measures changes in blood flow in the penis. For sexual offenders, it is typically used to determine the level of sexual arousal as the subject is exposed to sexually suggestive content, such as pictures, movies, or audio. It has been demonstrated to be one of the most accurate methods for identifying which sexual offenders will go on to commit sexual crimes against children. See R. Karl Hanson & M.T. Bussière, *Predicting Relapse: A Meta-Analysis of Sexual Offender Recidivism Studies*, 66 J. CONSULTING & CLINICAL PSYCHOL. 348 (1998).

103. NIETO, *supra* note 35, at 4.

104. See *supra* text accompanying note 24.

105. See Rebecca L. Jackson & Derek T. Hess, *Evaluation for Civil Commitment of Sex Offenders: A Survey of Experts*, 19 SEX ABUSE: J. RES. & TREATMENT 425, 428 (2007).

Treatment records—including completion of treatment, treatment failure, or refusal to participate in treatment—heavily affect the expert’s evaluations and testimony.¹⁰⁶ To determine future dangerousness, expert psychologists utilize actuarial instruments such as the Rapid Risk Assessment for Sex Offense Recidivism (RRASOR),¹⁰⁷ the Static-99,¹⁰⁸ or the Minnesota Sex Offender Screening Tool-Revised (MnSOST-R).¹⁰⁹ Each of these instruments utilizes mainly “static” (unchangeable) risk factors.¹¹⁰ In the MnSOST-R, treatment history is one of the sixteen items that affect the expert’s assessment of whether a sex offender meets the statutory requisites for civil commitment.¹¹¹ In addition to looking at static risk factors and assessment by actuarial instrument, evaluators often assess “dynamic” variables, such as criminal attitudes, social influence, and hostility, which may be documented in treatment records.¹¹² Evaluators are also influenced by some factors that are not empirically based but which incite strong emotional reactions. For example, evaluators invariably recommend for commitment offenders who articulate during treatment that they would commit another sexually violent act if released.¹¹³

Rebecca Jackson and Derek Hess observed that states require expert

106. Eric S. Janus, *Minnesota’s Sex Offender Commitment Program: Would an Empirically-Based Prevention Policy Be More Effective*, 29 WM. MITCHELL L. REV. 1083, 1122–23 (2003) (“In these processes, treatment failure is viewed as increasing the risk of sexual recidivism and suitability for commitment, while treatment success decreases these concerns. Non-entry into treatment, on the other hand, is seen as neutral, neither increasing nor decreasing risk.”).

107. The RRASOR, developed by Dr. Hanson, consists of four items: (1) having prior sex offenses, (2) having a male victim, (3) having an unrelated victim, and (4) being between the ages of eighteen and twenty-five years old. DENNIS M. DOREN, *EVALUATING SEX OFFENDERS: A MANUAL FOR CIVIL COMMITMENTS AND BEYOND* 123–24 (2002).

108. In addition to the RRASOR’s four items, the other items on the Static-99 include (1) number of sentencing occasions, (2) conviction for noncontact sexual offense, (3) conviction for nonsexual violent offense at same time as index sexual offense, (4) conviction for nonsexual violent offense prior to index sexual offense, (5) any stranger victim to sexual offense, and (6) if the offender ever lived with a lover for two consecutive years. *Id.* at 125–27; ANDREW HARRIS, AMY PHENIX, R. KARL HANSON, & DAVID THORNTON, *STATIC-99 CODING RULES, REVISED* (2003), available at http://www.publicsafety.gc.ca/res/cor/rep/_fl/2003-03-stc-cde-eng.pdf.

109. The sixteen MnSOST-R items are (1) number of sex-related convictions, (2) length of sexual offending history, (3) having been under supervision when committing a charged sexual offense, (4) having committed a charged sexual offense in a public place, (5) having used force within any charged sexual offense, (6) having done multiple acts on a single victim within a charged sexual offense, (7) number of victim age groups for charged sexual offenses, (8) history of victimizing thirteen- to fifteen-year olds within any charged sexual offense, (9) stranger victim within charged sexual offense, (10) evidence of adolescent antisocial behavior by offender, (11) history of drug or alcohol abuse, (12) employment history, (13) discipline history while incarcerated, (14) chemical dependency treatment while incarcerated or on release, (15) sex offender treatment while incarcerated or on release, and (16) age of the offender. DOREN, *supra* note 107, at 127–31.

110. Jackson & Hess, *supra* note 105, at 428.

111. See MnSOST-R items, *supra* note 109.

112. Miller, Amenta & Conroy, *supra* note 24, at 44–45.

113. Jill S. Levenson, *Sexual Predator Civil Commitment: A Comparison of Selected and Released Offenders*, 48 INT’L J. OFFENDER THERAPY & COMP. CRIMINOLOGY 638, 645 (2004).

examinations to determine whether an offender meets statutory criteria, yet no state provides clear guidance or standards for the expert's conduct.¹¹⁴ Hence, the researchers undertook a survey of experts who conduct sex offender civil commitment evaluations with the aim of identifying the "usual practice" of these evaluators.¹¹⁵ Table 1 reproduces their findings with regard to the importance of documentation—including reports, evaluations, and records—in conducting civil commitment evaluations. Jackson and Hess asked respondents to report the degree of importance for each source on which they relied by rating the document as essential, recommended, optional, irrelevant, or contraindicated. The results show that sex offender specific-treatment records (80.5% essential) were most essential to the evaluation, followed by police reports (78%), institutional records (75.6%), mental-health treatment records (53.7%), victim reports (53.7%), and pre-sentence evaluations (51.2%). The majority of respondents considered all other forms of documentation as either recommended or optional.

Table 1: Use of Documents in Civil Commitment Evaluations¹¹⁶

	Essential	Recommended	Optional	Irrelevant	Contraindicated
Victim reports	53.7% (22)	43.9% (18)	2.4% (1)	0% (0)	0% (0)
Police reports	78% (32)	22% (9)	0% (0)	0% (0)	0% (0)
Previous psychological evaluations	41.5% (17)	56.1% (23)	2.4% (1)	0% (0)	0% (0)
Pre-sentence evaluations	51.2% (21)	48.8% (20)	0% (0)	0% (0)	0% (0)
Institutional records	75.6% (31)	22% (9)	2.4% (1)	0% (0)	0% (0)
Mental health treatment records	53.7% (22)	41.5% (17)	4.9% (2)	0% (0)	0% (0)
Sex offender specific treatment records	80.5% (33)	19.5% (8)	0% (0)	0% (0)	0% (0)
Juvenile records	34.1% (14)	61% (25)	4.9% (2)	0% (0)	0% (0)
School records	7.3% (3)	53.7% (22)	34.1% (14)	4.9% (2)	0% (0)
Military records	4.9% (2)	51.2% (21)	36.6% (15)	7.3% (3)	0% (0)
Employment records	7.3% (3)	51.2% (21)	39% (16)	2.4% (1)	0% (0)
Medical records	22% (9)	56.1% (23)	22% (9)	0% (0)	0% (0)
Criminal trial transcripts	19.5% (8)	41.5% (17)	39% (16)	0% (0)	0% (0)

Not only are sex offender treatment records the most relied-upon documentation, but they also play a critical role at each stage of the commitment process. Specifically, experts evaluate the respondent and decide whether to refer him for civil commitment; testify at the initial commitment trial; and, if the individual is committed, evaluate the respondent and testify at each and every hearing for release.

114. Jackson & Hess, *supra* note 105, at 429.

115. *Id.*

116. *Id.* at 431 tbl.2, copyright © 2007 by SAGE Publications. Reprinted by Permission of SAGE Publications.

Treatment records may exist at the time of the initial commitment hearing because many state correctional systems either require or provide incentives for sex offenders to participate in prison-based specialized sex offender treatment programs before they are paroled to the community.¹¹⁷ Thirty-four states offer specialized sex offender treatment for incarcerated persons. Of the programs offered by these states, twenty-eight are at least one year long, including eight programs that last more than three years.¹¹⁸ Eighteen of the programs include components designed to facilitate an inmate's transition back to the community.¹¹⁹ Some states, including California, do not currently provide prison-based sex offender treatment.¹²⁰ Once an individual is committed to a state institution, all states with civil commitment programs offer or require treatment.¹²¹

Finally, judges and juries are extremely deferential to expert evaluations. In practice, commitment hearings tend to be "non-adversarial episodes" in which judges appear to "rubber stamp" the recommendations of clinical expert witnesses.¹²² Studies show that judicial agreement with expert witnesses ranges from 79 to 100 percent and most frequently exceeds 95 percent.¹²³ Hence, treatment records, as incorporated into the expert's evaluation and presented to the judge or jury as determinative, strongly affect an offender's chances of release.

Although this Section focuses primarily on the use of treatment records by expert evaluators and witnesses, screening committees also take treatment records into account when choosing whether to refer an offender for evaluation,¹²⁴ and prosecutors consider treatment indicators when determining

117. See NIETO, *supra* note 35, at 11–20. For a discussion of whether prison-based sexual offender treatment implicates the offender's Fifth Amendment right against self-incrimination, see David Heim, Note, *Damned if You Do, Damned if You Don't: Why Minnesota's Prison-Based Sex Offender Treatment Violates the Right Against Self Incrimination*, 32 WM. MITCHELL L. REV. 1217 (2006), and Brendan J. Shevlin, Note, "[B]etween the Devil and the Deep Blue Sea:" A Look at the Fifth Amendment Implications of Probation Programs for Sex Offenders Requiring Mandatory Admissions of Guilt, 88 KY. L.J. 485 (2000).

118. NIETO, *supra* note 35, at 11 (citing COLO. DEP'T OF CORRECTIONS, STATE SEX OFFENDER TREATMENT PROGRAMS: A 50 STATE SURVEY (2000)).

119. *Id.* at 16.

120. *Id.* at 49–50 (suggesting that the California Department of Corrections and Rehabilitation should create a prison treatment program that would include development of sex offender treatment guidelines).

121. See *supra* Part II.A.

122. WINICK, *supra* note 1, at 143 (2005) (discussing commitment of mentally disordered offenders and sexually violent predators generally).

123. *Id.* (citing Norman G. Polythress, *Mental Health Expert Testimony: Current Problems*, 5 J. PSYCHIATRY & L. 201, 213 tbl.2 (1977)); see also Eric S. Janus & Robert A. Prentky, *Forensic Use of Actuarial Risk Assessment with Sex Offenders: Accuracy, Admissibility, and Accountability*, 40 AM. CRIM. L. REV. 1443, 1448–49 (2003) (finding that frequently the liberty-deprivation decision comes to a credibility judgment between the clinical assessments of two competing expert witnesses).

124. See, e.g., N.H. REV. STAT. § 135-E:15(I) ("In order to protect the public, relevant

whether to file a probable-cause petition.¹²⁵ Thus, disclosures made in sex offender treatment, as well as professional assessments about performance in treatment, play a key role in referrals for commitment, the initial commitment case, and post-commitment hearings.

B. Current Legislative Schemes Give Sex Offenders a Strong Incentive to Refuse Treatment

The use of treatment records at every stage of the civil commitment and post-commitment process is not necessarily a bad thing. Theoretically, treatment records could help offenders prove they are fit for release, for example, by showing that they are no longer dangerous due to successful treatment. Moreover, inclusion of treatment records at trial arguably ensures the constitutionality of civil commitment proceedings by encouraging fact-finders to base their determination on *present* dangerousness or a *current* mental abnormality, as reflected in the recent treatment reports, rather than penalizing offenders for past sexual transgressions (which would render commitment unconstitutionally punitive). However, this Section observes that, on balance, the discoverability of treatment records does more harm than good by discouraging sex offenders from participation in treatment and disadvantaging those who do participate.

Sex offenders have a strong incentive to refuse treatment for three reasons: (1) during treatment, participants must confess to additional crimes or admit guilt to sexual transgressions and these admissions may be used against the participant in future court proceedings; (2) failure to complete treatment weighs in favor of commitment; and (3) completion of treatment does not correlate with release from commitment. These three reasons are discussed in more detail below.

1. Treatment Records May Be Used in Furtherance of Commitment

The treatment process requires that the offender admit guilt, accept responsibility, and produce other incriminating documentation.¹²⁶ Most treatment providers agree that successful treatment necessitates disclosure of past offenses and “a careful analysis of the thoughts, feelings and decisions which preceded past offenses.”¹²⁷ Moreover, entry into the treatment program, itself, generally requires offenders to admit responsibility for the offense

information and records that are otherwise confidential or privileged shall be released to the agency with jurisdiction, to a multidisciplinary team, or to the county attorney or attorney general for the purpose of meeting the notice requirements of this chapter and determining whether a person is or continues to be a sexually violent predator.”); *see also* FLA. STAT. § 394.913(2); MINN. STAT. § 253B.07(1)(b).

125. Janus, *supra* note 106, at 1122.

126. Anita Schlank & Rick Harry, *The Treatment of the Civilly Committed Sex Offender in Minnesota: A Review of the Past Ten Years*, 29 WM. MITCHELL L. REV. 1221, 1224 (2003).

127. *Id.* (citing *McKune v. Lile*, 536 U.S. 24 (2002)).

underlying the conviction.¹²⁸

Texas, for example, provides sexually violent predators with a five-stage treatment program monitored by polygraph at each stage. In Stage 1, offenders must accept responsibility for their acts and learn to control their aggression.¹²⁹ This requires admitting guilt, with the confession's veracity confirmed by polygraph examination. In Stage 2, offenders detail their sexual histories and pass a polygraph to ensure the history's accuracy.¹³⁰ Honest reflection regarding sexual arousal and sexual behaviors helps to facilitate the offender's self-confidence and self-worth. Stage 3 focuses on the offense cycle and adaptive behaviors; this requires cataloguing and confirming by polygraph the actual events, feelings, and plans that the sex offender goes through prior to offenses.¹³¹ Stage 4 focuses on positive sexuality and relationship issues.¹³² A penile plethysmograph is used to identify the sex offender's sexual preferences, which are then explored and dealt with in treatment through behavioral interventions. Stage 5 involves relapse prevention and intimacy. Offenders learn to avoid situations in which they might reoffend and prepare for release into the community.¹³³ Texas's program—including treatment phases, admission of guilt, construction of a sexual history, and use of polygraphs—resembles other state treatment programs.¹³⁴ Offenders who refuse to admit and accept responsibility for past offenses are declared unamenable to treatment and are rejected from the treatment program.¹³⁵

Everything that an offender confesses during these multiple stages of treatment—including sexual fantasies, uncharged offenses, and gruesome details regarding sexual offenses—is discoverable. Because treatment records provide “excellent sources of information about prior acts,” prosecutors teach each other to obtain otherwise private treatment data as part of the pre-petition review to

128. Anita M. Schlank & Theodore Shaw, *Treating Sexual Offenders Who Deny Their Guilt: A Pilot Study*, 8 SEXUAL ABUSE: J. RES. & TREATMENT 17, 18 (1996).

129. Walter J. Meyer, III, et al., *Outpatient Civil Commitment in Texas for Management and Treatment of Sexually Violent Predators: A Preliminary Report*, 47 INT'L J. OFFENDER THERAPY & COMP. CRIMINOLOGY 396, 401-02 (2003).

130. *Id.*

131. *Id.*

132. *Id.*

133. *Id.*

134. See, e.g., CAL. DEP'T OF MENTAL HEALTH, COALINGA STATE HOSPITAL: MODEL SEX OFFENDER TREATMENT, http://www.dmh.ca.gov/Services_and_Programs/State_Hospitals/Coalinga/Treatment.asp (last visited Nov. 19, 2009) (listing California's sex offender treatment components); DENIS PROUTY, IOWA LEGISLATIVE SERVICES AGENCY FISCAL SERVICES: SEXUAL PREDATOR COMMITMENT PROGRAM 3 (2006) (explaining Iowa's five-phase program); ASS'N OF STATE CORR. ADM'RS' PUBL'N, CORRECTIONAL BEST PRACTICES: DIRECTORS' PERSPECTIVES (2000), <http://www.drc.state.oh.us/web/Articles/article61.htm> (discussing Ohio's sex offender treatment program).

135. Heim, *supra* note 117, at 1223; see also, e.g., Johnson v. Fabian, 711 N.W.2d 540, 543 (Minn. Ct. App. 2006) (explaining that the sex offender treatment program requires the offender to admit his offense and to discuss its specifics before being admitted to treatment, and that refusal to discuss the offense was considered a disciplinary violation).

determine whether to proceed with a commitment.¹³⁶ Public defenders often advise sex offenders not to partake in treatment because nonparticipation will “increase their chance of being unconditionally released, or not committed at all.”¹³⁷ Offenders echo this concern, refusing to enter treatment because “their attorney advises them not to [participate]” and because “if they enroll, their written treatment assignments, assessments, and progress notes will be subpoenaed by the courts and used to prove they continue to need inpatient detainment and treatment.”¹³⁸

2. Treatment Failure, More than Non-Participation, Increases the Likelihood of Commitment

The second treatment disincentive arises from the fact that treatment status, and in particular non-completion of treatment, affects whether an individual will be referred for commitment and ultimately committed.¹³⁹ Treatment success or failure is an item in the Minnesota Sex Offender Screening Tool-Revised.¹⁴⁰ In the MnSOST-R calculations, treatment failure is viewed as increasing the risk of sexual recidivism and suitability for commitment, while treatment success decreases these concerns.¹⁴¹ Non-entry into treatment, on the other hand, is seen as neutral, neither increasing nor decreasing risk.¹⁴²

Because sex offender treatment programs have significant failure rates and offenders do not know in advance whether they will complete treatment successfully, an offender “might conclude that the safest bet is to avoid treatment altogether.”¹⁴³

136. Janus, *supra* note 106, at 1125 (quoting Janice M. Allen, *Meeting Standards for Commitment Under the Psychopathic Personalities Statute: Petitioner's Perspective*, in *PSYCHOPATHIC PERSONALITIES AND SEXUALLY DANGEROUS PERSONS 2* (Minn. Inst. Legal Educ. 1995)).

137. DEIRDRE M. D'ORAZIO ET AL., *THE CALIFORNIA SEXUALLY VIOLENT PREDATOR STATUTE: HISTORY, DESCRIPTION & AREAS FOR IMPROVEMENT 27* (2009), available at <http://ccoso.org/papers/CCOSO%20SVP%20Paper.pdf>.

138. *Id.*; see also WASH. STATE INST. FOR PUB. POLICY, *SEX OFFENDER SENTENCING IN WASHINGTON STATE: WHO PARTICIPATES IN THE PRISON TREATMENT PROGRAM 3* (2006) (“[T]he law authorizing civil commitment of sexually violent offenders could motivate some sex offenders to decline participation because revelations during their treatment about additional victims or violence could later be used as reasons for the state to file a Sexually Violent Predator petition.”); Mareva Brown, *Special Report: Sexual Predators Evading Treatment*, SACRAMENTO BEE, Feb. 12, 2006, at A1 (“Some Atascadero offenders list the court trials among their justifications for shunning therapy: They fear information from those sessions could arise in their hearings[.]”).

139. See Janus, *supra* note 106, at 1124.

140. See *supra* note 109 and accompanying text.

141. DOREN, *supra* note 107, at 127–31.

142. *Id.*

143. See Janus, *supra* note 106, at 1124.

3. Treatment Completion Provides No Positive Incentive for Participation

Not only does an offender's poor performance in treatment harm his chance of release, but good performance in treatment provides no countervailing positive incentive to participate. Very few individuals—approximately 0.9 to 4 percent of those committed—are ever released from inpatient commitment facilities,¹⁴⁴ the result being that “[c]ivil commitment for sexual dangerousness is, as a practical matter, a life sentence.”¹⁴⁵

Because states are not releasing sexually violent predators, including those who complete the entire institutional treatment program, patients perceive no benefit in participating in sex offender treatment.¹⁴⁶ In addition, sexually violent offenders feel disillusioned by a system that provides no way out and are reticent to take part in any aspect of the system, including treatment.¹⁴⁷ Offenders believe that “participating in treatment legitimizes a system they feel unfairly and illegally keeps them incarcerated after they have completed their prison sentences.”¹⁴⁸ This frustration with the system “may actually produce feelings of worthlessness and loss of dignity, exacerbating the mental illness and perhaps even fostering a form of learned helplessness that can further

144. According to 2008 data, only twenty-eight of the 3,200 civilly committed offenders (0.88 percent) from responding states had been discharged through treatment, with an additional two persons to be discharged by the end of the year; six states had not released a single individual. REBECCA JACKSON, TARA TRAVIA, JENNIFER SCHNEIDER, SOCCPN ANNUAL SURVEY OF SEX OFFENDER CIVIL COMMITMENT PROGRAMS 32 (2008). According to a Washington State report, of the 4,534 persons committed or held for evaluation as sexually violent predators nationwide, only 494 had been discharged or released, and only 188—or 4 percent—of those under program staff recommendation. WSIPP, *supra* note 25, at 3–4. A 2007 *New York Times* investigation reported that only 1.7 percent of committed sex offenders have been recommended for release:

Nearly 3,000 sex offenders have been committed since the first law passed in 1990. In 18 of the 19 states, about 50 have been released completely from commitment because clinicians or state-appointed evaluators deemed them ready. Some 115 other people have been sent home because of legal technicalities, court rulings, terminal illness or old age.

Davey & Goodnough, *supra* note 27, at A1.

145. Memorandum from Amy Baron-Evans & Sara Noonan to Defenders, CJA Counsel 1 (Sept. 10, 2007, as revised Sept. 25, 2007), *available at* http://www.fd.org/pdf_lib/Adam.Walsh.III.REV.9.24.07.FINAL.pdf. *See also* Jenny Roberts, *The Mythical Divide Between Collateral and Direct Consequences of Criminal Convictions: Involuntary Commitment of “Sexually Violent Predators”*, 93 MINN. L. REV. 670, 707 (2008).

146. D’ORAZIO ET AL., *supra* note 137, at 27 (listing as one of the six reasons that California sexually violent predators give for refusing treatment: “the likelihood of release is greater for those who are not in the treatment program”). Even more, treatment participation may, counterintuitively, harm an offender upon release: “the few offenders who actually follow the hospital’s full program find themselves not only targets of scorn inside Atascadero but subject to both tighter scrutiny and protests upon release.” Brown, *supra* note 138.

147. D’ORAZIO ET AL., *supra* note 137, at 27 (acknowledging that one reason California sexually violent predators give for nonparticipation in treatment is that “the treatment program is a hoax. . . . [and] the real goal of the SVP statute is to keep them locked up forever and the treatment program is a facade that covers a desire for indefinite commitment”).

148. Brown, *supra* note 138 (“Everyone says, ‘Don’t do the treatment, it’s a major trap,’ said former Atascadero patient Cary Verse. ‘They feel that if everybody would not do it the program would fall apart.’”).

diminish performance, motivation, and mood in ways that can be antitherapeutic.”¹⁴⁹

Thus, sex offenders have a strong incentive to refuse treatment because discoverable treatment records and failure to complete treatment have an incriminatory effect on both the initial commitment trial and post-commitment reviews. Moreover, sex offenders lack any countervailing positive incentive to participate in treatment because the completion of treatment does not enhance their likelihood of non-commitment or release from civil commitment.

Empirically, many offenders in involuntary commitment centers have refused treatment. For example, only 25 to 30 percent of sexually violent predators consent to participate in the active phases of California’s sex offender treatment program.¹⁵⁰ In Washington, slightly more than half of the committed offenders participate in inpatient treatment.¹⁵¹ Wisconsin has a higher treatment-participation rate of approximately 83 percent for committed “sexually violent persons,” and 72 percent when considering both committed and detained persons in the sex offender commitment system.¹⁵²

C. Enhanced Participation in Treatment Has Societal Benefits

As the above discussions demonstrate, there is a Catch-22 inherent in sexually violent predator treatment. On one hand, minimum treatment efforts are a statutory and constitutional requirement. Treatment gives offenders a chance at release, and full and candid treatment has positive mental and behavioral effects on the offender. On the other hand, all treatment records are discoverable and heavily relied on by experts, with the result that treatment participation disadvantages the very offenders that treatment purports to help. Treatment requires that offenders recount their sexual offenses, which in turn leads treatment providers, the judicial system, and the public to believe that the offenders continue to contemplate sexually violent acts and are still dangerous. This Section examines whether, apart from being constitutionally and statutorily required, treatment is something society should encourage. Doubts about the efficacy of treatment were central to the critique of the early sexual psychopath commitment laws and persist today.¹⁵³

Researchers and policymakers “have yet to agree on whether treatment effectively reduces sexual recidivism.”¹⁵⁴ This lack of consensus stems from

149. WINICK, *supra* note 1, at 146 (2005).

150. D’ORAZIO ET AL., *supra* note 137, at 27.

151. John Q. La Fond, *Sexually Violent Predator Laws and the Liberal State: An Ominous Threat to Individual Liberty*, 31 INT’L J. L. & PSYCHIATRY 158, 167 (2008).

152. STEVE WATTERS, SUPERVISED RELEASE AND DISCHARGE THROUGH TREATMENT: AN OVERVIEW OF WI’S SVP TREATMENT PROGRAM (May 2008), available at <http://www.wisspd.org/html/training/ProgMaterials/Ch980s/SRDTT.pdf>.

153. See *supra* Part I discussing sexual psychopath laws from the 1930s to 1980s.

154. R. Karl Hanson et al., *First Report of the Collaborative Outcome Data Project on the Effectiveness of Psychological Treatment for Sex Offenders*, 14 SEX ABUSE: J. RES. &

inherent difficulties with the evaluation of sex offender treatment programs. For example, researchers attempting to compare groups of treated and untreated sex offenders encounter underreported recidivism rates across both groups;¹⁵⁵ one must wait many years before treatment effects can be detected;¹⁵⁶ and treatment programs have changed considerably in recent years, rendering older studies unrepresentative of current treatment effectiveness.¹⁵⁷

One way to increase the power of statistical research is to aggregate studies through meta-analysis, which combines the results of multiple individual studies and creates a sample size sufficient to detect even small effects. Meta-analysis shows promising results for the effectiveness of sex offender treatment programs overall.¹⁵⁸ For example, a meta-analysis conducted by Hanson et al. reported sexual offense recidivism rates of 9.9 percent for treated versus 17.3 percent for untreated subjects, and general offense recidivism rates of 32 percent for treated versus 51 percent for untreated subjects.¹⁵⁹ A comparison of sixty-nine treatment studies, including thirty-one from the United States, seventeen from Canada, and twenty-one from other countries, confirmed a positive treatment effect, finding an 11.1 percent average sexual-recidivism rate for the treated group as opposed to a 17.5 percent average sexual-recidivism rate in the comparison group.¹⁶⁰ While pharmacological or hormonal treatments have the highest mean effect with regard to reducing recidivist tendencies, cognitive-behavioral and classical-behavioral approaches also have significant treatment effects.¹⁶¹

TREATMENT 169, 170 (2002).

155. *Id.* (citing R. Karl Hanson & Monique T. Bussière, *Predicting Relapse: A Meta-Analysis of Sexual Offender Recidivism Studies*, 66 J. CONSULTING & CLINICAL PSYCHOL. 348 (1998)) (explaining that, on average, only 10 to 15 percent of sex offenders are detected committing a new sexual offense within four to five years); see also David Lisak & Paul M. Miller, *Repeat Rape and Multiple Offending Among Undetected Rapists*, 17 VIOLENCE & VICTIMS 73, 73–74 (2002) (discussing undetected rapes and citing estimates that between 64 and 96 percent of all rapes are never reported to criminal justice authorities).

156. Hanson et al., *supra* note 154, at 170.

157. *Id.* at 188 (finding that older treatment programs were associated with a slight, but nonsignificant, increase in sexual recidivism, but that studies of these programs are no longer applicable because the treatment of sex offenders has changed considerably since the 1970s).

158. See *id.* at 170–71 (summarizing meta-analyses conducted by Alexander, Hall, and Gallagher et al., each of which reported a significant overall treatment effect, but challenging their methodologies).

159. *Id.* at 187 (2002). These numbers reflect recidivism rates among individuals who participated in “current treatments,” defined as any treatment currently offered and cognitive-behavioral treatments offered since 1980. *Id.* at 187. The recidivism rates for individuals who participated in other forms of treatment were not as low: averaged across all studies, the sexual offense recidivism rate was 12.3 percent for treatment groups and 16.8 percent for comparison groups. *Id.* at 181.

160. Martin Schmucker & Friedrich Lösel, *Does Sexual Offender Treatment Work? A Systematic Review of Outcome Evaluations*, 20 PSICOTHEMA 10, 11–12 (2008).

161. *Id.* at 13–14. See PERKINS ET AL., REVIEW OF SEX OFFENDER TREATMENT PROGRAMS 7–8 (1998), available at <http://www.ramas.co.uk/report4.pdf> (listing studies and concluding pharmacological intervention is best used in combination with other behavioral treatment

However, sexually violent predators—who have designated mental illnesses and pose a high risk of reoffending—may respond differently to treatment than the average sex offender analyzed in these meta-analyses. Few studies focus on high-risk prison inmates who, similarly to sexually violent predators, receive treatment in secure state hospitals. Thus, the Clearwater Treatment Program—a high-intensity inpatient sex offender program in a Canadian federal maximum-security correctional treatment facility—provides a valuable case study.¹⁶² The Clearwater Program study followed moderate-to-high-risk sex offenders who had completed a six-to-nine-month long cognitive-behavioral treatment program.¹⁶³ Significant group differences were observed between the treatment group and the control group at each stage of follow-up: 5.9 percent versus 13.6 percent after two years; 11.1 percent versus 17.7 percent after three years; 16.9 percent versus 24.5 percent after five years, and 2.8 percent versus 32.3 percent after ten years.¹⁶⁴ A related study examined the sexual-violence recidivism rates for the forty-five “psychopathic sex offenders” in the Clearwater Program over a ten-year follow-up period.¹⁶⁵ Psychopathic offenders who failed to complete the cognitive-behavioral treatment program were more likely to recidivate violently but not more likely to recidivate sexually than those who completed the program.¹⁶⁶ Researchers studying the Clearwater Program concluded that high-intensity treatment programs can decrease a moderate-to-high-risk sex offender’s risk of sexual recidivism in both the short and long run.¹⁶⁷

Not all studies of sex offender treatment programs report a positive treatment effect. One of the most comprehensive studies, California’s Sex Offender Treatment and Evaluation Project (SOTEP), compared the recidivism rates of offenders treated in an inpatient relapse prevention program with the rates of offenders in two untreated control groups, one containing offenders who volunteered for treatment and the other containing offenders who had not volunteered.¹⁶⁸ The study found no significant differences among the three

methods); see also Hanson, *supra* note 154, at 173 (explaining that, although many treatment approaches exist, “treatment providers have increasingly put their faith in some version of cognitive-behavioral treatment”).

162. See Mark E. Olver & Stephen C.P. Wong, *Therapeutic Responses of Psychopathic Sexual Offenders: Treatment Attrition, Therapeutic Change, and Long-Term Recidivism*, 77 J. CONSULTING & CLINICAL PSYCHOL. 328, 328–29 (2009).

163. Mark E. Olver, Stephen C.P. Wong & Terry P. Nicholaichuk, *Outcome Evaluation of a High-Intensity Inpatient Sex Offender Treatment Program*, 24 J. INTERPERSONAL VIOLENCE 522, 526 (2009) (subjects had a history of one or more prior sexual offenses).

164. *Id.* at 529, 531.

165. Olver & Wong, *supra* note 162, at 330–31. Psychopathic sex offenders are high-risk and high-need offenders with diagnosed mental abnormalities as evaluated by the Psychopathy Checklist–Revised (PCL–Revised). *Id.* at 328.

166. *Id.* at 331.

167. *Id.* at 335.

168. Janice K. Marques et al., *Effects of a Relapse Prevention Program on Sexual Recidivism: Final Results from California’s Sex Offender Treatment and Evaluation Project*

groups in the rates of sexual or violent offending over an eight-year follow-up period.¹⁶⁹ Perhaps most interesting, a positive treatment effect appeared for offenders who understood the program concepts—who “got it”—as compared to those who failed to meet the treatment objectives.¹⁷⁰ Although the SOTEP study did not focus on high-risk offenders,¹⁷¹ the positive treatment effect was greatest for the high-risk members of the “got it” group, which had an overall recidivism rate of 10 percent, as opposed to the high-risk group that did not meet program objectives, which had a recidivism rate of 50 percent.¹⁷² However, one could criticize that the “got it” group results were founded upon post hoc analysis of the data.¹⁷³

Finally, with regard to persons found to be sexually violent predators but eventually released from civil commitment, sexual recidivism is “[e]ssentially non-existent.”¹⁷⁴ One sex offender civil commitment program reported a charge of child pornography that occurred prior to release; but there were no incidences of sexual recidivism in the remaining programs, including outpatient programs.¹⁷⁵

These studies show that, in many situations, specialized sex offender treatment is better than no treatment with regard to lowering the likelihood of recidivism. Because treatment appears to be at least minimally effective, encouraging treatment achieves the statutory and constitutional aims of protecting society (state police power) and caring for mentally ill persons (state *parens patriae* power).

(SOTEP), 17 SEX ABUSE: J. RES. & TREATMENT 79 (2005). The offenders in this study were high-risk prison inmates who had completed a two-year intensive cognitive-behavioral treatment in a secure state hospital, similar to civil commitment hospitals for sex offenders, and a one-year aftercare program. *Id.* at 83.

169. *Id.* at 88 (finding 21.6 percent of the volunteer treated subjects sexually reoffended; 20 percent of the volunteer control group sexually reoffended; and 19.1 percent of the nonvolunteer control group sexually reoffended). However, the SOTEP study did not focus on high-risk offenders similar to the sexually violent predator population, *id.* at 102, and a positive treatment effect may have been present for shorter follow-up periods, Janice K. Marques, *How to Answer the Question: “Does Sex Offender Treatment Work?”*, 14 J. INTERPERSONAL VIOLENCE 437 (1999) (finding the treatment group performed slightly better than the volunteer and nonvolunteer control groups with regard to violent recidivism, and slightly better than the nonvolunteer control group with regard to sex offense recidivism, but neither finding was statistically significant); Janice K. Marques et al., *Effects of Cognitive-Behavioral Treatment on Sex Offender Recidivism: Preliminary Results of a Longitudinal Study*, 21 CRIM. JUSTICE & BEHAV. 28 (1994) (finding that the treatment group had the lowest reoffense rates for both sex and other violent crimes, though the results were not statistically significant).

170. Marques et al., *supra* note 168, at 102.

171. *Id.*

172. *Id.*

173. D’ORAZIO ET AL., *supra* note 137, at 9.

174. REBECCA JACKSON, TARA TRAVIA & JENNIFER SCHNEIDER, ANNUAL SURVEY OF SEX OFFENDER CIVIL COMMITMENT (2008), available at <http://www.njatsa.org/SCC-survey.pdf>. Because commitment programs have discharged few offenders, those persons recommended for release are likely not representative of the population of sexually violent predators currently in commitment settings.

175. *Id.*

Apart from treatment effectiveness, two additional considerations stem from the provision of treatment.

First, treatment should be encouraged, regardless of its general effectiveness, because it allows treatment providers to determine those offenders fit for release. Researchers have found that offenders who display good treatment behavior or have good post-treatment scores are less likely to recidivate, either sexually or violently.¹⁷⁶ Thus, encouraging treatment could help treatment providers identify which offenders lack mental illness or have responded to treatment, thereby supporting their petition for release.

Second, the treatment disincentive affects those sex offenders who never enter the civil commitment system. Inmates may opt out of treatment during their penal incarceration—prior to civil commitment—to decrease their chances of commitment. As a consequence, inmates who do not qualify as sexually violent predators will be released into society without any sexual rehabilitation or relapse-prevention training and often with no remaining parole time with which to enroll in treatment. Many treatment programs provide valuable transition skills and training to help offenders adapt to life outside the prison setting.¹⁷⁷ Assuming treatment can be effective in curbing recidivism, states should encourage participation for these offenders who will reenter society.

IV.

POLICY PROPOSALS

The treatment paradox arises when committed sex offenders view treatment—provided by states under their *parens patriae* authority to care for their citizenry—as contributing to their continued confinement. Currently, no statutory or constitutional remedies exist by which sexually violent predators can challenge the use of treatment records by the prosecution in furtherance of their confinement. As Part II points out, the current treatment scheme violates no statute or constitutional provision. While there may exist a right to the bare minimum provision of treatment, there is no statutory or constitutional obligation for states to provide a treatment regimen that individuals will elect to take. Because courts are extremely deferential to the legislature's stated objectives, it is up to the state legislatures to revamp their statutory schemes to confront this treatment paradox.

This Part explores three policy proposals that would alleviate the treatment paradox by encouraging participation in treatment while ensuring that expert psychologists can make fair and accurate assessments and that society can continue to confine those individuals who meet the criteria for a sexually violent predator. First, mandatory treatment would ensure that all offenders take part in treatment. Alternatively, an outpatient treatment program would

176. Marques et al., *supra* note 168, at 102; Olver & Wong, *supra* note 162, at 334.

177. See *supra* text accompanying note 119.

encourage participation by coupling mandatory treatment with the positive incentive of freedom from restraint. Finally, an enhanced psychotherapist-patient privilege would counteract the incriminating effect of treatment participation by removing treatment documents and reports from courts' reach. In each of these alternatives, states should make real efforts to release those offenders who successfully complete treatment, thereby creating a positive incentive for offenders to participate in treatment.

A. Mandatory Treatment

Mandatory treatment for civilly committed persons would solve the disincentive inherent to discoverable treatment records by giving offenders no choice but to participate in treatment. Required treatment has survived constitutional challenge for reasons of state police power, protection of citizens, and the decreased privacy interest of sexually violent predators.¹⁷⁸ Indeed, some states' existing statutory schemes already require treatment.¹⁷⁹

However, while required treatment would achieve universal participation in treatment, it raises a corollary concern that, without privacy protections, sexually violent predators will not candidly partake in the treatment and treatment may not be as effective.¹⁸⁰ Amenability to treatment and successful rehabilitation hinge upon eliminating denial and replacing it with an admission of responsibility for past sexual deviancy.¹⁸¹ This is a difficult hurdle for sex offenders, who are particularly likely to deny their offenses.¹⁸² As such, a

178. See Melissa M. Matthews, Comment, *Closing the Loophole in California's Sexually Violent Predator Act: Jessica's Law's Band-Aid Will Not Result in Treatment for Sexual Predators*, 39 MCGEORGE L. REV. 877, 897-900 (2008) (explaining that required treatment would not violate a sexually violent predator's constitutional rights and would be effective). However, mandatory treatment may be considered an invasion of the constitutional right to privacy and personal autonomy. See, e.g., *Jarvis v. Levine*, 418 N.W.2d 139, 145, 148-49 (Minn. 1988) (stating that there is a protected privacy interest in the individual's right to choose to refrain from taking neuroleptic drugs); *Price v. Sheppard*, 239 N.W.2d 905, 910-11 (Minn. 1976) (discussing the plaintiff's claim that his right of privacy was violated by being required to undergo electroshock therapy while involuntarily committed to a state mental health facility).

179. See *supra* note 48 and accompanying text.

180. See Karen J. Terry & Edward W. Mitchell, *Motivation and Sex Offender Treatment Efficacy: Leading a Horse to Water and Making It Drink?*, 45 INT'L J. OFFENDER THERAPY & COMP. CRIMINOLOGY 663 (2001) (discussing the debate regarding the efficacy of treatment for sex offenders); Robert M. Wettstein, *A Psychiatric Perspective on Washington's Sexually Violent Predator's Statute*, 15 PUGET SOUND L. REV. 597, 618 (1992) ("In enforced treatment, patients come to view their therapists as their jailers, agents of the state, and punitive authority figures. Involuntary patients learn to minimize symptoms, ingratiate their therapists, and seek forgiveness. The reciprocal, mutual, trusting relationship in voluntary mental health treatment is often reduced to a game of manipulations by the patient and staff in involuntary treatment.").

181. Mack E. Winn, *The Strategic and Systematic Management of Denial in Cognitive/Behavioral Treatment of Sexual Offenders*, 8 SEXUAL ABUSE: J. RES & TREATMENT 25, 26-27 (1996); see *supra* Part II.B.1 (explaining that treatment programs almost universally require that offenders admit responsibility for the offense underlying the conviction as a condition of entry and continued participation in the program).

182. Winn, *supra* note 183, at 26-27.

supportive and nurturing atmosphere, bolstered by an understanding of confidentiality, is essential for successful treatment.

Studies show that confidentiality correlates with openness and willingness to talk about one's sexual offenses.¹⁸³ One assessment found that:

If treatment is to be effective, relationships must be built between therapists and abusers that foster openness, disclosure, honesty, and change. As with all human beings, sex abusers need to believe they will be treated with dignity and professionalism before they will let their guard down and risk being vulnerable.¹⁸⁴

Moreover, researchers report a clear relationship between how cohesive members of a treatment group report to be, the extent to which freedom of action and expressions of feeling are encouraged in the groups, and treatment outcome as measured by significant reductions in pro-offending attitudes.¹⁸⁵ Development of a cohesive group leads to higher engagement, an environment conducive to disclosure through feelings of maintained confidentiality, and development of hope that the participants' situation can change.¹⁸⁶

Thus, while required treatment could overcome the first hurdle of treatment participation, it could not guarantee honest participation in treatment. Without an assurance of confidentiality, sex offenders lack incentive to partake candidly in the treatment and treatment may not be as effective.

B. Outpatient Treatment

Outpatient treatment better negates the treatment disincentive of discoverable treatment records. In addition to requiring mandatory treatment, the system encourages participation because offenders enjoy freedom from restraint and nonparticipation could result in criminal reimprisonment.

Texas's outpatient program provides a promising model of this carrot-and-stick approach.¹⁸⁷ Texas commits those sex offenders found to be "sexually violent predators" into an outpatient program that includes intensive sex offender treatment, electronic monitoring, polygraphs, penile plethysmographs,

183. For example, a study by Meg S. Kaplan et al. found that as confidentiality increased in interactions between parolees and parole officers or psychologists, reports of prior sex offenses and current urges to molest increased. Meg S. Kaplan, et al., *The Impact of Parolees' Perception of Confidentiality of Their Self-Reported Sex Crimes*, 3 *SEXUAL ABUSE: J. RES. & TREATMENT* 293 (1990).

184. ROBERT E. FREEMAN-LONGO & GERALD BLANCHARD, *SEXUAL ABUSE IN AMERICA: THE EPIDEMIC OF THE 21ST CENTURY* 169 (1998).

185. Anthony R. Beech & Catherine E. Hamilton-Giachritsis, *Relationship Between Therapeutic Climate and Treatment Outcome in Group-Based Sexual Offender Treatment Programs*, 17 *SEXUAL ABUSE: J. RES. & TREATMENT* 127, 129, 138 (2005) (measuring the group climate using self-reporting of group leaders and group members in the twelve sex offender treatment groups).

186. *Id.*

187. Meyer, et al., *supra* note 129, at 397.

biennial examinations, substance-abuse testing, and restricted transportation.¹⁸⁸ Sex offenders in outpatient treatment must follow strict rules, such as not going near schools or playgrounds, and may be charged with a third-degree felony and sent back to prison for breaking the rules of supervision.¹⁸⁹

This outpatient model has several advantages. First, it drastically decreases cost: in 2006 the cost to treat a person in the Texas outpatient program was \$17,391 per client, as compared to an inpatient treatment program that averaged \$97,000 per resident nationally.¹⁹⁰ Second, the Texas program provides legitimate treatment, eliminating concerns that civil commitment will be used to detain those who would be released from prison without treatment or supervision.¹⁹¹ Third, outpatient civil commitment protects the civil rights of sexually violent predators by allowing them to live in the community rather than in prison-like state hospitals. Even though conditionally released offenders have numerous restrictions, initially they can live with family and gradually they may earn more privileges.¹⁹²

However, some states may find this solution unfeasible because it requires reconceptualizing treatment programs; abandoning inpatient facilities; and finding suitable placements for offenders, a process that can take months.¹⁹³ Moreover, outpatient programs are politically unpopular because they place sexually violent predators back in the community.¹⁹⁴

C. Inpatient Commitment with an Enhanced Psychotherapist-Patient Privilege

Finally, if states maintain an inpatient commitment system, I propose resolving the treatment-disincentive problem by crafting a narrowly tailored psychotherapist-patient exemption. A narrow privilege could prevent sex-offender treatment records and treatment-provider testimony from being introduced at trial, and yet make admissible the state-ordered expert evaluation and information regarding the respondent's success or failure in treatment. This

188. LESLIE HUSS, OVERVIEW OF TEXAS SEXUALLY VIOLENT PREDATOR PROGRAM 2-3 (2008).

189. Meyer, et al., *supra* note 129, at 397.

190. See WSIPP, *supra* note 25.

191. Rahn Kennedy Bailey, *The Civil Commitment of Sexually Violent Predators: A Unique Texas Approach*, 30 J. AM. ACAD. PSYCHIATRY L. 525, 530-31 (2002).

192. Meyer, et al., *supra* note 129, at 404.

193. See CALIFORNIA HIGH RISK SEX OFFENDER AND SEXUALLY VIOLENT PREDATOR TASK FORCE, REPORT 5 (2006) (explaining that most landlords decline to rent to sexually violent predators when they become aware of the public notification process and resulting media attention). In one instance, a sexually violent predator received a "homeless" release after none of the 250 potential landlords contacted over the course of one year agreed to rent to him; individuals granted homeless release are difficult to supervise, and it is difficult to enforce the conditions of release, such as curfews. *Id.*

194. See LANE COUNCIL OF GOVERNMENTS, MANAGING SEX OFFENDERS IN THE COMMUNITY: A NATIONAL OVERVIEW 1 (2003), available at <http://www.atsa.com/pdfs/Managing%20Sex%20Offenders%20in%20the%20Community-A%20National%20Overview-2003.pdf>; <http://www.sexoffender.com/>.

proposal would encourage more candid participation in treatment and would be easily administrable.¹⁹⁵

It is unclear how severely this proposal would handicap the state's ability to assess a civil commitment candidate's future dangerousness. Although treatment records are heavily relied on by the prosecution,¹⁹⁶ many aspects of the sexually violent predator review and commitment system would remain unchanged. For example, the screening process and commitment hearings would still rely on psychologist interviews and assessments of the offender; the defendant could be called to testify during the commitment proceedings allowing firsthand observation by the judge or jury; and the prosecution and court would have access to police reports, victim statements, investigation reports, and other indicators of criminal history, as well as any reports regarding the offender's behavior during incarceration or parole.

The psychotherapist-patient privilege preserves the delicate balance between protecting the offender's privacy and disclosing information in the interests of justice. The blanket of confidentiality created by an enhanced privilege hopefully will incentivize sex offenders' candid disclosure of their offenses and participation in treatment without placing unnecessary burdens on state prosecutors who must put together a compelling case against the highest-risk sex offenders.

CONCLUSION

There is a role for civil commitment of the most violent, threatening, and mentally ill of our society. However, involuntary commitment programs must carefully balance the protection of the public with the recognition of the liberty interest of confined individuals. Because these programs must be civil in both form and nature, treatment should be provided in both promise and in reality.

Supreme Court precedent—including *Hendricks*' broad language, which seems to condone even meager treatment attempts, and *Young*'s rejection of as-applied challenges—makes it difficult for sexually violent predators to challenge their commitment and treatment status legally. However, state statutes and the federal constitution clearly indicate that sexually violent predators cannot be *civilly* confined unless both mentally ill and dangerous. Hence, as long as research shows that mental abnormalities are treatable, and that sexual dangerousness can be mitigated by treatment, the civil commitment system must provide treatment and release for those offenders who have

195. To implement this proposal, states could either create a statutory psychotherapist-patient privilege that would apply to treatment records in sexually violent predator hearings. Or, for many states, they need only revoke the evidentiary rules in the civil commitment statute. For example, revoking the provision of Florida's statute that "[t]he psychotherapist-patient privilege . . . does not exist or apply for communications relevant to an issue in proceedings to involuntarily commit a person under this part." See FLA. STAT. § 394.9155.

196. See *supra* Part III.A.

successfully completed treatment and are no longer a danger to society. Because courts are extremely deferential to the legislature's stated objectives, treatment and release policies must be remedied on the state level. A state policy requiring treatment or a bolstering of the psychotherapist-patient privilege in the civil commitment context safeguards the civil rights of sex offenders, encourages sex offenders to take control of their lives through treatment, and provides an economically efficient means by which states can detain only the most dangerous offenders.¹⁹⁷

197. Effective treatment and management of sexual offenders can reduce sexual reoffending, thereby reducing human suffering and the costs associated with the processing and reincarceration of recidivists. Olver, Wong & Nicholaichuk, *supra* note 163, at 522. Moreover, tailored treatment programs ensure that the civil commitment system, which costs taxpayers a yearly average of \$97,000 per offender, is reserved for the most dangerous offenders. *See* WSIPP, *supra* note 25.

APPENDIX I: INVOLUNTARY COMMITMENT AND THE FINE LINE BETWEEN
CIVIL AND CRIMINAL PROCEEDINGS

Civil commitment, although purportedly civil, constitutes an extreme deprivation of liberty. State civil commitment laws often afford heightened statutory protections, listed below, demonstrating the fine line between civil commitment and criminal punishment.

State	Right to jury trial	Proof beyond a reasonable doubt	Unanimous verdict requirement
Arizona	Yes	Yes	Yes
California	Yes	Yes	Yes
Florida	Yes	No	Yes
Illinois	Yes	Yes	Yes
Iowa	Yes	Yes	Yes
Kansas	Yes	Yes	Yes
Massachusetts	Yes	Yes	Yes
Minnesota	No	No	N/A
Missouri	Yes	No	Yes
Nebraska	Hearings before a mental health board	No	N/A
New Hampshire	Yes	No	Yes
New Jersey	No	No	N/A
New York	Yes	No	Yes
North Dakota	No	No	N/A
Pennsylvania	No	No	N/A
South Carolina	Yes	Yes	Yes
Texas	Yes	Yes	Yes
Virginia	Yes	No	Yes
Washington	Yes	Yes	Yes
Wisconsin	Yes	Yes	Yes
Total: twenty states	Fifteen states provide jury trials.	Ten states require proof beyond a reasonable doubt.	All (fifteen) states with trial by jury require a unanimous verdict.