

# **State of Maryland Sexual Offender Advisory Board**

**2010 Annual Report  
to the Governor and Maryland General Assembly**



**J. Joseph Curran, Jr., Chairman**

**December 31, 2010**

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The Honorable Martin O'Malley  
Governor of Maryland  
100 State Circle  
Annapolis, Maryland 21401

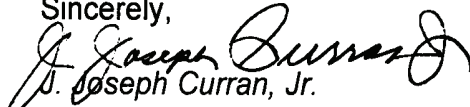
Governor O'Malley:

The Maryland Sexual Offender Advisory Board reviews existing policies and procedures associated with the management of the state's sexual offender population, with the goal of ensuring that Maryland's approach remains consistent with the best current research and the most effective practices in the nation.

Over the course of 2010, the reconstituted Sexual Offender Advisory Board worked toward gaining a comprehensive understanding of Maryland's complex sexual offender management practices and policies. The Board sees that there is a great deal more information, from a wide variety of sources, that we need to gather and evaluate before being able to make educated and thoughtful recommendations on all of our legislatively mandated tasks. Recognizing the enormity of the tasks before us, the Board focused extensively on two areas of sexual offender management that appeared to need immediate attention: the civil commitment of sexual offenders and development of certification standards for individuals who provide treatment to sexual offenders. Additionally, the Board thoroughly reviewed the procedures and practices of the Maryland Division of Parole and Probation's sexual offender "containment" model and has found that the program appears to be effectively reducing recidivism among supervised sexual offenders.

The Sexual Offender Advisory Board will continue to meet during the year ahead to review available research, to investigate promising developments, to propose necessary modifications to existing practices, to establish appropriate standards, and – most importantly – to continually monitor the effectiveness of our ongoing efforts to protect our communities from the devastating effects of sexual abuse.

Sincerely,

  
J. Joseph Curran, Jr.  
Sexual Offender Advisory Board, Chair

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## **Advisory Board Membership**

### **Ex Officio**

**Gary D. Maynard**, Secretary  
Department of Public Safety and  
Correctional Services

**Colonel Terrence B. Sheridan**  
Superintendent  
Maryland State Police

**Donald W. DeVore**, Secretary  
Department of Juvenile Services

**David Blumberg**, Chairman  
Maryland Parole Commission

**John M. Colmers**, Secretary  
Department of Health and Mental  
Hygiene

**Brian Hepburn**, Executive Director  
Mental Hygiene Administration

**Kristen Mahoney**, Executive Director  
Governor's Office of Crime Control and  
Prevention

**Patrick G. McGee**, Director  
Division of Parole and Probation

**Carole Shelton**, Director  
Criminal Justice Information System—  
Central Repository

### **Appointed by the Governor**

**General J. Joseph Curran, Jr.**  
*Citizen (Chair)*

**Laura Estupinan-Kane, PhD**  
*Sexual Offender Treatment Provider*

**Chief Arthur R. Smith**  
Hagerstown City Police Department  
*Law Enforcement Officer*

**Annette L. Hanson, M.D.**  
*Citizen Representative*

**Karla Smith, Esquire**  
Assistant State's Attorney Montgomery  
County  
*State's Attorney*

**Michele J. Hughes**, Executive Director  
Life Crisis Center, Inc.  
*Victim's Advocacy Representative*

**Catherine Meyers**, Executive Director  
Center for Children, Inc.  
*Child Advocacy Center Representative*

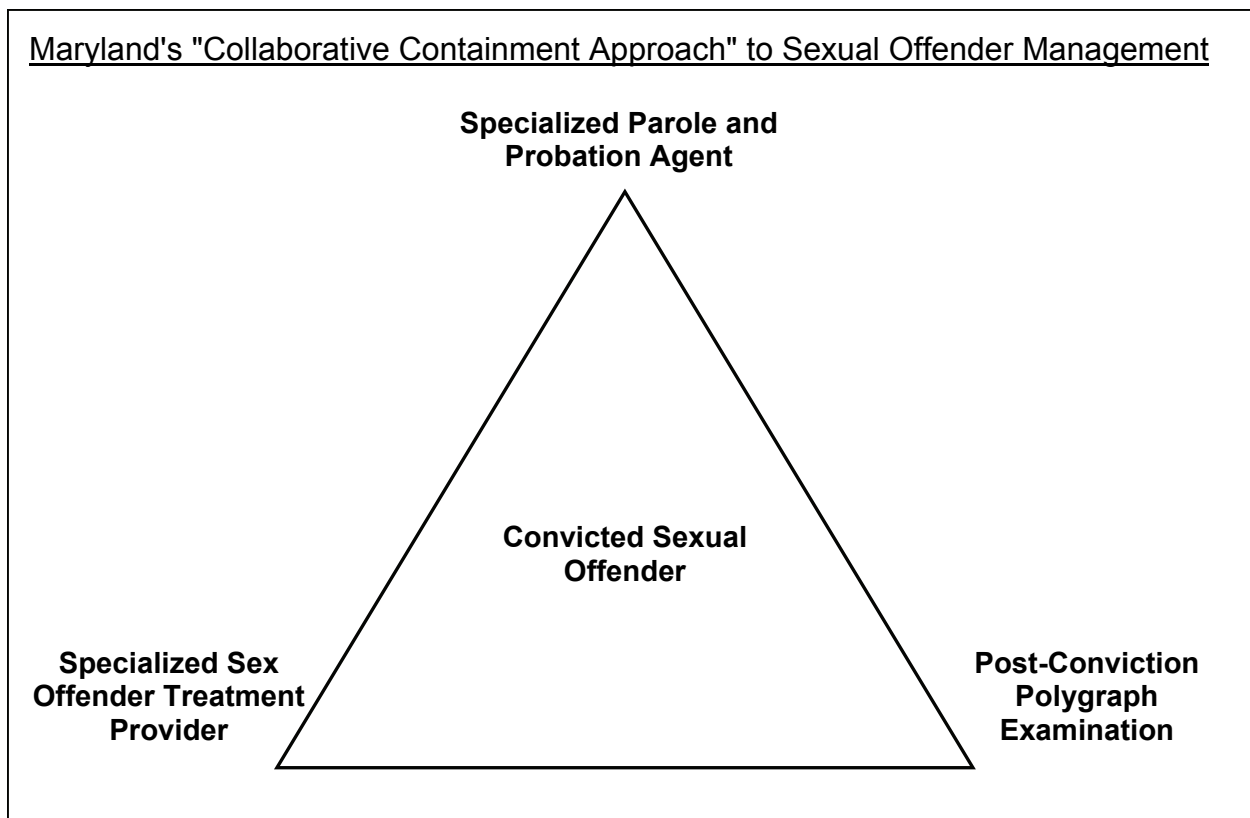
**David Walsh-Little, Esquire**  
Assistant Public Defender  
Office of the Public Defender,  
Baltimore  
*Criminal Defense Lawyer*

## The General Assembly's Charge to the Advisory Board

1. Develop criteria for measuring a person's risk of reoffending to assist the court in determining whether a person may be appropriately released from Lifetime Supervision.
2. Review the effectiveness of the State's laws and practices concerning sexual offenders, including sexual offender registration, notification, and monitoring requirements; and consider ways to increase cooperation among states with regard to sexual offender registration and monitoring.
3. Review the laws and practices of other states and jurisdictions concerning sexual offenders.
4. Review practices and procedures of the Maryland Parole Commission and the Division of Parole and Probation concerning supervision and monitoring of sexual offenders.
5. Review developments and make recommendations for the treatment, management, and assessment of sexual offenders, including:
  - existing and emerging technology for the tracking of sexual offenders;
  - civil commitment of sexual offenders;
  - existing and emerging technology for the treatment of sexual offenders; and
  - best practices for lowering recidivism rates and protecting the public.
6. Develop standards for the certification of sexual offender treatment providers based on current and evolving evidence-based practices and make recommendations for a statewide certification process.
7. Make recommendations to the Division of Parole and Probation for training sexual offender management teams.
8. Review the policies and procedures relating to ensuring the protection of residents of nursing homes and assisted living facilities where sexual offenders reside or may reside including:
  - Notifying residents and employees of nursing homes and assisted living facilities and family members of residents of the presence of sexual offenders who reside in the nursing home or assisted living facility;
  - Employing sexual offenders in nursing homes or assisted living facilities; and
  - requiring law enforcement notification to nursing homes and assisted living facilities if a sexual offender resides in the nursing home or assisted living facility;
  - Review the laws of other states and jurisdictions concerning protecting residents of nursing homes and assisted living facilities from sexual offenders;
  - Review and report on the potential impact on health care providers of recommended changes in policies and procedures concerning sexual offenders in nursing homes and assisted living facilities; and
  - Make recommendations for protecting residents and employees of nursing homes and assisted living facilities and the family members of residents from sexual offenders.

## **Sexual Offender Management in Maryland**

The approach to sexual offender management implemented by the Maryland Division of Parole and Probation is focused on discovering the nature of each offender's abusive behavior and working to minimize the likelihood that he (or she)<sup>1</sup> will repeat that behavior. It proceeds from an awareness that every sexual offender is different, and that success in reducing recidivism is correlated with an understanding of the unique characteristics of the offender and his behavior. The more that is known about what he did – to whom he did it; why he did it; where, when, how, and how often he did it; and, most importantly, how likely he is to do it again – the greater the potential for altering that behavioral pattern. However, given the secretive and deceptive nature of many sexual offenders, reaching this level of understanding can be a very time-consuming and frustrating task.



It is a task that requires constant effort on the part of a corps of agents who are specially trained in the characteristics of this population and in the implementation of a consistent, well-reasoned supervision strategy. These agents are part of what are referred to as COMET teams – for Collaborative Offender Management and Enforced Treatment – which were established throughout Maryland in response to 2006 legislation. These teams – led by experienced agents (for whom specialized training

<sup>1</sup> Women comprise approximately 1.7% of registered sexual offenders in Maryland. The use of the term "he" for sexual offenders does not minimize the seriousness of offenses committed by females.

has been extensive and is ongoing) – also include offense-specific treatment providers and specially-trained polygraph examiners as core members. In addition, each team has the flexibility to include those parties and agencies deemed essential to the effective management and treatment of each offender. The intent of this approach is to support and enforce a process of surrounding each sexual offender with a professional, multidisciplinary alliance capable of assessing and addressing his risks, needs, and progress from a number of different perspectives.

Ensuring that every sexual offender is assigned to such an agent is the first step in this strategy. There are two categories of sexual offenders that are automatically assigned at intake to these specialized caseloads: (1) individuals who are currently under supervision for a sexual offense; and (2) individuals who are currently under supervision for a non-sexual offense, but who are registered sexual offenders on the basis of a conviction for a prior sexual offense. In addition, offenders in a third category – those individuals who are not immediately identifiable as sexual offenders due to the apparently non-sexual offense of conviction (assault or disorderly conduct, for example, as a result of a plea bargain) or due to the existence of past sexual offense convictions which did not at the time require registration – are transferred to COMET agents as soon as they are identified.

After sexual offenders are assigned to these thirty-to-one ratio caseloads, agents use specialized, empirical assessment tools to preliminarily identify the highest risk offenders among them. One of these tools is the Static-99R, which is an initial assessment instrument completed within thirty days of intake; another is the Acute-2000, which is a reassessment instrument used at ninety-day intervals throughout the supervision period. The results of these assessments help guide the implementation of appropriate differential supervision protocols – establishing the type and frequency of various requirements and verifications for the offenders – and allowing for the application of the most intensive interventions to those offenders requiring the highest levels of oversight, treatment, and restriction.

Underlying the use of these specialized assessment tools for the classification of offenders is the recognition that they are not infallible. Therefore, for at least the first ninety days that any sexual offender is under supervision he is subject to all of the requirements associated with the highest level of supervision (higher risk offenders remain at the maximum supervision level for at least one year). This provides the agent sufficient time to obtain and review the available background material on the offender, make the necessary treatment referrals and confirmations, visit the offender's home, establish contact with the offender's family members, and develop a sense of the degree of cooperation and commitment to change which can be expected from the offender and those around him.

The supervision structure for sexual offenders is focused on risk reduction through extensive behavioral monitoring, a multi-disciplinary approach to containment, and the breakdown of the cognitive distortions, rationalizations, and deception

characteristic of many sexual offenders. As with other groups of offenders, regular office contacts and home visits are required – though both generally occur more frequently with sexual offenders and are utilized to assess and monitor potential risk factors. COMET agents are trained in specialized interviewing techniques which, when used during face-to-face contacts, ensure that these interactions are not only frequent but purposeful.

Visits to the homes of sexual offenders are conducted at least monthly throughout the supervision period – more frequently during the early stages of supervision – and agents are trained to look for signs of increased risk or relapse during home visits. For offenders claiming to be homeless, special protocols have been established which include adjustments in the frequency of contact, and the possible implementation of electronic tracking and polygraph testing.

As with other offenders, employment, substance abuse, mental health, and other issues are regularly addressed, as is compliance with all standard and special conditions of supervision. Offender responsibility, accountability, and commitment are encouraged through such techniques as daily telephone and kiosk reporting, which can also provide early indications of compliance issues prior to their development into offending behavior. For sexual offenders, transition to lower supervision levels can only occur after a designated minimum time period, and only when an offender has achieved a re-assessment score that reflects the absence of significant risk factors and has demonstrated both compliance and stability during that period.

For the most part, what has been described thus far represents an intensified form of the supervision that the Division of Parole and Probation has always provided. But that supervision alone has not always proven effective with particular types of offenders, sexual offenders among them. As noted, such offenders frequently tend to be secretive, self-deluding, and deceptive. Their crimes tend to occur out of the view of the communities in which they live, for reasons which can be difficult to understand. A number of them commit many more offenses than they are ever arrested for, and more kinds of offenses than anyone may realize.

For that reason, it is essential that care be taken in sentencing and supervising even what appear to be misdemeanor or “nuisance” offenders (e.g., those convicted of indecent exposure or peeping). Consideration should always be given to the possibility that an apparent non-contact offender may actually be at an early stage of a progression toward behavior involving increased contact with victims (and ultimately more dangerous offenses); or may have been apprehended for a kind of offense beyond which he has already escalated. This is also why it is appropriate to impose sexual-offense specific special conditions for such offenders, as well as for those whose charges – while sexual in nature – may be plea bargained to non-sexual charges.

Meaningful, effective supervision for sexual offenders, more so than for any



other population, requires an ability to see beneath the surface the offender presents. It requires access to behavior which is typically hidden, but which can be a clear precursor to reoffending. To address this need, the Maryland Parole Commission, in February of 2009, began imposing the following standardized, “as directed” special condition on all sexual offenders released from the Division of Correction:

Comply as directed by your parole/probation agent with the Division of Parole and Probation’s sexual offender management program, which may include intensive reporting requirements, specialized sex offender treatment, electronic monitoring, medication, polygraph testing, and computer monitoring.

The imposition of this condition allows for the timely implementation of targeted, individualized, flexible intervention strategies designed to contain sexual offenders and minimize their potential for re-offense. One such strategy involves the referral of appropriate offenders for specialized, offense-specific psychotherapeutic treatment. Agency policy makes such referrals mandatory for offenders with high risk assessment scores, but a referral may be made for any sexual offender deemed suitable by the supervising agent and the COMET team. The standard course of treatment consists of weekly group therapy sessions over a period of approximately twelve months, though modifications are possible.

Specialized treatment is closely integrated with the supervision process through the constant exchange of pertinent information between treatment providers and agents, and the mutual reinforcement of the efforts of each. Treatment participation is regularly verified and non-compliance is addressed promptly and firmly by agents. For sexual offenders, this integration of supervision and treatment has consistently been shown to be more effective than either supervision or treatment alone. In treatment, for example, offenders can be confronted by their peers in regard to the enabling lies they tell themselves and others about their actions. There are, unfortunately, very few other circumstances under which this is likely to occur.

The third element of the basic containment triangle – in which each team member offers a particular perspective on the offender and supplements and reinforces the efforts of the other members of the team – is polygraph testing. Polygraph testing is used to encourage honesty and openness in regard to ongoing behavior and communication, and to promote the acceptance of responsibility essential to the effectiveness of the treatment process. In most cases where testing is authorized, an instant offense examination – used to help resolve minimization, justification, or various degrees of denial relative to an offense – is conducted within thirty days of intake. Monitoring examinations are then used to confirm compliance with supervision conditions, to verify adherence to relapse prevention plans, and to assess the validity of specific claims or allegations by or about the offender. They are conducted at six-month intervals during the first year of supervision, though testing can continue beyond that point at the discretion of the agent. Monitoring examinations can

be extremely helpful in resolving concerns relative to such issues as residence (including homelessness) and surreptitious Internet use, which cannot be reliably confirmed in any other way.

Maryland State Police polygraph examiners have conducted approximately three hundred of these examinations to date, and the reports they generate have proven to be an invaluable tool for the management of sexual offenders, greatly enhancing the effectiveness of both supervision and treatment. They provide information to agents that would be otherwise unavailable, but which can be of substantial preventive value. Because it is possible that the information elicited may require an immediate response, agency policy mandates that a point-of-contact remain accessible during each examination to address any inquiries from the examiner and to respond to any significant issues or threats which emerge.

It must be emphasized, however, that polygraph testing results are employed for supervision and treatment purposes – to help agents make the necessary adjustments in the offender’s case plan or therapy model – and not as a basis for violation of supervision actions. Test “failure” (i.e., “deception indicated”) is never cited as a basis for violation of supervision charges, though verified high-risk, non-compliant behavior revealed through the testing process can result in such action. Every polygraph test is followed by a mandatory office interview in which the agent reviews the results of the report, corroborates any significant disclosures made by the offender and addresses any concerns or issues which were revealed during the examination. In order for a violation action to be initiated, an agent must independently corroborate the disclosures made during a polygraph examination – either through the follow-up interview with the offender or through some other source.

The “as directed” special conditions also allow agents to implement electronic tracking for sexual offenders. Two forms of technology are used for this purpose. Radio frequency tracking is used primarily to enforce curfews and restrictions on the movements of these offenders, but does not record an offender’s movements outside the home. Global positioning satellite (GPS) tracking, on the other hand, records an offender’s locations throughout the day. The passive system employed by the Division of Parole and Probation records and stores an offender’s location points at regular time intervals and, through a daily download of accumulated data, provides details regarding an offender’s movements.

Electronic tracking, through the creation of inclusion zones, can help to verify that an offender is living where he claims to be living, going to the job he reports having, and attending the programs he is required to attend. Perhaps more importantly, through the creation of exclusion zones, alerts can be generated whenever an offender goes to a location – such as one associated with victims, or potential victims – he is forbidden to frequent. These zones, which are programmed in accordance with court or Parole Commission imposed conditions and on the basis of an individual’s offense pattern – can be expanded or otherwise modified in response to

developments in the course of supervision.

The use of electronic tracking can also provide a basis for conversations with offenders about the questionable areas they may be frequenting and the reasons for that behavior, and it can provide an opportunity – previously non-existent – for an agent to intervene when an offender’s frequent presence in a particular location is believed to be associated with the scouting and grooming of potential victims. For an offender subject to electronic tracking, movement to a less restrictive phase requires full compliance with all tracking program requirements (including scheduling, zone, and curfew restrictions), consistent tracking data confirmation of the offender’s residence, and satisfactory progress relative to all standard and special conditions of supervision.

Computer monitoring is a tool that is typically implemented for offenders with child pornography convictions or for those convicted of offenses in which access to the victim was accomplished through the use of the Internet. When authorized, it can be used preventively, to monitor the computers of sexual offenders who have victimized children, even if their behavior to date is not known to have involved computer activity. Computer monitoring also makes it possible for agents to learn more about an offender’s interests – including any deviant interests – and any attempts to act on those interests.

Computer monitoring involves the installation on an offender’s computer of software designed to provide an agent access to the contents of the computer as well as the ability to monitor and record all of the activity conducted on the monitored computer. The programming also includes the activation of a list of high-risk terms pre-configured by the monitoring service and available through the monitoring software, to which the agent typically adds the names of any known current or past (or potential) victims, as well as his or her own name. The restriction or denial of access to certain sites and activities reflects the specific instructions contained in the supervision order, subject to modification by the agent on the basis of information relative to the sexual offender’s offense pattern – including known risk factors, offense precursors, behavioral triggers, and victim selection and grooming techniques.

This technology enables an agent to enforce any restrictions imposed by the court on an offender’s Internet activity – from restricting access to particular activities (e.g., chat rooms, file sharing programs) or designated web sites (including social networking sites) to preventing altogether any access to the Internet. When more than one member of an offender’s household uses a monitored computer, a biometric verification device can be connected to the computer and configured to distinguish – through fingerprint verification – the offender’s activity from that of other household members.

The effectiveness of all of these tools is directly related to the imposition of comprehensive “as directed” special conditions at the commencement of supervision. Such conditions enable an agent to initiate, adjust, terminate, and re-activate various

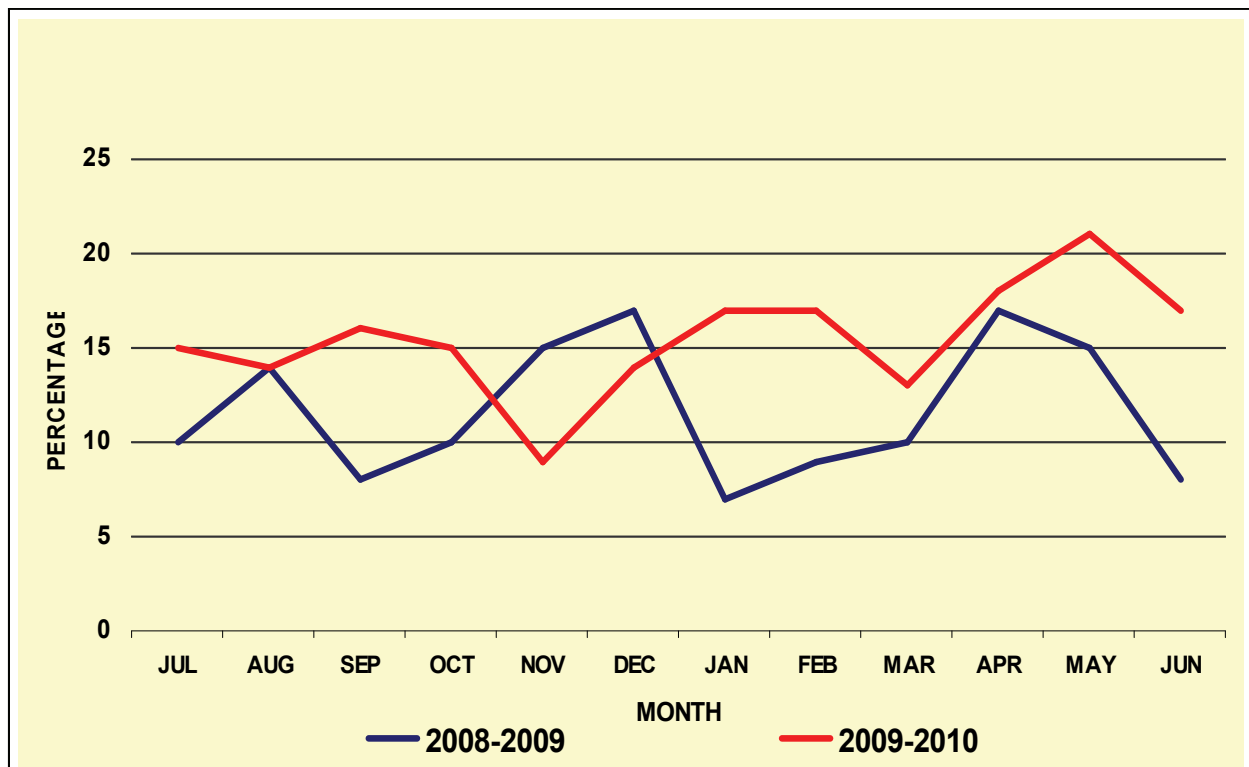
strategies as needed, without the redundant procedures associated with after-the-fact modifications. It allows the agent and the containment team to consider a variety of suitable responses to offender behavior which may not be a direct violation of a condition of supervision, but which raises concerns over the possibility of relapse.

In meetings with judges throughout the state, the Division of Parole and Probation has offered suggestions as to the wording of such special conditions, including a version similar to that employed by the Maryland Parole Commission, an abbreviated version of that condition, and a check-off menu format which allows for the authorization of one, or some, or all of the special initiatives discussed, as deemed appropriate. These suggestions have been modified in response to the questions and comments of each group and these discussions will continue during the year ahead.

Data from the periods preceding and during the availability of these special initiatives has been reviewed by the agency, and the preliminary results suggest that their use has had a measurable, positive impact on sexual offender supervision. The graph below, for example, shows an increase in the percentage of cases closed by technical violation – as opposed to new offenses – which can be attributed to the fact that agents can now know of, document, and respond to high-risk behavior on the part of these offenders before that behavior leads to new offenses.

#### TECHNICAL REVOCATIONS

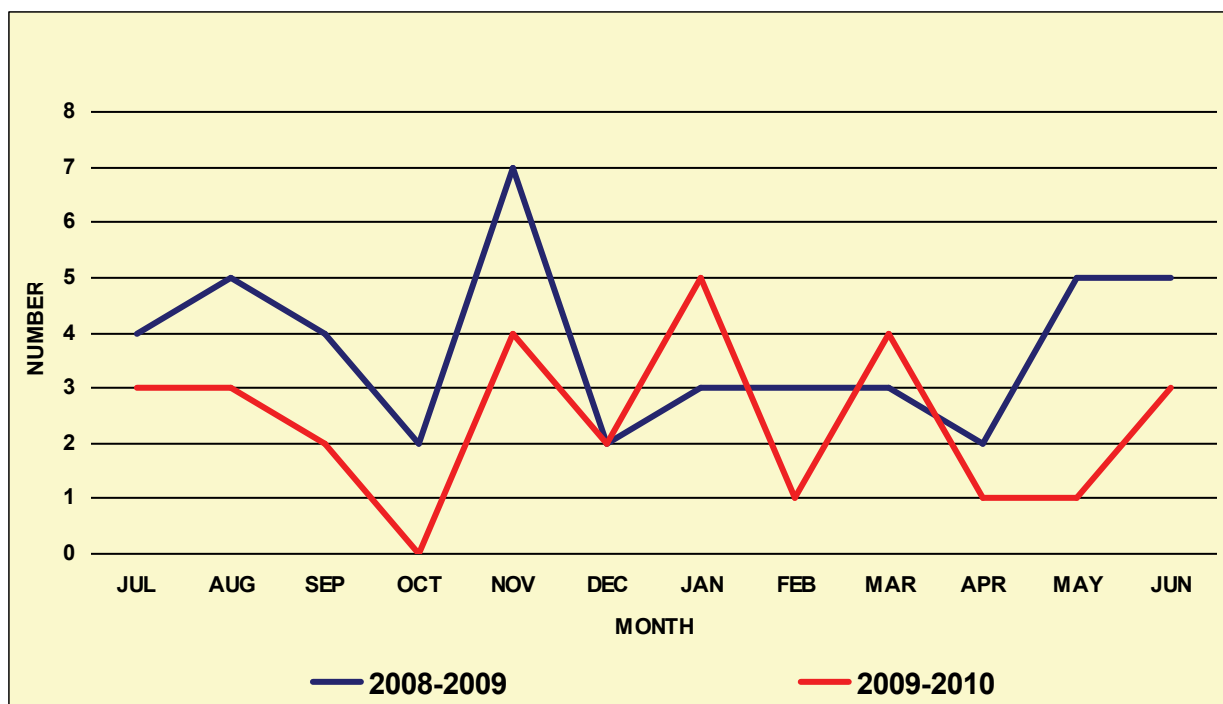
More importantly, as illustrated in the graph below, the number of supervised sexual offenders arrested for new sexual offenses was lower overall for fiscal year 2010 than



for the preceding year. These numbers were also lower for most months of fiscal year 2010 compared to the corresponding months of the previous year.

### NEW SEXUAL OFFENSE ARRESTS

These results provide encouraging evidence that it is possible to reduce recidivism among sexual offenders by effectively containing their deviant behavior to the extent that that is possible and, when it is not possible, by effectively sanctioning high-risk behavior before it results in additional victims.



### Recommendation of the Advisory Board

The Sexual Offender Advisory Board believes Maryland has significantly strengthened its criminal procedure laws for the management of sexual offenders and that the Maryland Division of Parole and Probation has fully enacted the provisions of Chapter 4 of the Acts of the Maryland General Assembly’s 2006 Special Session. It is the judgment of this Advisory Board that these procedures and technologies represent what has previously been established as the best and most effective use of Maryland’s resources for protecting the public from the risks sexual offenders present.

The Sexual Offender Advisory Board will continue to evaluate the management of sexual offenders in Maryland. In late 2008, The Center for Sex Offender Management (CSOM), a national repository for sexual offender management research and evaluation released a report entitled, “The Comprehensive Approach to Sex Offender Management”. “The Comprehensive Approach offers a promising and well-

grounded framework upon which jurisdictions can consider the informed integration of policies and practices to promote the shared goal of ensuring victim and community safety.” (CSOM 2008) Some of the recommendations for implementing a “Comprehensive Approach” which are discussed in that report appear to be solutions that Maryland is intuitively investigating and applying. There are three aspects of a comprehensive approach to sex offender management upon which greater attention should be focused in the coming year victim-centeredness, public education and sexual offender reentry.

### The “Comprehensive Approach” to Sex Offender Management



“The Comprehensive Approach recognizes the complex nature of adult and juvenile sex offending and the need for key system components to facilitate accountability, rehabilitation, and victim and community safety throughout all phases of the justice system.” *The Comprehensive Approach to Sex Offender Management*, November 2008. Center for Sex Offender Management.

<http://www.csom.org/pubs/cap/overview.htm>

The Maryland COMET Teams do not appear to consistently include non-governmental victim service organizations as is recommended by the “Collaborative Containment” model (as first articulated by CSOM in 2000) and the “Comprehensive Approaches” model of sexual offender management. The Division has indicated that during the initial assessment of sexual offenders the agents have, for example, “contact with the offender’s family members” but do not mention any involvement of or contact with the victim. Input from the victim (when the victim wishes to provide it) or a victim advocate, should be part of any victim-centered approach to assessment. The Advisory Board will attempt to determine over the next year what changes, if any, in the current management approach may be necessary to address this issue more effectively.

With the exception of a few public education hyperlinks located on the Sex Offender Registry Website the Advisory Board was not able to discover any comprehensive or meaningful educational or public awareness campaigns regarding sexual offenders or sexual assault. The Advisory Board will attempt to determine over the next year how to promote a greater understanding of sexual offending by the public in general.

Maryland does not currently support any transitional or reentry programs for sexual offenders who have been incarcerated. In the 2008 CSOM report it is stated that, “For the adult and juvenile sex offenders who are placed in correctional facilities or residential programs, planning for release should begin at the point of entry. This ensures that strategies to address any assessed needs and identified barriers to effective community reintegration can be developed well in advance of release.” Over the next several years the Advisory Board will evaluate both the “reentry” and “treatment” of sexual offenders incarcerated in Maryland’s correctional facilities.

The Division of Parole and Probation has conducted extensive and comprehensive training for the specialized sexual offender agents. It is the recommendation of the Sexual Offender Advisory Board that comprehensive training should also be provided to non-agency members of the containment teams in order to facilitate a greater understanding of the roles and expectations of all team members. The Advisory Board plans to work with the Division of Parole and Probation and the Governor’s Office of Crime Control and Prevention to establish a training protocol which can enhance the effectiveness of the collaborative efforts of these containment teams. The training protocol will provide for inclusion of non-governmental victim advocacy organizations such as Maryland’s rape crisis and recovery programs.

Finally, Chapters 176 and 177 of the 2010 Acts of the Maryland General Assembly instituted “Lifetime Supervision” for certain convicted sexual offenders. In the coming years, the Advisory Board will observe and assess the implementation of this provision by the Courts and by the Division of Parole and Probation, and will present its observations and recommendations in future reports.

## **Sexual Offender Treatment and Provider Certification**

### **Summary**

During 2010, members of the Advisory Board reviewed the research regarding the assessment and treatment of individuals who have committed sexual offenses. The Advisory Board appreciates the complexity involved in understanding the etiology and maintenance of sexual offending behaviors upon juveniles and adults as well as the fluidity of the research in progress to explore ways of effectively managing, treating and assessing individuals who have manifested this behavior. What is most evident is that any implemented management practices must be guided by research and specialized knowledge about sexual offending and victims. Thus, the Advisory Board's recommendation is that the guiding philosophy underlying Maryland's approach to policies and practices regarding individuals who have committed sexual offenses be comprehensive. The "Comprehensive Approach" to the management of individuals who have committed sexual offenses is a framework that has been developed to enhance accountability, rehabilitation and victim and community safety.<sup>1</sup> One of the major tenets of this approach is *specialized knowledge*, which recognizes that specific knowledge regarding offending behaviors, specialized assessments and effective interventions are crucial for informed decision making and effective management.

In response to the legislature's request that the Advisory Board develop a process for the certification of providers working with individuals who have committed sexual offenses, the Advisory Board compiled an overview of the practices in place in other states. Review indicated that several states have some type of mandated oversight of providers or are in the process of creating a method of oversight.<sup>2</sup> In other states, as in Maryland, specifications for providers are delineated in contracts for services put forth by various state agencies. In nearly every state, providers are required to have an active license, most often within the health or mental health arena. The Advisory Board discussed the pros and cons of implementing a process for certifying or otherwise monitoring providers. The overarching concern is that consumers and community members at large be assured that individuals who have committed sexual offenses are receiving optimal services in order to enhance public safety. Enhanced oversight would also provide a mechanism by which state agencies and courts could efficiently determine whether or not a specific professional had completed a specified minimum number of hours of training, supervision and direct abuse-specific assessment and/or treatment.

Concerns raised by some members of the Advisory Board include: 1) potential decrease in availability of providers due to the potential costs of meeting certification requirements, 2) a management board should not be the body to supervise or regulate providers since the composition of this type of board typically mandates that only one or a few members actually be a licensed mental health professional and 3) mechanisms already exist in the state to address the issue of providers who practice outside their scope of training or below the established standard of care.



The Advisory Board considered each of these concerns and acknowledges that adoption of any certification process would require a transitional phase that includes training opportunities for providers as well as a method of initially certifying existent providers who are already rendering appropriate services. The Advisory Board appreciates that its composition is multi-disciplinary and thus the majority of members are not mental health or health professionals, although the management boards in place in other states are not exclusively composed of providers and have been charged with overseeing providers rendering services to individuals who have committed sexual offenses. Although the Advisory Board acknowledges that there is no research to suggest that one particular profession or level of training is superior to another with regard to achieving positive outcomes, there have been significant changes to the models that drive treatment and assessment over a brief period of time. Thus, it is critical that providers remain abreast of advancements in the research and practice literature. Successful therapeutic outcomes require clinicians to be knowledgeable about the dynamics of sex offending and the models of treatment that have proven successful as well as to have experience in addressing the developmental issues that may be evident in individuals who have committed sexual offenses.

### **Recommendations of the Advisory Board**

The Advisory Board recommends that an additional year is needed to explore the feasibility of certification and the use of existing licensing boards for this purpose. The Advisory Board will be directly seeking the input of members of various Department of Health and Mental Hygiene licensing boards. The Advisory Board will also be seeking input from key stakeholders as well as members of sex offender management boards outside the state of Maryland.

There are several different state models in place for certification and it is crucially important to learn from the experience of other states who have already implemented standards, particularly as informal discussion with members of other states suggests that there is much to be gleaned from understanding the processes that other states have gone through in terms of development and implementation. This is information beyond the knowledge that can be assembled from reviewing written materials. This process is anticipated to require, at minimum, one year and thus it is the goal of the Advisory Board to present preliminary criteria for the potential certification of providers in the 2011 Annual Report.

The Advisory Board will be engaging in a simultaneous process of reviewing other states' guidelines and standards regarding the treatment and assessment of individuals who have committed sexual offenses. The Advisory Board has identified several states to potentially serve as models, largely based upon the detail evident in their already established standards or guidelines. It is the Advisory Board's position that creation of detailed guidelines or standards will require an extensive review period, which in other states has typically required two to three years of research post

establishment of the body charged with exploring this possibility. In effort to ensure that any recommended guidelines or standards are in accordance with best practices, the Advisory Board will be consulting with local and national experts in the assessment and treatment of individuals who have committed sexual offenses as well as the members of state management boards who have already established guidelines and standards.

The legislature also requested that the Advisory Board review Maryland's existing sex offender treatment programs and place these in the context of national practices. In 2000, the Colorado Division of Correction conducted a national survey of adult sex offender treatment programs. This study revealed that 39 states had state funded prison-based treatment programs which included community transition services, family education programs and extended outpatient treatment in the community. Thus preliminary review suggests Maryland is one of the very few states which does not provide prison-based sex offender treatment services. Potential implementation of prison-based programming as well as improved reentry practices are areas the Advisory Board will continue to explore.

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<sup>1</sup> Center for Sex Offender Management (2008) *The Comprehensive Approach to Sex Offender Management*. Silver Spring, MD: Center for Effective Public Policy.

<sup>2</sup> AK, FL, HI, ID, IA, PA, UT, WA, CA, CO, DE, IL, NM, OR, TN, TX, VA

<sup>3</sup> CA, CO, DE, IL, NM, OR, TN, TX

## The Special Civil Commitment of Sexual Offenders

Nineteen states, the District of Columbia, and the Federal jurisdictions have laws for the special civil commitment of sexual offenders completing a criminal sentence.<sup>1</sup> The other 30 U.S jurisdictions, however, have rejected commitment as a means of managing sexual offender risks, in favor of sentencing reforms and other proven and much less costly risk “containment” measures.

The Sexual Offender Advisory Board has closely examined the laws and practices in other states and has concluded that legislation for the special civil commitment of sexual offenders in Maryland would be ill-advised. Maryland in recent years has substantially strengthened its criminal laws and programs for the management of sexual offenders. As a consequence, the rate of recidivism (re-arrest) for sexual offenders released under the supervision on the Division of Parole and Probation is now less than 1%.<sup>2</sup> It is the judgment of this Advisory Board that these measures represent the best and most effective use of Maryland's resources for protecting the public from the risks sexual offenders present.

### Civil Commitment, Criminal Commitment, and the First-Generation Sexual Offender Commitment Statutes

To understand the emergence of laws for the special civil commitment of sexual offenders and appreciate the variety of other measures states have taken to contain the risks sexual offenders present, it is useful briefly to consider the evolution of civil and criminal commitment in the United States over the last 50 years.

#### *Civil Commitment*

Psychiatric civil commitment historically has followed a medical model in the United States. In most states, until the 1970s, an individual could be involuntarily admitted to a psychiatric hospital simply upon the certification of a physician that the individual was “in need of treatment.” Some states provided procedural protections for prospective patients, including court hearings and, in a few states, the right to a jury trial, but the standard for commitment—need for treatment—was nearly universal (P. Appelbaum, *Almost a Revolution: Mental Health Law and the Limits of Change*, 1994). Significant reform came only in the late 1960s and early 1970s, as part of the civil rights movement. Citing the sorry conditions that existed in many public institutions at that time and decrying the “massive deprivation of liberty” occasioned by commitment, critics challenged the authority of the state to commit someone simply on a belief that treatment would be beneficial. Heralding the “right to be different” (Kittree, 1971) and even challenging mental illness as a legitimate medical construct (Szasz, 1970), some called for abolition of commitment laws altogether. Courts and legislatures throughout the country took notice, and by the close of the 1970s, virtually every state had rewritten its civil commitment law. No longer was it enough that an individual would benefit from treatment. Now, to justify commitment, it would be necessary to show that, without treatment, an individual’s mental disorder would make him or her “dangerous” to self or others.

By the 1980s, virtually every state’s commitment law had been amended to require a showing of dangerousness. Today, people speak of the “dangerousness standard” for

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<sup>1</sup> AZ, CA, DC, FL, IL, IA, KS, MA, MN, MO, NE, NH, NY, ND, NJ, PA, SC, VA, WA, WI, Federal Jurisdictions

<sup>2</sup> Sex offenses continue to be vastly underreported, however re-arrest provides some measure of recidivism, particularly in this heavily supervised group

commitment as though the prevention of dangerousness were commitment's primary purpose. In fact, however, as before, treatment remains the essential aim of civil commitment. The dangerous requirement was added simply to constrain the state's authority to hospitalize people it believed needed treatment—"to insure that, among those individuals who might be candidates for treatment, only those whose mental condition placed them at significant risk of harm would be subject to commitment. By no means were these laws intended to *expand* the scope of commitment—to sweep up and institutionalize people who did not need treatment but who posed a threat to public safety. That was the business of the criminal justice system" (Fitch and Ortega, 2000).

### *Criminal Commitment*

The criminal law has long provided for the confinement (criminal commitment) of dangerous offenders. The purpose of such confinement is four-fold: (1) to punish offenders, commensurate with the seriousness of their behavior and the degree of their culpability; (2) to incapacitate offenders, denying them the opportunity to reoffend; (3) to deter offenders and others from committing offenses in the future; and (4) to rehabilitate offenders so that they could safely re-enter the community. For most of the last century, rehabilitation was the predominate purpose of the criminal sentence (Von Hirsch, 1983). Offenders requiring confinement were committed to Departments of "Correction," where, in keeping with the "rehabilitative ideal," efforts were made to alter the offender's "underlying personality and to make him safe to be returned to society." (La Fond, 1992). Sentences were generally open-ended, or "indeterminate." An offender might be sentenced to a potentially lengthy period of confinement but would be eligible at any time for an early release, on parole, if successfully rehabilitated.

It was in this spirit of rehabilitation that the nation's first statutes for the special civil commitment of sexual offenders were enacted. Reflecting the view at that time that "sexual offenders were ill and that psychiatrists could cure them" (American Psychiatric Association, 1999, p. 13), these laws provided for hospitalization (for treatment) in lieu of a traditional criminal sentence.

### *Sexual Offender Commitment: First Generation Statutes*

Michigan and Illinois were the first states to enact statutes for the special civil commitment of sexual offenders (in 1937-1938). Within two years, Minnesota, Ohio, Wisconsin, California, and Massachusetts had joined their ranks. By the 1950s, more than half the states had special sexual offender commitment laws, variously called "sexual psychopath" laws, "sexually dangerous persons" acts, "mentally disordered sex offender" acts, and "defective delinquent" statutes. Minnesota's law was typical, targeting for commitment individuals with "conditions of emotional instability or impulsiveness of behavior, or lack of customary standards of good judgment, or failure to appreciate the consequences of his acts, or a combination of any such conditions, as to render such a person irresponsible for his conduct with respect to sexual matters and thereby dangerous to other persons" (Minn stat §26.10 (1941)).

The American Bar Association has observed that the popularity of these early sexual offender commitment laws "rested on six assumptions: (1) there is a specific mental disability called sexual psychopathy, or defective delinquency; (2) persons suffering from such a disability are more likely to commit serious crimes, especially dangerous sex offenses, than

normal criminals; (3) such persons are easily identified by mental health professionals; (4) the dangerousness of these offenders can be predicted by mental health professionals; (5) treatment is available for the condition; and (6) large numbers of persons afflicted with the designated disabilities can be cured.” (American Bar Association, 1984, 1989, p. 457). In the 1970s, however, these assumptions came under attack. “The optimism of earlier decades that psychiatry held the cure to sexual psychopathy no longer shown so brightly.” (American Psychiatric Association, 1999, p. 11). One court observed that “[n]on-criminal commitments of so-called dangerous persons have long served as preventive detention, but this function has been either excused or obscured by the promise that, while detained, the potential offender will be rehabilitated by treatment. Notoriously this promise of treatment has served only to bring an illusion of benevolence to what is essentially a warehousing operation for social misfits.” (Cross V. Harris, 418 F2d10951107) D.C. Cir 1969)).

Calls for repeal were heard from the Group for the Advancement of Psychiatry (GAP, 1977), the President’s Commission on Mental Health (1978), and the American Bar Association (1984, 1989). In its 1977 monograph, *Psychiatry and Sex Psychopath Legislation: the 30s to the 80s*, the GAP observed that the “broad definition of mental illness in sex psychopaths statutes allows almost any mental aberration for emotional disorder to qualify.... More frequently than not, mental illness is deduced primarily, if not solely from the commission of the sexually deviant act.” The GAP concluded, “sex psychopath and sexual offender statutes can best be described as approaches that have failed.... The notion is naïve and confusing that a hybrid amalgam of law and psychiatry can validly label a person a “sex psychopath” or “sex offender” and then treat him in a manner consistent with a guarantee of community safety. The mere assumption that such a heterogeneous legal classification could define treatability and make people more amenable to treatment is not only fallacious; it is startling. Our position is that the experiment was a form of well-intentioned but misguided intervention” (GAP, 1997, p. 843). The GAP report sounded the death knell for these laws; in the next ten years, more than half would be repealed and nearly all the rest fall into disuse (Brakel, et al, 1985, p. 740).

Disillusionment with laws for the special commitment of sex offenders came at a time of growing disillusionment generally with the criminal justice system’s emphasis on rehabilitation. Nothing seemed to be working; crime rates were at record highs. Observers across the political spectrum called for change (Cornwall, 1998). Lawmakers responded, scrapping indeterminate sentencing laws and enacting in their place laws prescribing fixed or presumptive sentences that every offender would be required to serve in full. There would be no opportunity for early release. Parole was a thing of the past.

Although intended to “get tough on crime” and keep the “bad guys” locked up, in fact these reforms had the effect of accelerating the release of many of the criminal justice system’s most dangerous offenders. The reason requires some explanation but is important to understand. Under indeterminate sentencing, an offender sentenced to incarceration received a term of years representing the maximum possible period of imprisonment. An offender could be required to serve the maximum sentence-- and those presenting the greatest risks to public safety generally were-- but most offenders were released much sooner, on parole. When states moved to determinate sentencing, however, sentence lengths were recalculated based on how long, on average, offenders had served historically (i.e., before release on parole). This recalculation was necessary in order to maintain prison populations at roughly existing levels. If every offender were required to serve the maximum sentence prescribed under indeterminate sentencing, prison populations would explode. The upshot of this reform was that most

offenders—the large majority, who would have won early release under an indeterminate sentencing system—found themselves incarcerated for somewhat longer periods than before. But others—ironically the most dangerous offenders, who might never have won an early release on parole—were released much sooner. Among this group was a category of sexual offenders the public believed to be at particularly high risk for recidivism, a category soon to be labeled “sexually violent predators.”

Faced with these hard realities of determinate sentencing, states experimented with a variety of measures to prevent the premature release of dangerous sexual offenders. Some simply ignored the impact on correctional beds and established longer sentences for all sexual crimes or “enhanced” sentences for repeat offenders.<sup>3</sup> Others returned to indeterminate sentencing for certain offense categories and tightened the requirements of parole for offenders who might qualify. Colorado’s Lifetime Supervision of Sex Offenders Act authorized sentences of up to life in prison for serious offenders but provided an “intensive supervision parole program” for those who won release, including supervision by specially trained parole officers with small case loads, mandatory sexual offender treatment, and monitoring with polygraphs and physiological measures (Colorado Sex Offender Lifetime Supervision Act of 1998, 16-13-805). These more restrictive sentencing laws, however, were applicable only to offenders who committed their crimes after the laws took effect. Constitutional protections (against double jeopardy and ex post facto lawmaking) prevented states from extending an offender’s sentence after it had been served. For those already in the pipeline—offenders sentenced to a fixed term—retention under the jurisdiction of the criminal justice system would not be an option. For these offenders, states were forced to look to the civil law for remedies. And what they found there was psychiatric civil commitment—other than quarantine, the only mechanism for preventive detention outside the criminal law. But ordinary civil commitment would not do. As much as its focus may have turned to “dangerousness” over the years, civil commitment remained reserved for people with serious mental illnesses—illnesses most dangerous sexual offenders did not have. If civil commitment were to be the state’s remedy for a failed sentencing system, a new kind of commitment law would have to be written.

#### *Sexually Violent Predator Commitment: Second Generation Statutes*

In 1987, Earl K. Schriener completed a ten-year sentence in a Washington State prison for abducting and assaulting two 16-year old girls. Prior to his release, officials sought to have Mr. Schriener civilly committed, noting that he “had hatched elaborate plans to maim or kill youngsters while waiting out the final months of his prison sentence” (Tacoma Morning News Tribune, May 23, 1989). He was held for evaluation but, at his commitment hearing 72 hours later, was found not to meet commitment criteria (Id.). Four months after his release, Schriener stabbed a boy with a knife. He pled guilty to a reduced charge of simple assault and received (and served) the determinate sentence of 90 days in jail. Shortly after his release from this sentence, he was arrested again, this time for abducting a ten-year old boy, tying him to a fencepost, and beating him (Id.). An attempted rape charge was dismissed in exchange for Schriener’s agreement to plead guilty to attempted unlawful imprisonment. He served 67 days in jail. Five months after his release, Schriener abducted a seven-year old boy riding a bicycle in his Tacoma neighborhood, raped the boy orally and anally, and severed his penis. News coverage of the crime was extensive; community reaction was unprecedented. “The executive director of the State Sentencing Guidelines Commission stated that she had calls ‘from people

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<sup>3</sup> Partly as a result of states lengthening determinate sentences, the prison population nationally has grown sevenfold since 1972. U.S. Dept. of Justice Statistics.

who indicated they had never made a phone call on a matter of public policy in their lives” (Boerner, 1992, p. 534).

Less than a week after the crime, Washington’s Governor established a task force to “review the current criminal justice system and the mental health civil involuntary commitment process to measure their effectiveness in confining persons who are not safe to be at large in the community” (Executive Order No. 89-04, Wash. St. Reg. 89-13-055, 1989). The task force’s report, issued in November, 1989, included an ambitious legislative agenda for protecting the community from dangerous sexual offenders. Warmly received by the Washington Legislature, the task force’s legislative proposals were enacted into law in February 1990, as the Community Protection Act. Under the Act, sentences for most sexual crimes were increased and the nation’s first sexual offender registration requirement was established, providing a model for legislation in other states and for federal legislation (The Jacob Wetterling Act of 1991) imploring all states to enact sexual offender registration laws. Finally, the Act established a new procedure for the special civil commitment of sexual offenders leaving jail or prison (RCW §71.09.010 (1990)).

In a Preamble to the law, the Washington legislature explained why this new commitment procedure was necessary: “The Legislature finds that a small but extremely dangerous group of sexually violent predators exist that do not have a mental disease or defect that renders them appropriate for the existing Involuntary Treatment Act....In contrast to persons appropriate for [ordinary] commitment, sexually violent predators generally have antisocial personality features which are unamenable to existing mental illness treatment modalities....The Legislature further finds that the prognosis for curing sexually violent predators is poor, the treatment needs of this population are very long, and the treatment modalities for this population are very different from the traditional treatment modalities for people appropriate for commitment under the Involuntary Treatment Act” (RCW §71-09-010 (1990)).

Unlike its first-generation sexual offender commitment law, repealed only 10 years earlier, Washington’s new law made no provision for commitment as an alternative to imprisonment. In fact, it made no provision for treatment whatsoever until an offender had completed his or her sentence and was scheduled for release to the community. Commenting on laws like Washington’s, the American Psychiatric Association has observed that “their primary purpose would appear to be incapacitative rather than therapeutic. No one has suggested that these laws reflect a renewed faith in the power of psychiatry to cure sex offenders” (APA, *Dangerous Sex Offenders*, 1999).

Washington’s law provides for the indeterminate civil commitment of criminal offenders found to be “sexually violent predators” (a term coined by the Community Protection Act). The law defines “sexually violent predator” as “any person who has been convicted of or charged with a crime of sexual violence and who suffers from a mental abnormality or personality disorder which makes the person likely to engage in predatory acts of sexual violence if not confined in a secure facility” (RCWA 71.09.020 (16) (2003)). “Sexually violent offense” includes forcible rape, statutory rape, indecent liberties by forcible compulsion, indecent liberties or incest against a child under age 14, child molestation, and other crimes (including property crimes) determined to have been “sexually motivated” (RCWA 71.09.020 (15) (2003)). “Mental abnormality” is defined as “a congenital or acquired condition affecting the emotional or volitional capacity which predisposes the person to the commission of criminal sexual acts in a degree constituting such person a menace to the health and safety of others” (RCWA

71.09.020 (8) (2003)). "Personality disorder" is not defined in Washington law. "Predatory," under Washington law, is defined as "acts directed towards: (a) strangers; (b) individuals with whom a relationship has been established or promoted for the primary purpose of victimization; or (c) persons of casual acquaintance with whom no substantial personal relationship exists" (RCWA 71.09.020 (9) (2003)).

Although aimed primarily at convicted offenders completing a criminal sentence, Washington's law also may be used for the commitment of (1) criminal defendants found incompetent to stand trial or not guilty by reason of insanity of a sexually violent offense but not (or no longer) committable under applicable laws and (2) juveniles found delinquent for a sexually violent offense and about to be released from confinement in the juvenile justice system (RCWA 71.09.030 (2003)).

Individuals found to be sexually violent predators under the law are committed to a secure facility operated by Washington's Department of Social and Health Services. The period of commitment is indeterminate—"until such time as: (a) the person's condition has so changed that the person no longer meets the definition of a sexually violent predator; or (b) conditional release to a less restrictive alternative...is in the best interest of the person and conditions can be imposed that would adequately protect the community" (71.09.060 (2001)).<sup>4</sup>

Washington's law, the first of this new breed of post-sentence commitment law, has served as a model for legislation in other states. Laws in Kansas and Wisconsin (both enacted in 1994) were virtually carbon copies of Washington's law. Even today, most states' laws closely resemble Washington's. There are some notable differences, however:

- In Pennsylvania, commitment applies only to juveniles "aging out" of the juvenile justice system (and therefore no longer subject to detention). Pennsylvania has no law for the special civil commitment of adult sexual offenders leaving criminal justice confinement.
- Missouri law allows for the commitment of previously convicted individuals not currently in custody who have committed a "recent overt act" (one that creates a reasonable apprehension of sexually violent harm) and meet criteria of a sexually violent predator.

Among the most recent statutes for the special civil commitment of sexual offenders is the federal "sexually dangerous persons" law, enacted in July 2006 as part of the Adam Walsh Child Safety and Protection Act. Targeted at offenders leaving confinement in the federal criminal justice system, the law closely resembles the states' sexual offender commitment laws, with one big exception: no provision is made for a federal commitment facility. Rather, offenders found to be "sexually dangerous persons" under the law are committed to the custody of the United States Attorney General. The law directs the Attorney General to "release the person to the appropriate official of the State in which the person is domiciled or was tried if such State will assume responsibility for his custody, care, and treatment." The law goes on to provide that "the Attorney General shall make all reasonable efforts to cause such a State to assume such responsibility. If, notwithstanding such efforts, neither such State will assume such responsibility, the Attorney General shall place the person in a suitable facility, until a

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<sup>4</sup> Section (b), providing for conditional release to a less restrictive alternative, did not appear in the statute as originally enacted but was added later in response to a court decision.



State will assume such responsibility or [the person no longer meets criteria for commitment.]" Note that nothing in the new law requires states to assume responsibility for federal committees presented by the Attorney General.

**Current Statutes: Rates of Commitment and Release**

<b>States with the Largest Civilly Committed Populations</b>	
California	1045
Minnesota	565
Illinois	365
Massachusetts	317
Florida	670
New Jersey	402
Wisconsin	349

Surveys conducted by the Forensic Division of the National Association of State Mental Health Program Directors (NASMHPD) in 2006 and by the Sex Offender Civil Commitment Program Network (SOCCPN) in 2008 and 2009 show that there are at least 5,094 individuals confined in sex offender commitment facilities nationally. States with the largest patient populations include California (1045), Florida (670), Minnesota (565), New Jersey (402), Illinois (365); Wisconsin (349), and Massachusetts (317). Other states report the following numbers: 68 in Arizona; 74 in Iowa; 170 in Kansas; 147 in Missouri; an undetermined number in Nebraska; 2 in New Hampshire; 175 in New York; 60 in North Dakota; 24 in Pennsylvania; 90 in South Carolina; 0 in Texas

(where only outpatient commitment is permitted); more than 200 in Virginia; and 285 in Washington State. The District of Columbia serves a population of 4-- offenders committed under a first generation commitment law that no longer is used for new commitments but is still on the books to provide authority for the retention of earlier committees. Note that DC has reported a population of 4 each year since NASMHPD began surveying these programs in 1997.

In some states, the law allows for the alternative of commitment to outpatient treatment in the community--a "less restrictive alternative" to confinement (or "LRA"). In most states, an individual committed to a facility may be transitioned to an LRA on "conditional release" (AKA "supervised release" or "transitional release") after some period of inpatient commitment. In many states, supervisory responsibilities for individuals on conditional release rest with the state's Department of Probation and Parole. Typical conditions of placement in an LRA include: compliance with treatment; leaving one's residence only with supervision; electronic monitoring; no use of drugs or alcohol; no access to internet pornography; and restricted access to "vulnerable populations" (Fitch, W.L., and Hammen, D., 2002). Offenders on supervised release in Wisconsin are restricted to their residence for the first year "except for outings that are under the direct supervision of a Department of Corrections employee and that are for employment purposes, religious purposes, or for caring for one's basic living needs" (personal communication from the former Director of Forensic Services for Wisconsin's state mental health authority).

The NASMHPD and SOCCPN surveys described earlier show that, nationally, 141 offenders are committed to an LRA: 59 in Arizona (in a residence on the grounds of the state's maximum security facility); 6 in California; 19 in Illinois; 6 in Iowa; 7 in Kansas; 18 in New Jersey; 10 in Washington State; and 16 in Wisconsin. No one was committed to an LRA in DC, Florida, Massachusetts, Minnesota, Missouri, New Hampshire, North Dakota, Pennsylvania, South Carolina, Virginia, or the federal jurisdictions. The survey was unable to determine the number of offenders who had completed treatment and been discharged from commitment altogether. The New York Times, however, has reported that, nationally, 250

offenders have been released unconditionally in the years since Washington State's law was enacted 1990-- only about half having completed treatment, however; the rest were released "on legal or technical grounds unrelated to treatment" (M. Davey and A. Goodnough, "Doubts Rise as States Hold Sex Offenders After Prison," *New York Times*, March 4, 2007).

**Current Statutes: Costs**

Costs associated with implementing sexual offender commitment laws include the cost of end-of-sentence reviews (to determine who among the large number of qualifying

State	Annual Cost
North Dakota	\$97,502
California	\$107,000
Pennsylvania	\$300,000 (2005)
Kansas	\$41,267
Washington State	\$107,000 (2005)
Wisconsin	\$127,750
South Carolina	\$91,250 (2005)
Illinois	\$76,334 (2005)
Arizona;	\$92,500
Missouri	\$73,724
New Jersey	\$65,000
Virginia	\$170,000
California	\$173,000
New York and	\$175,000
Massachusetts	\$40,108
District of Columbia	\$237,000
Minnesota	\$120,000

offenders leaving prison should be referred for consideration of commitment), the cost of mental health evaluations and risk assessments conducted prior to commitment hearings, legal costs (attorneys' fees, court costs, other litigation costs), the cost of inpatient care and treatment (including the cost of operating commitment facilities), the cost of services and monitoring for offenders on conditional release (typically including housing), and capital costs (i.e., construction or renovation of inpatient and community facilities).

The 2006 NASMHPD survey of states with commitment laws found inpatient treatment costs (per patient, per year) ranging from \$40,108 (in Massachusetts) to \$237,000 (in the District of Columbia). In Minnesota, the state with the longest experience serving committed sexual offenders, inpatient costs were estimated to

be \$120,000 (Lohn, M, 2010).

The cost of serving an individual in the community is difficult to assess, as there have been relatively few outpatient commitment orders written to date and the needs of individuals placed in the community vary so widely. In Washington State alone, the range extends from \$25,000 to more than \$400,000 (Seling, M., 2002). Kansas reports that it spends about \$100,000 annually for "transitional services" for SVPs in the community; Illinois reports an average of \$80,000 for each of its five outpatients (2005 costs); Wisconsin reports an average of \$40,000 for each of its sixteen; Virginia an average of \$13,700 for each of its four; and California an average of \$125,000 for each of its four. The other states either had no offenders under outpatient treatment or were unable to provide cost estimates.

Costs associated with the legal process are particularly difficult to determine. The former clinical director of the Center for Forensic Services in Washington State has estimated that court costs and "litigation costs" in his state average approximately \$35,000 per patient per year (Hamilton, D., 2000). In response to a survey conducted in 1997, officials in Minnesota estimated that each commitment proceeding cost approximately \$100,000, for attorneys and experts alone, not including other court costs (NASMHPD, 1997).

## Diagnosis

One of the most pressing questions for mental health authorities charged with implementing laws for the special civil commitment of sexual offenders is whether the people these laws take in have the kinds of mental disorders for which facility-level care and treatment are clinically indicated. A NASMHPD survey in 2002 showed the diagnoses of all patients committed in 14 of the 16 jurisdictions with a sexual offender commitment law in effect at that time.<sup>5</sup> The survey determined<sup>6</sup> the number and percentage of patients in each state with any of the following conditions: "serious mental illness (such as would be common among patients committed under ordinary civil commitment laws);" mental retardation; paraphilia (differentiated); and personality disorder (differentiated for antisocial personality disorder). Nationally, 12 percent of all committed SVPs were diagnosed with a serious mental illness. Four percent were diagnosed with mental retardation. Eighty-five percent carried a diagnosis of paraphilia, including 49 percent (of all committed patients) with pedophilia; 6 percent with masochism or sadism; 14 percent with exhibitionism, fetishism, frotteurism, or voyeurism; and 23 percent with paraphilia, NOS. Seventy-five percent of all committed SVPs carried a diagnosis of a personality disorder. Forty-eight percent (of all committed SVPs) had antisocial personality disorder (Fitch, W.L., 2003).

Clearly, many committed SVPs carry more than one diagnosis. The 2002 survey, however, did not examine how different diagnoses cluster. Therefore, it is not known, for example, what percentage of individuals with pedophilia also carry a diagnosis of antisocial personality disorder. Citing a 1999 study by Raymond et al, Fagen et al recently reported that 60 percent of male pedophilic sexual offenders also meet criteria for a personality disorder, "the chief among them being obsessive compulsive (25 percent), antisocial (22.5 percent), narcissistic (20%), and avoidant (20 percent)." (Fagen, P.J., et al, 2002, p. 2461). Although the prevalence of personality disorders (and particularly antisocial personality disorder) among pedophiles committed as SVPs is not known, the survey data and anecdotal evidence suggest it is higher than the prevalence Raymond et al found among sexual offenders in general.

## Professional Concerns

Since they first appeared in the early 1990s, laws for the special, post-sentence civil commitment of sexual offenders have aroused serious concerns in the professional community. In 1994, with legislatures throughout the country considering sexual offender commitment bills, the American Psychiatric Association established a Task Force to study these laws. In 1996, the Task Force released an interim report observing that the individuals these laws were designed to commit in many cases did not have the kinds of serious mental disorders for which inpatient psychiatric services were appropriate. The Task Force declared that these laws employed psychiatric commitment as a "pretext for extended confinement that would otherwise be impermissible" and, thus, served to "distort the traditional meanings of civil commitment, misallocate psychiatric facilities and resources, and constitute an abuse of psychiatry" (American Psychiatric Association, 1996, p. 106). Note that the APA had used this characterization, "abuse of psychiatry," only once before-- in describing psychiatry in the former Soviet Union. Three years after releasing its preliminary report, the APA published the Task Force's Final Report. Employing slightly less sensational language, the report concluded:

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<sup>5</sup>Officials in Florida were unable to provide the requested information, and no one had yet been committed in Virginia, where the law's implementation date had been delayed until 2004.

<sup>6</sup> In some states, the data provided represented the "best estimate" of the state official completing the survey.

"[S]exual Predator Commitment Laws represent a serious assault on the integrity of psychiatry. [B]y bending civil commitment to serve essentially non-medical purposes, sexual predator commitment statutes threaten to undermine the legitimacy of the medical model of commitment..[T]his represents an unacceptable misuse of psychiatry" (American Psychiatric Association, 1999, p. 173-174). Rejecting civil commitment, the APA recommended that states contain the risk of sexual offender recidivism by "bring[ing] back indeterminate sentencing, at least for repeat sexual offenders. By prescribing lengthy sentences (e.g., life). but allowing for discretionary parole, the state could ensure the retention of inmates deemed to be at high risk, yet allow for the release of lower risk offenders, and it could do all this without the the pretext of treatment. Treatment, of course, might be available to offenders serving their sentences (and, indeed, release decision making might turn, in some cases, on an offender's response to treatment), but pretending that treatment is the *purpose* of confinement no longer would be necessary."

NASMHPD has taken a significant interest in these laws for many years, conducting annual surveys since the mid-1990's to assess legislative activity in different states and to monitor implementation efforts and legal developments in states with these laws. In 1997, and after much study, NASMHPD issued a formal Position Statement warning that laws for the special civil commitment of sexual offenders threatened to "disrupt the state's ability to provide services for people with treatable psychiatric illnesses,.undermine the mission and integrity of the public mental health system,.divert scarce resources away from people who both need and desire treatment,.and endanger the safety of others in those facilities who have treatable psychiatric illnesses" (NASMHPD, 1997, p. ii).

In 2007, NASMHPD re-visited the question of sexual offender commitment, establishing a work group to examine developments in the laws and practices since its earlier Position Statement. After careful study, the organization remained opposed and left its earlier Position Statement unchanged.

## **Legal Challenges**

Laws for the special civil commitment of sexual offenders have been challenged on the ground that they allow commitment without a finding of mental illness—that a “mental abnormality” or “personality disorder” does not constitute the kind of mental disorder that justifies commitment to a mental health facility. At the same time, states have been sued for failing to provide meaningful services for committed offenders.

### *Kansas v. Hendricks: Constitutionality of Special Commitment*

After conflicting decisions in the lower courts, the U.S. Supreme Court in *Kansas v. Hendricks* (1997) rejected the idea that civil commitment required a showing of mental illness (or any other condition recognized by organized psychiatry): “[W]e have never required State legislatures to adopt any particular nomenclature in drafting civil commitment statutes. Rather, we have traditionally left to legislators the task of defining terms of a medical nature that have legal significance.” The Court also rejected challenges based on the constitutional prohibitions against double jeopardy and ex post facto laws (arguments that the law in effect punished offenders for past conduct for which they already had been convicted and served their time), determining that the law was civil in nature based on its legislative intent and therefore not punitive. The Court was unmoved by the fact that Mr. Hendricks, the patient in this case, had received “essentially no treatment during this period of commitment.” The

majority attributed that apparent shortcoming to the novelty of the treatment program, pointing out that treatment, after all, was a stated purpose of the commitment.

In a concurring opinion, however-- an opinion essential to the holding in this 5-4 decision-- Justice Kennedy made clear his view that the availability of treatment was prerequisite to the law's constitutionality. " 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." Justice Kennedy went on to question the legitimacy of "mental abnormality" as the predicate condition for commitment: "If it were shown that mental abnormality is too imprecise a category to offer a solid basis for concluding that civil detention is justified, our precedence would not suffice to validate it.... In this case, the mental abnormality—pedophilia—is at least described in the DSM-IV."

In a dissenting opinion, Justice Breyer identified several aspects of the statute that made it appear more punitive than civil. In addition to the apparent lack of treatment for committed patients, he noted that the State's concerns about an offender's treatment needs were absent altogether prior to the offender's release from prison, suggesting that the real motivation for commitment was not to ensure treatment, but, rather, to ensure continued confinement. He also noted the State's failure to provide for alternative, less restrictive forms of treatment, routinely available for individuals subject to ordinary civil commitment.<sup>7</sup>

Note that in its opinion in *Hendricks*, the Court wrote that "[t]he pre-commitment requirement of a "mental abnormality" or "personality disorder" [in the Kansas law] is consistent with the requirements of these other statutes that we have upheld in that it narrows the class of persons eligible for confinement to those who are *unable to control their dangerousness*" (*emphasis added*). Nothing in the Kansas statute, however, required a showing of lack of control. That said, Hendricks testified at his commitment hearing that he was unable to control the urge to molest children and that "the only way he could keep from sexually abusing children in the future was "to die"" (*Kansas v. Hendricks*, p. 355). Suppose he had not given this testimony? Would his commitment still have withstood the Court's scrutiny? Hendricks was diagnosed with pedophilia. Would this diagnosis alone provide the basis for finding him unable to control his behavior? Did the Court mean to imply that all "mental abnormalities" or "personality disorders" render an individual unable to control their dangerousness? Or did it mean to suggest that commitment in every case requires specific evidence of such an inability? These questions lie at the heart of a subsequent Supreme Court case, *Kansas v. Crane*, 534 U.S. 407 (2002).

#### *Kansas v. Crane: Commitment Standard*

Like Leroy Hendricks, Michael Crane was committed pursuant to the provisions of Kansas' sexual offender commitment law. At the time he was committed, Crane had just completed a five-month sentence for lewd and lascivious behavior. At his commitment hearing, experts testified that he suffered from exhibitionism and antisocial personality disorder and that these conditions rendered him a sexually violent predator, at risk for future offenses. There was no testimony (or finding) that Crane was unable to control his dangerousness, but the trial court committed him nonetheless. Hearing his case on appeal, the Kansas Supreme Court overturned Crane's commitment, citing the state's failure to prove Crane's inability to control

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<sup>7</sup> Note that Kansas has since added a provision for commitment to a less restrictive alternative

his dangerousness as required by the Court in *Hendricks*. "A fair reading of the majority opinion in *Hendricks* leads us to the inescapable conclusion that commitment under the Act is unconstitutional absent a finding that the defendant cannot control his dangerous behavior. To conclude otherwise would require that we ignore the plain language of the majority opinion in *Hendricks* (In re *Crane*, 269 Kan. 578, 585 (2000)).

Kansas appealed the State Court's decision, arguing that its rationale (that the state need prove individuals "completely unable to control their behavior") reflected a misreading of *Hendricks*. The U.S. Supreme Court accepted the case for review and, in a decision announced in 2002, agreed with Kansas that "*Hendricks* set forth no requirement of total or complete lack of control" (*Kansas v. Crane*, p. 411). The Court, however, declared that some "lack of control" analysis was required.

"We do not agree with the state...insofar as it seeks to claim that the Constitution permits commitment of the type of dangerous sexual offender considered in *Hendricks* without any lack of control determination....[T]here must be proof of serious difficulty in controlling behavior. And this, when viewed in light of such features of the case as the nature of the psychiatric diagnosis, and the severity of mental abnormality itself, must be sufficient to distinguish the dangerous sexual offender whose serious mental illness, abnormality, or disorder, subjects him to civil commitment from the dangerous but typical recidivist convicted in an ordinary case" (*Kansas v. Crane*, p. 412).

The Court observed that 40-60 percent of male prison inmates have antisocial personality disorder and suggested that a law that would allow these inmates to be kept confined (after serving their sentences) under the guise of civil commitment might invite commitment to be used as "a mechanism for retribution or general deterrence—functions properly those of criminal law, not civil commitment" (*Kansas v. Crane*, p. 412).

Unresolved by the Court's opinion in *Crane* is the question whether diagnosis alone may establish "lack of control." Does the Court's lack of control requirement simply represent an effort to distinguish individuals with a serious enough mental condition to warrant commitment, or does it stand as an independent criterion that must be established in every case? Must individuals who have schizophrenia (and are dangerous) also be shown to have serious difficulty controlling their behavior in order to be committed? If so, are ordinary civil commitment laws, none of which require evidence of impaired behavioral control (apart from their requirement that dangerousness be due to a mental disorder) constitutionally suspect in light of *Crane*?

In distinguishing *Hendricks*' (valid) commitment from *Crane*'s, the Supreme Court described pedophilia as a "serious disorder," "a critical distinguishing feature [of which is] a special and serious lack of ability to control behavior" (*Kansas v. Crane*, p. 412)<sup>8</sup>. The 2002 Forensic Division Survey discussed above found that nearly half of all committed sexual offenders have pedophilia. Are their commitments validated by *Crane*, or, in the absence of specific proof of impaired behavioral control, are they suspect? Finally, what about those

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<sup>8</sup> Note that the Court also recognized *Hendricks*' admissions (that he could not control his urge to molest children) as evidence of his inability to control his behavior.

individuals with “less serious” diagnoses? Seventy-five percent of all committed SVPs have a personality disorder. Nearly 50 percent have anti-social personality disorder. If an individual suffers from a disorder like pedophilia (which carries with it some impairment in behavioral control) but also suffers from anti-social personality disorder (which the Court suggested may not adequately distinguish offenders suitable for commitment from those “convicted in an ordinary case”), must there be a determination which disorder accounts for the offender’s propensity to offend (or “serious difficulty controlling behavior”)? And if it is the latter, will commitment be permissible? Or would commitment under these circumstances amount to “a mechanism for retribution or general deterrence?” All of these are important questions that the Supreme Court has yet to take up.<sup>9</sup> In the meantime, many states have amended their commitment laws in accordance with *Crane* to require a finding of “serious difficulty controlling behavior.” Whether this additional requirement has had any effect on commitment practices is unclear.

### *Seling v. Young: Services and Conditions of Confinement*

The Supreme Court to date has heard only one other sexual offender commitment case, *Seling v Young* (531 U.S. 250 (2001)), a case with particularly important implications for mental health program directors. Andre Young was among the first sexual offenders committed (in 1990) under Washington’s new sexual predator commitment law. A litigious soul, Young spent the next 11 years in and out of court challenging his commitment. Finally, in 2001, his case reached the U.S. Supreme Court .

The issue before the Court in Young’s case was whether Washington’s sexual offender commitment law should be held unconstitutional not *on its face* (the Court’s opinion in *Hendricks* having effectively precluded that argument) but, rather, *as it was applied* in his case. Young argued that his confinement at the state’s Special Commitment Center was “too restrictive, that the conditions [were] incompatible with treatment, and that the system [was] designed to result in indefinite confinement.” Therefore, he insisted, his confinement was incompatible with the law’s stated purpose of treatment and, in effect, amounted to a term of punishment, in violation the Double Jeopardy and Ex Post Facto Clauses of the U. S. Constitution.

The Court, however, denied Young’s claim, on the ground that as-applied challenges “would prove unworkable.” The Court noted that treatment facilities, such as the one where Young was held, had changing conditions that made it difficult for federal courts to assess their constitutionality. The result was that, even if Young was receiving de facto punishment in the Center, the Court was in no position to provide the relief Young sought. Rather, the court suggested, Young’s remedy lay elsewhere.

Prior to the Court’s ruling in Young’s case, the federal district court in Washington had found the conditions of confinement at the state’s Special Commitment Center (SCC) to be

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<sup>9</sup> Note that the Washington Supreme Court has ruled that where commitment may be based on either a “mental abnormality” or a “personality disorder,” due process does not require a jury to indicate from which disorder the individual suffers; the two may operate independently or work in conjunction. “Thus, because a sexually violent predator may suffer from both defects simultaneously, the mental illnesses are not repugnant to each other and may inhere in the same transaction” (*In re the Detention of Halgren*, 156 Wash.2d 795, 132 P.3d 714 (2006)). If, however, one of the disorders provides an insufficient basis for commitment (as the U.S. Supreme Court in *Crane* suggested anti-social personality disorder would), then it may be necessary for a jury to specify the applicable disorder.

inadequate and issued what became a long-standing injunction against the Center. To remedy deficiencies, the court ordered Washington to (1) hire competent therapists, (2) rectify the lack of trust and rapport between staff and residents, (3) implement a treatment program that met prevailing standards, (4) develop treatment plans for all residents, and (5) hire a psychologist or psychiatrist with sexual offender treatment expertise to supervise the clinical staff (*Turay v. Seling*, 108 F. Supp. 2d 1148 (2000)). The Supreme Court in *Seling v. Young* cited these civil actions as the primary recourse for sexual offenders objecting to the conditions of their confinement. "It is for the Washington courts to determine whether the Center is operating in accordance with state law and provide a remedy," Justice O'Connor wrote in her majority opinion. In addition, she noted, confined sexual offenders might have causes of action under federal civil rights law, 42 U.S.C. § 1983.

### *Implications for Policy and Programs*

The Court's decision in *Young* makes clear that states with these laws must offer their patients some level of care and treatment in a therapeutic environment, lest they face lawsuits claiming denial of civil rights (Fitch, 2006). *Turay v. Seling* had produced rulings from both state and federal courts in Washington finding inadequacies in the state's treatment program. In 1998, 15 residents in Washington's SCC sought damages, and the State agreed to pay each \$10,000 as well as \$250,000 in lawyers' fees. Orders issued in 1998 and 1999 called for further improvement at the SCC. In a 1999 evidentiary hearing, the State conceded that it still had not met professional standards as required under the Constitution. Later that year, the *Turay* court found the State and the SCC guilty of "foot-dragging which had continued for an unconscionable time." The court admonished the State for a litany of "failures:" failure to provide sufficient staff training; failure to provide individualized treatment programs; failure to make adequate provisions for participation of the residents' families in treatment; failure to distinguish the facility from the state prison; failure to improve the treatment environment by providing for resident grievances and vocational training; failure to institute more oversight; and failure to take "all reasonable steps to bring a constitutionally adequate program into reality rather than merely describing it on paper."

After years of litigation, on March 23, 2007, the federal district court dissolved the *Turay* injunction, noting that "the defendants have worked long and hard to meet the constitutional requirements identified by this Court, and there is no longer any basis for the Court's continued oversight." The lesson in Washington's experience, however, is clear: states with laws for the special commitment of sexual offenders must provide meaningful services, and they must provide these services in a therapeutic environment. Failure to do so might not threaten the constitutionality of a state's law, but it almost certainly will become a lightning rod for patient litigation.

### **Practical Considerations**

This section of the paper presents observations made by mental health professionals, researchers, and attorneys from several states with sexual offender commitment programs during a two-day meeting held at the National Association of State Mental Health Program Directors in 2007. Participants were encouraged to speak frankly.

### *Services in Prison*



The meeting participants were unanimous in their opinion that if treatment is going to be provided for sexual offenders, it should begin while the offender is serving his or her sentence in prison, not reserved for such time as the defendant is about to be released. Ideally, the group suggested, sentences for sexual offenders should be indeterminate (i.e., potentially long-term but with the possibility for early release on parole), both to encourage offenders to participate in treatment if appropriate (in hopes of winning early release) and to provide officials with the authority to retain offenders whose risks remain high.

### *Recidivism Rates*

It was the sense of the group that the public (and policy-makers) over-estimate sexual offender recidivism rates--that most people believe sexual offenders in general re-offend at far higher rates than non-sexual offenders. Data collected by the Department of Justice, however, suggest just the opposite, showing that non-sexual offenders in fact are 50% more likely than sexual offenders to be arrested for a new criminal offense (68% of non-sexual offenders arrested within 3 years of release from prison versus 43% of sexual offenders, generally). More importantly, the offenses for which released sexual offenders are re-arrested very rarely are sexual offenses (5.3% arrested for a sexual offense versus 38% arrested for a non-sexual offense). That said, released sexual offenders (nationally) are significantly more likely to be arrested for a sexual offense than released non-sexual offenders (1.3% of non-sexual offenders rearrested versus 5.3% of released sexual offenders, generally). Note that in Maryland, the rate of recidivism (re-arrest) for sexual offenders released under the supervision on the Division of Parole and Probation is less than 1%, a tribute to the hard work the Division has done in recent years to manage this special offender population.

One participant in the NASMHPD meeting noted that sexual offense rates nationally are significantly lower than they were 20 years ago. Citing studies by Finklehor, he offered several possible explanations: (1) the country's population has aged (and sexual offenses, like other crimes, are committed disproportionately by men in their teens and twenties); (2) the population has become more obese, with increasing numbers suffering from diabetes (which tends to be associated with decreased libido and sexual functioning); (3) sexual offending behavior is seen as more repugnant and socially unacceptable than in the past, and offenders may have a greater fear of identification and prosecution; (4) parents are more protective of their children, at least with respect to risks associated with sexual molestation; and (5) fewer young adults today than in previous years were the victims of sexual and child abuse in their youth, reducing their risk to commit sexual assaults (D. Finklehor, 2004). Because rates of sexual re-offense have dropped so significantly, developers of the Static 99, an actuarial instrument used to assess the risk of sexual recidivism, have had to re-norm the instrument (Helms, L, Hanson, R, and Thornton, D, 2009).

### *Anticipating Bed Need and Rising Costs*

Everyone at the meeting noted that their states, when preparing to implement sexual offender commitment laws, significantly underestimated the number of offenders who would be committed. California, for example, watched beds at its Atascadero State Hospital fill to capacity with sexual offenders before finally constructing a new (1500 bed) facility exclusively for this population. In Kansas, unanticipated growth in the population of committed sexual offenders led to a Legislative Audit which concluded that "[u]nless Kansas is willing to accept a higher level of risk of re-offense, few options exist to curb the growth of the

program" (Performance Audit Report, 2005). Options the auditors suggested included reducing the number of sexual offenders who are eligible for commitment, allowing sexual offenders whose risk levels have dropped to be released, providing treatment to sexual offenders while they are in prison, establishing a community containment model for offenders in the transition phase of commitment, and transferring medically frail offenders to nursing homes.

In many states, authorities have established "filing considerations" to guide authorities responsible for deciding whom to petition for commitment. Designed to identify offenders who not only are at highest risk but also are clinically most appropriate, filing considerations can do much to regulate commitment rates. In Washington State, the Association of Prosecuting Attorneys promulgated filing considerations "calling for a petition only if:

- a qualified mental health professional has determined that the offender "(a) currently suffers from the requisite mental abnormality or personality disorder and (b) because of that mental condition is likely to engage in predatory acts of sexual violence";
- the offender has a "provable pattern of prior predatory acts" (in practice, at least three prior acts are required);
- the offender was not paroled for his or her most recent offense;
- all other civil commitment and/or criminal proceedings have been exhausted; and
- the victim and/or victim's family has been consulted and their willingness to testify has been considered" (Sappington, 1998, in Fitch, 2003).

Filing considerations, however, are not immutable or resistant to public pressures. After a study in Washington State showed a 59 percent criminal arrest rate (during a 5-70 month follow-up) for referred sexual offenders for whom no petition was filed, the filing rate in Washington jumped in one year from 35 percent (of offenders referred) to 84 percent. (NASMHPD/HSRI, 1999, pp. 22-23).

#### *Impact on Mental Health Resources*

In most states, the substantial cost of these special civil commitments falls squarely on the shoulders of the state's mental health department, threatening resources for the treatment of people with more serious mental disorders. In some states, it appears, budgets for the development and operation of sexual offender programs are provided separately from those supporting other mental health services. There are reports, however, that even in these states, bed availability for the traditional patient population has been adversely affected. In California, as noted above, until the state constructed its new 1500-bed sexual offender facility in Coalinga, committed offenders had displaced nearly all the psychiatric patients at Atascadero State Hospital. In Wisconsin, commitments reportedly have displaced mentally ill correctional inmates from beds in a secure hospital operated for this population by the state's mental health department. Finally, everyone recognized that regardless of how discretely agency budgets are maintained, these new offender commitment programs are costly to the states (with costs increasing each year as the committed population grows) and naturally have an impact on the amount of funding available for other state services.

#### *Patients' Rights*

Participants noted that patients committed under these special commitment laws presented behavioral issues that were significantly different from those seen in patients served

in ordinary inpatient psychiatric settings. The incidence of instrumental violence (violence not the product of a mental illness) is a particular problem that distinguishes this population. The group felt strongly that patients' rights regulations written for psychiatric facilities must be modified for use in these special commitment facilities. Some states' commitment programs are operated jointly by the state mental health authority and the state corrections authority (typically with mental health providing clinical care and corrections providing security services). All these programs, the participants suggested—whether operated by Departments of Correction or Departments of Mental Health, should be seen as distinctly different, with features of both mental health and corrections; the conditions of treatment should be regulated accordingly. Treating civil committees like correctional inmates, however, is a hot button issue with advocates.

### *Obstacles to Release*

Committed sexual offenders present with very complex problems; few ever reach a level of safety that is assured. Even if treatment has been successful and a patient's risk has been reduced, say, from 55% to 25%, the question arises, is 1 chance in 4 low enough? Can the program explain to the press its decision to release such a patient if things go awry? One participant observed: "If you have this law and you let someone out, there's going to be trouble; if you have this law and you don't let someone out, there's going to be trouble." Another suggested that the threshold for release should be the level of risk presented by sexual offenders completing criminal sentences who are not committed. If the state chooses not to commit these individuals, how can it justify retaining someone else whose threat to public safety is no greater?

Another significant obstacle to release in many cases is the difficulty programs have finding housing and other supportive services for offenders in the community. Not only is the public slow to embrace these new neighbors (and quick to organize in opposition), many states have onerous statutory restrictions on where registered sexual offenders may live (e.g, not within 2,000 feet of any school or day care center in Iowa). In some states, entire communities may be off limits. "Facility siting", a process by which organizations determine whether building a particular facility or structure imposes a hazard to the surrounding community, for community-based transitional release facilities presents special difficulties, forcing some states to consider locations so secluded that meaningful community reintegration is unrealistic. The *siting* of inpatient commitment facilities presents similar challenges. Too often, only remote locations are available, complicating efforts to recruit professional staff.

### *Staff Recruitment and Retention*

Staff recruitment and retention is a big problem for all of these programs. The patient population can be difficult to work with, especially those with high levels of psychopathy. Many patients are litigious and complain or file grievances incessantly. Staff often are named in lawsuits and sometimes are sued in their individual capacities. Some patients employ their psychopathic "charm" to curry the affections of naïve young staff members. Staff burn-out can be high. In addition, patient progress in treatment can be slow, frustrating providers who are accustomed to seeing more rapid recovery. Given these challenges, the workgroup participants felt that states must consider paying a differential rate for providers working in these facilities.

### *Alternatives to Commitment*

It is important to note that while many states have enacted laws for the special civil commitment of sexual offenders, most have not, particularly states, like Maryland, that never repealed indeterminate sentencing. Sentencing reform has been the preferred remedy in most states-- either longer sentences for convicted offenders or a return to indeterminate sentencing (where it had been repealed), with enhanced parole for released offenders (e.g., Colorado's Lifetime Supervision of Sex Offender's Act, discussed above). These less costly approaches allow the state to use its resources more efficiently, protecting the public from larger numbers of offenders.

Several states have established interagency committees to study the problem and offer solutions. After an extensive examination of all the options, Connecticut's "Committee to Study Sexually Violent Persons" flatly rejected commitment in favor of longer sentences, longer and more closely supervised probation and parole, improved reporting of juveniles' predatory sexual behavior, presentence evaluations of convicted sexual offenders to inform sentencing and release determinations, and increased availability of treatment for offenders serving sentences (Report of the Committee to Study Sexually Violent Persons, 1999).

### **Previous Maryland Study of Dangerous Sexual Offenders**

In 2001, Maryland's Department of Public Safety and Correctional Services and Department of Health and Mental Hygiene established a joint departmental task force to examine best practices and to consider legislative initiatives for managing dangerous sexual offenders in the state. The task force consisted of representatives of both departments, the Office of the Attorney General, the Governor's Office of Crime Control and Prevention, the Maryland Chiefs of Police, the Maryland Sheriff's Association, the Office of the Public Defender, the Maryland State's Attorney's Association, the Family Violence Council, the National Alliance for the Mentally Ill, and other agencies.

The final report of the task force, released December 3, 2001, contains the following recommendation:

"Civil commitment following incarceration is currently available in Maryland under Health-General Article, §10-632, with respect to a person who:

- (1) has a mental disorder;
- (2) needs inpatient care or treatment;
- (3) presents a danger to the life or safety of himself/herself or of others; and
- (4) is not amenable to a less restrictive form of intervention that is effective.

Legislation that would extend the civil commitment to a sex offender who does not have a mental disorder, who does not need inpatient care, or who does not present a danger to self or others is not recommended. It is believed that the

availability of longer sentences of up to life imprisonment, more intensive supervision, longer supervision, and effective programs in the community represent a better alternative for an offender who does not otherwise meet civil commitment criteria.”

### **Recommendation of the Advisory Board**

The Sexual Offender Advisory Board opposes legislation that would provide for the special civil commitment of sexual offenders at the end of a criminal sentence. In the years since the Joint Departmental study described above, and in accordance with its recommendations, Maryland has substantially strengthened its criminal laws for the management of sexual offenders. It is the judgment of this Advisory Board that these measures represent the best and most effective use of Maryland’s resources for protecting the public from the risks sexual offenders present.

## **New Areas of Evaluation and Assessment in 2011**

### **Sexual Offender Registration and Notification**

Chapter 174 and 175 of the 2010 Acts of the Maryland General Assembly enacted significant changes in Maryland's Sexual Offender Registration laws. The Advisory Board will over the course of 2011 evaluate the implementation and impact of the new registration laws and the State's compliance with the Federal Adam Walsh Child Protection and Notification Act. The Advisory Board hopes to complete this initial review and assessment of the new sexual offender registration laws in 2011 and report any recommendations in the next annual report.

### **Sexual Crime Statutes—Assessment**

The Advisory Board is required to evaluate Maryland's existing sexual crime statutes and to compare them national best practices. The Sexual Crime Statutes subcommittee in conjunction with the Governor's Office of Crime Control and Prevention and the Maryland Coalition Against Sexual Assault has begun collecting sexual crime statutes from other states to evaluate and compare language, penalties and registration requirements associated each sexual crime conviction. The subcommittee has identified the following topics for additional follow-up: statutory (age-based) offenses, use of coercion by persons in authority, and notification to victim(s) regarding investigations and forensic examinations. Other areas for investigation are expected to arise with further research. The Advisory Board hopes to complete this review and assessment in 2011 and report any recommendations in the next annual report.

### **Nursing Home and Assisted Living Facilities**

The Advisory Board is required to evaluate national best practices relating to ensuring the protection of residents of nursing homes and assisted living facilities where sexual offenders reside and to make recommendations to the General Assembly on what practices should be mandated in law. The Advisory Board will complete its evaluation and make recommendations in the 2011 Annual Report.

### **Lifetime Supervision—Risk Assessment for Discharge**

The Advisory Board is required to develop, in collaboration with the Division of Parole and Probation, criteria for measuring a sexual offender's risk of reoffense in order to assist the courts in making a determination to terminate an offender's Lifetime Supervision sentence. The Advisory Board anticipates that it will take a minimum of two years to research and develop an effective tool for Maryland Courts.

