

Sexual Predator Evaluations and Commitments

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Sexual predator (sometimes “sexually violent predator”) commitments are here to stay. Many states now have special commitment statutes for sex offenders who meet a legal definition of predator or likelihood of committing further sexually oriented crimes. This month, we’ll discuss several issues related to this special kind of commitment, then make some suggestions for those who evaluate defendants in commitment proceedings.

A FEW BASIC ISSUES

Most states’ sexual predator commitment laws have three basic requirements: 1) a history of sexually violent and/or predatory behavior (as defined by the statute, not the evaluator) and 2) a behavioral disorder or “abnormality” (usually including antisocial personality, but not necessarily a DSM diagnosis) which 3) creates a likelihood that the person will commit further sexually violent or predatory acts. The commitment process is a civil one. Although the defendant has probably been convicted of a crime and is likely to be in prison during the commitment evaluation, the process that allows a state to confine such people after they have completed their criminal sentence resembles a mental health commitment, not a criminal trial (although the state’s burden of proof is likely to be “beyond a reasonable doubt”).

Societal Stereotypes Versus Scientific Reason

The law, influenced by societal concerns and stereotypes about sex offenders, often gives short shrift to clinical recommendations and scientific reason. Many statutes do not discriminate between truly dangerous and/or violent acts and some less injurious behaviors. The law and the “predictors” used by prosecutors to effect commitment often include relatively minor sexual crimes (e.g., exhibitionism, voyeurism), nonviolent or isolative sexual behaviors (e.g., use of pornography or child pornography), adult consensual acts (e.g., promiscuity, consensual fetishism or bondage), and/or antisocial acts that are not particularly correlated with sexual predation

or for which the sexual behavior is not compulsive (such as most rapes and many intoxication-associated sexual assaults). In addition, some statutes define virtually any child-related sexual activity, such as exhibitionism or passive frotteurism, as “violent” and/or “predatory.” The evaluator should be prepared to discuss whether or not such behaviors really increase the probability of recidivism in a particular evaluatee.

Professionals’ Opposition to Sexual Predator Commitments

Many, perhaps most, mental health professionals disagree with the entire premise of a special sexual predator commitment process and/or with the idea of placing these offenders in the same category as mental patients. Psychiatrists and psychologists may choose not to participate in the process, but hoping sexual predator commitment laws will go away isn’t very productive. First, the concept is a “done deal.” The U.S. Supreme Court has ruled that such confinement does not violate an individual’s civil rights so long as it is done with certain due process safeguards and provides a *quid pro quo* for the civil loss of liberty (cf. similar requirements in mental health and substance abuse commitments). If you don’t agree with the way it is done in your state, you might consider mounting a campaign to have local voters oppose the sexual predator statute. Good luck with that one—it’s not going to happen. The next best option, and one with a lot more optimistic prospects, is to help legislators and lawyers change poorly constructed commitment laws and their implementation to make them

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fairer to defendants and more relevant to real public safety.

Second, many psychiatrists and psychologists defend their opposition to preemptive confinement by saying that we can't predict patients' (or defendants') future behavior. That argument is very likely to fail as well. It turns out that we can assess the likelihood of some behaviors (not exactly predicting behavior, but close enough for some courts and juries) and express that likelihood as a general probability within the confines of such things as available information, time considerations, environmental factors, presence or absence of effective treatments, and existence of external controls or monitors. Many of us already provide such assessments and express such probabilities, for example when we participate in the mental health commitment process or make other admission, discharge, and program privilege decisions. That doesn't mean, however, that one should agree with a lawyer's, or even a court's, version of prediction or likelihood (see discussion of actuarial instruments and risk factors below).

Unfair Jeopardy

Many sex offenders committed their crimes and went through their trials well before their states had sexual predator commitment laws. The U.S. Supreme Court appears to have approved the idea that they may still be committed, viewing this process as different from the criminal law concepts of "double jeopardy" or *ex post facto* (the doctrine that the state cannot punish someone for an act committed before it was declared illegal, or impose a punishment greater than that which was in force at the time of the act). Another group of offenders, however, voluntarily pled guilty (or *nolo contendere*) years ago in return for a promise of a certain maximum sentence. Those defendants never bargained for additional incarceration in the form of a sexual predator commitment, much less for the possibility of substantial additional prison time if they do not or cannot comply with the commitment rules.

Is Treatment Potential Necessary for Commitment?

We are accustomed to viewing mental health civil commitment in terms of both protection and our ability to help the patient. Since almost all of the social impetus for sexual predator commitment comes from a wish to protect the public rather than to help the offender, it is important to raise the question of whether or not a par-

ticular defendant can reasonably be expected to respond to, or even participate meaningfully in, the mandated treatment program. In my direct commitment experience, largely limited to conservative jurisdictions, treatability is not a factor in the statutes and court decisions. Defendants who probably cannot participate in the proposed programs—because of a severe mood disorder, mental retardation, or brain damage, for example—need, but do not usually receive, differential consideration by the prosecution, court, and/or the treatment system.^{1,2} For "routine" characterologically disordered offenders, the broader argument that the treatments available in most mandated programs do not reliably change—much less eliminate—antisocial character or ingrained paraphilic impulses has often been raised by the defense, but, so far as I know, to little avail.

THE EVALUATION PROCESS

Assessment Quality Versus Fees and Routines

Sexual predator commitment is a very serious matter for both the defendant and the public. The "patients" in sexual predator treatment programs are usually forced to remain incarcerated for many years, perhaps for life. On the other hand, government fees offered for sexual predator evaluations are quite low. The State can't afford our usual hourly rates, and there is pressure to make the assessment into a routine, generic procedure that can be completed in a couple of hours, sometimes for a flat fee. If you cannot afford to do a conscientious evaluation, write a complete report if asked, and be available for deposition and trial testimony, do not accept the referral.

Predicting, Actuarial Instruments, and Special Procedures

We are often asked to discuss the general likelihood of certain behaviors. Sex offender statutes and commitments, however, usually require the evaluator to be more specific in his or her prediction, with potentially dire consequences for the defendant. We (largely the psychological profession) have tried to develop instruments and procedures to help in those predictions, and society looks to those instruments and procedures for reassurance.

Unfortunately, while most experienced evaluators understand the limits of tests and measures, others rely inappropriately on them. Much of the lay public, including

agency administrators and commitment judges and juries, views them as gospel and is difficult to convince otherwise.* Retrospective instruments such as the revised Minnesota Sex Offender Screening Tool (MnSOST-R), the Rapid Risk Assessment for Sexual Offender Recidivism (RRASOR), and the Static 99⁴ are cheap and easy to use, don't require interviewing the defendant, and seem to give a nice, clean score that tells the user whether or not the defendant will re-offend.

Would that it were so. While the instruments' instructions and explanations usually provide appropriate disclaimers, one must guard against the temptation to rely on—rather than objectively consider—such “data.” The same caveat applies to scientific-appearing procedures such as penile plethysmography and the well-validated Abel Assessment for Sexual Interest (AASI, Abel Assessment).⁵ If one doesn't consider everything in context, the probability of error increases substantially. A somewhat complex case illustrates this point.

A middle-aged inmate with a long history of pedophilic behavior was being evaluated for commitment as a sexually violent predator. Several retrospective “actuarial” instruments were completed by the prison and the prosecutor's sex offender assessment team, using information from his pre-incarceration history. The results appeared to place him at extremely high risk of re-offending after release.

An outside evaluator retained by the defense discovered that the defendant had received a surgical orchiectomy for testicular cancer several years after entering prison (and well after committing his offenses). Laboratory tests for circulating testosterone confirmed that he had been effectively emasculated. The retrospective instruments, on which the prosecution heavily relied, were thus invalidated.

Defense hopes of showing the court that his risk of future offenses was nil and that he should not be committed were, however, premature. Understanding that a measurable portion of castrated men retain some sexual function, and that many “sex” offenses are not mediated entirely by testosterone, the defense evaluator recommended further study of the defendant's pedophilic potential using plethysmography

and the Abel Assessment. Both indicated continuing aberrant impulses that were sufficient for concern. Although the scores were likely to have been much lower than before the orchiectomy, in the absence of prior testing, one could not be certain.

History and Record Review

Be sure you have all necessary, or at least all available, reliable information about the defendant's offenses (sexual and nonsexual), other sexual behaviors, psychiatric/psychological history, social and vocational history, education, juvenile history, substance use or abuse, and relationships. Most commitment evaluations are done while the defendant is in prison, where records from other settings may be incomplete or difficult to obtain. Many prisons have a generic packet of information which they send to evaluators, but which may omit materials from before incarceration, prison treatment notes, medical (nonpsychiatric) information, and details of the inmate's prison life (e.g., rules infractions or “cases”). As in many institutional settings, errors or omissions in early documentation are likely to be copied in later reports and become entrenched in the inmate's file. Prison reports, screenings, testing, and the like are, in my experience, more error-prone than ordinary health care records, in part because staff are often undertrained and overworked.

Do not feel compelled to offer diagnoses or other opinions if you believe the available information may be inaccurate or incomplete. If you are evaluating a defendant for the defense, do not simply review the materials used by the prosecution evaluator (unless you believe them to be accurate and comprehensive). Request additional materials when necessary and carefully consider whether or not you can form an opinion if the additional materials cannot be provided. If you do express an opinion, be sure to comment on any doubts raised by the unavailability of information.

Examination

Prisons are not ideal locations for psychiatric or psychological assessment. It is often difficult to arrange a face-to-face (or “contact”) visit with the offender. An acceptable combination of privacy and personal contact must be found; this can be accomplished in most prison settings. If institution rules strictly forbid a contact visit, one should carefully consider whether or not an adequate evaluation can be completed under the conditions offered.

*There are exceptions. A recent Massachusetts ruling held that the commonly used Abel Assessment for Sexual Interest did not meet the *Daubert* test for scientific validity in legal settings. The defendant had sought to introduce the test as evidence that he was no longer in danger of re-offending.³

Do not proceed if you believe the assessment conditions are either professionally inadequate or unsafe. Most sex offenders are not violent or threatening. If they are in administrative segregation or restricted in some other way, it is likely to be for their protection. Nevertheless, evaluator safety is a top priority; do not allow yourself to be placed in a position with which you are uncomfortable (and do not overestimate your safety or ability to recognize danger).

If full contact is prohibited, one can usually do a better evaluation with a shackled inmate in an interview room than by speaking through a thick metal screen that occludes facial expressions and other visual cues. Bars that are wide enough to allow a good view and easy communication are acceptable, and far preferable to a glass barrier and telephone or intercom; I decline evaluations with the latter. I do not do evaluations with a guard in the room, even several feet away; consider suggesting a setting in which the guard can observe through a large window. It is useful to ask the inmate if he feels he can talk freely, without being overheard.

The examination itself is similar to other criminal forensic interviews; I won't outline the technique, which has been described in previous columns. Provide the usual information and disclaimers about your role, lack of confidentiality, lack of clinician-patient relationship, and so on, and ascertain whether or not the inmate understands; I provide a written explanation. This is not, however, a "consent" process. The inmate may choose whether or not to talk with you and may wish to consult his attorney beforehand, but once he is participating you do not owe him the duties afforded a "patient."

If the defendant was not notified in advance of your examination and given a chance to discuss it with his lawyer, you should usually postpone the interview until he has done so. This is rarely an issue for defense evaluations, but is quite important for prosecution ones. Law enforcement investigators may question a defendant after merely notifying him of his rights and having them competently waived. Psychiatrists and psychologists, on the other hand, aren't "investigators"; the defendant's lawyer should be notified and approve your interview (absent a court order).[†] The mere "opportunity" to consult a lawyer is probably insufficient for an ethical forensic assessment.

Some evaluators discuss the attorney's strategy with the defendant or share their findings at the end of the

interview. In my view, forensic evaluations should not include strategic advice, since the clinician is not an attorney, does not have an adversarial role, and is not generally privy to the lawyer's thoughts and insights. It seems unwise to discuss one's findings with the defendant, in part because the examination is only part of the evaluation process and one's views may change. In addition, the defendant may take one's comments as a promise or guarantee. The forensic evaluator must be free to come to his or her opinions objectively; discussing them with the defendant or predicting what one will say at a later date may limit that objectivity.

Finally, understand the requirements of the statute and what is likely to be asked at trial, and be certain that you have covered those topics. Be familiar with the special tests that may be used and try to get information relevant to them. Be aware of the benefits and drawbacks of objective tests and procedures, such as penile plethysmography and the Abel Assessment.

Getting to the Truth

Sexual predator commitment evaluations require constant sensitivity to the credibility of the data on which one bases his or her opinions. I have already discussed the accuracy and reliability of records, especially prison records. It is often impossible to assess the defendant's truthfulness and, more to the point, at what specific times the defendant is or isn't telling the truth. I marvel at reports that conclude that certain comments are accurate while doubting other items, or that describe a defendant's statements as if they were all factual.

Experienced evaluators usually admit that they can't tell when a defendant is lying without reliable collateral information. Commonly described "clues" such as eye contact, including details in conversation, and even polygraphic measures are not very useful in this setting. The interview is important to one's evaluation, but it shouldn't be the evaluator's main source of "truth" about the defendant's history, offenses, or current impulses.

Don't Get "Used" by the System

Sex offender evaluations, like death penalty evaluations, are fraught with opportunity for personal views and countertransference (and we all know countertransference is a subtle thing). The court relies on the forensic evaluator's objectivity. If, for example, your feelings about sex offenders or, conversely, your disagreement with the concept of sex offender commitment is likely to get in the way of that objectivity, don't participate in the

[†]I rarely allow the evaluatee's attorney to actually attend the interview, although I am quite willing to audio- or videotape it if authorized by the lawyer who retained me.

process. Don't be too flattered by prosecution or defense lawyers who seek you out, perhaps because you are inexpensive or inexperienced.

WHAT HAPPENS AFTER COMMITMENT?

One criticism of the sexual predator commitment process is the lack of reliably effective treatment for those who are committed. Current programs are usually generic rather than individualized, with few modifications or allowances for different kinds of crimes or offenders (although many states have separate tracks for psychotic or mentally retarded offenders). Cognitive and educational portions are usually required for everyone, regardless of relevance, ability to benefit from them, or even ability to understand them. The refractoriness of many paraphilic behaviors and/or character pathology suggest that it will be very difficult to complete the program and attain discharge. That refractoriness and community social/political anxieties about sex offenses (particularly those involving children) combine to make most sexual predator commitments likely to last for many years, often a lifetime. There are, thus far, almost no good outcome studies, reports of release rates, or reliable recidivism figures for these mandatory civil programs, in part because they are a recently legislated phenomenon in the United States.

Older programs' outcome data often suggest broad pessimism tempered with some optimism associated with 1) tailoring treatment, discharge, and outcome statistics to type of offense, paraphilic behavior, and underlying diagnosis and 2) the program's ability to individualize care and to consider anti-androgen medications or surgical approaches (orchiectomy, stereotaxic procedures). Currently, although there is much talk about them, anti-androgen medications are very rarely available in mandatory treatment programs in the United States. Selective serotonin inhibitors, which have antilibidinal effects in some patients, are sometimes prescribed but are not reliable substitutes when true anti-androgens are indicated. Stereotaxic neurosurgery for paraphilic indications is essentially unavailable in the United States. Castration, sometimes highlighted in the popular media, is almost never performed to alleviate paraphilic or violent impulses.

It should be noted that these biological approaches, sometimes touted on television and encouraged—even demanded—by laypersons, are not panaceas. Anti-

androgen treatment is complex, controversial even in the medical field, and certainly not appropriate for every sex offender. Castration is an unreliable means of controlling sexual, violent, and impulsive behaviors in many patients. Stereotaxic thalamotomy, hypothalamotomy, and similar procedures may be appropriate for some severe paraphilias, but data about them are sparse and they are virtually unavailable to U.S. offenders.⁶

Reports of treatment program "success" are almost always couched in terms of statistical significance, sometimes on the order of a 30%–50% reduction in re-arrests, new crimes, and the like (cf. Grossman et al. 1999⁷ and Nicholaichuk et al. 2000⁸). Such reductions are helpful, but are not likely to meet the community's need for real assurance that the defendant will not re-offend. That is, if members of an untreated group have a 60% probability of re-offending and those of a treated group have a 30% chance of molesting, raping, or killing children, the statistics seem unlikely to encourage a judge or jury to release the patient.

THE LAST WORD

Understand the seriousness, and often the permanence, of sexual predator commitments.

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