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# The Treatment of the Civilly Committed Sex Offender in Minnesota: A Review of the Past Ten Years

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**ESSAY: THE TREATMENT OF THE CIVILLY COMMITTED  
SEX OFFENDER IN MINNESOTA:  
A REVIEW OF THE PAST TEN YEARS**

Anita Schlank, Ph.D., L.P. & Rick Harry<sup>†</sup>

I.	INTRODUCTION .....	1221
II.	SELF-INCRIMINATION .....	1223
III.	THE MINNESOTA SEX OFFENDER PROGRAM .....	1224
	A. <i>Treatment Structure</i> .....	1225
	B. <i>Strengths and Weaknesses</i> .....	1227
	C. <i>Higher Costs/Slow Release Rate</i> .....	1228
	D. <i>The Problem of Institutionalization</i> .....	1232
	E. <i>Effects of Working in a Civil Commitment Program for the         Therapists</i> .....	1234
IV.	DEPARTMENT OF CORRECTIONS/DEPARTMENT OF HUMAN SERVICES COLLABORATIVE.....	1236
V.	FUTURE DIRECTIONS .....	1237
VI.	CONCLUSION.....	1239

### I. INTRODUCTION

Society has long struggled in its attempt to understand the motivations of sexual offenders. For many, this type of behavior is so difficult to comprehend that it is assumed to be due to some type of mental illness. As early as the 1930s, states began attempting to identify sexual offenders who suffered from mental disorders and required specialized treatment. Civil commitment statutes, often referred to as Mentally Disordered Sex Offender Statutes, or Sexual Psychopath Laws, were developed. These

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statutes were intended to identify the most mentally disturbed sexual offenders and offer them hospitalization in lieu of imprisonment.<sup>1</sup> Additionally, these statutes protected society by providing for ongoing commitment until the offender no longer presented a risk of committing future offenses.<sup>2</sup> The statutes were quite popular for a period of time. By the 1960s, most state legislatures had passed some form of a civil commitment statute.<sup>3</sup>

Despite their popularity, many civil commitment statutes were subjected to extensive constitutional challenges.<sup>4</sup> For example, opponents of civil commitment statutes questioned the appropriateness of detaining individuals<sup>5</sup> for treatment when they had often been deemed unamenable to such treatment. In addition, sex offenders were often considered dangerous even after they had completed their prison term, so they were confined indeterminately to state hospitals where sex offender-specific treatment was not necessarily available. In other cases, offenders seeking to avoid prison presented themselves as mentally disordered in the hopes of securing more humane treatment. This caused the accuracy of all sex offender assessments to be called into question. Moreover, in some states, offenders who were diverted to mental health facilities “were released outright, often sooner than they would have been released from prison if they had been ordered to serve their sentences.”<sup>6</sup> Eventually, given both the concerns about treatment and unease over the possible infringement of civil liberties, states began repealing their civil

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1. See Alan Held, *The Civil Commitment of Sexual Predators – Experience Under Minnesota Law*, in 1 THE SEXUAL PREDATOR: LAW, POLICY, EVALUATION AND TREATMENT 2-1, 2-4-2-22 (Anita Schlank & Fred Cohen eds., 1999) (providing an overview of state civil commitment laws).

2. *Id.*

3. Judith V. Becker & William D. Murphy, *The Science of Sex Offenders: Risk Assessment Treatment and Prevention: What We Know and Do Not Know About Assessing and Treating Sex Offenders*, 4 PSYCHOL. PUB. POL’Y & L. 116, 116 (1998).

4. See John Q. LaFond & Bruce J. Winick, *Sex Offenders and the Law*, 4 PSYCHOL. PUB. POL’Y & L. 3, 11-16 (1998).

5. This article employs gender-neutral language. However, it may be noted that the population of civilly committed sexual offenders is overwhelmingly male. In Minnesota, only one woman has been civilly committed as a sex offender, which is similar to the numbers seen in other states with these laws. It appears that these few women could likely benefit from one state being willing to form a program especially for female sexual offenders and serving the women committed in all states. However, at this time, no such program exists.

6. John Q. LaFond, *Sexually Violent Predator Laws and Registration and Community Notification Laws: Policy Analysis. The Costs of Enacting a Sexual Predator Law*, 4 PSYCHOL. PUB. POL’Y & L. 468, 472 (1998).

## 2003] CIVILLY COMMITTED SEX OFFENDERS IN MINNESOTA 1223

commitment statutes. By the late 1980s, most states had done away with these laws. In the few states that retained their civil commitment statutes, they were infrequently used.<sup>7</sup>

Following the demise of the first generation of civil commitment statutes, the focus of sex offender treatment shifted to the development of prison-based programs and community outpatient programs. Unfortunately, few residential community programs were available. Therefore, many relatively dangerous sexual offenders were treated on an outpatient basis. Beginning in the 1990s, after a spate of highly publicized crimes committed by recently released sex offenders, many states began to reconsider the possibility of civilly committing offenders who posed the highest risk of reoffending. It did not take long before states developed a second generation of statutes, attempting once again to address the distinct social problems posed by sexual offenders. In Minnesota, the earlier statute, the Psychopathic Personality Statute,<sup>8</sup> had never been repealed. The statute was updated and renamed the Sexual Psychopathic Personality Statute.<sup>9</sup> The Minnesota legislature also passed an additional law, the Sexually Dangerous Person Statute,<sup>10</sup> which made it easier to demonstrate that a sex offender needed civil commitment. As concern for public safety increased, many other states enacted similar laws, despite their controversial nature. As a result, hundreds of sex offenders have been civilly committed in recent years.<sup>11</sup>

## II. SELF-INCRIMINATION

Critics believe that civil commitment laws may impede the treatment of sex offenders in prison. Participants in prison-based treatment programs should be informed that statements made during therapy might be used against them in civil commitment hearings. As a result, the laws can create a Hobson's choice for sex offenders. "If they do not seek treatment in prison, the government can use this fact against them in a subsequent Sexually Violent Person (SVP) commitment. If they do seek treatment, the government may use information obtained from treatment against

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7. Becker & Murphy, *supra* note 3, at 116.

8. 1939 Minn. Laws Ch. 369, §§ 2, 3.

9. MINN. STAT. § 253B.02, subd. 18b (1998).

10. MINN. STAT. § 253B.02, subd. 18c (1998).

11. Laura Barnickol, *Missouri's Sexually Violent Predator Law: Treatment or Punishment*, 4 WASH U. J. L. & POL'Y 321, 329 (2000).

the offender in a subsequent SVP commitment.”<sup>12</sup> Some offenders attempted to circumvent this situation by attending treatment but failing to disclose their entire offense history. This is counter-therapeutic because most treatment providers believe that rehabilitation begins with acceptance of responsibility. Furthermore, the integrity of the treatment program would be questioned if treatment providers were forced to say that participants had successfully completed the program without disclosing other offenses they may have committed.<sup>13</sup> In addition, one of the main goals of any sex offender treatment program is to develop an effective relapse prevention plan based on a careful analysis of the thoughts, feelings and decisions which preceded past offenses.<sup>14</sup> If any past offenses are left out of that analysis, particularly offenses that were exceedingly violent or targeted uncharacteristic victims, the effectiveness of the plan is impaired.

Civil commitment programs present less of a dilemma regarding self-incrimination. In these programs, each patient is informed of confidentiality limitations and provided the opportunity to discuss unreported offenses in a manner that allows the patient to learn from them and to develop an effective relapse prevention plan. Patients may accomplish this without providing enough details about time, place and victim so as to trigger a mandatory report from the treatment provider. In addition, by the time many patients reach the point of civil commitment, their unreported offenses have reached the statute of limitations. Consequently, discussing them does not pose a risk of additional prison sentences. In Minnesota’s civil commitment program, there is very little concern for self-incrimination because commitments last for an indeterminate period of time, so there are no “re-commitment hearings” where disclosure about past offenses would present a concern.

### III. THE MINNESOTA SEX OFFENDER PROGRAM

Like most current sex offender treatment programs, the Minnesota Sex Offender Program (MSOP) is mainly cognitive-behavioral and based on the relapse prevention model.<sup>15</sup> However,

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12. LaFond, *supra* note 6, at 496.

13. *Mckune v. Lile*, 536 U.S. 24, 122 S. Ct. 2017, 2032 (2002).

14. *Id.*

15. For a detailed description of the Minnesota Sex Offender Program, see Anita Schlank et al., *The Minnesota Sex Offender Program*, THE SEXUAL PREDATOR:

it should be noted that elements of Dialectical Behavior Therapy<sup>16</sup> are incorporated for those offenders who suffer from Borderline Personality Disorder,<sup>17</sup> and chemical abuse treatment is offered to those with a history suggesting problematic use of mood-altering chemicals. In addition, psychopharmacological interventions are available for patients with psychiatric needs and/or symptoms of sexual compulsivity requiring medication. For those offenders who have involved romantic partners or family members, a family information/support component is available and tailored to the specific support person's needs.<sup>18</sup>

#### A. Treatment Structure

The MSOP is offered in three stages: the Evaluation Stage, the Inpatient Treatment Stage, and the Transition Stage.<sup>19</sup> In the Evaluation Stage, a comprehensive assessment of the offender's treatment needs is completed to assist in the preparation of an individualized treatment plan.<sup>20</sup> As recommended by the Association for the Treatment of Sexual Abusers' policy statement,<sup>21</sup> the Inpatient Stage is structured with identifiable phases so that committed residents can easily gauge their progress in treatment toward objective, reliable phase goals. An assessment of the benefit obtained from participation in prior treatment programs is included in this process. This allows the treatment provider to determine the point at which the offender might start in the program.<sup>22</sup> The first phase of the inpatient treatment stage focuses on assisting patients to accept full responsibility for their

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LAW, POLICY, EVALUATION AND TREATMENT 10-1-10-17 (Anita Schlank & Fred Cohen eds., 1999).

16. Dialectical Behavior Therapy is a form of cognitive-behavioral therapy found to be particularly helpful for the treatment of Borderline Personality Disordered clients. See MARSHA LINEHAN, COGNITIVE-BEHAVIORAL TREATMENT OF BORDERLINE PERSONALITY (1993).

17. Borderline Personality Disorder is a severe personality disorder involving a pervasive pattern of instability of relationships, self-image and affect, with marked impulsivity. This disorder is often noted as being very difficult to treat. See AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL IV-TR (4th ed. 2000).

18. Schlank et al., *supra* note 15, at 10-11.

19. *Id.* at 10-7-10-11.

20. *Id.* at 10-7.

21. Association for the Treatment of Sexual Abusers (ATSA), *Civil Commitment of Sexually Violent Offenders*, available at <http://www.atsa.com/ppcivilcommit.html>.

22. Schlank et al., *supra* note 15, at 10-8.

offense history without the use of denial or minimization.<sup>23</sup> During the second phase of treatment, patients evaluate the build-up period to each of their past offenses and develop insights into their sex offending cycle.<sup>24</sup> By the time a patient reaches phase three, consistent behavioral change is expected in all areas of the patient's life.<sup>25</sup> In phase four, the patient prepares for the transition stage.<sup>26</sup>

The fact that MSOP patients are civilly committed enables the program to be an improvement over prison-based treatment programs in several important ways. However, as will be explained, civil commitment also creates unique difficulties.

As with any high-risk population, it is extremely important that sex offenders are observed at all times during their treatment. One crucial difference between the MSOP and most other sex offender treatment programs is that all staff, regardless of their position in the facility, are trained on the program model, program goals and how to observe and chart their observations regarding the patients' progress toward treatment goals. Therefore, even staff members who are working in facility maintenance or food service are monitoring patients' progress and have input into deciding if a patient is genuinely meeting phase goals. Continual observation is a particularly important component of the program because some patients have duped treatment providers into believing that they have made genuine progress, when in actuality, the patients have merely been "talking the talk" during treatment. Many offenders have a diminished capacity to form meaningful interpersonal relationships, although they can be quite good at mimicking this ability.<sup>27</sup> Only through constant observation, and with the assistance of polygraph examinations and measures of disordered sexual arousal/interest, such as a penile plethysmograph<sup>28</sup> or the Abel Assessment,<sup>29</sup> can the staff be assured that the patients have

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23. *Id.* at 10-8.

24. *Id.* 15, at 10-8.

25. *Id.* at 10-8.

26. *Id.* at 10-8.

27. Kevin Price, *Treating Sex Offenders in a State Hospital*, PSYCHIATRIC TIMES, June 1, 2002, available at <http://www.psychiatrictimes.com/PO20671.html>.

28. A penile plethysmograph is an assessment tool that measures any changes in penile engorgement when the client is shown various types of visual stimuli.

29. G.G. ABEL, ABEL ASSESSMENT FOR SEXUAL INTEREST: ADULT OFFENDERS (1996). The Abel Assessment is a computerized assessment tool that measures sexual interest in a variety of categories, using different types of visual stimuli, such as images of children.

progressed to a point where they can be gradually re-integrated into the community. This level of constant observation is extremely difficult to achieve in prison settings and impossible to achieve in outpatient settings.

### *B. Strengths and Weaknesses*

The major strength of a civil commitment program lies in its ability to insist on observable, consistent behavioral modification prior to the offender's release back into the community. While offenders may believe they can con their way to release, it is difficult to maintain such deception for several years, especially when patients are monitored twenty-four hours per day.<sup>30</sup> This arrangement is preferable to prison-based treatment programs that must conclude when the offender's sentence ends, and where staff can often be pressured to admit those on the waiting list into the limited space available. Community-based treatment programs face comparable time restrictions, as those who are attending such treatment as a condition of their supervised release may reach the end of that time period before they are rehabilitated. Community-based treatment programs also face funding limitations, as providers may be limited by the variable funding provided by outside sources.

The inability to terminate treatment of certain participants is a major downfall of the civil commitment program. While prison-based programs and community-based programs retain the ability to terminate the treatment of patients who resist treatment, break rules or interfere with the treatment of others, civil commitment programs must continue to treat such patients. This can create a counter-therapeutic environment for those patients who are motivated to participate in treatment. In addition, without having a less desirable setting to which they would be moved when they fail to participate in treatment, there is less incentive for participation. Another problem is that the rights associated with civil commitment can sometimes appear to interfere with the patients' treatment. This problem will be described more fully later in this article.<sup>31</sup>

An important aspect of any civil commitment program for sexual offenders is the component of the program that allows for a

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30. Price, *supra* note 27.

31. See *infra*, Part III.D.

gradual reintegration of the offender back into the community. Since many of these patients have been incarcerated for lengthy periods of time (usually both in prison and in the program itself), returning to society can be quite an adjustment.

In Minnesota, the Transition Stage of the program is currently located in St. Peter at the Minnesota Security Hospital (MSH).<sup>32</sup> Both the St. Peter site of the MSOP and the MSH also share a campus with the St. Peter Regional Treatment Center. While this arrangement allows for the availability of many services for patients in transition, such as access to MSH nursing, physicians, recreation areas and opportunities to work on the campus, it also has several drawbacks. Because the program shares the building with a program for patients who are committed as Mentally Ill and Dangerous, strict contraband rules must be followed. MSOP transition patients would not normally require such strict security. In addition, many of the civilly committed sexual offenders have committed crimes against vulnerable adults, and the close proximity to the Vulnerable Adult population presents a high risk factor.

Efforts are currently underway to provide a more appropriate living situation for MSOP transition patients. Rather than sharing a building with Mentally Ill and Dangerous patients, planners hope to house MSOP transition patients in a facility on the hospital grounds that would resemble a group home. In such a setting, MSOP transition patients could prepare their own meals and care for their own living area without being exposed to the increased security and heightened risks associated with the current facility. This arrangement would hopefully provide a more effective transition to the community, while still allowing access to necessary aspects of the hospital. It would also limit the patients' contact with Vulnerable Adults to only those brief encounters that are unavoidable.

### C. *Higher Costs/Slow Release Rate*

Treating sexual offenders who are civilly committed comes at a very high price to taxpayers. With costs throughout the country typically ranging from \$90,000 to approximately \$120,000 per year,

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32. Roxanne Lieb & Craig Nelson, *Treatment Programs for Sexually Violent Predators: A Review of States* 2 THE SEXUAL PREDATOR 5-1-5-12 (Anita Schlank ed., 2001).

## 2003] CIVILLY COMMITTED SEX OFFENDERS IN MINNESOTA 1229

per offender,<sup>33</sup> many question whether such programs can be maintained. In Minnesota, the cost of the MSOP far exceeds the cost of prison incarceration.<sup>34</sup> The cost differential between Department of Human Services (DHS) and Department of Corrections (DOC) facilities is directly related to the number and types of staff employed at each facility.<sup>35</sup> In DOC facilities, even those which offer sex offender treatment, per diem costs are less than in DHS facilities because they are primarily concerned with custody when the offender is not actively participating in treatment sessions. Conversely, DHS facilities employ staff in appropriate classifications and in sufficient numbers to monitor the behavior of the offenders on a twenty-four hour a day basis. In a DOC facility, one or two correctional officers may be responsible for supervising large numbers of offenders, while in a DHS facility, three or four security counselors may be assigned to a twenty-five bed unit. The DHS staff is trained to interact with patients, implement specific behavior change programs and observe and document the conduct of patients. These duties require additional staff beyond those necessary for custody and security. This intensive staff-to-patient ratio, which in Minnesota is approximately 1.66 staff to 1 patient, results in a higher per diem cost.

This high cost can anger taxpayers, especially when they hear that a fair number of patients appear to be unwilling and unmotivated to take advantage of the treatment offered and cannot be forced to participate in the treatment groups. However, proponents of the civil commitment program contend that the cost is relatively small when viewed from a cost-per-taxpayer basis. They point out that each taxpayer is providing the equivalent of the cost of one movie ticket each year toward holding the state's highest risk sex offenders in a secure setting, and protecting potential victims until the time that the offender can be safely returned to

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33. *Id.*

34. The per diem for MSOP is \$310/day, as compared to a per diem of \$78/day in the Department of Corrections.

35. In the Department of Corrections, it is not unusual to see one correctional officer assigned to monitor approximately seventy inmates on a living unit, while in the DHS facility, three security counselors might be assigned to a twenty-five bed unit. This increased DHS staffing is necessary because the security counselor's duties go beyond simply maintaining the safety of the living unit, and include observation and charting of progress toward treatment goals, and counseling regarding issues concerned with problem-solving on the living unit. In addition, in the DHS facility, professional clinical staff are assigned at a rate of one psychologist, one social worker and one behavior analyst per twenty-five bed unit.

society.<sup>36</sup> They also argue that the fact that many sex offenders refuse treatment simply reinforces the notion that they are not ready to return to the community. After hearing these arguments, many taxpayers are less concerned about the cost of sex offender treatment.

Some critics question the length of time that is required for completion of sex offender treatment. It should be noted that the civil commitment referral process, when used correctly, will end up selecting those offenders with the longest sex offending histories, the most serious disorders, and those who have been the most treatment-resistant while in prison.<sup>37</sup> Not surprisingly, these offenders progress through the program at a slow pace. The treatment of patients with personality disorders can take significantly longer than the treatment of psychotic individuals.<sup>38</sup> Antisocial personality traits, seen in nearly every civilly committed sexual offender, “are a poor prognostic feature, primarily related to lack of motivation and remorse.”<sup>39</sup> Most of the patients in the MSOP have both paraphilias,<sup>40</sup> which can be very difficult to treat, and personality disorders (most frequently “Antisocial Personality Disorder”).

Two patient variables, client openness (or non-defensiveness) and motivation for treatment, are “moderately related to treatment outcome.”<sup>41</sup> In addition, the ability of the patient to “establish and maintain meaningful interpersonal relationships” has also been

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36. Personal communication from Stephen Huot, Director, Chemical Dependency and Sex Offender Programs, Minnesota Department of Corrections, to Anita Schlank (May 2002).

37. Only approximately four percent of MSOP patients had successfully completed a sex offender treatment program while in prison. Most had either consistently refused, or had been terminated after a brief stay in the prison program. Janice Marques et al., Best Practices in Civil Commitment, Pre-conference workshop presented at the 20th Annual Research and Treatment Conference of the Association for the Treatment of Sexual Abusers (ATSA), San Antonio, TX (2001).

38. Price, *supra* note 27.

39. *Id.*

40. A paraphilia is a psychosexual disorder in which the person has intense sexually arousing fantasies that are problematic for him/her and generally involve either nonhuman objects, the suffering or humiliation of oneself or one's partner, or children, or other non-consenting persons. For example, Pedophilia, the disorder in which a person has intense sexually arousing fantasies about prepubescent children, is a type of paraphilia.

41. Denise L. Preston & Stafford Murphy, *Motivating Treatment-Resistant Clients in Therapy*, available at <http://www.csc-scc.gc.ca/text/pblct/forum/e092/e092i.shtml>.

## 2003] CIVILLY COMMITTED SEX OFFENDERS IN MINNESOTA 1231

correlated with treatment motivation and “this is a major impediment for those whose lives are revolved around mistrust and fear of, or indifference to, others.”<sup>42</sup> A study conducted in the Canadian prison system noted that those patients who were likely to be diagnosed with Antisocial Personality Disorder and/or Borderline Personality Disorder and were likely to score fairly high on the Psychopathy Checklist-Revised<sup>43</sup> (a combination often seen in civilly committed sexual offenders) would be difficult to treat. According to the study, these patients are likely to be less motivated for treatment, more resistant while in treatment, have higher attrition rates, demonstrate fewer positive behavioral changes while in treatment and possibly higher recidivism after treatment completion.<sup>44</sup> While this would suggest that the treatment providers should work extremely hard to help the patients remove attitudinal obstacles to change, the high level of psychopathy found in the population can further complicate this task. As previously noted, psychopaths have a diminished capacity to form meaningful interpersonal relationships, although they can be quite effective in mimicking this ability.<sup>45</sup> As one commentator explains, “[s]exual predators are already narcissistic; they laugh behind their masks at our attempts to understand and rehabilitate them. We have earned their contempt by our belief that they can change.”<sup>46</sup> While this view may be overly pessimistic, it is important for treatment providers to realize that many members of the civil commitment population are adept at manipulating others, and that efforts on the part of clinicians to form therapeutic alliances with psychopathic offenders are likely to fail. In addition, these efforts may be risky because clinicians may perceive a false sense of personal safety with these clients.<sup>47</sup>

In addition to motivational problems and severe personality disorders, it is difficult to determine when a patient’s risk level has been sufficiently reduced to allow a return to society. While fairly extensive research has been conducted on variables that suggest a

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42. *Id.*

43. ROBERT D. HARE, MANUAL FOR THE PSYCHOPATHY CHECKLIST-REVISED (1990).

44. Preston & Murphy, *supra* note 41.

45. Price, *supra* note 27.

46. Andrew Vachss, *Sex Predators Can't Be Saved*, N.Y. TIMES, Jan. 5, 1993, at A14-15.

47. *Id.* See also ROBERT D. HARE, WITHOUT CONSCIENCE: THE DISTURBING WORLD OF THE PSYCHOPATHS AMONG US (1999).

high likelihood that a person will commit another dangerous offense,<sup>48</sup> less attention has been focused on how to determine when a high-risk sexual offender has substantially lowered the risk that the offender presents to the community.<sup>49</sup> Currently, one of the few clear indicators of lowered risk is the successful completion of a comprehensive sex offender treatment program, yet other dynamic risk factors warrant further attention. If civil commitment laws are applied as they are intended, only the most high-risk sex offenders will be civilly committed. Therefore, there appears to be a fair probability that even the most successful civil commitment programs may have a high recidivism rate after release, simply due to the base reoffense rate of this population.<sup>50</sup>

Minnesota is not unique in its relatively slow rate of discharge. Of the sixteen states with civil commitment laws,<sup>51</sup> fourteen states appear to have similar types of programs.<sup>52</sup> In reviewing statistics from those fourteen states,<sup>53</sup> only Minnesota, New Jersey and Kansas have released offenders following successful completion of a treatment program, and in these states, only five offenders have been released in total.<sup>54</sup> Of the fourteen programs, Minnesota had the highest number of patients in the transition stage.

#### *D. The Problem of Institutionalization*

One question faced by many civil commitment programs throughout the nation is how to reconcile patients' civil liberties with the need for a secure, highly supervised setting. The confusion surrounding this issue is present in the Client Handbook published by the Minnesota Department of Human Services (DHS).<sup>55</sup> This handbook, which was essentially written for all

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48. DENNIS M. DOREN, D., *EVALUATING SEX OFFENDERS: A MANUAL FOR CIVIL COMMITMENTS AND BEYOND*, 146-51 (2002).

49. Becker & Murphy, *supra* note 3, at 116-37.

50. *Id.*

51. The sixteen states with civil commitment statutes are: Arizona, California, Florida, Illinois, Iowa, Kansas, Massachusetts, Minnesota, Missouri, New Jersey, North Dakota, South Carolina, Texas, Virginia, Washington and Wisconsin.

52. For example, Texas utilizes outpatient commitment and Arizona has a law which allows courts to commit offenders directly to a less restrictive alternative, similar to the transition stage of most other programs.

53. E-mails from the Directors of the sixteen SVP programs to Anita Schlank (July 2002) (on file with author).

54. *Id.*

55. MINNESOTA DEPARTMENT OF HUMAN SERVICES, *MENTAL HEALTH TREATMENT PROGRAM BILL OF RIGHTS (CLIENT HANDBOOK)* (2000).

## 2003] CIVILLY COMMITTED SEX OFFENDERS IN MINNESOTA 1233

individuals either admitted voluntarily or through civil commitment to state operated facilities, states that “[a]ny person admitted to this facility is a Vulnerable Adult, under the Vulnerable Adult Act.”<sup>56</sup> The handbook fails to clarify that patients committed under the Sexual Psychopathic Personality or the Sexually Dangerous Person statutes are categorically excluded from the Vulnerable Adult Act. Persons committed under these statutes almost never show characteristics that would lead one to believe that they are incapable of protecting themselves from abuse or are deficient in their ability to report abuse. Nevertheless, many of the protections afforded Vulnerable Adults are also available to sexual offenders.

In some cases, these protections are antithetical to the aims of the sexual offender program. For example, patients who are civilly committed to DHS facilities have a right to privacy while making telephone calls. While many would consider this an important right, it can actually be quite risky for a sexual offender. In several instances, civilly committed sex offenders in Minnesota have abused this policy by contacting minors and engaging in sexually explicit conversations. Even when staff members are able to detect such behavior and place the patients on individual behavior programs<sup>57</sup> that allow staff to supervise their calls, some have found ways to circumvent the supervision. Furthermore, after a designated period of time has passed in which the patient demonstrates successful management of the terms of the individual behavior program, the staff is required to allow the patient to resume making unsupervised phone calls.

The right to privacy regarding communication through the mail may also lead to difficulties. Several civilly committed sexual offenders have continued their pattern of predation by abusing their unsupervised access to the mail. Some have even created false letterheads in order to convince others that they run a modeling agency. Through this type of misrepresentation, parents have been convinced to send pictures of their children, and women have been convinced to submit personal data, including their social security numbers. As with the misuse of the phone, mail can be restricted on an individual basis if the abuse is detected. However, once the

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56. *Id.* at 11.

57. Individual behavior programs are temporary programs in which the patient’s behavior around a certain issue, such as mail or phone use, is monitored closely until they demonstrate signs of more responsible behavior.

patient meets certain criteria, unsupervised mail privileges resume.

In other cases, patients have used the phone and mail to accumulate huge debts that they do not intend to repay. In many cases, businesses simply write off such losses without prosecuting patients. When patients perceive that they will be held less accountable for fraudulent behavior as long as they stay in the treatment facility, they are more likely to become institutionalized.

The patients' lifestyle within the treatment facility can also contribute to institutionalization. Because their civil rights have been restored, patients earn minimum wage for any work assignments completed during treatment. Patients face few consequences if they choose not to participate in treatment or if they participate only minimally. While incentives can be offered for treatment participation, the staff must respect a patient's rights to refuse to participate in sex offender-specific treatment groups. In addition, in Minnesota, the patients enjoy the benefits of local restaurant and store delivery, as well as access to many personal possessions, including such items as VCRs and CD players. This lifestyle, which is considered comfortable by some of the patients, combined with fears of community notification and employment unavailability once discharged, contribute to a tendency for patients to become institutionalized. Some have even reported that they have no desire to leave the facility.

Faced with problems such as those mentioned above, many states have recognized the need to curtail the liberties granted civilly committed sex offenders. Some states have already taken action to restrict these rights. Other states are in the process of drafting a revised version of the Bill of Rights that is more applicable to civilly committed sex offenders.<sup>58</sup> This appears to be something worth considering by Minnesota.

*E. Effects of Working in a Civil Commitment Program  
for the Therapists*

Working in a comprehensive, residential treatment program such as a civil commitment program can be rewarding in that treatment providers witness some patients truly changing all aspects of their lifestyle. However, some aspects of this work can be quite fatiguing. Patients who are extremely resentful about their civil

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58. E-mails from the Clinical Directors of certain states with SVP statutes to Anita Schlank (Sept. 2002) (on file with author).

## 2003] CIVILLY COMMITTED SEX OFFENDERS IN MINNESOTA 1235

commitment may displace their anger on treatment providers. The public's hatred of the sex offender population is sometimes misdirected onto those who treat sex offenders. Some members of the public are angry that time and money is being spent to provide quality programs for people who have so seriously harmed others. Even patients' family members and romantic partners are not always supportive, as they have sometimes been told distortions about the treatment program. As explained on the website for the Seguin Family Institute Training conferences:

The problems we often encounter in doing this work include the fact that these criminals know how to con in such a way we often cannot detect it. When we do figure it out and try to set boundaries, we often find ourselves in a tug-of-war with the client's attorney, family members, and friends. Sometimes it seems even our colleagues and supervisors do not understand or support us. When no one else can see the manipulations of these offending clients, and it feels like everyone in society is against the work we are trying to do, we can feel overwhelmed, tired, and defeated. After all, we are supposed to be working on the same "side" in society.<sup>59</sup>

It can also be quite frustrating for treatment providers to see offenders continue to commit crimes from within the treatment program. As noted above, some patients abuse rights designed to protect Vulnerable Adults. Other patients assault staff members or deliberately expose themselves to treatment providers. For various reasons, few patients face jail or prison sentences for such behavior. The failure to prosecute such offenses provides an incentive for patients to remain in treatment rather than join a society that would hold them responsible for their actions.

In addition, while it can be extremely rewarding for treatment providers to assist offenders who are motivated to change their ways and rejoin society, it can be extremely wearing to see other patients stuck in their offending cycle with no apparent desire to make changes. Some patients demonstrate their lack of motivation by continuing to attempt to obtain child pornography or other forms of media that promote sexual violence. Others continue their offending cycle through various methods of intimidation. Many

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59. Seguin Family Institute, *How to Tell When a Con is Conning: Techniques for Professionals Who Deal with Those Who Break the Law*, available at <http://www.seguinfamily.com/WorkDesc.shtml>.

offenders employ various forms of veiled threats in an attempt to control the behavior of others. They may have used these same techniques in the past to dissuade victims from reporting their sexual offenses. Some patients try to keep staff members from documenting negative behavior by continually bringing legal challenges each time their negative behavior is documented. While treatment providers are aware that they cannot allow themselves to be manipulated into looking the other way, it can be difficult to maintain the energy level needed to consistently challenge patients' attempts at intimidation.

#### IV. DEPARTMENT OF CORRECTIONS/DEPARTMENT OF HUMAN SERVICES COLLABORATIVE

Recently, the Minnesota DOC and the Minnesota DHS began a fairly unique collaboration. This collaboration seeks to address many issues facing sex offender treatment programs. Among these are: (1) the fact that civilly committed sexual offenders are being admitted at a much faster rate than they are being discharged; (2) the concerns of some sex offenders that they did not know when they were likely to get civilly committed; (3) the fact that some sexual offenders had successfully completed the DOC's sex offender treatment program but were nevertheless civilly committed because it was believed they were in need of a lengthier, more intensive program; and (4) the fact that some patients who refused treatment in the civil commitment program had supervised release time remaining from their DOC sentences.

The first action taken in response to this collaboration was to revoke the supervised release of any offender in the civil commitment program who refused to participate in treatment. Prisoners are released early with the expectation that they will meet certain supervisory conditions. In the case of sex offenders, one of these conditions is usually participation in treatment. Under the collaboration, sex offenders who have been civilly committed and have supervised release remaining, but are refusing treatment are sent back to prison. This action encourages many patients to participate in treatment but has no effect on those civilly committed patients with no supervised release time remaining.

Through the collaboration, the DOC also identifies earlier in their sentence those offenders who are likely to be civilly committed at the end of their sentence if they do not successfully complete treatment. These offenders are notified of the results of

## 2003] CIVILLY COMMITTED SEX OFFENDERS IN MINNESOTA 1237

this assessment and are strongly encouraged to participate in treatment.

One of the most significant undertakings of the collaboration occurred when the MSOP opened an additional site within the prison system. This program is run by DHS staff and closely approximates the DHS program.<sup>60</sup> Those offenders judged to be the highest risk and likely to be committed at the end of their sentence or those who were already committed, but whose supervised release was revoked due to nonparticipation, are referred to this program. It is hoped that by completing the MSOP-DOC program, offenders who would have been civilly committed following their sentence will make enough progress in treatment to avoid the need for civil commitment.

This plan seems ideal for many reasons. It should result in fewer sex offenders being committed to the higher-cost DHS facility because it offers them a chance to lower their risk for reoffending while still in prison. If an offender is unable to complete the prison program and gets civilly committed when the offender's prison sentence ends, the offender should be able to make a seamless transition to the DHS site, entering at the same stage of treatment that he was in at the DOC-site of the program. This will presumably lead to fewer days spent in the high-cost DHS facility. This plan also appeals to offenders who are not yet civilly committed, since it means they may spend less time overall in a secure setting.

## V. FUTURE DIRECTIONS

Are civil commitment statutes for sex offenders unwise? Are these statutes therapeutic or counter-therapeutic? These are questions that have no clear answer. States that enact civil commitment laws should be prepared to spend significant funds implementing them and should be aware that offenders will likely be admitted at a much faster rate than they are discharged. States should recognize that some offenders might never reach the point of discharge. State administrators and legislators should be aware that, despite the best efforts of clinicians, the treatment of dangerous sex offenders is an inherently slow process. The highest

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60. The DHS prison-based program differs from the regular program in that it offers only the evaluation stage and inpatient treatment stage. It does not offer the transition stage of the program.

risk, most treatment-resistant sexual offenders require continual supervision, and their privileges should be restricted until they have made substantial progress in their treatment.

Civil commitment can provide an unparalleled opportunity to work with high-risk offenders in an intensive, comprehensive manner without the ever-present time restrictions involved in treating incarcerated offenders. This assures greater safety for the community and better treatment for offenders. However, with the restoration of the offenders' civil rights and the expectation that they will be treated nearly the same as Vulnerable Adults, many characteristics of civil commitment are actually counter-therapeutic. Therefore, it appears that treatment for sexual offenders is most likely to be successful if it occurs while they are still in prison. Many states are now increasing sentences for chronically violent sex offenders.<sup>61</sup> Arizona is attempting to address these concerns through lifetime intensive probation for offenders who are deemed especially dangerous.<sup>62</sup> Minnesota appears to have developed a potentially successful solution to many of the problems caused by civil commitment through its collaborative efforts between the DOC and the DHS. This collaboration ensures that high-risk sexual offenders are identified and offered the chance to complete essentially the same program as civilly committed offenders while still in prison. This appears to be a very promising new direction. However, it will not address the difficulties faced in treating those offenders who are already civilly committed.

For states such as Minnesota that do have civil commitment statutes, state government and human service agencies must recognize that treatment programs for sex offenders need to be entirely different from those for patients who suffer from mental illnesses, including the privileges offered to them.<sup>63</sup> States initiating such programs should look at the possibility of creating a revised Bill of Rights for sex offenders in order to avoid unintentionally enabling criminal behavior and/or contributing to institutionalization of the patients.

Finally, in the future, states may also wish to focus their attention on the special problems presented by juvenile sex

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61. LaFond, *supra* note 6, at 494-95.

62. *Id.* at 494.

63. National Association of Mental Health Program Directors (NAMHPD), *Position Statement on Laws Providing for the Civil Commitment of Sexually Violent Criminal Offenders*, available at <http://www.nasmhpd.org/sexpred.htm>.

offenders. Some MSOP patients are admitted on their eighteenth or nineteenth birthday, following failure in juvenile treatment programs but before they have an adult offense record. It is risky to house juvenile sex offenders with adult offenders. Adult offenders who have targeted adolescent boys in the past may “groom” young-looking offenders into sexual acting-out behavior, or may influence juvenile offenders by encouraging them to engage in more criminal behavior. A closer evaluation of the treatment histories of youthful offenders might reveal some useful data that could help treatment providers deal with treatment-resistant youths without resorting to civil commitment.

## VI. CONCLUSION

Is the Minnesota Sex Offender Program successful? The program has evolved and improved significantly over the years. Treatment participation has risen from 34% in 1995 to 76% in recent years.<sup>64</sup> It has been recognized as one of the best civil commitment programs in the country,<sup>65</sup> particularly because of its success in evaluating change in offenders that can be observed outside of scheduled group sessions. Staff members have dedicated themselves to ensuring that patients consistently demonstrate change in all aspects of their lives, thereby indicating that these changes are genuine. Staff members have also helped motivate patients’ transitions back into the community as productive citizens. However, the commitment laws themselves can make treatment extremely difficult, especially when the rights afforded patients are exploited or contribute to the patients’ continued institutionalization. In some ways, the civil commitment laws for sexual offenders create nearly as many problems as they solve. Hopefully, the promising new collaborative effort between the DOC and the DHS will lead to even more success in helping sexual offenders to change and become productive members of society.

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64. Janice Marques et al., *supra* note 37.

65. John Kip Cornwell et al., *The New Jersey Sexually Violent Predator Act: Analysis and Recommendations for the Treatment of Sexual Offenders in New Jersey*, 24 SETON HALL LEGIS J. 1, 20 (1999). See also Austin T. Deslauriers & J. M. Gardner, *The Sexual Predator Treatment Program in Kansas* 1 THE SEXUAL PREDATOR: LAW, POLICY, EVALUATION & TREATMENT 11-1, 11-8 (Anita Schlank & Fred Cohen eds., 1999).