Chapter 7

Similar Statutes, Different Treatment Needs— A Comparison of SVP and Mentally Ill Populations

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INTRODUCTION

In June 1997, the U.S. Supreme Court upheld the constitutionality of the use of civil commitment statutes to continue to confine sexually violent criminal offenders after the end of their sentence, provided that they have a "mental abnormality" that causes them to pose a danger to others.[1] These statutes arose out of a perception that some inmates who posed a very high risk of violent sexual recidivism would be released, in many cases without any supervision at all, in the community upon the expiration of their sentences. Because they had already been sentenced, more severe sentences would not be legally permissible for these offenders, so states began to look for ways to preventively detain them.

To avoid the constitutional prohibition against ex post facto laws and double jeopardy, the first efforts to confine sex offenders after expiration of their sentence looked toward other examples of preventive detention that are allowed under constitutional law. Those seeking to confine these offenders might have relied on public health quarantine laws, such as those historically used to fight outbreaks of tuberculosis (Mindes, 1995–1996). Instead, they looked to and adopted the civil commitment statutes that have traditionally been used to confine persons with serious mental illness who posed an imminent danger to themselves or others. However, there were obvious differences between disorders that had traditionally been viewed as "mental illnesses" for the purposes of commitment and the predilection to commit sex offenses. Most important,

traditional mental illnesses such as schizophrenia and bipolar disorder are widely accepted as squarely within the fields of clinical psychiatry and psychology. Sex offender treatment, on the other hand, is at best a small niche of the traditional mental health professions.

Second, although serious mental illnesses are believed in some cases to often overcome free will, there is no real consensus on the degree to which sexual disorders such as paraphilias diminish the offender's ability to "just say no" to his or her illegal desires; the difference between irresistible impulses and unresisted ones is often unclear. An example of this lack of consensus can be seen in the trial of serial killer Jeffrey Dahmer. During that trial, psychiatrist Fred Berlin testified that Dahmer was "insane" and not responsible for his actions; however, forensic psychiatrist Park Dietz stated that, in his opinion, "the thing that makes people willing to commit offenses for gratification of sexual arousal is exactly the same thing that makes others willing to commit robbery in order to get more money" (Keiger, 1994). Dietz testified that Dahmer was mentally disordered due to paraphilias, alcoholism, and personality disorders but not legally insane, and he noted that he draws a distinct line between psychotic mental illness and other disorders such as pedophilia or antisocial personality disorder. For the new wave of sex offender civil commitment statutes, it appears that a similar distinction was made and the term "mental abnormality" was used because most such offenders were not considered to have a "mental illness" sufficient to justify involuntary commitment under regular commitment statutes (Alexander, 2000).

Many observers and advocates have opposed the use of civil commitment statutes for those who are not mentally ill for several reasons (National Association of State Mental Health Program Directors, 1997). First, it could have severe and negative consequences for individuals with mental illnesses by increasing the stigma against them. The public already associates mental illness with dangerousness, despite that fact that people with serious mental illness are more likely to be victims than perpetrators of violence (Link & Phelan, 1999; Link, Phelan, Bresnahan, Stueve, & Pescosolido, 1999; Mulvey & Fardella, 2000). Second, we live in a time at which there are already too few resources devoted to the treatment of serious mental illness. Hospital beds are difficult to access, and community mental health services are far too few and not nearly intensive enough to prevent the most serious consequences of undertreated mental illness. As a result, jails and prisons have increasingly become unwilling and poor substitutes for more appropriate mental health treatment settings (National GAINS Center, *www.gainsctr.com*). By basing sex offender commitment statutes on mental disorders, it was feared that already thin resources would be taken from these programs and devoted to locking up sex offenders. Finally, there is the question of cost. Psychiatric hospitals are very expensive to run, far more so than prisons. To house sex offenders in psychiatric facilities, at a cost of up to $200,000 per bed per year or more, it would mean spending money on services (e.g., intensive twenty-four-hour nursing care) that have little to do with sex offender treatment.

Despite these arguments and the considerable attention that has been paid to the issue of how civilly committed sexual offenders differ from populations that are mentally ill, there continues to be considerable confusion in this area. Clinical directors for the sexually violent predator (SVP) programs frequently find that the public assumes that civilly committed sexual offenders are "mentally ill," and some advocates have

assumed and asserted that their treatment programs should look just like those provided for patients with severe and persistent mental illnesses (Summit on the Treatment of Sexually Violent Predators, 2000). Others believe that sex offenders should be held in relatively inexpensive, even prison-like, circumstances, with sex offender treatment added on only to the meager extent required in *Kansas v. Hendricks*.[1] This chapter focuses on clarifying the differences between the populations of civilly committed sexual offenders and those who have been civilly committed for major mental illnesses. In addition, this chapter makes recommendations regarding specific treatment approaches that are appropriate for each type of client.

STRUCTURE OF STATUTES

Only recently have states used civil commitment statutes for sex offenders for confinement following completion of their prison sentences. Previously, in some states, statutes for mentally disordered sexual offenders (MDSO statutes) tended to divert offenders from the prison system into state hospitals or treatment centers, typically on a voluntary basis, allowing for return to the prison setting if they requested to do so, or if they showed a lack of progress in treatment (Reisner, Slobogin, & Rai, 1999). With the new postconfinement commitment arrangement, there was some confusion regarding how the statutes should be written. Some states, such as Minnesota, based the statutes on their statute for the confinement of individuals found to be mentally ill and dangerous (MI&D). This led to some aspects of the MI&D statute being applied illogically to sexual offenders. For example, the population committed as MI&D is committed initially on a temporary warrant, to be reviewed in sixty days (Minnesota Commitment Act of 1982). This sixty-day hearing is to determine whether the individual still meets commitment criteria, or whether his or her condition has changed significantly to suggest that he or she no longer meets those criteria. Because psychotropic medications can work fairly quickly, this procedure makes sense for individuals whose psychosis led them to be a danger to self or others. The Sexually Dangerous Person and Sexual Psychopathic Personality statutes in Minnesota use this same temporary warrant and sixty-day hearing, despite the fact that an individual who is committed as a dangerous sex offender will not be likely to show any significant change in sixty days. By modeling after a statute for the mentally ill, it appears that court time and tax dollars are wasted on numerous hearings that simply confirm that individuals who have been found to be repetitive, dangerous sexual offenders will not show significant improvement in only sixty days. Interestingly, in other ways Minnesota did seem aware of the differences in the two populations to some degree, as the civilly committed sexual offenders were categorically excluded from the vulnerable adult clause that applied to other committed populations.[2] By doing so, it was recognized that those individuals committed as sexual offenders are not suffering from mental illnesses that make them especially vulnerable to exploitation and abuse. In addition, Minnesota developed a special licensing rule, "Rule 26,"[3] which applied only to the program for the civilly committed sexual offenders. This separate licensing rule recognizes that the Department of Health/Department of Human Services regulations to set standards of care for the treatment of the mentally ill populations need to differ significantly from the standards for the treatment program for civilly committed sexual offenders.

PSYCHIATRIC INVOLVEMENT

Because civilly committed sexual offenders are not usually suffering from major mental illnesses, there is less need for treatment by psychiatrists. Programs have estimated that only approximately 10 percent of residents committed to SVP programs required treatment with antipsychotic medications, and most of those were well stabilized on their medications prior to their sex offender commitment (Sarteschi, 2000). Most SVP programs have clinical psychologists as clinical directors and use a consultative model with psychiatry, which differs from the programs for the civil commitment of individuals with mental illness.

In Minnesota, a review of diagnoses among the committed sex offender population showed that none had been diagnosed solely with a major mental illness, and only 9 percent had a diagnosis of a major mental illness along with a paraphilia and/or personality disorder. Ninety-three percent had diagnoses of paraphilias and personality disorders. (And, at the SVP Summit ("Summit on the treatment . . ." 2000) other states reported similar findings.) These statistics differed greatly from the diagnoses of those patients committed as mentally ill and dangerous, even when compared to those who also had histories of sexual offenses. The agency responsible for licensing the Minnesota Sex Offender Program (MSOP) recognized this difference and approved a licensing variance for psychiatric treatment. According to the variance, residents no longer are required to have automatic assessments by a psychiatrist upon admission, or yearly follow-ups. Only those who were admitted on psychiatric commitments or determined to be in need of such services by the psychology department are currently referred to the consulting psychiatrist.

It should be noted, however, that one very important role for psychiatrists is in the treatment of obsessive sexual thoughts and compulsive sexual behaviors, which are symptoms sometimes seen in this population. A variety of medications have been found to be useful in treating these symptoms, including serotonin-specific reuptake inhibitors and antiandrogens (Bradford, 1991, 1994, 1995; Stein et al., 1992; Walker & Meyer, 1981; Gagne, 1981). There is empirical evidence that these medications have a suppressing effect on disordered sexual arousal and may also enhance the arousal toward adult consensual sexual activity. Therefore, the use of these medications may be a crucial component for some offenders in a comprehensive sex offender treatment program (Heath & Schlank, Chapter 8, in this volume, examine this topic in further detail).

RESPONSE TO RESIDENT VIOLENCE

In a treatment program for patients who are committed as mentally ill, it is presumed that incidences of violence on their part are likely to be the product of their mental illness. For that reason, care is taken to ensure that patients are isolated following aggressive behavior only long enough to stabilize them and allow them to regain control over their behavior. Once the patient has regained behavioral control (perhaps with the assistance of necessary psychotropic medications), the patient is returned to his or her living unit. Many resident advocates or hospital review boards believe these same procedures should be used with the sex offender population, however, we (Schlank and Dvoskin) disagree. Violence conducted in a sex offender psy-

ulation is often planned and rationally executed, with the offender often demonstrating behavioral control immediately before and following the act of violence. There is no reason to assume that violence in SVP facilities is any more or less the product of mental illness than violence in any other congregate living setting, such as military barracks or college dormitories. Isolating the individual only until he or she has "regained control" is essentially a useless gesture, there is no reason to assume that the individual has in fact lost control in the first place. Such a brief period of isolation has no therapeutic purpose for the offender and no assurance of safety for the rest of the resident population. Perhaps most important, brief periods of separation provide no material negative consequences for violent or predatory behavior.

Some have argued that methods outside the treatment program can be used for such acts, such as pressing criminal charges and transfer to county jails. However, in reality police and sheriffs are quite reluctant to fill already crowded jail cells with offenders who are already in a secure facility. They are often unaware of the limitations that may be placed on SVP treatment staff to use methods such as segregation, which are available in prisons. In addition, when offenders are transferred to jail, they can sometimes post bail and return to the treatment center almost immediately. On at least one occasion in Minnesota, when a resident was charged and sentenced for an assault he committed against staff, he received "jail time credit" for time spent in the treatment facility prior to resolution of the charge, despite the fact that the treatment facility was not a jail. Law enforcement officials and prosecutors can also be extremely reluctant to press charges for some offenses, such as deliberate indecent exposure to staff members, without realizing that facing consequences for such behavior is an important part of treatment for these offenders.

The absence of a system of consequences for violent and predatory behavior within an SVP facility poses an unacceptable risk to staff and residents alike. Requiring a facility to follow illogical and irrelevant seclusion and restraint rules, as if the behavior were due to the symptoms of a serious mental illness, is wasteful of psychiatric and nursing resources and quite unlikely to be effective in changing the behavior. Prisons have responded to this challenge by creating disciplinary systems, with administrative due process, that have passed constitutional muster (Dvoskin, Petrila, & Stark-Riemer, 1993).[3] The primary purpose of these systems is not to punish offenders but to vindicate the state's compelling duty to maintain safe institutions; consequences for violent behavior are one essential component of this task.

Most recently, a class action suit involving the SVP program in Illinois[4] supported the view that civilly committed sexual offenders may receive different consequences for violent behavior than those individuals who are committed with serious mental illnesses. In that case it was held that the American Psychiatric Association Standards for seclusion and restraint did not "apply wholesale" to the use of secured or special management status, because the patient population was noted to be "significantly different from that found in psychiatric hospitals."[5]

CONDITIONS OF CONFINEMENT

One similarity between treatment programs for civilly committed sexual offenders and forensic mental health facilities is their shared need for security. In both cases, perimeter security systems often include two fences, with the main purpose of the

inner fence to define an area beyond which patients are not allowed. Perimeter fences often have electronic alarm systems that are able to alert security staff of entrance into the area between the fences (Dvoskin & Patterson, 2000). Razor ribbon or alarm systems such as motion detectors are also often used on the outside fence. Because there is a high need for security in these programs, the external appearance of a facility can often resemble that of a prison, and the rights of residents or patients will be limited to a significant extent by the security needs of the institution and the existence of a secure perimeter. This can be somewhat concerning for family members and/or resident advocates. The residents of several SVP programs have filed class action lawsuits challenging their conditions of confinement.[7] In these cases, the residents allege that the facilities are too restrictive, and appear more like a prison than a treatment center (American Civil Liberties Union, 2004; C. Nelson, personal communication, 2008).

Ironically, residents have also argued that they observed more rights and privileges in prison than they now have in SVP facilities. For example, even after a long sentence, a prisoner may have earned status as a minimum custody inmate or trustee. Trustees often have the freedom to move about the prison complex, perform jobs within the prison, and so on. SVP facilities, however, are likely to treat such new admission as "starting over," at the highest level of restrictiveness. There is understandable controversy about this practice. From the residents' point of view, they have earned trust, perhaps by years of good institutional behavior. From the facility's side, however, the inmate may have achieved trustee status based largely on the fact that he has little time left to serve and thus "a lot to lose" by misbehaving or escaping. In contrast, SVP committees have no fixed release date to which they are looking forward, and many believe that the state does not intend to release them, ever.[8] Thus, the facility may reasonably believe that the same person may perceive him- or herself as having more to lose as a resident than he or she did as an inmate.

At this time, the correct balance between security needs and the provision of a therapeutic environment remains unclear, and program directors for SVP programs are faced with a dilemma of providing a secure environment for offenders deemed to be highly dangerous without appearing punitive. They must ensure the safety of the surrounding community by preventing escape and ensure the safety of the staff and residents by preventing institutional violence while simultaneously giving residents the opportunity to grow and learn new, safer sexual behaviors.

In an effort to avoid having a "prison-like" setting, some programs have allowed residents to have VCRs and CD players and, in Minnesota, local restaurants and stores are allowed to deliver meals to the residents. The Minnesota program is also required to pay minimum wage to residents for any work that they do. Unfortunately, this lifestyle, which is considered comfortable by some of the residents, contributes to a tendency to become institutionalized. Some residents in the Minnesota program have even reported that they have no desire to leave the facility, and consider it their "retirement home."

In addition to the problem of potential institutionalization, an environment that is far less restrictive than a prison can allow some offenders to continue their criminal behavior. Sexual offenders who have completed their prison sentences do have their civil rights restored; however, in some cases, these rights are antithetical to the aims of sexual offender treatment. For example, most patients civilly committed to state-run hospitals have a right to privacy while making telephone calls.[9] Although this may

be considered an important right. It can actually create an opportunity for further criminal behavior by a sexual offender. For example, civilly committed sexual offenders in the Minnesota program abused this right by contacting minors and engaging in sexually explicit conversations. When staff members were able to detect some of that behavior and place the offenders making the calls on individual behavior programs that allow for supervision of their calls, some offenders found ways to circumvent the supervision (Schlank & Harry, 2003). Similar problems occurred because of the protected right to privacy of communication through the mail. Some civilly committed sexual offenders continued their patterns of predation by abusing this right. Some created false letterheads in order to convince others that they ran a modeling agency, convincing parents to send pictures of their children, or vulnerable women to send identifying information including their social security numbers. In other cases, residents used phone and mail to accumulate huge debts that they had no intention of repaying. In many cases, the businesses simply wrote off the losses without prosecuting the residents, which served to reinforce this criminal behavior. One individual (in addition to defrauding several businesses) created a fraudulent company in which he listed other residents as employees and filed false tax returns obtaining thousands of dollars illegally (Oakes, 2004).

The balance between providing a secure environment and a therapeutic environment was addressed, to some degree, in *Norgett v. Aikens*.[v] In that case, the court found that although the physical structure of the facility in Illinois did not facilitate a positive therapeutic environment, it was not a significant impediment to the delivery of effective treatment and the security decisions fell "under the purview of reasonable professional judgment in the administration of a hybrid detention and treatment facility."[vi]

Whatever limitations are ultimately deemed appropriate for these programs, it seems clear that residents and staff alike have a right to know what the rules are. No one's interests are well served by ambiguity when it comes to resident rights; indeed, sincere misunderstandings about unclear institutional rules can pit staff against residents, detracting from the therapeutic alliance that treatment requires. Whereas residents have an understandable interest in maximizing their rights and freedoms, at the very least they have the right to know and understand the rules under which they are required to live. If SVP facilities are neither prisons nor psychiatric hospitals, then a set of rules must be developed that is unique to this new kind of institution.

In 2002, the clinical director of the Minnesota program proposed developing a revised bill of rights specifically for the SVP population that would be different from the one applied to the mentally ill populations. Central office administrators were not in favor of it at that time, stating that it would be too difficult to pass.[vii] However, other states took the initiative to implement variations on the rights outlined for their SVP populations. California has restricted some parts of its patient bill of rights for the sexual offenders through policies and directives and proposed a modification of state regulations related to forensic hospital patients (Bukowski, personal communication, 2002). Florida had a specific reference in its SVP statute that provisions of its civil commitment of persons with mental illness act shall not apply to SVPs. Illinois also has a "rights" section in its Administrative Code that is specific to SVPs and allows for restrictions of rights. Missouri's statute allows for rights to be modified or denied if the facility head determines that the right "is inconsistent with the person's thera-

proper care, treatment, habilitation or rehabilitation and the safety of other facility or program clients and public safety."[14] These modifications, for the most part, focus on the SVP facilities' need to supervise visits and inspect mail and packages for contraband.

ALTERNATIVES TO CIVIL COMMITMENT

There are many alternatives to civil commitment available to address the problems posed by dangerous sexual offenders. Obviously, one alternative is to dramatically increase sentences for repeat offenders of certain kinds of crimes. Though more severe sentences would do nothing to solve the problem of those offenders who have already been sentenced and whose sentences will expire soon, it might reduce and ultimately eliminate the need for such facilities in the future. Some states already have the option for judges to give lengthier sentences for those determined to be "paternal sexual offenders."[15] Other states have indeterminate sentencing (Terry, 1999) or are considering the possibility of reintroducing open-ended sentences just for dangerous sexual offenders (Governor's Commission on Sex Offender Policy, 2003). In Florida, the Jessica Lunsford Act was recently pushed through by lawmakers and passed both the Senate and House unanimously. This act imposes tougher penalties on child molesters and requires many sexual offenders who have been released from prison to wear satellite tracking devices for the rest of their lives (Associated Press, 2005).

Minnesota has opened a prison-based site of its civil commitment program that is aimed at giving the highest-risk sexual offenders in prison a chance to obtain the same level of treatment they would receive if committed, but prior to their prison release. In past years, most of the offenders in Minnesota who were referred for civil commitment had not participated in the treatment programs offered in the prison, with only approximately 4 percent of the committed population having previously completed a treatment program (Becker, Marques, Nelson, & Schlank 2001). Those who did complete the prison-based program who were still civilly committed were assessed to have participated in a program that was not intensive enough or comprehensive enough for their treatment needs. With the availability of this new program, offenders are now screened early in their prison sentence and warned if they have histories that suggest the likelihood of being civilly committed. They are then instructed that if they do not participate in treatment while incarcerated, they are highly likely to face an indeterminate period of civil commitment at the end of their sentence. Because the new prison-based site of the civil commitment program is run by the same staff as the regular site of the program and has similar comprehensiveness and level of intensity, it may prevent the need for some offenders to continue to be detained after the end of their sentences.

Colorado does not have a civil commitment statute for sexual offenders, however, in 1998 this state did pass a law allowing for the lifetime supervision of certain sex offenders. Other states have followed this model, and currently twelve states altogether provide for some type of lifetime supervision of some sexual offenders (Mulligan, 2005). In these states, specially trained probation officers often work exclusively with the sexual offenders who have been released to the community. These probation officers are willing to take a more active role in monitoring the daily life and habits of those they supervise, as compared to the role they might take with other types of offenders, and must be willing to openly discuss avoidance of prevention planning and

behaviors. In addition, it is necessary that they be assigned lower caseloads in order to achieve this higher level of supervision. Intensive parole or lifetime supervision of sexual offenders appears to be a promising tool and can provide a needed therapeutic link of accountability for offense behavior management.

SUMMARY

The SVP laws may look somewhat similar to the laws for the civil commitment of persons with mental illness; however, the populations are quite different and require very different treatment programs. The diagnoses of the SVP population vary greatly from those committed individuals who suffer from mental illness, and the procedures used for isolating aggressive civilly committed patients who are mentally ill are often inappropriate when applied to the sexual offender population. Sexual offenders who complete their prison term have their civil rights restored. However, it is difficult to reconcile residents' civil liberties with the need for a secure, highly supervised setting. In addition, some of the rights that are restored may present few problems for mentally ill populations but actually appear to interfere with the provision of good sexual offender treatment and create the opportunity for the very crimes that these institutions have been created to prevent.

It is clear that the provision of treatment for the highest-risk, most disordered, and most treatment-resistant population presents many challenges. If civil commitment is to be used for sexual offenders, it is important that the treatment programs recognize the difference between this population and the population of mentally ill patients. A separate bill of rights will be crucial for such programs.

Dvoskin (1991) has argued that the absence of evidence that institutional treatment works suggests that it is better suited to prerelease and parole-based circumstances. But, that was written in 1991, prior to the wide-scale implementation of civil commitment statutes. Since that time, there have been some contradictory research findings regarding treatment outcome and inherent difficulties in attempting to evaluate the effectiveness of sex offender treatment programs (Marques, 1999). However, some recent research has found that the sexual offense recidivism rate was lower for treatment groups than for comparison groups, provided that cognitive-behavioral techniques based on the relapse prevention model were used (Hanson et al., 2002; Nagayama-Hall, 1995). In a recent study (Marques, Wiederanders, Day, Nelson, & van Ommeren, 2005), no significant effect on recidivism was found for the group of offenders randomly assigned to treatment; however, results did show that those sex offenders who were judged to have truly met the program's treatment goals did have a lower reoffense rate than those who did not. Thus, there is still disagreement about the overall effectiveness of sex offender treatment and about the ability of clinicians to determine for whom treatment has worked. All this being said, to whatever extent that institutional treatment is needed and effective in lowering risk, it would make little sense to waste the offender's entire period of incarceration only to provide it at great public expense after the sentence has expired. Thus, it may be that state dollars would be better spent on improving the quality and comprehensiveness of prison treatment programs and increasing treatment and scrutiny on parole for those sex offenders who are not civilly committed, rather than initiating any new civil commitment statutes.

States vary greatly in where they place the threshold for commitment, and many

dangerous sex offenders will not be subject to civil commitment, even in the most aggressive states. Therefore, civil commitment should be only one aspect of a state's response to the problem posed by sexual offenders, and other alternatives, such as more severe or indeterminate sentencing, intensive community supervision, or lifetime supervision, should be considered.

Footnotes

[1] Kansas v. Hendricks, 117 S. Ct 2072 (1997).

[2] Id.

[3] In Minnesota Statutes, a "vulnerable adult" included any person who is a resident or inpatient of a facility, as it was assumed that they must possess a physical or mental infirmity or other physical, mental, or emotional dysfunction that impaired their ability to adequately provide for their own care and places them at risk for abuse or exploitation. However, the statutes noted that a person who is committed as a sexual psychopathic personality or as a sexually dangerous person is not automatically considered to be a vulnerable adult, and is only classified as such if it is clearly demonstrated that they have a severe developmental disability or a major mental illness that interferes with their ability to care for themselves (Minn. Stat. § 626.557).

[4] Minn. Stat. § 256.9657, ch. 9515.3000-9515.3110.

[5] *See also* Wolf v. McDonald, 428 U.S. 539 (1974); Powell v. Coughlin, 953 F.2d 744 (2d Cir. 1991).

[6] Hargett v. Adams, Case No. 02 C 1456 (sp. U.S. District Court, 2005).

[7] Id. at 36.

[8] Id.; Turay v. Seling, 108 F. Supp. 2d 1148 (W.D. Wash. 2000).

[9] Hargett v. Baker, 2002 WL 1433729 (N.D. Ill.). See Appendix 2, this volume.

[10] Cal. Welf. & Instit. Code §§ 5325–5337 (available: *www.leginfo.ca.gov/cgi-bin/displaycode?section=wic&group=05001-06000&file=5325-5337*); State of Connecticut, *Your Rights in a Psychiatric Facility* (available: www.ct.gov/opapd/cwp/view.asp?a=1756&q=277272); Minnesota Department of Human Services, *Bill of Rights for for Patients and Residents of Healthcare Facilities* (Document No. DS-2907-G) (2000).

[11] *Supra* note 6.

[12] Id. at 35.

[13] Most recently, Minnesota has finally proposed to the legislature some revisions to the rights afforded to civilly committed sexual offenders. Minn. Stat. ch. 134-S.F. No. 906 (signed by governor on February 17, 2004). According to these changes, residents can be placed in administrative restriction if suspected of committing a crime and, if charged with a crime, may continue on administrative restriction until the charge is resolved.

[14] Mo. Stat. § 630.110.

[15] Minn. Stat. ch. 609.108 (2004).

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