Mental Illness and Sexual Offending

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KEYWORDS

• Child sexual abuse • Sexual abuse • Mental disorders • Offenders • Sex offenses • Paraphilias • Rape

KEY POINTS

- Mentally disordered sexual offenders (MDSOs) comprise a small but significant portion of sexual offenders who require special treatment and resources.
- Psychosis should be stabilized with antipsychotic medications to allow MDSOs to participate in treatment.
- Depression, anxiety, and attention-deficit/hyperactivity disorder can interfere with group treatments and future risk management.
- Dementing illnesses likely provide a special risk factor for those with late-onset offending.
- Ultimately, mental disorders require stabilization before or as part of offender rehabilitation.

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Abbreviations	
ADHD	Attention-deficit/hyperactivity disorder
ECT	Electroconvulsive therapy
GAD	Generalized anxiety disorder
MDSOs	Mentally disordered sexual offenders
NCR	Not Criminally Responsible on Account of Mental Disorder
NGRI	Not Guilty by Reason of Insanity
OCD	Obsessive-compulsive disorder
PTSD	Posttraumatic stress disorder
SORAG	Sex Offender Risk Appraisal Guide
SSRIs	Serotonin-specific reuptake inhibitors

INTRODUCTION

There are now more than 3 times more seriously mentally ill persons in American jails and prisons than in hospitals.[1] Of note, Arizona and Nevada have almost 10 times more mentally ill persons in jails and prisons than in hospitals.[1] With the influx of mentally ill individuals in the criminal justice system, a portion will commit sexual offenses. These mentally disordered sexual offenders (MDSOs) have committed sexual offenses and have comorbid major mental disorders (not including substance or personality disorders). The management plan for MDSOs must include consideration of their illness, and they may need a specialized approach for effective risk management and treatment, both in custody and in the community. This article describes the transinstitutionalization phenomenon, the prevalence of major mental disorders among sexual offenders, and the special considerations and approaches for MDSOs.

TRANSINSTITUTIONALIZATION

Before the 1960s, seriously mentally ill individuals were warehoused in asylums. However, 2 major factors came into play, resulting in an emptying of the asylums, originally termed deinstitutionalization.[2] First, antipsychotic medications became available in the 1950s, providing the first effective treatments for serious mental illness such as schizophrenia and bipolar disorder. Second, the civil rights movement of the 1960s extended to the mentally ill. Institutions with poor conditions were ultimately required to provide a therapeutic environment with appropriate numbers of trained staff. This requirement exponentially increased the cost of providing care for the mentally ill. Furthermore, civil commitment legislation became much stricter. The result of these factors was a dramatic reduction in the number of chronic care beds for the severely mentally ill. For some, this meant significant increases in liberty and true community reintegration. However, for a large number of people with mental illness this meant a lack of appropriate community supports, leaving many without stable housing and without needed supervision. Many of these individuals migrated into the criminal justice system as part of "transinstitutionalization."

The concept of transinstitutionalization is not new, with a historical article from 1939 noting the inverse relationship between beds for the mentally ill and the rates of incarceration in 14 European countries.[3] This trend can clearly be seen in **Fig. 1**. This phenomenon has been observed internationally,[4] including in England and Wales,[5] Canada,[6] and the United States,[7,8] and results in high rates of mental illness among inmates, including sexual offenders.