

Civil Commitment of Sexually Violent Persons

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History

Twenty states (Arizona, California, Florida, Illinois, Iowa, Kansas, Massachusetts, Minnesota, Missouri, Nebraska, New Hampshire, New Jersey, New York, North Dakota, Pennsylvania, South Carolina, Texas, Virginia, Washington, and Wisconsin) and the District of Columbia have enacted laws permitting the civil commitment of sexual offenders. In addition, the Adam Walsh Child Protection and Safety Act of 2006 authorized the federal government to institute a civil commitment program for federal sex offenders (42 USC 16971). Typically, these laws provide a legal mechanism for the confinement of a limited number of adult sexual offenders in a secure treatment facility after incarceration when a court determines they are likely to engage in future acts of sexual violence. Texas has an exclusively community-based commitment program and Pennsylvania has a civil commitment program only for juvenile offenders aging out of the delinquency system. To meet the criteria for commitment, the offender must suffer from a mental abnormality or personality disorder predisposing the offender to commit future acts of sexual violence.

The use of civil commitment for sexual offenders has generated considerable debate in legal and clinical professions, and it continues to be debated even among professionals who work with and conduct research on sexual offenders.

Proponents argue that such provisions offer an important community protection safeguard by incapacitating a high risk subgroup of sex offenders. In addition, civil commitment can provide opportunities for these individuals to receive treatment interventions that may reduce their potential to recidivate upon release to the community, particularly offenders for whom specialized treatment was not available in the prison setting.

Objections to civil commitment are generally threefold. First, the legal mechanism by which the offenders are detained when civilly committed depends on clinical criteria primarily created or defined by legislative bodies rather than by the scientific or mental health communities.

Second, there is concern about the legitimacy of detaining someone as a mentally ill person when there is some doubt about the accessibility of effective treatment. And third, questions exist about the potential diversion of mental health resources away from individuals diagnosed with severe,

persistent, and debilitating mental health difficulties in order to serve a limited population of sexual predators who tend not to have such diagnoses and for whom the use of correctional resources may be more prudent.

Although a number of constitutional challenges - typically involving due process, ex-post facto, and double jeopardy clauses - have been raised regarding the civil commitment of sexually violent predators or those with similar designations, the United States Supreme Court has upheld the constitutionality of civil commitment statutes three times [[Kansas v. Hendricks, 521 U.S. 346, 356-358, 117 S.Ct. 2072, 138 L.Ed.2d 501 \(1997\)](#); [Kansas v. Crane, 534 U.S. 407, 122 S.Ct. 867, 151 L.Ed.2d 856 \(2002\)](#); and [United States v. Comstock, 560 U.S._____, 2010 WL 1946729 \(2010\)](#)]. The Association for the Treatment of Sexual Abusers (ATSA) does not take a position either in favor of or opposed to the use of civil commitment for sexual offenders. However, ATSA believes that jurisdictions choosing to implement such legislation should do so in a careful manner consistent with relevant research and best practices in assessing, treating, and managing sexual offenders. ATSA suggests that if a state cannot meet the following recommendations, then the state should not institute laws providing for the civil commitment of sexual offenders.

Summary and Recommendations

1. For a small group of chronic, violent, or predatory offenders, confinement and treatment may be appropriate and necessary to safeguard the community and provide an opportunity for treatment in a secure setting.
2. Sexual predator assessments should be conducted using empirically validated risk assessment instruments, measures, and methods.
3. ATSA recommends that states provide a contemporary, properly designed prison-based treatment program to enable incarcerated offenders to receive treatment in order to promote risk-reduction and successful community reintegration. This treatment should be consistent with current research and professional standards and guidelines, and it should reflect each individual's qualifying mental disorder(s), relative risk, and criminogenic needs. Individualized treatment plans are critical and should provide for systematic measurements of the sex offender's progress in treatment.
4. If a state chooses to implement civil commitment, it should be reserved for sexual offenders who are found to pose the highest threat to public safety, and it should be viewed as only one part of a comprehensive continuum of responses to sexual offending behavior.
5. Treatment that follows the end of incarceration/criminal jurisdiction, in cases where a state elects to implement civil commitment, should also be consistent with current research and professional

standards and guidelines, and reflect each individual's qualifying mental disorder(s), relative risk, and criminogenic needs. Such treatment should include a reassessment each year to evaluate progress toward treatment goals.

6. Prior to being considered for civil commitment, offenders should be offered opportunities during their regular criminal sentences to address their risk-relevant mental disorders and criminogenic needs through properly designed and competently implemented treatment.

Discussion

An interdisciplinary response to sexual crime involves a continuum of strategies. Ideally a sex offender should receive a sex offense specific evaluation, including a risk assessment, prior to sentencing. To most accurately evaluate the risk of future sexual violence, the evaluation should include the best available risk assessment instruments that have demonstrated predictive validity for the population of sex offenders to which the specific sex offender belongs. Risk assessment is a process for determining the likelihood of reoffense, utilizing specific factors, with specific scoring rules, that places a specific sex offender within a certain risk group. It should be noted that general psychological testing methods, while valuable in evaluating the sex offender's overall mental health functioning, personality attributes, and self-regulation, are not appropriate for use as risk assessment instruments.

If a state chooses to enact a civil commitment law, the resulting civil commitment treatment program should be housed in a treatment-oriented facility that is structurally similar, but physically separate, from other programs for the mentally ill. Staff in civil commitment facilities and programs should be adequately trained, qualified, and appropriately licensed and supervised. A program should establish internal and external multi-disciplinary bodies to provide oversight of program, staff, and client issues.

Such civil commitment programs should develop steps for a sex offender to be conditionally released to a less restrictive setting, if and when appropriate, while taking into account community safety considerations. The transition needs to include a thorough case plan that speaks to community visitation, work release, approved housing and employment, family support systems, supervision, monitoring, and ongoing treatment as they are crucial to the success of reentry into the community. Service and supervision intensity should be matched to the sex offender's level of risk and need.

***The focus of this Policy Paper is civil commitment programs in the United States.**