Civil commitment:
Best Practice Informed Recommendations

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Introduction

This statement provides information and recommendations regarding best practices for policy and treatment in sex offender civil commitment programs and recommendations for future research. These recommendations are made through a collaboration between the Association for the Treatment of Sexual Abusers (ATSA) and the Sex Offender Civil Commitment Network (SOCCPN). Neither ATSA nor SOCCPN takes a position for or against the existence of sex offender civil commitment (SOCC).

This document is a summary of the full paper, which can be found at https://www.atsa.com/policy/CivilCommitmentApproach%20forManagement.pdf.
For a more comprehensive overview and references, readers are encouraged to review the full publication.

Facts about civil commitment

Evidence suggests the most effective practices with individuals convicted of sexual offenses are based on a continuum of services available at a range of service level intensity, offered within both the community and secure settings, and applied based on each individual's identified areas of risk and need in a manner that engages the person by considering their individual characteristics (Andrews & Bonta, 2010a). Sex offender civil commitment (SOCC) is a legal mechanism that may be one component of this comprehensive continuum.

SOCC is an intervention intended to be reserved for those who present exceptional risk for re-offense due to mental condition(s). Contemporary SOCC laws provide for the involuntary commitment of individuals post-criminal sentence. Currently, 21 U.S. jurisdictions (20 states, plus the federal government) have laws permitting the civil commitment of individuals who have sexually offended and have mental conditions, and present an exceptional risk to recidivate. During 2020, there were approximately 5,362 individuals civilly committed pursuant to U.S. SOCC statutes (Herbert et al., 2020).

The U.S. Supreme Court has clarified that the constitutionality of SOCC rests on its treatment focus, non-punitive nature, strict procedural safeguards, and immediate release upon sufficient change in dangerousness (Kansas v. Hendricks, 521 U.S., 346, 1997; Kansas v. Crane, 534 U.S. 407, 2002).

Policies and treatment for individuals subjected to civil commitment

Effective and evidenced-based policies and treatment practices are grounded within the Risk-Need-Responsivity (RNR) principles of offender rehabilitation, which provide guidance concerning how much service, what types of interventions, and how services should be delivered to offending individuals.

Applying RNR to SOCC means accurately identifying those individuals who present exceptional risk, providing prompt and adequate interventions to address the conditions that led to civil commitment, and providing prompt release from commitment when sufficient change is demonstrated.

Treatment should address the exceptional risk deemed present, and the factors underlying this risk including, but not limited to, the predisposing mental disorders. Interventions must be delivered in a manner that maximizes treatment response, which can be especially difficult considering the potentially indefinite nature of commitment and the effect upon participants' sense of autonomy, dignity, locus of control, and hope. The provision of a positive, engaging therapeutic environment with interventions that residents see as responsive to their needs improves outcomes.

The dosage and intensity of interventions should be responsive to shifts in risk. For example, less restrictive alternatives to full detainment should be applied when risk is sufficiently managed. Continuity of care and effective discharge planning is essential for successful outcomes.

Recommendations for implementing best practices within civil commitment programs

The degree to which SOCC laws result in less recidivism compared to other interventions is largely unknown. Although a few studies have been completed, further research is needed on representative samples of those released from civil commitment and those with comparable risk who were not civilly committed.

ATSA and SOCCPN make the following suggestions to improve SOCC adherence to evidence-based best practice principles.

1. **Civil commitment should be considered only for individuals who continue to demonstrate exceptional risk** after other less restrictive interventions are unsuccessful.
2. **Every jurisdiction with SOCC statutes should offer sexual-offense-specific treatment in its prison system** that is afforded to those subjected to review for SOCC. Treatment should focus on the reduction of risk by targeting criminogenic needs. The intervention setting, level, and intensity should be commensurate with the assessed level of risk and need, and implemented in a manner that maximizes response.
3. **SOCC statutes in individual states should be renamed in ways that prioritize person-first language**. Re-naming will deter emotion-based decision-making and encourage fair, rational decision-making anchored in the RNR research-based principles. For example, "Sexually Violent Predator" laws should be renamed "Persons with Sexually Dangerous Behavior" or a different title reflecting the inherent dignity in all humans.
4. **SOCC decision-making should be determined by the RNR factors of each individual** subjected to its provisions. This means their treatment in service of community safety is the primary focus.

5. **SOCC programs and the systems they are ensconced in should facilitate treatment engagement and monitor against punitive and prejudicial practices**. Ideally, all of those subjected to SOCC will participate in treatment and services designed to reduce their risk of reoffending.
6. **Evaluation, treatment, courtroom practices, and discharge conditions should monitor for bias, sensationalism, and other features** that would be expected to lead to unfavorable outcomes including treatment/supervision resistance and unrealistic conditions of release. Information about individuals under SOCC should be provided only to those who need to know, and media should not be permitted in SOCC courtroom proceedings.
7. **SOCC proceedings and interventions should be implemented without preventable delays**, with utmost ethical protections, and with respect to the loss of freedom of those subjected to the SOCC process.
8. **SOCC should occur only until the person no longer presents as likely to reoffend by nature of a mental condition**. While it is possible that some individuals meet commitment criteria indefinitely, others do not. SOCC individuals must be provided unambiguous understandable information on what is needed to be released.
9. **Transition services are necessary for long-term positive outcomes**. Conditional release and other less restrictive alternatives to inpatient commitment should be made available to SOCC individuals whose risk can be managed in the community.
10. **There should be a mechanism to swiftly transition individuals to less restrictive alternatives** and full discharge, without preventable delays, once risk and need are reduced to a level that is manageable within a community-based setting.
11. **SOCC programs should be applied in ways that are consistent with RNR principles** and they should be subjected to review on the degree that they adhere with RNR.
12. **SOCC programs should make publicly available information about their programming, completion rates, and duration**.
13. **SOCC programs should include systematic program evaluation or research on their efficacy**. Collaboration across programs in disseminating program information, outcomes, and best practices facilitates evidence-based implementation and is strongly recommended.
14. **SOCC programs require adequate resources and training**. This includes evaluator, treatment provider and other support staff, administration, and courtroom personnel. If society is going to confine the highest risk individuals following termination of their prison sentence in order to receive treatment, then competent, skilled professionals are needed to work in these clinically complex systems. Staff must be competent in their areas of professional responsibility. Evaluator and treatment staff must be particularly adept in diagnostic skills and risk assessment.