

CIVILLY COMMITTED SEX OFFENDERS: A Description and Interstate Comparison of Populations

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Although 20 states have passed statutes enabling rehabilitative detention of sex offenders subsequent to a their release from their prison sentences, so far data from only six states' civilly committed sex offender populations have been made available through publication. To augment the scant literature about this small yet high-risk population, the current article presents offense, risk, and diagnostic characteristics for 134 civilly committed male sex offenders in Nebraska. Committed individuals exhibited medium-to-moderate recidivism risk levels. Paraphilias were, by far, the most common diagnosis. Just over half of the sample was diagnosed with at least one personality disorder. When compared to analogous groups in other states, the committed portion of the Nebraska sample posed a substantially lower risk of recidivism and the Nebraska sample was more likely to be diagnosed with pedophilia. Findings merit further investigation into how decision-makers render civil commitment dispositions.

Keywords: civil commitment; risk assessment; sexual violence; decision-making

In the United States during the 1940s, statutes addressing sexual psychopathy were enacted in approximately half of the states (Lieb, 2003; Wilson, 1998), and these statutes provided for the involuntary civil commitment of mentally disordered sex offenders. Due, in large part, to their ineffectiveness at preventing detainees' sexual recidivism, many first-generation sexual psychopathy laws were either repealed, significantly altered, or went unenforced by the early 1980s (Brakel, Parry, & Weiner, 1985). In 1990, Washington State led the second wave of sex offender civil commitment legislation.

In response to grassroots campaigns against sexual victimization and public hearings featuring the testimony of over 150 sexual assault victims (Siegel, 1990; Wilson, 1998), the governor of Washington created the Task Force on Community Protection (Simon, 1990). In 1989, that task force concluded that Washington lacked an effective means to prevent dangerous sex offenders who had served their maximum prison sentences from committing further acts of sexual violence in the community. The task force drafted a series of recommendations designed to control, monitor, and change the behavior of sex offenders (Bodine, 1990).

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Recommendations included: increasing prison terms for all convicted sex offenders; civilly committing sex offenders found to be sufficiently dangerous; mandating extended postsentence supervision of convicted sex offenders; increasing restrictions on sex offenders in outpatient treatment programs; limiting how much “good time” a sex offender can count toward an early release from prison; and creating a statewide sex offender registry (Maleng, 1992). In 1990, the Washington Legislature enacted these recommendations as The Community Protection Act (Wash. Rev. Code Ann. § 71.09), which included Washington State’s Sexually Violent Predators Act (Wash. Rev. Code Ann. § 71.09.030). According to the most recent count, 20 states (Gookin, 2007), as well as the U.S. government, have passed similar statutes that enable rehabilitative detention subsequent to release from a prison sentence (Lieb, 2003).

Sex offender commitment laws differ from state to state, but they share a similar set of eligibility criteria (Jackson & Hess, 2007; Jackson, Rogers, & Shuman, 2004; Janus, 2000). First, the individual must have been charged with at least one sexually violent offense (as defined by state penal code). Second, the individual must have a mental abnormality or personality disorder. Third, the individual must be likely to commit another sexual offense, if released to a community setting. Finally, the individual’s mental abnormality must increase the likelihood that person will commit another sexual offense.

Although the statutes share eligibility criteria, differences between other elements—and likewise, possible differences in how these statutes are applied—may contribute to heterogeneity between states’ civilly committed sex offender populations. More comprehensive information about commitment-petitioned offenders’ characteristics could be used to compare treatment programs, to improve treatment delivery, and to advance understanding of how states implement their civil commitment laws.

Despite the anticipated benefits of making such information available, only six publications have reported data on either civil commitment-referred or civilly committed sex offenders (Becker, Stinson, Tromp, & Messer, 2003, Arizona; Elwood, Doren, & Thornton, 2010, Wisconsin; Jackson & Richards, 2007, Washington State; Janus & Walbek, 2000, Minnesota; Levenson, 2004, Florida; Vess, Murphy, & Arkowitz, 2004, California). These studies demonstrate that civilly committed sex offenders tend to have higher rates of paraphilias, personality disorders, and psychopathy, and lower proportions of serious mental illnesses, compared to other civilly committed inpatient populations and noncivilly committed sex offenders. Additionally, sex offenders in these studies’ samples posed a moderate-to-high risk of sexual recidivism. Elwood, Doren, and Thornton’s (2010) study, along with earlier conference presentations (McLawsen & Scalora, 2009; McLawsen, Darrow, & Scalora, 2010) conducted the earliest state-by-state comparisons of civilly committed sex offenders. The current article augments the scant literature on civilly committed sex offenders by providing a brief overview of Nebraska’s sex offender civil commitment procedures (for a more detailed analysis, see Pearce, 2007), and then describing characteristics of commitment-petitioned male sex offenders in Nebraska. Data are examined in aggregate. Risk and diagnostic characteristics from the committed portion of the Nebraska sample are compared to analogous samples described by earlier studies.

Nebraska's Sex Offender Civil Commitment Procedures

Nebraska's Sex Offender Commitment Act (SOCA; Neb. Rev. Stat. § 71.12, 2006) provides for "the court-ordered treatment of sex offenders who have completed their sentences but continue to pose a threat of harm to others" (§ 71.1202). These sex offenders must have a mental illness or personality disorder that makes them more likely to commit future sexually violent acts, be "substantially unable to control his or her criminal behavior," and have at least one—if diagnosed with a mental illness—or two—if diagnosed with a personality disorder—prior sexual offense convictions.

If a county prosecuting attorney suspects that an inmate fits the above criteria and should receive involuntary treatment beyond the duration of their criminal sentence, then the attorney must file a petition to initiate civil commitment proceedings under SOCA. After the county attorney files the petition, a mental health board¹ holds a hearing to determine, by clear and convincing evidence, whether the respondent meets civil commitment criteria. The respondent has the right to attend the hearing and be represented by counsel, and remains in protective custody for the duration of the hearing. Mental health board hearings are closed to the public unless the respondent requests otherwise. The procedures are considered adversarial in nature, so the state has the burden, by clear and convincing evidence, of proving that the statutory commitment criteria are met (Neb. Rev. Stat. § 71.1209, 2006). Additionally, the rules of evidence apply (§ 71.1226) and the respondent is entitled to all the procedural rights afforded under the general Mental Health Commitment Act (e.g., right to counsel or right to appointed counsel if found indigent, and right to consult with counsel "at all reasonable times"; § 71.1224, citing § 71.943.960). If the respondent denies the allegations, then the state must attempt to prove the respondent meets civil commitment criteria, and voluntary hospitalization or less restrictive treatment alternatives either are not available or would not prevent subsequent violence.

The mental health board can reach one of several conclusions, ranging from unconditional discharge to out- or inpatient commitment. If the respondent does not meet civil commitment criteria, then the respondent is unconditionally discharged. If the respondent meets civil commitment criteria but voluntary hospitalization or other less restrictive treatment alternatives are both sufficient and

¹ Each Nebraska judicial district has its own mental health board, created by a respective district judge. Mental health boards carry out functions specified by the Nebraska Mental Health Commitment Act. Each board consists of a licensed attorney (who chairs the board), along with any two individuals who must come from different listed categories of mental health professionals and/or "a layperson with a demonstrated interest in mental health and substance dependency issues" (§ 71-915, Cumulative Supplement 2006). The mental health board may request the assistance of the Department of Health and Human Services, or any other person or entity, to provide advice about the person named in the petition (§ 71-1209(7)). Given that this subsection goes on to state that the person may need to "submit to reasonable psychiatric and psychological evaluation to assist the board," one can presume that the aforementioned "advice" refers to information relevant to the person's psychiatric and/or psychological functioning. Although the statute indicates that mental health boards "may request" a psychological evaluation, it is routine practice for a Nebraska Department of Correctional Service psychologist to submit a risk-oriented psychological evaluation to the mental health board when an inmate is petitioned for civil commitment (M. Weilage, personal communication, February 18, 2010).

available, then the respondent may be unconditionally discharged, or the board may suspend proceedings for up to 90 days to allow the subject time to enroll in voluntary treatment. If the respondent meets civil commitment criteria and less restrictive treatment options are either not sufficient or not possible, then the board orders out- or inpatient treatment, characterizing the latter as “an alternative of last resort” (Neb. Rev. Stat. § 65(6); § 71–1209(6), 2006). A sex offender mandated to receive treatment is committed to the custody of the U.S. Department of Health and Human Services to receive out- or inpatient treatment and periodic risk reviews.

Method

Sample

Archived legal and clinical records from a state correctional agency and state sex offender treatment program were reviewed to identify sex offenders who underwent a civil commitment hearing. Cases that resulted in civil commitment to in- or outpatient treatment were included in the current study. In- and outpatient data are combined because analyses revealed no significant between-group differences in terms of actuarial risk assessment scores and diagnostic profiles.

We used three criteria to exclude cases from data collection procedures. First, sex offenders who were committed as juveniles and underwent civil commitment hearings when they reached the age of majority (19 years in Nebraska) were excluded ($n = 4$) from data collection because the actuarial risk assessment instruments used in the current study are designed for use with individuals who have committed sexual crimes as adults. Second, female sex offenders were excluded ($n = 4$) from data collection procedures because the actuarial risk assessment instruments used in the current study are designed for use with male sex offenders. Third, sex offenders who were committed while unlawfully present in the United States were excluded ($n = 3$) because, by default, the administrative bodies that conduct Nebraska’s civil commitment procedures release such respondents to U.S. Immigration and Customs Enforcement’s custody (T. Ewing, personal communication, November 6, 2009).

Investigators coded 138 cases, which constituted the entire population of commitment-petitioned sex offenders whose commitment hearings had reached dispositions, and whose legal and clinical records were institutionally feasible for administrative staff to access. Mental health boards unconditionally released 4 of the 138 cases without imposing a commitment hold, so ultimately data for 134 male sex offenders who received in- and outpatient ($n = 14$) commitment dispositions were included in the current study.

Procedure and Measures

Institutional review boards affiliated with all partnering institutions approved the current study’s research procedures. Investigators adhered to ethical guidelines. Data were found in individuals’ legal and clinical records. The following categories of data were coded:

1. Data used to score actuarial risk assessment instruments: the Static-99², the Minnesota Sex Offender Screening Tool—Revised (MnSOST-R), the Violence Risk Appraisal Guide (VRAG), and the Sex Offender Risk Appraisal Guide (SORAG);
2. Psychiatric diagnoses (relevant at time of offender’s civil commitment hearing);
3. Incarceration, commitment, and release dates; and
4. Demographic information.

Investigators culled information from archived legal and clinical records to score four actuarial risk assessment instruments (listed above), all of which are commonly used in civil commitment evaluations. These instruments were dismantled, and individual items were arranged thematically in the coding form³ to facilitate efficient data collection and to ensure that previously conducted risk assessment total scores (occasionally included in offenders’ files) did not influence how we scored actuarial instruments for the present study. After we concluded data entry, we used software algorithms to compute actuarial instrument total scores.

Professionals reach decisions about recidivism risk through a variety of approaches based on either *professional judgment* or *actuarial decision-making* (Hart, Kropp, Laws, Klaver, Logan, & Watt, 2003). According to *Risk for Sexual Violence Protocol* (Hart et al., 2003), a defining characteristic of professional judgment techniques is that “the evaluator exercises some degree of discretion in the decision-making process” (para. 4), whereas actuarial decision-making proceeds according to “fixed and explicit rules” (para. 4).

Predictions informed by empirically supported risk factors tend to result in more accurate estimates than truly unstructured techniques (Grove & Meehl, 1996; Grove, Zald, Lebow, Snitz, & Nelson, 2000; Monahan, 1981; Swets, Dawes, & Monahan, 2000a, 2000b). *Structured professional judgment*, a type of *professional judgment* technique informed by empirically based information and guidelines, and *actuarial risk assessment instruments*, an assortment of mechanical strategies for reaching actuarially based decisions, routinely yield acceptably accurate predictions about sexual recidivism. A meta-analysis conducted by Hanson and Morton-Bourgon (2009) found that sexual recidivism risk estimates based on structured professional judgment yielded Cohen’s *d* values ranging from .67 to .42, whereas estimates based on actuarial techniques resulted in a Cohen’s *d* = .67 (see also Hanson & Morton-Bourgon, 2004; Doren, 2002; Douglas, Cox, & Webster, 1999; Hart et al., 2003; Quinsey, Harris, Rice, & Cormier, 1998). On the other hand, Hanson and Morton-Bourgon reported a substantially lower level of accuracy for estimates based on unstructured predictive strategies, Cohen’s *d* = .42. The present study relied on four actuarial risk assessment instruments so that

² Shortly after data collection for the present study concluded, a revised version of the Static-99 became available. We opted to continue coding the Static-99, rather than switch to the updated version to ensure that our data (1) was comparable to Static-99 results from comparison states and (2) reflected information that was typically included in evaluations submitted to mental health boards. (During data collection for this study, no evaluators included estimates from the newly revised Static-99 estimates in the reports they submitted to mental health boards.)

³ Please direct requests to the first author.

data could be compared to results from similar studies conducted in other states, and to facilitate future comparisons.

The Static-99. The Static-99 (Hanson & Thornton, 1999) is an actuarial risk assessment instrument designed to predict sexual and violent recidivism among adult males convicted of at least one sexual offense. It contains 10 items: Age less than 25 years, Never lived with a lover for at least 2 years, Any prior convictions for nonsexual violence, Any current convictions for nonsexual violence, Four or more prior sentencing dates, Prior sexual offenses, Noncontact sexual offenses, Any male victims, Any unrelated victims, and Any stranger victims. All items are scored as either 0 or 1, except for "Prior sexual offenses," which can yield a score of up to 3 points. Previous studies have found high levels of interrater reliability (intraclass correlation coefficient [ICC] = .87; Harris et al., 2003) and moderate accuracy in predicting sexual recidivism (average $d = .63$, based on a meta-analysis that included 5,103 offenders from 21 studies; Hanson & Morton-Bourgon, 2004). Risk categories correspond to raw scores of 0 to 1 (low), 2 to 3 (moderate to low), 4 to 5 (moderate to high), and 6 to 12 (high).

The Minnesota Sex Offender Screening Tool-Revised. The MnSOST-R (Epperson, Kaul, Huot, Goldman, & Alexander, 2003) was developed to assess risk for sexual recidivism among adult males who have committed at least one sexual offense against an unrelated victim (i.e., nonincest offenders). Epperson, Kaul, Huot, Goldman, and Alexander (2003) reported that the MnSOST-R demonstrates high interrater reliability (ICC = .80) and moderate accuracy in predicting sexual recidivism (area under the curve [AUC] = .73). The MnSOST-R contains 16 items, 12 of which are coded using historical information and 4 of which are coded using information pertaining to the offender's incarceration for the index offense. Examples of historical items include: Length of sexual offending history, Any sexual offense committed in a public place, Force or threat of force used in any sexual offense, Number of different age groups victimized across all sexual offenses, and Substantial drug or alcohol abuse in year prior to arrest. Examples of institutional items include: Discipline history while incarcerated, Involvement in treatment while incarcerated, and Age at time of release. Total MnSOST-R scores can range from -14 to 30. Individuals are assigned to risk levels according to their total score. Total scores correspond to three risk levels. Level 1 reflects scores of 3 or lower (low risk), level 2 reflects scores between 4 and 7 (moderate risk), and level 3 reflects scores of 8 or above (high risk). Epperson et al. make note of a fourth risk level, a subset of Level 3, for scores of 13 or higher. They recommend that evaluators refer offenders with scores of 13 or higher for civil commitment evaluations proceedings.

The Violence Risk Appraisal Guide. The VRAG (Harris, Rice, & Quinsey, 1993) was developed to assess risk for violent recidivism (including sexual offenses involving physical contact with the victim) among offenders with diagnosed with mental illness. Harris, Rice, Quinsey, Lalumiere, Boer, and Lang (2003) reported that the VRAG demonstrates high interrater reliability (ICC = .94). Langton, Barbaree, Seto, Peacock, Harkins, and Hansen (2007) found that it demonstrates moderate accuracy in predicting sexual recidivism (AUC = .61). The VRAG consists of 12 items including the following: Elementary school maladjustment; Age at index offense; History of alcohol problems; and Any female victim. Total VRAG scores can range from -24 to 32. Individuals are

assigned to one of three risk categories depending on their total score, which can range from -24 to -8 (low risk), -7 to 13 (moderate risk), and 14 to 32 (high risk).

The Sex Offender Risk Appraisal Guide. The SORAG (Quinsey, Rice, & Harris, 1995) is a modification of the VRAG, and was developed to assess violent recidivism among adult sex offenders diagnosed with mental illness. Harris et al. (2003) reported that the SORAG demonstrates high interrater reliability ($ICC = .88$). Langton et al. (2007) found that it demonstrates moderate accuracy in predicting sexual recidivism ($AUC = .66$). The SORAG consists of 14 items, the bulk of which are identical to items in the VRAG, with two additional items: Phallometric test results; and Number of previous convictions for hands-on sexual offenses, prior to the index offense. SORAG scores can range from -17 to 34 , and individuals are assigned to a risk level according to their total score. Scores between -17 and 2 correspond to low risk, scores between 3 and 19 correspond to medium risk, and scores between 20 and 34 correspond to high risk.

All authors underwent formal and supervised training in scoring the four actuarial risk assessments included in the current study prior to collection of data. First, we reviewed official instructions for each actuarial risk assessment instrument. Next, we verified that interrater reliability levels were satisfactory (i.e., ICC values $\geq .75$) by scoring risk assessments for 10 offenders' files not included in the study sample. Having achieved satisfactory interrater reliability levels during the initial round of practice coding, two of us (McLawsen, Darrow) began to independently code files for inclusion in the present study. Throughout the data collection phase, we used regular reliability checks to identify coding discrepancies, which were arbitrated by a third party (Scalora). We regularly referenced instrument manuals and, when necessary, sought scoring clarification from instrument developers. When we encountered conflicting information in a single file (e.g., number of reported victims, age range of victims), we scored whichever information was deemed most likely to be relevant and/or known to the decision-maker at the time of the offender's civil commitment hearing.

To ensure continued reliability, we coded actuarial risk assessment instruments with a 10% overlap. ICCs were calculated for each risk assessment instrument's total score using one-way fixed effects models. All ICCs exceeded Fleiss's (1986) benchmark for "excellent" interrater reliability (ICCs of at least $.75$). The Static-99 yielded an $ICC = .94$, 95% confidence interval [CI] $[.84, .98]$, the VRAG yielded an $ICC = .92$, 95% CI $[.76, .97]$, and the SORAG yielded an $ICC = .88$, 95% CI $[.66, .96]$. The interrater reliability of the MnSOST-R was lower, but still satisfactory, $ICC = .78$, 95% CI $[.45, .92]$. ICCs from the current study are commensurate with published interrater reliability values for these actuarial risk assessment instruments (Epperson et al., 2003; Harris et al., 2003; Langton et al., 2007).

Results

Data are presented first for the sample as a whole. Next, risk and diagnostic characteristics of civilly committed Nebraska sex offenders are compared to results from earlier studies that described analogous samples.

Sample Characteristics

The mean age of the sample at the time of their commitment hearings was 42.49 years ($SD = 12.74$), and ranged from 19 to 74 years old. At the time of data collection, the mean age of the sample was 47.26 years ($SD = 12.85$), with a range of 22 to 79 years old. The sample was predominantly white (81.9%). The remainder identified as African American (9.4%), Hispanic or Latino (5.8%), and Native American (2.9%). Just over half of the sample (56.5%) had never been married or lived with a romantic partner for at least two years. Individuals had completed an average of 12.21 years of education ($SD = 2.13$), and most (81.9%) had earned a high school diploma or equivalency. Nearly two thirds (62.7%) of the men who withdrew from school before earning a diploma eventually received a general equivalency degree.

Sentences ranged from a minimum of 6 months to 29 years, with an average duration of 6 years 5 months ($SD = 5$ years 5 months). Pearson product-moment correlation coefficients were computed to assess linear relationships between civil commitment hearing date and sentence duration. Results revealed that later commitment dates were associated with significantly longer minimum sentences, $r = .256$, $p = .009$, and a nearly significant trend toward longer maximum sentences, $r = .189$, $p = .054$. These results mirror how Nebraska sentencing structures for certain sexual offenses have changed over the past few decades. Although penalty ranges for sexual assault have not changed, those for sexual assault of a child changed radically in 2006, when SOCA was enacted (Neb. Rev. St. § 28–105, 2006). At this point, the *maximum* penalty for a first offense of sexual assault of a child increased from 5 years to lifelong imprisonment. However, it is worth noting that if prior to 2006, particularly heinous offenses against children had been charged under sexual assault to enable harsher penalties, then the recent shift may not be as dramatic as it appears.

Civil commitment hearing dates ranged from February 1990 until September 2009. By the end of data collection, 50 individuals had been discharged. These individuals' discharge dates ranged from December 1998 to November 2009. Their average duration of their commitments was four years ($SD = 2$ years 9 months, *range* = 6 months to 13 years 6 months).

Individuals reported an average of 8.88 victims ($SD = 13.95$, *range* = 0 to 80), and an average offense history duration of 9 years 7 months ($SD = 8$ years 11 months, *range* = a single incident to 38 years). These figures should be interpreted cautiously, because records reflected different points in individuals' adjudication processes. Records for sex offenders who had been committed for substantial periods of time often contained information collected posthearing, whereas records for sex offenders who recently undergone civil commitment hearings and were still incarcerated contained information collected prehearing—and in a few cases, information collected shortly after the hearing. Although we made every effort to record data only from records that would have been available at the time of the mental health board hearing, it was often either impossible to make such a determination or infeasible to obtain an individual's prehearing records.

It seems reasonable to expect that most sex offenders facing civil commitment would underreport the number of individuals they had assaulted and the duration of their offense histories in an effort to appear lower risk and secure a more

favorable mental health board decision. Likewise, given that Nebraska's sex offender treatment encourages participants to "come clean" and disclose (although not necessarily identify) previously unreported victims, and also considering that sex offenders who are already committed have less incentive to minimize offense information, it makes sense that committed offenders who have participated in the state's intensive treatment program tended to report more victims and longer offense histories. Consistent with this speculative explanation, Pearson product-moment coefficients revealed that as commitment duration increased, so did number of reported victims, $r = .246$, $p = .004$, and duration of offense history, $r = .484$, $p < .001$.

Categorically speaking, average actuarial risk assessment levels for the 134 committed individuals are best described as moderate to medium. Static-99 scores ($M = 3.5$, $SD = 1.88$) corresponded to a moderate-to-low risk category, MnSOST-R scores ($M = 3.76$, $SD = 5.75$) corresponded to the lower end of the instrument's moderate risk category, VRAG scores ($M = 2.48$, $SD = 8.63$) corresponded to the lower end of the instrument's medium risk category, and SORAG scores ($M = 4.45$, $SD = 10.12$) also corresponded to the lower end of the instrument's medium risk category.

The most obviously qualifying diagnoses for civil commitment are paraphilias. Most ($n = 122$, 89.6%) of the Nebraska sample were diagnosed with at least one paraphilia. The remaining 12 sex offenders had primary diagnoses of depressive disorder ($n = 3$), bipolar disorder ($n = 1$), schizophrenia ($n = 3$), delusional disorder ($n = 2$), cognitive disorder not otherwise specified ($n = 1$), while the remaining 2 were diagnosed with only Axis II personality disorders and substance-related diagnoses. Table 1 displays diagnostic summaries for the entire committed sample. Note that because occurrences of diagnoses are reported, rather than the frequency of individuals' diagnoses, counts sum to more than 134 and percentages sum to more than 100%. That is, when an individual received multiple diagnoses (e.g., pedophilia and depression), counts were increased by one for both the pedophilia category and the depression category. If a diagnosis is not listed in Table 1, no one received that diagnosis.

Among the 122 offenders diagnosed with a form of paraphilia, 84.4% ($n = 103$) were diagnosed with pedophilia and 23.8% were diagnosed with other paraphilias ($n = 29$). The numbers do not add up to 122 because 8.2% ($n = 10$) of these offenders were diagnosed with both pedophilia and another paraphilia. Among the 103 offenders diagnosed with pedophilia, 62.1% ($n = 64$) had nonexclusive sexual attractions to female children, 23.2% ($n = 24$) bore nonexclusive sexual attractions to male and female children, 12.6% ($n = 13$) bore nonexclusive sexual attractions to male children, and 1.9% ($n = 2$) bore exclusive sexual attractions to male children. Of the 29 offenders who received paraphilia diagnoses, 65.5% ($n = 19$) were diagnosed with paraphilia not otherwise specified (rape or nonconsent), 13.8% ($n = 4$) were diagnosed with voyeurism, 10.3% ($n = 3$) were diagnosed with exhibitionism, 6.9% ($n = 2$) were diagnosed with sexual sadism, 3.4% ($n = 1$) was diagnosed with fetishism, and 17.2% ($n = 5$) were diagnosed with paraphilia not otherwise specified (excluding the rape or nonconsent subtype) because they did not meet criteria for any specific paraphilia categories.

When compared to other civilly committed populations, civilly committed sex offenders were less likely to receive a serious mental illness diagnosis and more likely

Table 1
Diagnostic Information

Diagnostic Measures	<i>n</i>	%
Paraphilias		
Pedophilia	103	76.9
Paraphilia NOS, Rape/Nonconsent	10	14.2
Voyeurism	4	3.0
Exhibitionism	3	2.2
Sexual Sadism	2	1.5
Fetishism	1	0.7
Paraphilia NOS	5	3.7
Serious Mental Illness		
Depressive Disorder	20	14.9
Bipolar Disorder	8	6.0
Schizophrenia	5	3.7
Schizoaffective Disorder	3	2.2
Delusional Disorder	4	3.0
Psychotic Disorder NOS	1	0.7
Other Axis I Diagnoses		
Anxiety Disorder	3	2.2
Intermittent Explosive Disorder	3	2.2
Cognitive Disorders		
Cognitive Disorder NOS	1	0.7
Borderline Intellectual Functioning or Mental Retardation	11	8.2
Dementia	1	0.7
Substance-related Diagnoses		
Alcohol	30	22.4
Cannabis	8	6.0
Methamphetamine	3	2.2
Cocaine	1	0.7
Polysubstance	13	9.7
Personality Disorders		
Antisocial	39	29.1
Narcissistic	2	1.5
Schizotypal	1	0.7
Dependent	1	0.7
Schizoid	1	0.7
Personality Disorder NOS	27	20.1

Note. *N* = 134. NOS = Not otherwise specified.

to receive a primary diagnosis of paraphilia or a personality disorder (Lieb & Nelson, 2001; Vess, Murphy, & Arkowitz, 2004). This observation is consistent with the prevalence of personality disorder diagnoses within nonforensic inpatient samples (Kullgren, 1992; Widiger & Rogers, 1989), where virtually all patients tend to receive serious mental illness diagnoses, yet somewhere between a quarter and a third are diagnosed with personality disorders. By comparison, just 30.6% (*n* = 41) of sex offenders civilly committed in Nebraska received serious mental illness diagnoses, while 57.5% (*n* = 77) were diagnosed with personality disorders. Interestingly, however, this percentage is on par with rates of personality disorders among outpatient sex offenders (60%; Raymond, Coleman, Ohlerking, Christenson, & Miner, 1999). Only 27.4% (*n* = 38) of the Nebraska sample were diagnosed with concurrent serious mental illness and personality disorder diagnoses.

However, just over half of sex offenders civilly committed in Nebraska (56.7%, $n = 76$) were diagnosed with both a paraphilia and a personality disorder. Regarding serious mental illness diagnoses, 14.9% ($n = 20$) were diagnosed with depressive disorder, 6% ($n = 8$) were diagnosed with bipolar disorder, 3.7% ($n = 5$) were diagnosed with schizophrenia, 3% ($n = 4$) were diagnosed with delusional disorder, 2.2% ($n = 3$) were diagnosed with schizoaffective disorder, and 0.7% ($n = 1$) was diagnosed with psychotic disorder not otherwise specified. Sixteen offenders were diagnosed as having other disorders, including 8.2% ($n = 11$) with mental retardation or borderline intellectual functioning, 2.2% ($n = 3$) with anxiety disorders, 2.2% ($n = 3$) with intermittent explosive disorder, 0.7% ($n = 1$) with dementia, and 0.7% ($n = 1$) with cognitive disorder not otherwise specified.

A third of offenders (33.6%, $n = 45$) received substance-related diagnoses. Two thirds of these diagnoses were alcohol-related (66.7%, $n = 30$), 17.8% ($n = 8$) were cannabis-related, 6.7% ($n = 3$) were methamphetamine-related, and 2.2% ($n = 1$) was cocaine-related. Approximately a quarter of those diagnosed with substance-related problems (28.9%, $n = 13$) received diagnoses of polysubstance abuse or dependence.

Comparing Nebraska Sample Results to Results From Earlier Studies

Methodological differences limited efforts to compare results from the current study with the results from certain earlier studies. First, studies varied in terms of whether—and if so, which—actuarial risk assessment instruments they used. Neither the California study (Vess et al., 2004), the Arizona study (Becker et al., 2003), nor the Minnesota study (Janus & Walbek, 2000) reported actuarial risk assessment scores. The Florida study (Levenson, 2004) and the Wisconsin study (Elwood et al., 2010) reported actuarial risk assessment scores for only two of the four instruments used in the current study.

With respect to clinical data, the California study did not report diagnoses, while the Arizona and Wisconsin studies reported only certain diagnoses. Furthermore, the Washington study subsumed instances of pedophilia under the paraphilia category⁴, whereas the Minnesota and Florida studies reported instances of paraphilia and pedophilia separately. Although combining Minnesota's and Florida's pedophilia and paraphilia proportions yields results that are closer to the those of the Washington study (81% for Minnesota, 90% for Florida), it appears that the Minnesota and Florida studies' pedophilia and paraphilia percentages are not mutually exclusive, rendering the sum of the two percentages difficult to interpret. Finally, the Wisconsin sample included offenders awaiting a commitment trial (12%, or $n = 41$ out of $n = 331$), raising questions about whether that study's results apply to civilly committed sex offenders, the population of interest in the present study.

Based on known properties of the Nebraska dataset (e.g., a normal distribution and sampling conducted independently from the other states' sampling procedures) and presumed properties of data underlying previously published

⁴ Consistent with the Washington study's methodology (Jackson & Richards, 2007) The DSM-IV (APA, 2000) identifies pedophilia as a diagnosis that lies within the paraphilia category (which also includes diagnoses such as exhibitionism, frotteurism, sexual masochism and sadism, voyeurism, and paraphilia not otherwise specified).

results, Student's *t* tests were selected as an appropriate statistical technique to evaluate hypothesized differences between mean values of each state's data. Because the Student's *t* test is robust to the presence of heteroscedasticity between samples, different datasets' variances were not examined. Significance levels were adjusted to .0065, using Bonferroni's correction to reduce the likelihood of alpha inflation due to multiple comparisons. Results revealed that sex offenders civilly committed in Nebraska were significantly lower risk than those committed in Washington, Florida, and Wisconsin. Table 2 displays mean risk assessment scores for offenders in each state, and indicates significant differences between the Nebraska sample and the other three samples.

Student's *t* test results comparing the Nebraska sample to the Washington sample were as follows: Static-99, $t(133) = -11.731, p < .001$; MnSOST-R, $t(133) = -7.86, p < .001$; VRAG, $t(133) = -10.152, p < .001$; and SORAG, $t(133) = -16.745, p < .001$. Student's *t* test results comparing the Nebraska sample to the Florida sample were as follows: Static-99, $t(133) = -15.436, p < .001$; and MnSOST-R, $t(133) = -12.556, p < .001$. Student's *t* test results comparing the Nebraska sample to the Wisconsin sample were as follows: Static-99, $t(133) = -11.731, p < .001$; and MnSOST-R, $t(133) = -7.86, p < .001$.

We used *z* tests for two proportions to compare the frequencies of pedophilia, paraphilia, substance-related, and personality disorder diagnoses between the Nebraska sample and its counterpart samples in Washington, Minnesota, Florida, Arizona, and Wisconsin. Data fulfilled the assumptions required for this statistical technique, because there were more than five data points in each comparison group, and samples reflected data obtained through independent observations. Significance levels were adjusted to 0.01, using Bonferroni's correction. Comparisons are reported by state, and summarized in Table 3.

Compared to civilly committed sex offenders in Washington, the Nebraska sample had a higher proportion of pedophilia diagnoses (Nebraska: 76.9%, $n = 103$; Washington: 56.3%, $n = 107, z = 3.697, p < .01$), a lower proportion of paraphilia diagnoses (Nebraska: 21.6%, $n = 29$; Washington: 82.6%, $n = 157, z = 10.82, p < .01$), and a lower proportion of substance-related diagnoses (Nebraska: 33.6%, $n = 45$; Washington: 84.2%, $n = 160, z = 9.193, p < .01$). The two samples did not differ with regard to proportions of individuals diagnosed with personality disorders (Nebraska: 57.5%, $n = 77$; Washington: 50%, $n = 95, z = 1.212, p > .05$).

Comparisons between Nebraska and Minnesota yielded similar results. Civilly committed sex offenders in Nebraska had a higher proportion of pedophilia diagnoses (Nebraska: 76.9%, $n = 103$; Minnesota: 35.4%, $n = 35, z = 6.241, p < .01$), a lower proportion of paraphilia diagnoses (Nebraska: 21.6%, $n = 29$; Minnesota: 46.5%, $n = 46, z = 3.867, p < .01$), and a lower rate of substance-related diagnoses (Nebraska: 33.6%, $n = 45$; Minnesota: 51.5%, $n = 51, z = 2.616, p < .01$). The two samples had equivalent rates of personality disorder diagnoses (Nebraska: 57.5%, $n = 77$; Minnesota: 48.5%, $n = 48, z = 1.226, p > .05$).

Again, pedophilia diagnoses were more common in the Nebraska sample than in the Florida sample (Nebraska: 76.9%, $n = 103$; Florida: 38.9%, $n = 89, z = 6.892, p < .01$). Rather than reporting the total number of offenders who received any sort of paraphilia diagnosis, the Florida study reported frequencies of offenders diagnosed with paraphilias, excluding sexual sadism, exhibitionism, and

Table 2
Mean Risk Assessment Scores (and SDs) for Civilly Committed Sex Offenders in Nebraska, Washington, Florida, and Wisconsin

Instrument total score	Nebraska	Washington	Florida	Wisconsin
	<i>n</i> = 134	<i>n</i> = 190	<i>n</i> = 229	<i>n</i> = 331, 156 ^b
Static-99	3.5 (1.88)	5.40 (1.87)	6 (1.7)	6.17 (1.58)
MnSOST-R	3.76 (5.75)	7.62 (5.93)	10 (4.7)	11.08 (4.76)
VRAG	12.48 (8.63)	10.05 (6.51)	Study did not report information	Study did not report information
SORAG	4.45 (10.12)	19.08 (7.36)	Study did not report information	Study did not report information

^a Value signs indicate direction of difference relative to Nebraska data. ^b Static-99s were completed for 331 cases, and MnSOST-Rs were completed for 156 cases.

* *p* < .001.

Table 3
Diagnostic Information for Civilly Committed Sex Offenders in Nebraska, Washington, Minnesota, Florida, Arizona, and Wisconsin

Diagnosis	Nebraska	Washington	Minnesota	Florida	Arizona	Wisconsin
Pedophilia	n = 134 76.9%	n = 190 56.3%	n = 99 35.4%	n = 229 38.9%	n = 121 63.3%	n = 331 47.1%
Paraphilia (other than pedophilia)	n = 103 21.6%	n = 107 82.4%	n = 35 46.5%	n/a 45.9% ^b	n = 76 55.9%	n = 156 37.5%
Substance-related	n = 29 33.6%	n = 157 82.6%	n = 46 51.5%	n = 105 ^b 54.2%	n = 67 Study did not report information	n = 124 55.6%
Personality Disorders	n = 45 57.5%	n = 160 50%	n = 51 48.5%	n = 124 57.2%	n = 92 76.7%	n = 184 41.4%
	n = 77	n = 95	n = 48	n = 131	n = 92	n = 137

^a Value signs indicate direction of difference relative to Nebraska data. ^b Values exclude exhibitionism and sexual sadism diagnoses.
 * $p < .05$. ** $p < .01$.

pedophilia (the study reported those results separately). Because many offenders received multiple diagnoses in a single diagnostic category, it was not possible to calculate the total percentage of Florida offenders who received any paraphilia diagnosis. And because an insufficient number of sex offenders in the Nebraska sample had been diagnosed with exhibitionism and sadism ($n = 3$ and $n = 2$, respectively) to allow for statistical comparisons, the two states' samples were compared just according to what percentage of their populations had been diagnosed with a paraphilia other than exhibitionism or sexual sadism. The Nebraska sample had a lower proportion of nonexhibitionism and nonsexual sadism paraphilia diagnoses (Nebraska: 17.9%, $n = 24$; Florida: 45.9%, $n = 105$, $z = 5.254$, $p < .01$) and lower rates of substance-related diagnoses (Nebraska: 33.6%, $n = 45$; Florida: 54.2%, $n = 124$, $z = 3.682$, $p < .01$). The samples were virtually identical in terms of personality disorder diagnoses (Nebraska: 57.5%, $n = 77$; Florida: 57.2%, $n = 131$, $z = .063$, $p > .05$).

As was the case with previous comparisons, the Nebraska sample had a higher proportion of pedophilia diagnoses compared to the Arizona sample (Nebraska: 76.9%, $n = 103$; Arizona: 63.3%, $n = 76$, $z = 2.224$, $p < .05$) and a lower proportion of paraphilia diagnoses (Nebraska: 21.6%, $n = 29$; Arizona: 55.9%, $n = 67$, $z = 5.481$, $p < .01$). Because it was not possible to determine the absolute percentage of individuals who received a substance-related diagnosis, this comparison was not conducted. The Nebraska sample had a lower rate of personality disorder diagnoses (Nebraska: 57.5%, $n = 77$; Arizona: 76.7%, $n = 92$, $z = 3.106$, $p < .01$).

Comparisons between the Nebraska and Wisconsin samples also yielded similar results. Civilly committed sex offenders in Nebraska had a higher proportion of pedophilia diagnoses (Nebraska: 76.9%, $n = 103$; Wisconsin: 47.1%, $n = 156$, $z = 5.744$, $p < .01$), a lower proportion of paraphilia diagnoses (Nebraska: 21.6%, $n = 29$; Wisconsin: 37.5%, $n = 124$, $z = 3.179$, $p < .01$), and lower rates of substance-related diagnoses (Nebraska: 33.6%, $n = 45$; Wisconsin: 55.6%, $n = 184$, $z = 4.197$, $p < .01$). The Wisconsin sample had a lower proportion of personality disorder diagnoses (Nebraska: 57.5%, $n = 77$; Wisconsin: 41.4%, $n = 137$, $z = 3.046$, $p < .01$).

Discussion

Results from the current study indicate that civilly committed sex offenders in Nebraska have different risk and diagnostic profiles compared to analogous samples in Washington, Minnesota, Florida, Arizona, and Wisconsin. Pedophilia diagnoses were more common within the Nebraska sample, whereas paraphilia and substance-related diagnoses were more common within the other samples. Results underscore the need for civil commitment programs to offer comprehensive evidence-based treatment for patients' widespread pedophilia, paraphilia, and substance-related diagnoses, along with comorbid personality disorder diagnoses. Results also invite speculation about what factors contribute to differences observed between the samples.

It does not appear that the lower levels of recidivism risk among sex offenders civilly committed in Nebraska were an artifact of the large percentage of offenders diagnosed with pedophilia, at least compared to percentages of pedophilia diagnoses in the other four states' samples. In reviewing studies that have reported

recidivism rates for offenders according to victim preference, Marshall and Barbaree (1990) found that even when sex offenders were grouped by offense types, they demonstrated relatively comparable recidivism rates. Specifically, Marshall and Barbaree calculated that offenders who perpetrate against adults (“rapists”) recidivate between 7% and 35% of the time, whereas offenders who perpetrate against children outside their family (“extrafamilial child molesters”) recidivate between 10% and 40% of the time. Intrafamilial child molesters exhibit the lowest recidivism rates of 4% to 10%. Additionally, Hanson (2002) found that extrafamilial child molesters demonstrated higher recidivism risk than rapists.

On average, civilly committed sex offenders in Washington, Florida, and Wisconsin received higher actuarial risk assessment instruments compared to the Nebraska sample. It is initially unclear why Nebraska’s civilly committed sex offenders exhibited lower levels of risk compared to analogous samples in other states. This finding raises a host of possible explanations.

How Is Risk Best Assessed and Managed?

The observation that sex offenders were rarely committed to least restrictive alternatives, despite the Nebraska sample’s modest risk levels, merits consideration of how mental health professionals and decision-makers conceptualize risk assessment and management. The current study examined risk in terms of a variety of variables known to increase a sex offender’s likelihood of recidivism, but primarily focused on static risk factors as measured by four conventional actuarial risk assessment instruments and diagnoses. Each risk assessment instrument consists of several actuarial items. Some items are common across multiple instruments, whereas others are unique to a particular instrument. For example, the VRAG and SORAG include several items pertaining to general criminal history and childhood maladjustment, whereas the Static-99 and MnSOST-R items focus more so on sexual offense conduct (e.g., number of victims, relationship to victim, victim gender, victim age range). An offender’s risk level can vary considerably depending on how a risk assessment instrument measures the particular constellation of risk and protective factors. To this effect, Barbaree, Langton, and Peacock (2006a, 2006b) demonstrated that how risk assessment instruments’ items represent constructs such as antisocial behavior and manifestations of sexual deviance affects how a given instrument gauges sexual violence risk. Considering these findings, it makes sense that different risk assessment instruments measured risk differently within the present study. Ideally, any entity tasked with protecting public safety and civil liberties carefully considers static and dynamic⁵ risk factors along with deviant sexual preferences when determining how an individual’s level of risk can be most effectively and least restrictively managed. A particular sex offender’s recidivism risk depends on how risk is conceptualized, an idiographic process that should be guided, but never dictated, by nomothetic actuarial risk assessment procedures. Likewise, effective risk management strategies depend on the pertinent risk factors for a particular

⁵ Whereas static risk factors rarely change, dynamic factors are, by their very nature, in flux, and therefore represent valuable supervision and treatment targets. Examples of dynamic risk factors include substance use, mood, employment, and living situation (Hanson & Harris, 1998).

offender. For example, an offender who finds children sexually arousing and has a high risk of recidivating, according to actuarial risk assessment instruments, may pose little risk in an environment where he is prevented from gaining unsupervised access to children. However, identical conditions would do little to reduce the risk posed by a man who derives sexual arousal from nonconsensual sex with adults.

A potential explanation for why many lower risk offenders were committed and so few offenders were unconditionally released at their initial mental health board hearing could be that psychological evaluations submitted to commitment decision-makers justify risk estimates by weighing information differently from the statistical weights determined by actuarial risk assessment instruments, or citing information not represented by the instruments included in the present study. To date, just one study has examined what clinicians consider when assessing dangerousness in sex offenders (Mercado, Elbogen, Scalora, & Tomkins, 2001). Clinicians participating in this study identified a number of factors as relevant to predicting sexual recidivism. Some factors, such as social support and treatment compliance, were robustly linked to recidivism risk. On the other hand, clinicians cited having intrafamilial victims as important to predicting risk, despite ample evidence to the contrary.

When Mercado Elbogen, Scalora, and Tomkins (2001) collected their data, research on dynamic risk factors was in its infancy and information about empirically supported risk factors—both static and dynamic—was not yet widely disseminated among U.S. practitioners. Today, professional organizations make this information easily accessible to practitioners via a variety of modalities. If Mercado et al.'s study were replicated today, it is expected that clinicians' would identify characteristics associated with recidivism closer to those research has identified as empirically supported risk factors. This prospect is encouraging, because accurate psychological evaluations are a crucial ingredient for ensuring just and effective civil commitment procedures. However, it is uncertain whether a clinician accurately identifying risk factors would improve the validity of commitment decisions.

Considering the time frame of the sample's commitment dispositions, one should note the evolving nature of tools used by recidivism risk evaluators. Commitment dates ranged from 1990, when actuarial science was in its infancy, to 2009, at which point it would be rather unusual to conduct a risk-oriented evaluation without incorporating results from at least one of these tools. On the one hand, the Nebraska sample did not exhibit different risk levels over time. Still, it is likely that the content of psychological evaluations submitted to mental health boards has changed over the years, detracting from the validity of the current study's attempt to intuit mental health board decision-making through standardized, "modern-day" measures of recidivism risk.

Whereas results from the present study suggest that civil commitment decisions are influenced by something other than empirically supported risk factors, this does not necessarily mean that professionals involved in the decision-making process ignore empirically supported risk factors. Another possibility is that decision-makers consider factors that they expect will *mediate* empirically supported risk factors; in which case, the present study may have simply neglected to measure this information. Alternatively, commitment decisions may be strongly governed by speculations about

dynamic risk factors, which the present study could not accurately measure. Likewise, whereas the present study did not examine the availability of community-based treatment and monitoring, it seems reasonable to expect that the availability of outpatient resources factor into commitment dispositions. Finally, given the small number of individuals committed to outpatient settings and not committed at all, it is important to remember that results are preliminary and may change as decision-makers issue more outpatient and release decisions. Despite these methodological limitations, comparing sex offenders civilly committed in Nebraska to analogous groups in other states still raises concerns about whether Nebraska's civil commitment procedures fulfill their stated objective of relying on least restrictive risk management strategies.

Limitations and Directions for Future Research

Because limitations necessarily imply directions for future research, the two topics are discussed together. Perhaps decision-makers in Nebraska recommend inpatient civil commitment too liberally. Another possibility is that decision-makers recommend outcomes appropriately, but conceptualize risk in ways that were poorly represented by the present study's data collection methods, and incomparable to the risk assessments relied on by the Washington and Florida studies. Or, professionals involved in Nebraska's civil commitment procedures may recommend inpatient commitments so frequently because they have little faith in outpatient treatment and other risk management strategies, perhaps coupled with less risk tolerance. If so, then decision-makers may harbor concerns about whether law enforcement can effectively monitor sex offenders committed to outpatient settings. Yet even if decision-makers have confidence in extant community monitoring strategies, they may have doubts about whether those responsible for monitoring outpatient-committed sex offenders could effectively address noncompliance. Future research could respond to these questions by investigating the quality and availability of community-based treatment and monitoring across Nebraska, along with professional's perceptions of such services.

Another consideration is that patterns of commitment decisions in Nebraska could reflect a belief that civil commitment should serve a shorter-term detention and treatment function than the long-term confinement it has come to signify in many other states. Future research could shed light on this possibility by probing decision-makers' perceptions of the proper function of civil commitment.

The present study's data collection procedures gave rise to limitations. First, because the present study sought to clarify civil commitment decisions, we made every effort to code archival data that was pertinent to risk and known to the commitment decision-makers at the time of the individual's hearing. Clearly, this raises questions about how accurately we were able to intuit what information decision-makers were able to access when rendering dispositions. Future research could resolve this limitation by obtaining permission to access commitment hearing records, which we attempted, but were unable to do for the present study. This would allow for a more accurate understanding of what factors influence commitment decisions.

Lack of access to commitment hearing records also contributed to the present study's inability to measure dynamic risk factors or other risk factors utilized.

Granted, dynamic risk factors have been examined only in outpatient settings (Levenson, 2006), raising questions about their utility for predicting risk in inpatient sex offender populations. However, because sex offenders who undergo commitment hearings could be committed to outpatient settings—or not committed at all—it would be valuable to examine the relationship between dynamic risk and commitment decisions.

A final limitation stemming from the present study's inability to access commitment hearing records is the need to make a sizable conceptual leap between the available data and whatever information decision-makers took into consideration as they reached dispositions. For example, although it is routine for a psychologist to provide the mental health board with an evaluation of a respondent's recidivism risk, it remains uncertain how much—if any—attention mental health boards give to these evaluations. Certainly, this question could be answered only by directly measuring how mental health boards incorporate psychological evaluation into their decision-making processes. Still, it seems reasonable to anticipate that mental health boards place considerable weight on recommendations proffered within psychological evaluations when formulating commitment decisions. Although actuarial risk assessment instrument results predict neither evaluators' opinions nor fact finders' decisions, evaluator recommendations do predict court outcomes (Hilton & Simmons, 2001). Therefore, future research should examine psychological evaluations submitted to decision-makers, because this information will improve efforts to understand what factors influence commitment dispositions.

The present study examined relationships between only five states' sex offender civil commitment statutes and civil commitment program patient characteristics. Such a limited scope raises questions about whether results can be generalized to other states. Therefore, as more civil commitment programs make patient characteristics available, future research should examine relationships between these states' laws and characteristics of the sex offenders committed under them. Such information will allow for a more conclusive response to whether the language of sex offender civil commitment laws bears any reliable relationship to characteristics of civilly committed sex offenders, and will clarify how these laws are being implemented across the country.

Concluding Remarks

Sex offender civil commitment processes are designed to identify, contain, and treat sex offenders who pose a high risk of sexual recidivism. Stakes are high with respect to both civil liberties and public safety. Confining someone who will not reoffend and releasing someone who will are both objectionable possibilities. Therefore, sex offender civil commitment decisions should be rendered in a manner that balances the two interests as accurately as possible. A seemingly reasonable strategy for reaching an optimal balance would be for decision-makers to rely heavily on empirically supported risk assessment procedures when recommending commitment dispositions, a decision-making process consistent with a structured professional judgment model. Decision-makers may also wish to consider dynamic risk factors in a conditional sense. For instance, they could invite the respondent, ideally in collaboration with an unbiased treatment pro-

vider, to submit a proposed release plan. Next, they could evaluate the plan's feasibility, as well as how it would address the nature and degree of the respondent's dynamic risk. A plan that seemed feasible and likely enough to sufficiently reduce the respondent's dynamic risk could weigh in favor of an outpatient commitment. Conversely, no plan at all or a plan that seemed infeasible and ill-equipped to help the respondent manage the dynamic risk could provide evidence in favor of an inpatient disposition.

Data from the present study suggest that in Washington, Florida, and Wisconsin, civilly committed sex offenders exhibit high levels of risk that would not be sufficiently mitigated by typical community supervision resources. These results strongly suggest that in these three states, sex offender civil commitment procedures operate in accordance with empirically supported risk assessment and management strategies. On the other hand, sex offenders civilly committed in Nebraska exhibited moderate to low levels of recidivism risk, raising questions about how decision-makers determined that these offenders were dangerous enough to merit alternatives "of last resort." The possibility that dynamic risk factors and limited community supervision and treatment resources exerted more influence over mental health boards' decisions than did the static risk factors measured by the present study could partially account for why sex offenders civilly committed in Nebraska were lower risk than those committed in the comparison states.

Inpatient commitment is a costly remedy for preserving public safety, both in terms of figurative costs to the committed individual's personal liberty and the more literal costs of the civil commitment programs themselves (La Fond, 2003; Schlank, Harry, & Farnsworth, 1999). Certainly, the societal costs of sexual victimization are immeasurable; still, liberally committing sex offenders to inpatient settings may not be a sustainable solution to preventing sexual violence.

As civil commitment statutes indicate, inpatient commitment should be implemented only in situations where less restrictive alternatives are insufficient to mitigate an individual's risk. While it is ultimately up to legislators and decision-makers charged with implementing civil commitment laws to decide how they would like to allocate state resources in the service of public safety, one hopes that these entities strive to allocate resources wisely. The observation that Nebraska commits moderate- to low-risk sex offenders to inpatient settings at such a high rate merits consideration of whether this practice represents the most fiscally responsible use of the state's limited correctional and mental health dollars. It also underscores a need to evaluate the availability and effectiveness of community-based sex offender treatment and monitoring.

A *New York Times* article reported that, in Nebraska, the average cost of inpatient civil commitment is estimated at \$100,000 per individual per year. This figure includes direct costs such as the hospital operating budget as well as more peripheral costs associated with attorneys' fees, psychological evaluations, keeping the respondent in protective custody, and court fees. By comparison, it costs, on average, \$26,031 to incarcerate someone for a year (Davey & Goodnough, 2007). Finally, there are less quantifiable financial consequences of funding civil commitment by diverting fiscal support from other state-funded mental health programs.

Whether they occur before a judge and jury or a county mental health board, sex offender civil commitments are adversarial proceedings, and decision-makers are presented with a broad range of evidence throughout the adjudication process. Of that evidence, the assessment instruments discussed in the present study constitute the most valid and reliable tools for estimating an individual's risk for reengaging in sexual violence. To ensure that commitment decisions deliver an informed balance between preserving civil liberties and defending public safety, it is imperative that decision-makers appreciate the value of evidence-based practice (Institute of Medicine, 2001; Sackett, Straus, Richardson, Rosenberg, & Haynes, 2001) and, more specifically, the robust predictive power of empirically supported risk assessment procedures.

For sex offender civil commitment to be a credible and effective public safety mechanism, it should be carried out based on our best understanding of how to effectively fulfill its objectives. No psychological test can decide whether an offender's risk level warrants a more or less intrusive disposition. Nor can any psychological test weigh the risk of sexual victimization against the competing interest of an offender's personal liberty. Rather, such decisions connote how decision-makers apply this law to achieve what they understand to be a satisfactory balance between these two competing interests. Yet when civil commitment dispositions appear to be based on something other than an empirically supported understanding of risk, it reduces confidence that the balance is being struck wisely.

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