Expert Testimony in Sexually Violent Predator Commitments: Conceptualizing Legal Standards of "Mental Disorder" and "Likely to Reoffend"

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The most recent type of civil commitment for dangerous sex offenders is found under the sexually violent predator laws. Forensic psychiatrists or psychologists must render an opinion as to whether the sex offender has a diagnosed mental disorder and, as such, represents a risk to public safety if released from custody into the community. Thus, expert testimony provided by these professionals has taken a central role in the commitment determinations. There is considerable debate as to what disorders predispose individuals to sexual recidivism and what the term "likely" signifies. In this article, the authors explore the debate in terms of whether Antisocial Personality Disorder is a qualifying diagnosed mental disorder for classification as a sexually violent predator and how a likely threshold of risk of sexual recidivism can be conceptualized.

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Since 1995, several jurisdictions in the United States have instituted sexually violent predator (SVP) or sexually dangerous person (SDP) civil commitment statutes. These laws seek to identify the small group of extremely dangerous incarcerated sex offenders who represent a threat to public safety if released from custody. The laws provide for psychiatrists and psychologists to evaluate the inmate prior to release on parole, and to determine whether the identified individual meets the criteria for civil commitment as an SVP/SDP. A sexually violent offense is defined statutorily by specific sex crime felony convictions, such as child molestation, sodomy, or rape. With the exception of California's renewable two-year commitment period,[1] no state has a definite term; that is, the individual remains committed as an SVP/SDP until the person is no longer a threat to public safety. All states provide for periodic review of the commitment, ranging from six-months (e.g., Ref. 2) to once every two years (e.g., Ref. 3). The intent of the SVP/SDP laws is not punitive. Rather, it is to provide for containment along with mental health treatment directed toward reducing the individual's dangerousness.

The SVP/SDP laws require a finding that: (1) the person was convicted of the offenses determined by the state to constitute a sexually violent crime; (2) the person suffers from a diagnosed mental disorder; and (3) as a result of that disorder, the person represents a risk to public safety if released to the community. If the individual is found by the clinical evaluators to meet the criteria, each state has a procedure for referring the case for civil commitment proceedings. Typically, due process procedures for these commitments involve hearings to determine whether there is probable cause that the individual is an SVP/

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SDP. If probable cause is found, the case is referred for trial.

In the courtroom, the testifying expert must render an opinion regarding two critical issues: does the person have a "diagnosed mental disorder" and what is the "likelihood" of sexual recidivism. Individuals cannot be identified as SVPs/SDPs and accordingly committed, unless they are found to be positive on both elements. Thus, expert testimony provided by forensic psychiatrists and psychologists has taken a central role in these commitment determinations. These are also the very points on which there is argument and controversy among testifying professionals. Specifically, there is debate as to what disorders predispose individuals to sexual recidivism and whether a condition such as Antisocial Personality Disorder fulfills this element. Risk analysis focuses on what the term "likely" signifies, whether a quantitative description of such risk is prudent or acceptable peer practice, and relatedly, the discussion involving actuarial versus clinical analysis.

Trial judges charged with evaluating the validity of expert witnesses' testimony face a daunting task in relation to conflicting opinions in the scientific literature regarding the areas of mental disorder and risk analysis.[4–7] In a recent article, Appelbaum[8] states that although the trial judge has the responsibility of "screening testimony that is likely to be misleading. . ., anyone with courtroom experience knows that the ability of judges to determine the scientific or clinical validity of proposed testimony is imperfect at best" (Ref. 8, p 389). This is only further compounded when the field is mired in controversy regarding definitions and application, as is the case in SVP/SDP commitments.

Appelbaum proposes that peer review and professional association guidelines can improve the quality of expert testimony, but so can efforts to clarify the controversial elements by examining the area in light of practice, legal interpretation, and current research. The purpose of this article is to explore the debate in terms of whether Antisocial Personality Disorder is a qualifying "diagnosed mental disorder" for classification as an SVP/SDP and how a "likely" threshold of sexual recidivism risk can be conceptualized.

Sexually Violent Predator/Dangerous Person Laws: An Overview

Currently, there are 17 jurisdictions that have adopted some form of an SVP/SDP commitment.[9–25] Table 1 lists the states and the terms for their enacted legislation. All of these states provide for the commitment after the individual's imprisonment.

Table 1 Commitment Classification Term by State

Term	State
Sexually violent person	Arizona, Illinois, Wisconsin
Sexually violent predator	California, Florida, Iowa, Kansas, Missouri, New Jersey, South Carolina, Texas, Virginia, Washington
Sexually dangerous person	Massachusetts, Minnesota
Sexual psychopathic personality	Minnesota
Sexually dangerous individual	North Dakota
No term	Tennessee

An overview of the number of offenders actually retained under these civil commitment statutes provides for an understanding of the refined nature of the evaluators' assessment. That is, only a very small number of sex offenders are referred for such evaluation, and an even smaller number are considered to meet the criteria. California's statistics serve to illustrate the population trends regarding SVP commitments. In California, approximately 350 sex offenders are released each month from custody.[26] Since the inception of the Californian SVP law on January 1, 1996, through August 2, 2001, the California Department of Mental Health estimates that 18.6 percent (3,776) of all sex offenders awaiting parole release were referred for evaluation under the civil commitment statute. Of these, 669 were rejected as not meeting the criteria after a record review conducted by the Department of Mental Health. The remaining 2,107 cases were referred to psychiatrists and/or psychologists for further evaluation. Of these, 45 percent (948) were determined by the evaluators as meeting the criteria for commitment and thus supporting further judicial proceedings. As of August 2, 2001, 236 individuals had been committed under the SVP statute, with 172 individuals awaiting further proceedings. As these numbers illustrate, a very small percentage (i.e., 236 sex offenders committed of a total of 20,301 (1.16%) sex offenders released) of all California sex offenders who had been retained under the SVP law.

The California Department of Mental Health[26] also cited statistics for individuals in other states who were in various phases of the SVP/SDP commitment

Table 2 Definition of the Required Mental Condition

State	Mental Condition
13 states	A congenital or acquired condition affecting the emotional or volitional capacity that predisposes the person to the commission of criminal sexual acts to a degree constituting the person a menace to the health and safety of others
	In the 13 states, the terms for the mental condition are as follows:
California	Diagnosed mental disorder
Florida	Mental abnormality or personality disorder
Illinois	Mental disorder
Iowa	Mental abnormality
Kansas	Mental abnormality or personality disorder
Missouri	Mental abnormality
New Jersey	Mental abnormality or personality disorder
South Carolina	Mental abnormality or personality disorder
Texas	Behavioral abnormality
Virginia	Mental abnormality or personality disorder
Washington	Mental abnormality or personality disorder
Wisconsin	Mental disorder
Massachusetts	Mental abnormality and "personality disorder," a congenital or acquired physical or mental condition that results in a general lack of power to control sexual impulses.
Arizona	"Mental disorder" means a paraphilia, personality disorder, or conduct disorder or any combination of paraphilia, personality disorder and conduct disorder that predisposes a person to commit sexual acts to such a degree as to render the person a danger to the health and safety of others.
Minnesota	"Sexual psychopath personality" means the existence in any person of such conditions of emotional instability, or impulsiveness of behavior, or lack of customary standards of good judgement, or failure to appreciate the consequences of personal acts, or combination of any of these conditions, which render the person irresponsible for personal conduct with respect to sexual matters, if the person has evidenced, by a habitual course of misconduct in sexual matters, an utter lack of power to control the person's sexual impulses and, as a result, is dangerous to other persons.
	"Sexually dangerous person" means a person who . . . has manifested a sexual, personality, or other mental disorder or dysfunction; and as a result, is likely to engage in acts of harmful sexual conduct . . . . For purposes of this provision, it is not necessary to prove that the person has an inability to control the person's sexual impulses.
North Dakota	Congenital or acquired condition that is manifested by a sexual disorder, a personality disorder, or other mental disorder or dysfunction that makes that individual likely to engage in further acts of sexually predatory conduct which constitute a danger to the physical or mental health or safety of others . . . . For these purposes, mental retardation is not a sexual disorder, personality disorder, or other mental disorder or dysfunction.
Tennessee	Mental illness or serious emotional disturbance . . . because of that illness, poses a likelihood of serious harm . . . , and is in need of care and treatment in a mental hospital or treatment resource.

process. These numbers are all lower than those of California and indicate that, across the country, the actual total number of sex offenders either awaiting or under commitment range by state from fewer than 50 (e.g., Iowa, Kansas, North Dakota, Missouri, and South Carolina) to close to 400 (e.g., Florida) as of 2001.

Diagnosed Mental Disorder: Statutory and Case Law Definitions

Of the 17 states with laws permitting the involuntary postconviction commitment of sex offenders, 13 have similar wording regarding the mental condition necessary for commitment under their SVP/SDP statutes. The remaining four states use a different standard. Table 2 presents a summary of the required mental condition and its definition, by state.

Specific DSM-IV-TR[27] type classifications are not identified by statute for what does or does not constitute a qualifying mental disorder or mental abnormality. The most common definition of a mental disorder across the states is similar to that in the California § 6600 Welfare and Institutions Code (WIC)—that is, "a congenital or acquired condition affecting the emotional or volitional capacity that predisposes the person to the commission of criminal sexual acts in a degree constituting the person a menace to the health and safety of others" (Ref. 10, WIC 6600(a)). This definition implies a causal relationship between the mental disorder and deviant sexual acting out. The definition also implies that the condition impacts emotional and volitional capacity, terms that are not found in the DSM-IV-TR.

Two U.S. Supreme Court decisions addressed mental abnormality in the SVP laws. The first case is *Kansas v. Hendricks*.[28] Leroy Hendricks was a sex offender with a long history of molesting children. Hendricks' history began in 1955 when he exposed

his genitals to young girls. In 1957 he was convicted of lewdness involving a young girl, in 1960 he molested two young boys while he worked at a carnival, and he was later arrested for molesting a seven-year-old girl. Shortly after release from prison, he performed oral sex on an 8-year-old girl and fondled an 11-year-old boy. After release on parole, for four years he forced his stepdaughter and son to engage in sexual activity with him. He was then convicted of indecent liberties with two 13-year-old boys. Hendricks was about to be released from prison when Kansas sought to commit him under their SVP Act. During the commitment hearing, Hendricks agreed with the State's diagnosis that he suffered from Pedophilia and that he could not control aberrant sexual thoughts, particularly during periods of stress. The jury found him to be an SVP. On appeal, the Kansas Supreme Court invalidated the Act on the grounds that "mental abnormality" did not satisfy the "substantive" due process requirement that involuntary civil commitment must be predicated on a "mental illness." The case was then appealed to the U.S. Supreme Court.

The Supreme Court rejected Hendricks' claim that mental illness, as opposed to mental abnormality or personality disorder, had to be present to satisfy civil commitment constitutionally. The Court noted that states were left to define such terms, and Kansas had done so. Further, the Court wrote that states, in narrow circumstances, provide for the involuntary commitment of individuals who are unable to control their behavior and therefore pose a risk of danger to public health and safety. Accordingly, the Court viewed Hendricks' condition of Pedophilia as one that satisfied the criterion related to an inability to control his dangerousness. The Court justified Hendricks' civil commitment on the basis of his admission of a lack of volitional control (over sexual impulses) together with his risk for future dangerousness. The justices opined that these elements differentiated Hendricks from other dangerous individuals who were better dealt with through criminal proceedings.

The second case considered by the U.S. Supreme Court was that of *Kansas v. Crane*.[29] Michael Crane was convicted of lewd and lascivious behavior and pled guilty to aggravated sexual battery for two incidents that occurred on the same day. Crane exposed himself to a tanning salon attendant. Shortly thereafter, he exposed himself to a video store clerk, whom he then grabbed by the neck, demanding that she perform oral sex on him and threatening to rape her before running out of the store. Crane was diagnosed as suffering from Exhibitionism and Antisocial Personality Disorder. Exhibitionism alone was not thought by the experts to support classification as an SVP; however, the combined disorders of Exhibitionism and Antisocial Personality Disorder were considered by them to meet SVP criteria, and the jury agreed. The case was appealed to the Kansas Supreme Court, which reversed the lower court finding, interpreting *Hendricks* as requiring a determination that the individual could not control his behavior. The case was then appealed to the U.S. Supreme Court. The Court noted that in their ruling in *Hendricks* they referred to the Kansas SVP Act as requiring a mental abnormality or disorder that made it difficult for the person to control his or her behavior. In addressing this, the Court asserted that there was no requirement for a complete lack of control determination in their *Hendricks* decision. Consequently, in *Crane*, the Court held that while an " 'inability to control behavior' will not be demonstrable with mathematical precision. It is enough to say that there must be proof of serious difficulty in controlling behavior" (Ref. 29, p 407). Thus, the Court vacated and remanded the case.

Both *Hendricks* and *Crane* offer the High Court's rationale in how to interpret the criterion mental disorder in SVP/SDP laws. The Court also noted in Crane that states retain considerable flexibility in the definition of mental abnormalities and personality disorders that make an individual eligible for civil commitment. In *Crane*, the experts opined that the combination of Exhibitionism and Antisocial Personality Disorder (but not Exhibitionism alone) was thought to rise to the threshold of a qualifying mental disorder. Although this was an opportunity for the Court to address whether Antisocial Personality Disorder should be considered a qualifying diagnosis for an SVP/SDP commitment, they did not.

Antisocial Personality Disorder: Is It a Qualifying Mental Disorder?

The matter of where Antisocial Personality Disorder fits in the civil commitment of sex offenders has been long debated. A historical review of the arguments (particularly as occurring in California) offers a context for addressing this quandary when consid-

ering definitions of mental disorders in SVP/SDP evaluations.

The first sexual psychopath laws appeared in Michigan in 1937. California followed in 1939,[30,31] and by the mid-1960s more than half the states had similar laws for sex offenders. The intent of the sexual psychopath law was to provide for hospitalization and treatment of persons who perpetrate sexual acts offensive to society and who have a mental abnormality that is receptive to treatment.[32] As a result of work within this population, much was learned about those individuals who could benefit from treatment and those who could not. In California, it was found that sex offenders classified as incorrigible sociopaths were not individuals who lacked the ability to control their sexual impulses as much as they lacked the ability to control their antisocial impulses. Thus, it was believed that this category of individuals should be judged according to the merits of the case and committed to correctional facilities when indicated.[33]

In 1963, California instituted many reforms to the sexual psychopath laws, including the name change to "mentally disordered sex offender." This new set of laws reiterated the need to limit the proceedings to those who could benefit from hospital treatment. As such, persons with a record of a wide range of criminal activity, including sexual offenses, were not perceived of as appropriate for commitment as mentally disordered sex offenders. While it was thought that some may have a mental disorder, it was believed that they were not predisposed to commit sexual offenses specifically. The then Director of the California State Department of Mental Hygiene believed that treatment for such individuals would not be of much help and therefore was not warranted. Rather, he believed that, "the social forces of a prison treatment setting offers just as good or a better chance for rehabilitation" (Ref. 34, p 132).

The original sexual psychopath laws were viewed as alternatives to imprisonment for sex offenders. They were intended to provide treatment and offer a possible cure for future sexual offending. Those with Antisocial Personality Disorder were found not to be amenable to such treatment efforts, and it was understood that they should be excluded from such categorization and commitment.[34] In general, specialized treatment for sex offenders began to lose favor, and in the 1970s and 1980s many states repealed their sexual psychopath laws as a result of the viewpoint that the treatment of sex offenders was ineffective.[32] By 1990, only 13 states had sexual psychopath laws in effect.[35]

This social policy trend toward repeal of special sex offender laws held sway until the mid-1990s, when a series of sexual offenses committed by paroled sex offenders became highly publicized. As a result, many states reviewed their policy regarding the civil commitment of sex offenders and enacted the most recent set of sexual dangerous person laws. These states' legislatures drafted SVP/SDP Acts that acknowledged the difficulty in treating these particular sex offenders and instituted involuntary commitment proceedings different from their general involuntary civil commitment statutes. The legislatures reasoned that, while the ultimate goal of the SVP/SDP statutes is the treatment, and ideally the cure, of the mental condition that causes individuals to commit sexual offenses, the immediate purpose is to protect society by ensuring the commitment of such individuals.[36] This rationale was addressed by the American Psychiatric Association's Task Force[35] who argued that these laws undermine the legitimacy of the medical model of civil commitment and therefore should be opposed vigorously.

The primacy of the need to protect society over the need for the committed sex offender to benefit from treatment is illustrated by the absence of any state's requiring that the individual be considered amenable to treatment efforts to be designated an SVP/SDP. Indeed, California's commitment law states clearly that amenability to treatment is not necessary for finding that the person is an SVP nor for the person to be referred for treatment.[37] The statute states further that, ". . .treatment does not mean that the treatment be successful or potentially successful, nor does it mean that the person must recognize his or her problem and willingly participate in the treatment program."[37] Consequently, the individual with an Antisocial Personality Disorder, who may not have been identified as able to profit from treatment and therefore qualify under the original sexual psychopath laws, now could well be found to meet current SVP/SDP criteria.

As a result, the testifying expert should be aware of the changed context for the newer commitment laws in which amenability to treatment is not a factor and take this into account with respect to both their biases and opinions. In addition, clinicians may be reluctant to place purely antisocial individuals in facil-

ities that provide psychiatric treatment, given the questionable effectiveness of treatment programs for this population.[38–40] Clinicians also may have concerns, similar to those expressed by the American Psychiatric Association's Task Force, regarding the use of psychiatric facilities when they believe the sole purpose of the commitment is confinement, and thus another means to deliver punishment. This view is articulated most strongly by those who believe that sex offenders cannot be treated successfully, particularly if they suffer from Antisocial Personality Disorder. Nevertheless, the U.S. Supreme Court has upheld repeatedly the constitutionality of the SVP/SDP laws. In both *Kansas v. Hendricks*[28] and *Kansas v. Crane*,[29] the U.S. Supreme Court affirmed the constitutionality of the SVP law and stated clearly that commitment under this Act is not punishment, because neither of the two primary objectives of criminal punishment, retribution or deterrence, is implicated (Ref. 28, p 2082). Moreover, the Court wrote in *Hendricks* that:

> . . .incapacitation may be a legitimate end of civil law. . . . While we have upheld state civil commitment statutes that aim both to incapacitate and treat, we have never held that the Constitution prevents a State from civilly detaining those for whom no treatment is available, but who nevertheless pose a danger to others [Ref. 28, p 2084].

Another argument offered by the Court that the Act is not punitive is their acceptance that while the state's overriding concern was the continued segregation of sexually violent offenders, an ancillary purpose of the Act was to provide treatment if such is possible.

The viewpoint that Antisocial Personality Disorder cannot be applied in SVP/SDP Acts is unsupported by statutory and case law, as there is no proscription of this disorder as a qualifying mental condition. Both Florida[41] and Iowa[42] recognize that, "SVPs generally have antisocial personality features which are unamenable to existing mental illness treatment modalities and that render them likely to engage in criminal, sexually violent behavior."[42] According to these states' definitions, it could be argued that Antisocial Personality Disorder qualifies as a mental disorder under the SVP laws. Several states include personality disorder in their definition of what constitutes a mental disorder (Massachusetts, New Jersey, North Dakota, South Carolina, Virginia, and Washington). In addition, no state expressly excludes Antisocial Personality Disorder. Finally, some states address this diagnosis specifically and its relation to their SVP law.

A review of case law reveals that judges have ruled for the inclusion of Antisocial Personality Disorder as a qualifying mental disorder. In the Arizona case of *Martin et al. v. Reinstein*,[43] the court relied on the legislature's determination that antisocial personality features rendered petitioners likely to engage in future acts of sexual violence. In the New Jersey case of *In the Matter of the Commitment of W.Z.*,[44] the petitioner was diagnosed as having an Antisocial Personality Disorder with narcissistic features. The Appellate Court upheld the lower court's decision that such a disorder affected emotional capacity in a manner as to predispose him to commit acts of sexual violence. In a Washington case, *In re Detention of Scott W. Brooks*,[45] the Appellate Court held that persons committed as SVPs constitute a narrowly defined group of individuals with antisocial personality features that render them likely to engage in sexually violent behavior. In Wisconsin, the case of *State v. Adams*[46] held that a person diagnosed with Antisocial Personality Disorder coupled with another disorder may be found to be sexually violent. Finally, as mentioned previously in *Kansas v. Crane*,[29] the combination of Crane's diagnoses of Exhibitionism and Antisocial Personality Disorder served as a qualifying mental disorder, supporting his commitment as an SVP.

Without the clear prohibition of certain psychiatric disorders, the SVP/SDP commitment laws have become more inclusive in an effort to capture as many of those who pose a threat of dangerous sexual offending. However, while some individuals with Antisocial Personality Disorder meet the requisite mental criteria under SVP/SDP Acts, it could be argued that not all sex offenders with such a diagnosis should be committed as an SVP/SDP. A central element for a qualifying mental disorder is a showing of some lack of volitional control. Therefore, those with only an Antisocial Personality Disorder may argue that their crimes were the result of voluntary choice and not impulses for which they lack control. For example, in the case of *In re the Commitment of George Taylor*,[47] the petitioner argued that because there was no evidence to support Antisocial Personality Disorder with sexually violent conduct, the application of such a disorder to SVP commitments was unconstitutional. The Wisconsin Court of Appeals, however, rejected this argument on the

grounds that the nexus was not between the disorder and the violent sexual act, but rather between the disorder and its specific effect on the individual to predispose him to sexual violence.

Using the Wisconsin Court of Appeals' guideline, it could be argued that the examining psychiatrist or psychologist can distinguish between two types of individuals who have long, nonsexual criminal histories that meet the diagnostic criteria for Antisocial Personality Disorder. There are those antisocial individuals whose sexual offenses are the result of specific features of their personality disorder, and there are those who are merely opportunistic criminals. An example of the former would be an individual who stalked the neighborhood looking for women who lived alone, then broke into a series of homes in a period of a week, sexually assaulted the women, and demanded on each occasion their money and valuables before he left. This example could be contrasted with a man who broke into a house to commit a burglary and, during the course of the crime, discovered a mother and her two teenage daughters whom he then raped before he left with some of their valuables. For both perpetrators, there was no preexisting pattern of sexual assault or fantasies of such assault, and the minimum criteria for a paraphilic disorder were not met.

In the first instance, the individual's criminal behavior was motivated primarily by a desire to seek out single women and sexually assault them. The burglaries were of secondary consideration or were opportunistic. In our second case, however, the individual's criminal conduct was motivated by the intent to commit a burglary followed by opportunistic sexual assaults. In this latter example, it would be difficult for a mental health professional to prognosticate whether the second individual with an Antisocial Personality Disorder is likely to commit subsequent sexual offenses, whereas in the first example, a stronger argument could be made that the individual's Antisocial Personality Disorder had a facet of sexual deviancy that may well predispose him to commit future sexual offenses. The need to differentiate between these two types of offenders was recognized in *Kansas v. Crane* when the Court wrote that:

> There must be proof of serious difficulty in controlling behavior. And this when viewed in light of such features of the case as the nature of the psychiatric diagnosis, and the severity of the mental abnormality itself, must be sufficient to distinguish the dangerous sex offender whose serious mental illness, abnormality, or disorder subjects him to civil commitment from the dangerous but typical recidivist convicted in an ordinary criminal case [Ref. 29, p 413].

The use of Antisocial Personality Disorder to justify civil commitment is unlikely to find general acceptance among mental health professional groups. This disorder does not readily fit into assumptions of the medical model of involuntary civil commitment—that is, the necessity to protect individuals when they are unable to recognize their need for treatment because of a serious mental illness. Given the controversy surrounding the efficacy of treatment for persons with Antisocial Personality Disorder or whether this diagnosis even represents a severe mental disorder, it could be argued that SVP/SDP commitment for such persons would not serve traditional medical purposes but rather would fulfill society's need to detain these individuals. The testifying expert will have to confront this dilemma because neither statutory nor case law proscribe Antisocial Personality Disorder as a qualifying mental disorder (although some states permit this diagnosis if in combination with another disorder) for SVP/SDP commitments. The forensic mental health professional who relies on the issue of amenability or *a priori* assumptions that persons with Antisocial Personality Disorder should be excluded from SVP/SDP commitments is misinterpreting the law as it currently stands.

"Likely" Threshold of Sexual Recidivism Risk

Statutory and Case Law Definitions

In addition to demonstrating that the individual suffers from a diagnosed mental disorder, there must also be a finding that as a result of that disorder the person poses a risk, or likelihood, of sexual recidivism. The definition of likelihood as provided by statutory and case law varies across the states, as can be seen in Table 3.

Most states have additional definitions for "likely to engage in sexual violence." The standard is further defined as "highly probable," "highly likely," "substantially probable," or "more likely than not." While persons facing SVP/SDP commitments have challenged these standards as not satisfying due process because the terms are ambiguous and probability determinations are not always specified, such arguments have been rejected based on the landmark U.S.

Table 3 Statutory and Case Law Language of Risk Threshold

State	Threshold
Arizona	Statutory: likely to engage in acts of sexual violence Case Law: "highly probable"; cites dictionary definition (*In re the Matter of Leon G.,* 26 P.3d 481, Ariz. 2001)
California	Statutory: likely that he or she will engage in sexually violent criminal behavior Case Law: "serious and well-founded risk"; "substantial probability; erroneous if defined as over 50% (*People vs. Ghilloti,* 44 P.3d 949 (Cal. 2002))
Florida	Statutory: likely to engage in acts of sexual violence Case Law: "highly probable"; "having a better chance of existing or occurring than not"; cites dictionary definition (*Westerheide vs. Florida,* 767 So.2d 637 (Fla. Dist. Ct. App. 2000))
Illinois	Statutory: substantially probable that the person will engage in acts of sexual violence Case Law: "not reduced to mere percentages"; "much more likely than not"; cites dictionary definition (*In re Detention of Troy A. Walker,* 731 N.E.2d 994 (Ill. App. Ct. 2000); *In re Detention of Richard W. Bailey,* 740 N.E.2d 1146 (Ill. App. Ct. 2000))
Iowa	Statutory: more likely than not will engage in acts of a sexually violent nature
Kansas	Statutory: likely to engage in repeat acts of sexual violence
Massachusetts	Statutory: likely to engage in sexual offenses
Minnesota	Statutory: likely to engage in acts of harmful sexual conduct Case Law: "highly likely" (*In re Dennis Darol Linehan,* 594 N.W.2d 867 (Minn. 1999))
Missouri	Statutory: more likely than not to engage in predatory acts of sexual violence
New Jersey	Statutory: likely to engage in acts of sexual violence Case Law: no specific time frame reference for likely risk (*In the Matter of the Commitment of W.Z.,* 773 A.2d 97 (N.J. Super. Ct. App. Div. 2001))
North Dakota	Statutory: likely to engage in further acts of sexually predatory conduct
South Carolina	Statutory: likely to engage in acts of sexual violence
Tennessee	Statutory: likelihood of serious harm
Texas	Statutory: likely to engage in a predatory act of sexual violence
Virginia	Statutory: likely to commit sexually violent offenses
Washington	Statutory: likely to engage in predatory acts of sexual violence; more probably than not will engage in such acts Case Law: highly probable; references language that probability of reoffending exceeds 50%; (*In the Matter of the Detention of Scott W. Brooks,* 36 P.3d 1034 (Wash. 2001))
Wisconsin	Statutory: substantially probable that the person will engage in acts of sexual violence; substantially probable means much more likely than not Case Law: use of dictionary definition of "much more likely than not" (*In re the Commitment of Frank Curiel,* 597 N.W.2d 697, (Wis. 1999))

Supreme Court case of *Addington v. Texas*.[48] In *Addington*, the appellant argued that there was no substantial basis for determining that he posed a danger to himself or others and therefore was subject to civil commitment. While the Court did not address the probability determination for dangerousness, it did hold that to meet due process demands in commitment proceedings, the state must justify confinement by proof more substantial than a mere preponderance of the evidence. Thus, in SVP/SDP commitments, courts have held that whatever information (e.g., expert testimony, psychometric testing, actuarial instruments) a trier-of-fact uses to determine the likelihood of an individual's reoffending, it must be with a sufficient degree of certainty.[44,49–51] In that the degree of proof for all SVP/SDP commitments exceeds preponderance of the evidence, the courts have opined that the term "likely" can be given its ordinary and common meaning without compromising due process considerations.

While the term "likely" is defined by statutory and case law in all of the jurisdictions, no specific direction is given to clinicians on how to translate such terms to an assessment of an individual's risk for sexual recidivism. This issue is further compounded by the fact that there has been considerable discussion about the accuracy of clinicians' predictions with respect to future violence and, consequently, what constitutes competent risk assessment. The three most common methods for evaluating sexual recidivism include actuarial ratings, "guided or adjusted" empirical risk assessment, and clinical judgment.

There has been a long-standing debate regarding the use of "actuarial" assessments as superior to "clinical judgment" for predicting risk of violence. Testifying experts who are actuarial proponents rely heavily on statistically based algorithms that utilize a small number of factors to generate risk percentages over a defined period. In addition, there are experts

who espouse "adjusting" the actuarial rating through the use of empirical factors not included in the risk scale, a process called "adjusted actuarial." Finally, there are experts who favor clinical judgment and view rating scales as an aspect of data that are interpreted in light of case-specific factors relevant to the individuals whom they are assessing.

Actuarial Risk Assessments

Actuarial rating scales were developed through the use of statistically derived factors to differentiate between sexual recidivists and nonrecidivists.[52–55] The strength of the actuarial rating scale is the utilization of a scientific methodology to quantify risk. The factors differentiate between sex offenders released to the community who have reoffended and those who have not. The rating scales use a small number of statistically identified variables and apply rules for translating ratings on the individual variables into an overall risk percentage or level. The rating scales offer exact risk percentages or base rates for sexual recidivism risk at defined points after release (i.e., 5, 10, and 15 years). In addition, differentiations can be made across risk levels—low, medium, or high—as a means of characterizing the individual. A low-risk offender would have few of the statistically identified risk factors, while a high-risk offender would have many if not all of the elements. Further, risk assessment is not influenced by the subjective biases of the clinician, given the fixed and uniform nature of the variables assessed. Proponents of the actuarial approach have cited large group findings to demonstrate the low predictive ability of clinicians' judgments in contrast to the superior ability of rating scales.[56,57] Consequently, actuarial researchers have advocated the sole or predominant use of actuarial risk assessment scores as the basis for prediction of sexual recidivism.[53,58,59]

Actuarial risk percentages can be very appealing, particularly to attorneys and the trier-of-fact who may like quantification. The testifying expert should be aware that such scores may give the appearance of a greater degree of accuracy and precision than in fact exists.[60,61] Therefore, experts should counter the appearance of certainty conveyed by numbers with an acknowledgment of the limitations of such rating scores. There are several methodological concerns common to actuarial rating scales. Some of the frequently raised issues undercutting actuarial rating systems include the generalizability of findings from the development group to the individual being assessed (e.g., ethnic differences), the inability to include case-specific factors that may reduce risk (e.g., health changes) or aggravate (e.g., sadism) risk, and the accuracy of the risk percentage estimates. For example, a recent analysis[62] indicated that the sexual recidivism percentages given in the development study for the Static-99, a sex offender risk actuarial assessment rating scale, were not fully corroborated in cross-validation studies. The risk percentages varied based on the base rate of sexual recidivism in the sample studied. Specifically, in the development sample, a score of four (medium-high risk) corresponded to a 25.8 percent rate of sexual recidivism; however, in a combination of data from seven cross-validation studies, a score of four was associated with only a 12.9 percent rate. It should be noted that in the developmental Static-99 study, a 12.9-percent rate of sexual recidivism was considered a medium-low risk.[62] These findings underscore that a sole reliance on Static-99 percentages to assess risk level is premature. An additional criticism is that there is no consistency in the research as to the outcome factors used for measuring recidivism (e.g., criminal charges, convictions, or return to hospital) nor in the length of the follow-up period.[63]

Another criticism of actuarial rating scales is that the estimate of sexual recidivism is obtained through "rap sheets" that underestimate the true rate of recidivism.[64–66] Some actuarial risk researchers, such as Hanson *et al.*,[57] suggest that a reasonable estimate of actual recidivism rates (i.e., number of actual sex crimes committed) would be 10 to 15 percent higher than observed rates (i.e., the number of arrests or convictions). In fact, the rate of the underestimation may be much larger. These authors note that, while experts agree that observed rates are minimal estimates, specifying the amount of underestimation due to unreported sexual assaults is difficult to measure, given that the phenomenon (undetected sex offenses) is not observable.

The U.S. Department of Justice[65] addressed this question through data from the National Crime Victimization Survey with comparisons to law enforcement reports. In measuring the extent of sex offenses involving rapes, the Department of Justice document noted that in the 1995 National Crime Victimization Survey, in individuals aged 12 and older, there had been 260,300 reported incidents of attempted or completed rapes. In contrast, the number of such

crimes actually reported to the police in 1995 was 97,460. These findings suggest that only 37 percent of the sexual crimes that were reported to the National Crime Victimization Survey came to the attention of law enforcement. Therefore, the number that were never reported (i.e., undetected offenses) to the police was fairly high (63%). Law enforcement officials estimated that half of all the reported rapes were cleared by arrest (i.e., 48,730 of the reported 97,460 sexual assaults). Therefore, of the number of rapes and attempted rapes reported to the National Crime Victims Survey (260,300) only 19 percent (48,730), at most, were cleared by arrest. The Bureau of Justice Statistics findings for the years 1992 through 2000 also found a much lower rate of rape and sexual assault reported to law enforcement than that uncovered by the National Crime Victimization Survey.[66] For example, during this period, 63 percent of completed rapes, 65 percent of attempted rapes, and 74 percent of completed and attempted sexual assaults against females were not reported to the police. The figures from both of these reports suggest that observed rates (i.e., arrests and reports to law enforcement) highly underestimate the actual number of sexual crime incidents. Thus, the suggested additive correction of 10 to 15 percent by Hanson *et al.*[57] for the underestimation of observed rates does not fully adjust for the high rate of undetected (i.e., unreported) sexual assault.

Adjusted Actuarial

A recent approach favored by some actuarial proponents is that of an "adjusted actuarial assessment," a process of estimating the base rate of recidivism through a rating scale and adjusting this risk by external empirically derived risk factors.[56] The adjusted method refers to either increasing or decreasing the probabilistic base rate estimate derived from the rating scale. Actuarial rating scales are largely composed of "static" or unchangeable elements, such as the number of prior arrests. Factors not included in actuarial risk assessments are those that are "dynamic" or changeable, such as the impact of participation in treatment.[59] Adjustments to the actuarial rating are made on the basis of factors that do not correlate with each other. Thus, the adjustment to the rating scale score is made based on a review of dynamic and other factors not included or correlated with those in the actuarial instrument. An example of an adjusted actuarial approach would be an individual who is rated as a moderate risk for sexual recidivism by a rating scale but is adjusted to a lower level of risk on the basis of his successful participation in treatment, a factor not included in actuarial rating measures. The adjustment would represent an actual lowering of the probabilistic base-rate derived from the actuarial scale.

A criticism of this method is that there is no empirical justification for the adjustment.[57] That is, there is no statistically based method of adjusting an actuarial rating score with dynamic or other factors external to the actuarial rating. In addition, proponents of this method are the same individuals who have offered the contradictory suggestion that base rates derived from actuarial rating scales should not be adjusted or should be adjusted very slightly.[53] The recommendation to adjust actuarial ratings is viewed by other actuarial researchers as a method of "diluting" the accuracy of the statistically based instruments.[58,67] While the adjusted approach appears richer than a fixed actuarial rating through its inclusion of factors supported by clinicians as modulating risk, there is no research to support the validity of an adjusted rating. Moreover, the adjusted actuarial rating may give the appearance of an objective score; however, given that there is no standard or uniform guideline for adjusting the weight of the factors external to the actuarial rating, this methodology in practice relies on the evaluator's subjective judgment. An additional criticism is the exclusion of external factors that are correlated with the actuarial rating scale items when adjusting the risk score. For example, actuarial rating scale factors such as number of prior sex offenses are very likely to be correlated with an external factor such as sexual deviancy. Similarly, Antisocial Personality Disorder has been found to correlate with a number of factors (e.g., prior sentencing dates, prior nonsexual violence) on the Static-99, a commonly used actuarial rating tool.[68] All of these factors are identified empirically as related to sexual recidivism risk[69] and yet could not be used for adjusting the actuarial score.

The disadvantage of using the adjusted approach, particularly as currently formulated, in identifying an individual's likelihood to reoffend sexually is that it may result in more confusion than clarification. In addition, the adjusted actuarial approach's caution against the use of factors correlated with an actuarial rating scale, such as Antisocial Personality Disorder, limits its utility in conveying the complex behavior

and personality patterns that discriminate between high- and low-risk individuals.

Clinical Judgment

Recent risk assessment research has taken a dismissive stance regarding the application of expert clinical judgment[58]; however, some courts[44,70] have suggested a more reasoned approach to risk analysis by the trier-of-fact—one that goes beyond probability estimates. Those critical of clinical judgment have argued that such opinions represent "unguided" efforts that are frequently inaccurate.[54] Generally, unguided clinical judgment refers to assessments by clinicians that are based on risk factors that have no basis either in theory or empirical research. Guided clinical judgments are based on a review of empirically derived risk factors for sex offending.[71] One article describing different approaches to risk assessment[56] differentiated between the accuracy of guided and unguided clinical judgments. The finding reported was that the average correlation values for predictive accuracy of sexual recidivism were significantly greater for guided than unguided assessments.

Actuarial proponents view attempts by clinicians to use their expert knowledge in assessing risk as unguided if the decisions are not based solely on statistically confirmed risk factors. One such document noted, "unguided clinical opinion is widely practiced and routinely accepted by the courts, but there is little justification for its continued use given the demonstrated superiority of structured, actuarial risk assessments" (Ref. 59, p 14). Therefore, the testifying expert who uses clinical judgment for risk assessment may be confronted with questions as to why such a method represents competent risk analysis. Leading clinical researchers, however, emphasize the importance of clinical judgment in conducting sexual recidivism risk assessments.[61,63,71–73] Litwak[63] noted that there is little empirical support that actuarial assessment of dangerousness is superior to clinical judgment; indeed, he found empirical evidence to the contrary. Further, a recent cross-validation study by Sjostedt and Langstrom[73] of two popular sex offender risk assessment rating scales, the Rapid Risk Assessment of Sex Offender Recidivism (RRASOR) and Static-99, noted that neither scale could be used as sole methods for deciding whether sex offenders should be released from custody. They stated that "the validity of these 'instruments' to actually 'predict' sexual reconvictions is still too low to recommend either model to be used as stand-alone devices for risk assessment in clinical or legal practice" (Ref . 73, p 640). The Static-99 and RRASOR were viewed as scales to be used primarily in a research context, with extreme caution suggested for application in a clinical situation, and only if "properly supplemented with other (nonactuarial) approaches" (Ref. 73, p 640).

Clinical judgment is apt to remain a target of severe criticism when based on an intuitive method that ignores an existing body of scientific literature. Alternatively, clinicians who use their expert judgment in a manner informed by the scientific database, but tailored to case-specific factors can argue reasonably that they conducted a competent assessment.[74] Testifying experts should emphasize that their opinion is formed not only by the use of a systematic method (e.g., empirically derived risk factors or actuarial rating) but also one that utilizes clinical judgment to assess case-specific risk factors.[75] This was underscored by a recent California Supreme Court finding. In *Cooley v. The Superior Court of Los Angeles County*; *Paul Marentez*,[76] the Court agreed that the trial court acted properly in an SVP probable cause hearing when it found that the testimony of the district attorney's experts lacked persuasiveness because of an over-reliance on the actuarial measure, the Static-99.

Clinical opinion that is informed by empirical research is not unique to forensic risk assessment and in fact is widely practiced in other areas of medicine. Physicians and other health professionals who render health risk assessments base their opinions on a process described as "evidence-based medicine." For example, oncologists may use an evidence-based approach to estimate actuarial survival rates in a patient with melanoma. An oncologist would not stop at the survival statistics but would include a consideration of factors that are present in the individual patient that might either decrease or increase the person's chance for survival (e.g., comorbid conditions and genetic loading). This method relies on the expertise and knowledge of the oncologist to incorporate all of the relevant data to form an opinion as to that specific patient's survival risk. Similarly, forensic psychiatrists and psychologists conducting sexual recidivism risk assessments can reasonably characterize their opinions as fueled not only by an evidence-

based methodology, but also one, like the oncologist, that is sensitive to case-specific factors.

The "Likely" Risk in SVP/SDP Testimony and Evaluations

The trier-of-fact may become confused when testifying experts present conflicting opinions as to the most accurate method for risk assessment. It is important for expert witnesses to understand critically these various approaches and how they can be applied in their jurisdiction to the legally defined standard of "likely" to reoffend sexually.

The "likely," "probable," or "substantially probable" threshold of risk for sexual recidivism in the SVP/SDP laws has been conceptualized in a number of ways. In some cases testifying expert witnesses are asked by attorneys to quantify such risk into percentages. Some defense attorneys argue that "likely" should reflect a "more likely than not" standard and thereby represent a risk percentage of 51 or greater. The legal interpretation of "likely" and its relation to quantification of risk has been addressed recently. In the state of Washington, the term "likely" was defined as "more likely than not" and as representing a greater than 50 percent risk for sexual reoffense.[51] In New Jersey, the appellate court in the case of W.Z.[44] stated that in order for an individual to be committed as an SVP, the risk of reoffending should be substantially greater than 50 percent. The court, however, wrote that triers-of-fact should take a "more complicated, and thoughtful analysis of a person's future dangerousness than proposed by W.Z.'s assignment of simple probability to the term 'likely'." (Ref. 44, p 115). By contrast, in the case of *People v. Ghilotti*[77] the California Supreme Court ruled that "likely" meant a "substantial danger" further defined as a "serious and well-founded risk" (Ref. 77, p 1). The Court wrote that it would be erroneous legally for an evaluator to state that an individual does not meet SVP criteria if the evaluator believes an individual represents a serious and well-founded risk if freed without conditions, but with a risk that does not exceed 50 percent.

For those few states in which "likely" has been defined as "greater than 50 percent," the mental health professional's assessment must rely on using an actuarial method to formulate a clear risk percentage. Such an approach does not preclude the psychiatrist or psychologist from incorporating clinical judgment in the final legal determination of risk. For example, an individual who falls in a 15-year risk range of 40 percent as corresponds to a Static-99 score of five, may still be considered as "likely" to reoffend sexually if the mental health professional adjusts the score by utilizing the presence of additional "aggravating" risk factors. Similarly, if an individual obtains a Static-99 score of six with a 15-year recidivism percentage of 52 percent, the mental health professional can opine that the individual's risk does not rise to the threshold of "likely," based on "mitigating" factors. Therefore, when professionals conduct an SVP/SDP evaluation, the clinician's role is to integrate all available information about the individual and to avoid relying mechanically on a statistically based algorithm of risk to reach conclusions.

In that most states do not quantify "likely," clinicians in these jurisdictions have greater latitude in assessing risk. That is, they are not restricted to offering a risk percentage score and therefore are dependent on an actuarial measure as a primary basis for their opinions. In communicating the likelihood of risk to triers-of-fact, the testifying expert should place the risk assessment within a context. For those who advocate strongly the use of actuarial measures because of their ability to quantify risk and thus place individuals in risk categories of high, medium, and low, the numbers and categories may be meaningless if even a small risk is viewed as unacceptable. For example, a 10-percent chance of a radiation leak from a nuclear power plant may be an unacceptably high risk to warrant building a housing development adjacent to such a facility. However, a 10-percent chance of slight knee strain from playing a game of tennis may, to some, represent a very acceptable or low level of risk. Similarly, with respect to sexual recidivism, an individual who has repeatedly assaulted young boys and who is categorized at a 30-percent recidivism rate may be identified as posing too high a risk, if the release environment is placement in his mother's home, which is located across from an elementary school.

Despite the advent of a burgeoning body of literature advocating the superiority of actuarial tools, testifying experts should not substitute this simplistic approach for a comprehensive assessment. Forensic risk assessment should represent a reasoned consideration of all the available data (both actuarial and nonactuarial) in the formation of an opinion. Table 4 provides a chart for the expert rendering testimony to

Table 4 Structured Analysis when Testifying on "Likely" Criterion

Actuarial analysis for risk	
Strengths	Weaknesses
Statistically derived factors	Underestimates true rate of recidivism
Scientific method	Conveys a degree of precision that is misleading
Sample-based norm	Statistics are sample based, not population
Risk percentages	Ignores unique case-specific risk factors
Dynamic variables/adjusted actuarial analysis for risk	
Strengths	Weaknesses
Assesses change	No empirical justification for actuarial adjustments
Method to adjust actuarial base rates	Normed on released offenders (may not apply to incarcerated offenders)
Empirically identified factors	
Other assessment approaches for risk	
Psychopathy checklist-revised	
Strengths	Weaknesses
Quantifies personality trait	No validity scale
Large scientific base to support use	Findings not consistent across sex offender types for sexual recidivism
Phallometric analysis	
Strength	Weaknesses
Empiric association with sexual recidivism	Differences between test pictures and real-life stimulation
	Negative finding does not eliminate sexual deviance
Clinical assessment of risk	
Psychiatric diagnosis	
Strengths	Weaknesses
Structured assessment of mental condition	Vulnerable to patient manipulation
Nexus between diagnosis and possible recidivist behavior	Relationship to recidivist behavior may be weak
Cooperation with treatment in institution	
Strength	Weaknesses
Assessment of change in deviant sexuality	Improvement in institution may not generalize to community
	Modest correlation with recidivism
Antiandrogen and estrogen treatment impacts	
Strength	Weaknesses
Reliably reduces sex drive	Contingent on patient's adherence to treatment
	Negative side effects
Castration	
Strengths	Weaknesses
Very low recidivism rates	Can be replaced by exogenous testosterone
Reliably reduces sex drive	No recent studies regarding recidivism
Impact of community treatment	
Strength	Weakness
If mandated and supervised, relapse behavior can be more realistically observed and managed	If not mandated and supervised, compliance may be low, possibly resulting in increased risk to community

the Court about "likely" to reoffend sexually. While the "likely" standard may appear simple at face value, it is the result of a complex summation of many factors bearing on risk assessment in SVP/SDP cases. In that this calculation is inexact and prone to many sources' biases, it is incumbent on the ethical testifying expert to convey to the court the imprecise nature of such calculations. The chart in Table 4 is offered to provide a balanced discussion of factors and professional methods that may enter into the expert's decision-making procedure and how available scientific information is considered in this process.

The testifying expert should emphasize that forensic risk assessment is not risk prediction (i.e., that a specific offender will commit another sex offense at a specific time). Neither is such a process based on ill-formed or unsupported theories of risk. Moreover, it should be differentiated clearly from "unguided" clinical judgment. The latter would not represent competent risk assessment and may in fact be the cause of the confusion and controversy found in cases involving legal determinations, as has been the case when flamboyant experts testify as to dangerousness based solely on their subjective experience in

capital sentencing cases.[78] Rather, within SDP/SVP commitments, the legal definitions of "likely," whether quantified as risk over 50 percent or described in terms such as "probable," "substantial," or "substantially probable," are best conceptualized through a systematic and structured approach to risk assessment in which the explanation for the opinion is clear.

Conclusion

The SVP/SDP statutes have brought about a renewed interest in the risk of sexual recidivism. Psychiatrists and psychologists testifying in such civil commitment hearings confront a complicated array of legally defined terms, such as "mental disorder" and "likely" to reoffend. Translating such terms into meaningful opinions based on sound reasoning is the cornerstone for competent forensic practice. The SVP/SDP laws remain controversial and will continue to challenge testifying experts to provide a clear and well-formulated rationale for their opinions.

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