Linking Mental Disorder and Risk in Sexually Violent Person Assessments

Linda E. Weinberger, PhD, Shoba Sreenivasan, PhD, Allen Azizian, PhD, and Thomas Garrick, MD

A common criticism of sexually violent person (SVP) laws is that psychiatric commitment has been co-opted to continue the incarceration of dangerous criminals, not dangerous individuals with mental illness. This opinion may have credence because some forensic clinicians use a "silo" approach (i.e., diagnosing based on historical criminal behavior rather than current symptomatology, and formulating risk for future sexual violence based on actuarial scores rather than characteristics and features of the mental condition). A silo process fosters a missing link; namely, the absence of a nexus between the mental condition and risk. This approach violates the necessary predicate for involuntary civil commitment, that the symptoms of an individual's current mental disorder be linked to and support a present sexual danger to others. In this article, we provide a brief overview of SVP statutes; describe how the silo approach compromises accurate diagnosis and identification of relevant risk factors; and present actual and fictitious cases illustrating the presence and absence of the missing link.

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Civil commitment specific to dangerous sexual offenders was promoted by several elements: public concern related to the release of dangerous sexual offenders; the inadequacy of prisons to rehabilitate sufficiently such offenders before their release into the community; and the need for long-term treatment in modalities that differ from those used in general involuntary commitment. Since 1990, 20 states and the federal government have adopted specialized civil commitment statutes for sex offenders, which are known collectively as sexually violent person (SVP) laws. More specifically, most jurisdictions (California,[1] Florida,[2] Iowa,[3] Kansas,[4] Missouri,[5] New Hampshire,[6] New Jersey,[7] South Carolina,[8] Texas,[9] Virginia,[10] and Washington[11]) use the term sexually violent predator to identify the classification; however, other terms are also used (sexually dangerous person: Massachusetts,[12] Minnesota,[13] and Federal Law[14]; sexually violent person: Arizona,[15] Illinois,[16] and Wisconsin[17]; dangerous sex offender: Nebraska,[18] and New York[19]; sexually dangerous individual, North Dakota[20]; and sex offender, Tennessee[21]).

Regardless of the particular name used, each jurisdiction follows a relatively similar procedure for commitment. That is, prisoners incarcerated for sexual offenses are evaluated to determine whether they have a mental condition that predisposes them to commit sexually dangerous acts toward others. All commitments follow due process procedures; hearings are held before a judge or jury. The burden is on the state or federal government to prove that the individual meets the criteria for an SVP civil commitment and the individual can present evidence to refute such a finding. If the individual meets the criteria, the person is committed to treatment after his release from prison until such time when his mental condition no longer predisposes him to commit sexually dangerous acts.

The most common criticism of the SVP laws is that psychiatric commitment has been co-opted to continue the incarceration of dangerous criminals and not dangerous individuals who have mental illness.[22,23] Civil commitment based on an individual's historical behavior alone, with no evidence of current

Dr. Weinberger is Professor Emerita and Dr. Sreenivasan is Professor of Clinical Psychiatry and the Behavioral Sciences, Keck School of Medicine, University of Southern California (USC), Los Angeles, CA. Dr. Sreenivasan is also with Forensic Outreach Services, and Dr. Garrick is Chief of General Hospital Psychiatry, Greater Los Angeles VA Medical Center, Los Angeles, CA. Dr. Azizian is Assistant Professor of Criminology, California State University, Fresno, and Senior Psychologist, Department of State Hospitals, Sacramento, California. Dr. Garrick, is Professor of Psychiatry, Geffen School of Medicine, University of California, Los Angeles, CA. Address correspondence to: Linda E. Weinberger, PhD, Chief Psychologist, USC Institute of Psychiatry, Law and Behavioral Science, P.O. Box 86125, Los Angeles, CA 90086-0125. E-mail: leweinbe@usc.edu.

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symptoms, would mean that anyone who has engaged in criminal violence could be psychiatrically committed, precisely what some critics of the SVP laws have suggested occurs,[24–26] and have argued that the Diagnostic and Statistical Manual, Fourth Edition, Text Revision (DSM), has been misused deliberately in SVP proceedings.[27,28] That criticism may have credence, given the practice of some forensic clinicians of using DSM criteria to identify a mental condition based predominantly on historical criminal case facts, not current symptomatology,[27–30] and to identify risk for future sexual violence based upon an actuarial score and not the characteristics and features of the mental condition.[31] We call this approach the "silo" method. This strategy violates what courts have long held as the necessary predicate for involuntary civil commitment: current symptoms of a serious mental disorder linked to and supporting specifically the conclusion of a present danger to others.[32–35] The failure to establish the nexus is the "missing link."

A related facet of the silo approach is characterized by forensic experts' merely listing codes from the DSM-5,[36] with few or insufficient narratives to describe the mental condition as it is present in that individual. Such a process may occur when the sexually deviant criminal behavior does not fit precisely a specific DSM-5–defined mental disorder, or may reflect symptoms that overlap multiple disorders.

We acknowledge that there are forensic evaluators who, in their reports and testimony, explain and demonstrate the nexus. This approach, however, is not universal. When the link is missing, it leads to serious criticism.

In this article, we emphasize how the silo and missing-link approaches can serve to mislead the trier of fact, and risk negative outcomes of false-positive and -negative misidentifications of individuals. Toward this end, we provide a brief overview of SVP statutes and the mental condition criterion by jurisdiction. We describe the silo approach (i.e., the use of historical offense facts to define mental condition and the use of actuarials to describe risk) and how this approach fosters the missing link (i.e., the lack of a nexus between the current mental condition and the risk of sexually violent behavior). We present an actual court case to illustrate common errors that occur in the missing-link methodology, as well as a fictitious case example where the link is established. We conclude by underscoring that it is important for forensic practitioners to engage in a narrative explanation that incorporates the missing link.

Mental Condition Criterion by Jurisdiction

All 21 jurisdictions that have SVP laws require a mental condition for civil commitment. The terms include mental abnormality (Florida,[2] Iowa[3], Kansas,[4] Massachusetts[12], Missouri,[5] New Hampshire,[6] New Jersey,[7] New York,[19] South Carolina,[8] Virginia,[10] and Washington[11]); mental disorder (Arizona, [15] Illinois,[16] Minnesota,[13] North Dakota,[20] and Wisconsin[17]); diagnosed mental disorder (California[1]); behavioral abnormality (Texas[9]); and mental illness (Nebraska[18] and Tennessee[37]). The federal government[14] uses the terms mental illness, abnormality, or disorder. Irrespective of the specific term used, the statutory definitions tend to be more descriptive than symptom identifying; for example, "a congenital or acquired condition affecting the emotional or volitional capacity that predisposes the person to" commit sexually dangerous acts. This definition, or a derivative, is used by most jurisdictions (California,[1] Florida,[2] Illinois,[16] Iowa,[3] Kansas,[4] Massachusetts,[12] Missouri,[5] New Hampshire,[6] New Jersey,[7] New York,[19] South Carolina,[8] Texas,[9] Virginia,[10] Washington,[11] and Wisconsin[17]).

The terms listed are not the only qualifying mental conditions for an SVP commitment. The statutes in Arizona,[15] Florida,[2] Kansas,[4] Massachusetts,[12] Minnesota,[13] Nebraska,[18] New Hampshire,[6] New Jersey,[7] North Dakota,[20] South Carolina,[8] Virginia,[10] and Washington[11] also include personality disorder. Moreover, the statutory definitions of a qualifying disorder in other states (Minnesota,[13] North Dakota,[20] and Arizona[15]) explicitly identify paraphilia or sexual disorder; Arizona includes conduct disorder.

With respect to case law for the 21 jurisdictions, most states' supreme and appellate courts have acknowledged that any mental condition, and not necessarily a sex-related disorder, can be used as the basis for an SVP commitment. This criterion is acceptable as long as the condition relates to the individual's "inability to control sexual impulses," and thus supports the person's predisposition to commit sexually dangerous acts, including an antisocial personality disorder (Arizona,[38] Florida,[39] Iowa,[40] Kansas,[41] Massachusetts,[42] Minnesota,[43] Missouri,[44] Nebraska,[45] New Hampshire,[46] New Jersey,[47]

New York,[48] North Dakota,[49] Virginia,[50] Washington,[51] and Wisconsin[52]).

DSM Codes and SVP Mental Conditions

Is a specific DSM-5 diagnostic disorder legally necessary for an SVP commitment? Mental health professionals who conduct SVP evaluations may be under the impression that the law requires listing specific diagnostic codes as found in the DSM-5,[36] and more specifically, that the diagnosis must be a paraphilia. As demonstrated above, the law may not hold clinicians to this standard. In the landmark case of *Kansas v. Hendricks*,[35] the U.S. Supreme Court wrote:

> Indeed, we have never required state legislatures to adopt any particular nomenclature in drafting civil commitment statutes. Rather, we have traditionally left to legislators the task of defining terms of a medical nature that have legal significance. As a consequence, the States have, over the years, developed numerous specialized terms to define mental health concepts. Often, those definitions do not fit precisely with the definitions employed by the medical community [Ref. 35, p 359].

Further, diagnostic debate has focused generally on two specific DSM codes and whether antisocial personality disorder (ASPD) can or should qualify, and whether the disorder has to be a paraphilia. Case law in most states has noted that ASPD can serve as a qualifying mental condition as long as a connection is formed between that individual's mental disorder and its current relationship to the risk for sexually dangerous behavior if released from confinement. Moreover, the DSM-IV-TR[28] definition for paraphilia not otherwise specified (and more recently, the DSM-5's[36] other specified and unspecified paraphilic disorder) have led some to levy this criticism: criminal offenses involving a sexual assault, such as rape, have been used inappropriately to justify a paraphilic mental disorder.[53,54]

We believe that forensic evaluators are placing themselves in an unnecessary constraining box when trying to fit the individual's mental state into DSM codes so as to substantiate that an SVP qualifying mental condition exists. Doing so reflects a silo approach; particularly, when it is based heavily on historical offenses. Rather, it is more important that the forensic evaluator recognize and articulate DSM conditions through a discussion of the traits and features present in the individual that drive sexual violence risk, and not necessarily focus solely on one diagnostic code. Indeed, it is frequently the presence of multiple diagnostic conditions with specific traits and features that collectively interact with one another to enhance deviant impulses and lower sexual impulse control, thereby presenting the predisposing risk (e.g., a person with paraphilia and stimulant use disorder).

Conducting an SVP evaluation is an individualized enterprise. It should not be presumed that an individual's history of a previous paraphilic diagnosis is sufficient to support a current diagnosis of a paraphilic disorder. In addition, historical sexual offending behavior informs the diagnosis of a paraphilic disorder, but should not be the sole basis for a diagnosis. The DSM-5 acknowledges that pedophilic disorder "includes other elements that may change over time with or without treatment. . . . Therefore, the course of pedophilic disorder may fluctuate, increase, or decrease with age" (Ref. 36, p 699).

Relying heavily on historical criminal case facts to identify a qualifying mental condition for an SVP commitment may be not only misleading, but false. For example, there may be contextual factors (e.g., marital stress, poor interpersonal skills, use of alcohol or drugs) that led to the behavioral expression of pedophilia 20 years ago, but are no longer present. Thus, basing a diagnosis only on historical data and with no discussion of such factors as the individual's current psychosocial maturation, interest in age-appropriate activities, long-term pattern of sobriety, and adherence to treatment conditions raises the question of how this individual's current mental condition predisposes him to future sexual offenses. On the other hand, if an individual who committed child molestations 20 years ago and was diagnosed with pedophilia and a comorbid stimulant use disorder now presents with current evidence of preoccupation with children (e.g., has pictures of children in states of undress in his possession; shows interest in child-oriented activities and movies) and use of substances frequently while in a secure setting, an argument could be made that this individual's mental condition predisposes him to future sexual offenses.

The DSM-5 acknowledges the limitations of categorical characterization of mental disorders (i.e., the criteria set forming a specific diagnostic code). The introduction of the DSM-5[36] includes the following statement, "Indeed, the once plausible goal of identifying homogeneous populations for treatment and research resulted in narrow diagnostic categories that did not capture clinical reality, symptom heteroge-

neity within disorders, and significant sharing of symptoms across multiple disorders" (Ref. 36, p 12). Sexual deviancy is driven by multiple factors; it may be related to paraphilic disorders, learning processes, neurobiological disturbances, alcohol or drug abuse, or other pathological conditions. Moreover, many of the specific traits and features relevant for SVP evaluations could overlap across several DSM diagnoses. Consequently there can be criticism and confusion of diagnostic impressions instead of clarifications of the mental condition that puts the individual's at risk.

Reliance on Actuarials for Risk Assessment

Because of the initiation of SVP laws, actuarials such as the Static 99/Static 99R have assumed prominence in sexual violence risk assessments and testimony.[31,55–60] They frequently form the basis for forensic evaluators quantifying the level of risk an individual has for future sexual violence.[31,57,61] Caution should be taken when using, and perhaps relying too heavily on, the results from actuarial instruments at the expense of clinical judgment and the consideration of individual differences.[62–64] For example, at one time, the SVP commitment laws of the state of Virginia required the use of a specific actuarial risk assessment instrument as a screening tool. If the score was at or above an established number, the individual would undergo further assessment (including an in-person evaluation) to determine whether the criteria for an SVP civil commitment were met. However, if the score fell below the established number, no further attempt for an SVP civil commitment would be made, and the individual would be released from prison at the end of his sentence. The reliance on a specified actuarial instrument and score was challenged. Among the reasons cited were that it "limits the ability of qualified individuals to use their professional discretion to decide which offenders should be further evaluated, including some offenders who are likely sexually violent predators" (Ref. 65, p 29) Recently, the statute was amended wherein an actuarial is not required but may be included in the assessment.[66]

The acknowledgment that people being considered for an SVP commitment should have an individual clinical examination, particularly as it relates to the person's risk of sexual harm, underscores the importance of clinical judgment. The over-reliance on risk assessment tools that are based on group data and do not allow for the consideration of individual differences is a naïve and faulty approach to identifying people at risk of violence, and it leads to the silo approach.

By way of brief explanation, actuarials yield a score based on the sum of the number of risk factors present and that number in turn is associated with a risk percentage (i.e., individuals studied in that sample with an *X* score had a *Y* rate of sexual recidivism, defined usually as arrests, over *Z* period of time). Actuarials use a small number of factors identified through statistical analyses as related to sexual recidivism; they are nontheoretical and are not a facet of any particular mental condition, DSM defined or otherwise. (It should be noted that an exception is the Static-2002R, which according to the test developers includes theoretical categories; for example, persistence of sexual offending, deviant sexual interests, and general criminality.[67]) In addition, actuarials are often based on limited group data and therefore do not give a risk assessment unique to the individual assessed. Finally, actuarials require no mental health expertise to administer, score, or interpret. For example, in some jurisdictions, parole and probation officers perform an actuarial to determine the level of supervision for sex offenders while in the community.[68,69]

Historically, this drive to quantify risk has been prompted by the statutory language of "likely," which in some jurisdictions has been defined as "more likely than not," "more probable than not," or "greater than 50 percent."[70] Although it may be argued that, for those few states where likely has been defined as greater than 50 percent, the current literature related to actuarial risk percentages associated with a score make it clear that these percentages cannot be applied to a specific individual.[71] Some actuarial proponents suggest that the scores can be used to assign relative risk; that is, compared with the average offender, this score is either higher or lower than that reference group.[72,73]

Forensic evaluators must acknowledge that we have no ability to predict with quantification whether an individual will act out sexually, let alone do so within a specified time frame. Risk assessment is not equivalent to risk prediction. Whether providing a score derived from an actuarial offers clarification or obfuscation may be debatable. However, it is clear that a risk score has no logical association with the mandate of civil commitment; *viz*, how does it

relate to the person's risk of sexual offending due to a mental disorder?

The Silo Approach and the Missing Link

A silo process fosters a missing link type of SVP evaluation. By offering separate opinions regarding the diagnosis and the risk, without connecting the two, the forensic evaluator fails to address adequately the ultimate issue; *viz*, whether the individual does or does not meet the standard for an SVP commitment. Case law discussion supports the reasoning behind establishing the nexus between a mental condition and sexual offending behavior.[44,49,74–76] Consequently, the forensic evaluator in an SVP evaluation should describe to the trier of fact those pertinent aspects of the evaluee's psychological functioning that are features of a mental condition (or DSM diagnoses) that contributed to the person's engaging in sexual offending previously, and whether (and how) those conditions remain current so as to predispose the individual to sexual reoffense if not contained in a forensic facility. Simply stated, if a forensic evaluator identifies the individual with a specific diagnosis, the evaluator must then explain in a narrative manner what traits, symptoms, and impairments the individual manifests currently that predispose him to act in a sexually dangerous manner. Historical offense facts may be useful in understanding past behavior, but should not be the only basis for identifying a current mental condition.

The second aspect of the silo approach pertains to the risk criterion, and in particular, the use of actuarial scores to identify risk. Actuarial scores are not a mental disorder and thereby have no connection to a current mental condition. Regardless of how high or low the score may be, it offers no information related to what there is clinically about the individual's mental condition that places him at risk.[27] The mere statistical correlation of demographic factors, criminal history, and relationship to previous victims may yield a risk score, but contributes no clinical data on why this particular offender's current mental condition places him at risk or not. In parallel, dynamic risk factors identified through structured professional judgment (SPJ) tools such as "lack of concern for others," "impulsivity," and "negative attitudes" can be viewed as meaningless with respect to the requirements of the SVP law if there is no explanation as to how they relate to a person's risk for sexual violence precipitated by a mental condition.

Moving Beyond the Silo Approach

The ways in which mental health experts render diagnoses can engender doubt as to the credibility of the diagnostic enterprise, and indeed the expert. The failure to articulate the link between the mental disorder and current predisposition to commit sexually violent criminal offenses can, at minimum, result in a level of frustration to the trier of fact and, at a more detrimental level, cast doubt as to the legitimacy of forensic psychiatry and psychology.

Actual Court Case

As noted in the SVP proceedings of *People v. Gudino*,[77] the judge was not convinced by the prosecutor's expert witnesses that the respondent's antisocial behavior at the state hospital would translate into sexual deviancy in the community. The judge stated,

> The diagnoses of these disorders is far more art than science. It is based on human beings attempting to detect, analyze, and categorize a virtually limitless range of human behavior over a period of years, trying to make sense of contradictory data amassed over a period of decades and to fit people into boxes [Ref. 77, p 3].

In this case, ASPD was the diagnosis used by the experts as the SVP-qualifying disorder, even though the individual had not demonstrated sexual acting-out behavior in 20 years. In relation to this, the judge mentioned that, although the respondent had engaged in antisocial conduct at the state mental hospital (such as belligerence, yelling, flooding the nurses' station, writing on the walls, and using drugs), none of it had been sexual in nature. The trier of fact wanted to hear evidence supporting a diagnosis of ASPD as the mental condition criterion, noting that there was a situational context for the respondent's belligerent behaviors (related to pain management) in the state hospital. The judge further underscored the critical importance of the forensic evaluator explaining how a diagnosed mental disorder makes an individual "a serious and well founded risk" to engage in sexually violent crimes if released into the community. The frustration of the judge in the experts' failure to detail this linkage was notable, "I asked the doctors several times, 'why do you think this aggressiveness that he still has will manifest itself sexually,' and nobody offered a good answer" (Ref 77, p 16). The judge emphasized that the horrific nature of the crimes was not minimized, "They're horrible, horrible crimes. But this decision has to be

based on the current situation, not the situation as it was in the early 1990's" (Ref 77, p 21).

To give short shrift to the connection between the diagnostic criteria and their relation to sexual violence risk represents the lack of a meaningful contribution to the legal system. The judge in the case stated it most clearly:

> The key here is linkage. It's not just that there has to be a serious or well-founded risk that he will commit sexually violent offenses upon release. That serious or well-founded risk must be as a result of, resulting from or linked to the diagnosed mental disorder, again here ASPD. It's the disorder that must make him such a danger [Ref 77, pp 14–15].

The judge continued, "Is he still impulsive? Yes. Is he still aggressive? Yes. But what makes one reasonably think that his acting out, should he be released, will likely have a sexual component to it, much less be likely to constitute the commission of a sexually violent crime." (Ref. 77, pp 15–16) In the end, the judge concluded that the mental disorder condition for SVP commitment was not met.

Fictitious Case Example

This case reflects an amalgamation of facts, characteristics, behaviors, and clinical findings of persons examined for SVP commitment based on the authors' experiences and is presented to illustrate how a narrative approach, including the link, may be applied.

> Mr. X. is a 55-year-old, divorced, Caucasian man who is housed in a forensic facility awaiting an SVP trial after having served 25 years in prison. Recently, he was placed in a forensic state hospital after a "probable cause" hearing found that he met SVP criteria; he is now awaiting an SVP commitment trial. Mr. X.'s last sexual crime occurred more than 25 years ago. His sexual offenses happened over a five-year period, beginning at age 25, against two adult female victims aged 24 and 35. All of his crimes involved breaking into the home of a single woman in the early morning hours and engaging in forcible rape and oral copulation, followed by theft of property from the home. Mr. X. was convicted of kidnapping, forcible rape, forcible oral copulation, assault with a deadly weapon, and burglary. His adolescent years involved habitual antisocial behaviors, such as stealing, vandalism, trespassing, fighting, carrying a weapon, and making homemade bombs, for which he was placed in juvenile detention facilities. His marriage at age 23, lasted one year and ended because his wife could no longer tolerate his verbal assaults against her as well as his infidelity. He had no substance abuse history.
>
> Mr. X. denied having rape fantasies or thoughts about forced sexual activity. A polygraph examination showed no deception in response to rape fantasy questions. Early in his prison term, he engaged in prison rule violations related to his defiance and anger. His defiant behaviors diminished with age, with none being present during the last 20 years of his detention (incarceration and forensic facility). When asked about his crimes, he attributed his sexual offenses largely to bad judgment and poor self-control. He regretted his past behavior, not because of the impact on the victims, but because he had to serve time for something that was "not worth the trouble." He believed that what he did was not that serious because no one died or incurred permanent injuries. An actuarial method was used to assess sexual violence risk, and his score fell in the moderately high range.

Does Mr. X. present with a diagnosable mental disorder that affects emotional or volitional capacity and predisposes him to the commission of dangerous sexual acts? Experts faced with cases such as Mr. X.'s have to demonstrate in a clear and persuasive manner the relationship of the history of past sexual crimes, cluster of symptoms, presence of risk factors, and environmental cues and contexts that are present currently for the individual and how these then predisposed the individual to the commission of dangerous sexual acts.

A narrative regarding his diagnosis is as follows:

> Mr. X.'s temperament patterns and life experiences appear central to the development of procriminal attitudes. Although he qualifies for a DSM-5 diagnosis of ASPD, his prison behavior suggests diminishing antisocial features, noted as commonly occurring when individuals are in their fourth or fifth decades of life, as is the case in our example. Based upon the available data, there is no convincing evidence that the rapes were motivated by intense and persistent deviant sexual urges or fantasies with nonconsenting adults. It appears more likely that his opportunistic tendencies coupled with a need for immediate gratification were the primary drives leading to the sexual offenses during his mid-20s to age 30. Given the information derived from the clinical interviews and collateral sources, there is insufficient material to support a paraphilic disorder and no reliable way to link Mr. X.'s sexual misconduct with a paraphilia that predisposes him to commit criminal sexual acts. To use the diagnosis other specified paraphilic disorder, nonconsent, is to engage in a process of forcing a psychiatric diagnosis to fit the behavior (or in this case, a crime) without substantiating the clinical features.

ASPD is a polythetic diagnosis for which an evaluator must gather evidence from various sources to support a pervasive disregard for the rights of others, based on at least three of the seven enumerated criteria. One consequence of polythetic diagnostic sets is that there is no specific criterion or any specific combination of criteria that is necessary to establish the diagnosis. Thus, it is possible for two individuals to be diagnosed with ASPD and yet have no diagnostic features in common. One individual may meet the diagnostic criteria mainly because of criminal history (e.g., failure to conform to social norms, reckless disregard for others, consistent irresponsibil-

ity), whereas another individual may meet the diagnostic criteria based on interpersonal and affective features (e.g., deceitfulness, impulsivity, and lack of remorse). As a result, there is a fair amount of heterogeneity among people who meet the ASPD diagnostic criteria.

Moreover, none of the criteria for ASPD address specifically a predisposition to risk for deviant sexual behavior. Thus, it is imperative that the clinician describe this nexus. That is, how do the ASPD diagnostic criteria present in the individual examined demonstrate a likelihood of sexual harm to others? With respect to Mr. X., there was not enough material regarding his current mental condition to support that he is presently predisposed to engage in future acts of predatory sexual violence.

The actuarial yielded a score that placed Mr. X. in the moderately high-risk range for sexual recidivism. There may be a temptation to use this as a proxy for predisposition for risk (i.e., this is an antisocial individual who committed violent sexual crimes and is similar to sex offenders who recidivate sexually). However, actuarial scores are not a mental disorder. Therefore, without identifying the presence of clinical features and behaviors in the examined individual that would support specifically a current risk for sexual reoffending, the forensic clinician would be hard pressed to offer a persuasive opinion, or more important, one that can be rendered with a degree of reasonable medical (or psychological) certainty, that Mr. X. has a mental disorder that meets the mental condition definition required for an SVP commitment.

Conclusion

SVP laws have serious ramifications for both the individual and society. These evaluations are controversial for many reasons, including whether it is possible to assess future risk for sexually offending behavior, as tied to a current mental condition.[53] Moreover, actuarials have been relied upon greatly as they give a sense of quantification to the process; however, dependence on actuarials has been criticized as representing to the trier of fact a sense of certainty regarding risk that is not supported by the data.[78] Involuntary civil commitment is reserved for individuals whose serious mental conditions are so impaired that they cannot otherwise be treated safely in the community and therefore require secure psychiatric hospitalization. The possibility that an SVP civil commitment can be a commitment for life enhances the seriousness of SVP laws.

Forensic psychiatrists and psychologists have the tools and abilities to answer properly and credibly the SVP concern and offer a concluding opinion; *viz*, that the individual meets the standard or does not meet the standard. They can also offer an opinion that "there is insufficient material to support that this individual meets the standard." The silo process, with its missing link, represents a failure to service the justice system. It is our evaluation methods as well as our reasoning that is as much on trial as the individual being assessed.

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