No. 81644-1

SANDERS, J. (concurring)—I concur with the majority that the 2005 amendments are unconstitutional. I write separately, however, to emphasize that a person can also challenge admissibility of an expert's opinion if it is not based upon generally accepted scientific theory and methodology. *See Frye v. United States*, 54 App. D.C. 46, 293 F. 1013, 1014 (1923). The trial court must evaluate the State's expert testimony under the *Frye* test to assure that opinion evidence is based upon both valid and reliable scientific theory *and* methodology that are generally accepted in the scientific community. *See* ER 702, 703; *State v. Gregory*, 158 Wn.2d 759, 829, 147 P.3d 1201 (2006) (citing *State v. Gore*, 143 Wn.2d 288, 302, 21 P.3d 262 (2001)); *State v. Cauthron*, 120 Wn.2d 879, 886, 846 P.2d 502 (1993) (adopting the standard from *Frye*, 293 F. at 1014).

David McCuistion presented the declaration of Dr. Lee Coleman,[1] which purported to systematically tear apart the theory and methodology utilized by the State's experts. If Dr. Coleman is correct, the opinions of the State's experts are inadmissible under *Frye* for failing to employ valid and reliable

[1] The text of Dr. Lee Colman's declaration is reproduced and attached hereto as Appendix A.

scientific theory and methodology generally accepted in the scientific community. Coleman declared: (a) the "scientific analysis" in the state expert opinions is nothing more than a recitation of McCuistion's criminal record and is devoid of any actual scientific theory or methodology, Clerk's Papers (CP) at 617-18 (Coleman Decl. ¶¶ 5-6); CP at 619 (Coleman Decl. ¶ 9); CP at 620-21 (Coleman Decl. ¶¶ 13-14); (b) Dr. Ronald Page's diagnosis is based upon McCuistion's "history of alcohol dependence and immature personality traits," even though "only a tiny percentage of individuals like this commit criminal sexual acts," CP at 617 (Coleman Decl. ¶ 5); (c) the risk assessment instruments utilized by Dr. Richard Packard are strictly experimental and not generally accepted for the purpose here, CP at 620 (Coleman Decl. ¶ 11); and (d) these conclusions are based upon circular reasoning—individuals have a mental abnormality because they commit sex offenses and commit sex offenses because of that abnormality, CP at 620-21 (Coleman Decl. ¶ 13); CP at 622 (Coleman Decl. ¶ 16).

Like Dr. Coleman, the Washington State Psychiatric Association in its amicus brief in *In re Personal Restraint of Young*, 122 Wn.2d 1, 857 P.2d 989 (1993), also took the position that a mental disorder cannot be diagnosed by looking only at past deviant criminal behavior, including sexual predation. Br. of Amicus Curiae Wash. State Psychiatric Ass'n (Br. of Amicus WSPA) at 3; *In*

re Pers. Restraint of Young, No. 57837-1 (Wash. Sup. Ct. Sept. 23, 1991), *reprinted in* 1 Briefs 122 Wn.2d (1993).

The trial court must act as the gatekeeper of opinion testimony to assure such evidence is based upon scientific theory and methodology generally accepted in the scientific community. *See, e.g., Gregory*, 158 Wn.2d at 829. But here the trial court failed to analyze testimony of the State's experts under the *Frye* test, even in light of Dr. Coleman's declaration. *See* CP at 585 (Order on Show Cause Hrg. ¶ 6).[2]

According to Coleman the proposition that a person can be diagnosed with a mental disorder that *makes* him likely to commit sex offenses, *see* RCW 71.09.020(18), ignores the fact that there is no such mental disorder currently recognized in the scientific community, *nor* is there any methodology by which a professional can causally *link* a disorder to an *inability* to control one's behavior. As Dr. Coleman testified: (a) the sexually violent predator classification has no connection to any condition recognized by the DSM-IV-

[2] The trial court accepted the State experts' testimony without considering whether they were valid under *Frye* but proceeded to reject Dr. Coleman's testimony out of hand: "Dr. Coleman's report and conclusion are contrary to the conclusions reached by previous examiners of Mr. McCuistion, and is essentially a re-argument of the original finding that Mr. McCuistion is a sexually violent predator. That Dr. Coleman disagrees with past examiners and fact-finders does not, itself, make his opinion the correct one." CP at 585 (Order on Show Cause Hrg. ¶ 6). And yet that doesn't make his opinion wrong either.

TR (Am. Psychiatric Ass'n, *Diagnostic and Statistical Manual of Mental Disorders*: DSM-IV-TR (4th rev. ed. 2000)), which is generally accepted among mental health professionals in the United States, *see* CP at 622 (Coleman Decl. ¶¶ 15, 16); and (b) even where a mental disorder is identified, mental health professionals are unable to scientifically link that disorder to a deficit in volitional control—there is no generally accepted scientific method to do so, CP at 618-19 (Coleman Decl. ¶ 8).

Moreover, the Washington State Psychiatric Association's amicus brief in *In re Detention of Young*, supports Dr. Coleman's declaration: (a) "mental health professionals do not consider sex offenders to be suffering from a personality disorder which causes an individual to commit a sex offense," Br. of Amicus WSPA at 5; (b) "it is inappropriate to make broad generalizations as to a causal connection between sexual offenses in general and any particular psychiatric condition," *id.* at 4; and (c) many sex offenders do not commit crimes because of an illness and many individuals diagnosed with paraphilia—characterized by arousal to unconventional sexual objects, situations, or imagery—do not commit crimes, *id.*

To protect the public and address growing concern that sex offenders upon release were committing additional offenses, the legislature created a mechanism to involuntarily and indefinitely hold these persons in civil custody

based upon an "expert" prediction they would be *compelled* to commit a sex crime due to a "mental abnormality or personality disorder." *See* RCW 71.09.020(18) (defining "sexually violent predator"), .060. However if the scientific community does not recognize such a condition, much less possess any methodology to identify individuals with such a condition, the statutory test cannot be met.

Without a scientifically recognized condition that compels a person to commit sex offenses, civil confinement also runs afoul of the constitution. Statistically, an individual who has previously committed a sex offense may be more likely to commit a future sex offense than an individual who has no record of sex offenses. So too an individual who has previously committed a theft or assault is more likely to do so again than a person who has not. However, individuals cannot be civilly confined for offenses they have not committed simply because they have a propensity to commit future offenses. Civil commitment is not permitted under the constitution unless the individual *lacks control* over his or her actions due to a mental disorder; it is not enough that a person has a propensity to reoffend based on his or her criminal record. *See Kansas v. Crane*, 534 U.S. 407, 412, 122 S. Ct. 867, 151 L. Ed. 2d 856 (2002).

Where a person is deprived of his or her freedom based upon opinion testimony lacking scientific credibility, reliability, and accepted methodology,

courts must step forward and announce with the courage of a small child that the Emperor wears no clothes.

AUTHOR:
Justice Richard B. Sanders

WE CONCUR:

DECLARATION OF LEE COLEMAN, MD

1. The following declaration is based on my review of records pertaining to David McCuistion and his status as a "sexually violent predator" (SVP) under the laws of the State of Washington.

2. I am familiar with the statutory requirements in Washington, having participated in several such cases in the past, and several dozen similar cases in California, where the laws are virtually identical.

3. The primary focus of this declaration concerns the question of whether there is current evidence that Mr. McCuistion continues to meet the statutory requirement for SVP status. Regardless of estimated risk for re-offending, such status requires that the individual be judged to suffer from a mental abnormality (defined as a "congenital or acquired condition affecting the emotional or volitional capacity which predisposes the person to the commission of criminal sexual acts in a degree constituting such person a menace to the health and safety of others").
Furthermore, adjudication of this issue shall be based on the findings of a "professionally qualified person."

4. Given these statutory requirements, I have reviewed

institutional records and professional evaluations of Mr. McCuistion and I have formed the opinion that his evaluators have not presented any evidence that such a mental abnormality exists, or has ever existed. Instead, they have relied on his past crimes: *the required "mental abnormality" has been "determined" by simply summarizing his past behavior, and the "evidence" for the alleged disorder is a recitation of the details of his past behavior.* As such, this information is not an expert finding worthy of credibility in the determination required by the Washington statute.

5. The above pattern may be seen from the very first SVP evaluation, performed in 1992 by Ronald Page. Nowhere does Dr. Page discuss any expert findings demonstrating that Mr. McCuistion has the required deficit of emotional or volitional capacity. Instead, he simply cites a history of alcohol dependence and immature personality traits. Such factors are clearly far too broad to fulfill the requirements of the SVP statute, since only a tiny percentage of individuals like this commit criminal sexual acts. Dr. Page offers nothing other than Mr. McCuistion's criminal record as justification for finding him to fit the SVP requirement. If this were sufficient, there would of course be no statutory requirement that a "professionally qualified person" offer opinions to the Court.

6. Dr. Savio Chan in 1995 likewise summarized Mr. McCuistion's criminal history, which now included a 1993 conviction for third degree rape and third degree assault. He described Mr. McCuistion's behavior during an interview, and reported that an MMPI was considered invalid. Based on this and nothing else, he wrote, "…the nature and pattern of his offenses, the number and age range of his victims, and his inability to control himself suggest the presence of sexual deviancy of paraphilia, NOS, and a personality disorder with antisocial

features." In other words, Dr. Chan *announces* an alleged deficit of emotional or volitional capacity but demonstrates no *methods or findings* to support this conclusion. The crimes become the evidence, and this clearly violates the legal requirements for SVP status, which require a determination that a particular violent sexual offender has *something more*—the congenital or acquired condition—that is not always present in such offenders.

7. The next evaluation I have seen is from the End of Sentence Review Subcommittee in 1998. Once again, criminal history is reviewed, and the aforementioned conclusions of Drs. Page and Chan were cited. Dr. Chan was asked to do another evaluation and he concluded that "Paraphilia and Antisocial Personality Disorder constitute, congenital or acquired conditions affecting the emotional or volitional capacity which predisposes McCuistion to the commission of criminal sex acts in a degree constituting him a menace to the health and safety of others." This conclusion is completely without any basis because the label "paraphilia" does not represent an expert finding, but simply a re-statement of the fact that Mr. McCuistion's crimes involved sexual behavior outside the norm: "*para*" meaning beyond the ordinary and "*philia* meaning attraction to or preference for. Likewise for "antisocial personality disorder," obviously nothing more than a re-statement of a pattern of criminal conduct. There is nothing expert here, as required by the statute.

8. Furthermore, the linking of *any mental disorder*, even if one had been demonstrated, to an alleged deficit in volitional control
is something specifically addressed in the "*American Psychiatric Association Statement on the Insanity Defense*" *(1982)*, which has concluded that any attempt by mental health professionals to make such a determination is beyond their special skills. What this means is that legislatures that have mandated that experts

determine whether such a disorder is present in a particular offender have ignored consensus opinion from the relevant profession that such examinations *do not exist.*

9. Psychologist Richard Packard also performed an evaluation in 1988. He concluded that the correct diagnosis for Mr. McCuistion was "paraphilia, not otherwise specified," i.e., "sexual activity with non-consenting females." Can there be a more obvious example of "doublespeak"? Sexual activity with a non-consenting person is the crime of rape; this fact does not fulfill the legal requirement for SVP status, and the use of this meaningless "diagnosis" is obviously an attempt to give the appearance that the legal requirements have been met.

10. Dr. Packard also opined that it was "more likely" that outside of an institution Mr. McCuistion would re-offend, but based this opinion on the above "diagnosis" and "the absence of evidence to the contrary." Despite many well-intended efforts by countless professionals, the fact is that no inmate can produce such "evidence to the contrary." This is because no reliable association between participation in the sex-offender treatment programs and reduced recidivism has been shown. Kelley Blanchette of the Research Division of the Canadian Correctional Services has summarized current knowledge on this question: "Having recognized the potential shortcomings, a foregone response to the question 'Does sex offender treatment work?' is this: We are still uncertain. There is disagreement even amongst the most prolific and knowledgeable researchers in the area." (**Sex Offender Assessment, Treatment and Recidivism: A Literature Review** Kelly Blanchette Research Division Correctional Services Canada August, 1996)

11. Dr. Packard also supported his conclusions with a "risk assessment" despite admitting that "Some of these risk

assessment instruments are still considered as experimental and may have limited applicability specifically to Washington State sex offenders." In fact, *all* such instruments are strictly experimental, as has been repeatedly acknowledged by their most influential proponents, such as Karl Hansen of Public Safety and Emergency Preparedness Canada. Dr. Packard also argues that these instruments *underestimate* risk and mentions several factors that may do this. He fails to recognize other factors that may *overestimate* risk, such as inclusion of uncharged arrests in some studies, or unconvicted charges in others. He even includes an instrument called the "Sexual Violence Risk-20", which includes factors which have been mentioned in "clinical literature." In other words, it includes a catch-all of factors that may have been "excluded" in more controlled analyses, but are nonetheless to be included in Mr. McCuistion's risk analysis.

12. The most important factor, however, concerning these risk analyses is the fact that unless the individual has been found to have the requisite "congenital or acquired condition," risk analysis is moot.

13. The opinions of Dr. Gollogly, based on record review, are based on the same circular reasoning as the preceding. He summarizes Mr. McCuistion's criminal past, summarizes his sexual crimes with the label "Paraphilia NOS (Rape), and his other crimes with "Antisocial Personality Disorder," and then summarily states that "these diagnoses predisposes (sic) him to act out sexually deviant urges without regard to the rights of his victims…' There is no mention of the legal requirement of a disorder of volitional control, undoubtedly because *mental health professionals have no means to make such a determination.* In his conclusion, Dr. Gollogly writes that "My opinion is based on my clinical judgment and the fact that instruments utilized in this assessment, commonly relied upon by experts in this field, indicate that Mr.

McCuistion is at a high risk of sexually re-offending." These are flimsy supports indeed, given the consensus opinion in Psychiatry and Psychology that "clinical judgment" cannot determine "volitional control" and considering that SVP evaluators may rely on risk assessment procedures but SVP evaluators are but a tiny minority in the mental health community and the mainstream of specialists in the field of sex offender evaluation and treatment do not accept such procedures. (See **Dangerous Sex Offenders. A Task Force Report of the American Psychiatric Association, American Psychiatric Press, Washington, D.C., 1999.**

14. Finally, the October 31, 2004 Annual Review of Carole DeMarco demonstrates the identical problems as previous evaluations. The majority of her report is simply a repetition of previous records. In the section labeled "diagnosis and mental abnormalities, she writes that "Consistent diagnoses across time from a variety of doctoral-level clinicians are a strong indicator of diagnostic accuracy." This ignores, of course, the virtually universal practice in institutions whereby succeeding evaluators routinely apply whatever "diagnostic" labels were used by earlier evaluators. Consensus is not science and the fact that consensus is held out as "evidence" is revealing in itself.

15. Next, she writes that "Residents of the SCC usually suffer from a paraphilia." (!) Once again, citing the very fact that an institution that holds sex offenders would have a lot of sex offenders (the term "paraphilia" means nothing more) speaks volumes about the emptiness of this "diagnostic" process. Paraphilias, according to the DSM-IV-TR are said to be "chronic and lifelong" but there is nothing in the DSM that corresponds to the legal requirements for SVP status. The fact that evaluators almost universally try to boot-strap the DSM into these evaluations does nothing to alter this fact.

16. Then, in a classic example of circularity, Dr. DeMarco writes that "Individuals with mental disorders and/or personality disorders that impair the ability to inhibit impulses are often at a disadvantage to control his/her urges to engage in paraphilic behavior." This ignores the fact that the SVP law requires that a distinction be drawn, through the identification of a "congenital or acquired condition" between offenders who are simply repeat sex offenders and those who have an alleged disorder of "impaired volitional control. Because there *is no such mental disorder*, and the DSM includes nothing like this, and because mental health professionals cannot distinguish between those who commit such crimes as part of a "mental abnormality" and those who commit such crimes for other reasons, this type of circularity is offered instead.

17. Dr. DeMarco claims that "Paraphilia Not Otherwise Specified (Nonconsent) is an accepted diagnosis among practitioners knowledgeable about sexual offenders." I believe it would be more accurate to say that the only practitioners who use this label are those who perform SVP evaluations. But regardless of how many use it, the so-called "diagnosis" is obviously nothing more than doublespeak for the crime of rape. If this is the best the

evaluators are capable of doing, when seeking the "congenital or acquired condition," surely it means that the entire evaluation process is a sham created to fulfill legal and legislative agendas.

18. Dr. DeMarco comes to the heart of the matter, writing that "While many, if not most, cases of rape are not considered a mental abnormality per se, there is a small proportion of rapists who repetitively engage in rape behavior and display significant arousal to nonconsenting sexual activity. Such individuals report having recurrent, repetitive, and compulsive urges and fantasies to commit rapes, and at times they find it difficult to resist such urges." If there were established procedures (the penile plethysmograph notwithstanding) for distinguishing between those who rape by choice and those driven to it by a mental disorder that impairs volitional control, wouldn't we expect this to be part of the DSM? The only mental health professionals who insist they can identify such a disorder are those who perform SVP evaluations.

19. Dr. DeMarco calls as well on actuarial risk assessment instruments, and I have commented on the unproven nature of these attempts, as well as the fact that they are moot if the legally required "congenital or acquired condition" cannot first be demonstrated. She also repeats the claim that such instruments underestimate risk, and I have already discussed this false idea as well.

20. As a "dynamic risk factor" (characteristics that could change over time, as opposed to the static nature of one's criminal past), she wrote that Mr. McCuistion "continues to associate with individuals who have an antisocial attitude and engage in a high level of fault finding with SCC rules and policies indicating an antisocial lifestyle." Given the universal recognition by SVP inmates that the evaluation and treatment program is based on a

law that has no recognized basis in science or psychology, it is totally unacceptable to equate "fault finding with SCC rules and policies" with risk of sexual re-offending.

21. Finally, I believe it is important to recognize that it is impossible for any person, whether mental health professional or lay person, to become familiar with past behavior such as exhibited by Mr. McCuistion without feeling revulsion. This is precisely why it is crucial to recognize how easy it is for mental health evaluators, expected as they are to have something "special," to re-package
this typical and perfectly expectable reaction as a "diagnosis," "risk assessment," etc. In reality, there is no recognized "congenital or acquired condition" that fits the desires of the legislature of Washington, California, or any of the other states with these laws. The findings of each of Mr. McCuistion's evaluators amount to no evidence whatever.

22. The above has been written by me in Berkeley, California, on September 21, 2005, and is offered under penalty of perjury.

(Signed) Lee Coleman
Lee Coleman, MD