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No. 71343-4-I

IN THE COURT OF APPEALS OF THE STATE OF WASHINGTON  
DIVISION ONE

IN RE THE DETENTION OF:

ROY STOUT

ON APPEAL FROM THE SUPERIOR COURT OF THE  
STATE OF WASHINGTON FOR SKAGIT COUNTY

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**A. ASSIGNMENTS OF ERROR**

1. The superior court's denial of Mr. Stout's motion for relief from judgment pursuant to CR 60(b)(11) was manifestly unreasonable because of the following extraordinary circumstances: (1) the rejection of rape as a mental disorder by the psychiatric community; (2) the meager three percent agreement rate among the State's experts regarding Mr. Stout's diagnoses; and (3) Mr. Stout's continued confinement without a trial when the basis for his commitment has changed.

2. The superior court was required to grant Mr. Stout an evidentiary hearing because the State failed to meet its prima facie burden to establish that Mr. Stout continued to satisfy the criteria for confinement during the following review periods: (1) July 2009 through August 2010; (2) August 2010 through September 2011; and (3) October 2011 through September 2012.

**B. ISSUES PERTAINING TO ASSIGNMENTS OF ERROR**

1. A superior court may relieve a party from a final judgment, order or proceeding pursuant to CR 60(b)(11) for any reason that justifies relief from the operation of the judgment. This rule applies to situations involving extraordinary circumstances caused by

irregularities unrelated to the action of the court. Did the trial court abuse its discretion when it denied Mr. Stout's motion for relief from the original commitment order where: (1) Mr. Stout presented evidence that the diagnosis under which he was civilly committed has been rejected by the psychiatric community as a legitimate diagnosis in the manner in which it was applied to him; (2) there is only a three percent agreement rate among the State's experts regarding Mr. Stout's diagnoses; and (3) Mr. Stout is now being detained for a mental abnormality other than that for which he was initially committed?

2. Due process requires that involuntarily committed individuals have a right to an annual examination to determine whether they still have the mental abnormality that they cannot control and which renders them unsafe to be free from total confinement. A superior court must grant a full evidentiary hearing if the State has failed to present prima facie evidence that the committed person continues to meet the criteria for confinement. Did the superior court violate Mr. Stout's statutory and constitutional rights by failing to grant an evidentiary hearing when the State failed to meet its evidentiary burden for each of the relevant review periods?

### C. STATEMENT OF THE CASE

Mr. Stout has been civilly committed under RCW 71.09 for over ten years. CP 128. At his initial commitment trial in 2003, the superior court<sup>1</sup> concluded that the combination of paraphilia NOS non-consent and antisocial personality disorder caused Mr. Stout difficulty controlling his behavior. CP 126. “A paraphilia of this kind is a mental disorder that causes recurrent intense sexually arousing fantasies, urges and behaviors involving non-consenting adults, that lasts for more than six months, and results in negative consequences to the individual.” CP 125.

The superior court’s factual findings relied on the circumstances of Mr. Stout’s prior offenses and testimony of the State’s expert. *See* CP 117-27. The State’s expert did not testify as to fantasies or urges, but only concerning Mr. Stout’s behaviors and acts to support his paraphilia NOS non-consent diagnosis. CP 279. The trial court found:

Mr. Stout has exhibited recurrent sexual *behaviors* involving non-consenting adults on several occasions. These *behaviors* occurred from at least 1990 through 1997, a period of longer than six months. These *behaviors* have resulted in legal consequences and disadvantages for Mr. Stout on numerous occasions.

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<sup>1</sup> Mr. Stout waived his right to a jury trial and elected to have the superior court judge act as the fact finder. CP 117.

CP 125 (emphasis added). The State's expert did not testify that Mr. Stout experienced urges or fantasies that evidenced an arousal to coercion. *See* CP 128, 279.

Since Mr. Stout's trial, the psychiatric community has overwhelmingly rejected rape as a mental disorder. CP 344. Paraphilic coercive disorder, which attempted to characterize rape as a mental disorder, has been rejected four separate times from the Diagnostic and Statistical Manual of Mental Disorders (DSM). *See* CP 280-81. State evaluators then began using paraphilia NOS non-consent to diagnose rape as a mental disorder for purposes of civil commitment, which contravened the intent of the DSM drafters. CP 344. This misuse of the paraphilia NOS non-consent diagnosis has been renounced by recent forensic psychiatry literature. *See id.*

Paraphilia NOS non-consent is regarded by many in the psychiatric community as the most controversial concept in civil commitment evaluations. *Id.* The diagnosis has a long history of misinterpretation and misapplication and its function has only recently been clarified. *Id.* The chair of the DSM-IV Task Force has explained that paraphilia NOS non-consent cannot be diagnosed on the basis of behaviors alone, but requires "considerable evidence documenting that

the rapes reflected paraphilic urges and fantasies linking coercion to arousal.” CP 344. This presently accepted notion represents a dramatic shift from how paraphilia NOS non-consent was diagnosed at the time of Mr. Stout’s initial commitment trial. The DSM-IV Task Force chair has made clear that a paraphilia NOS non-consent diagnosis can *never* be justified on the basis of acts alone. *Id.*

Based on this change in the psychiatric community’s understanding and application of the paraphilia NOS non-consent diagnosis, Mr. Stout moved the court for relief from judgment pursuant to CR 60(b)(11). CP 276. Mr. Stout argued that the subsequent repudiation of rape as a mental disorder and paraphilia NOS non-consent in the manner in which it was applied during his civil commitment proceedings constituted extraordinary circumstances that warrant vacation of the initial commitment order. CP 283. Mr. Stout provided the superior court with updated academic literature establishing that paraphilia NOS non-consent had been misinterpreted and then misapplied to individuals that had committed acts of rape. CP 339-48. The superior court denied Mr. Stout’s CR 60(b)(11) motion. CP 451.

At that same hearing, the superior court also addressed the following RCW 71.09.090 hearings: (1) the State's motion for reconsideration of the superior court's prior ruling granting Mr. Stout a new trial, which related to the review period from July 2009 through August 2010;<sup>2</sup> (2) the show cause hearing for the review period from August 2010 through September 2011; and (3) the show cause hearing for the review period from October 2011 through September 2012.

11/6/13 RP 4.

The superior court considered the following reports concerning Mr. Stout: (1) Dr. Spizman's annual review report dated October 2, 2010 (July 2009 to August 2010 review period);<sup>3</sup> (2) Dr. Spizman's annual review report dated November 8, 2011 (August 2010 to September 2011 review period);<sup>4</sup> (3) Dr. Yanisch's annual review report

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<sup>2</sup> On March 24, 2011, the superior court found that Mr. Stout was entitled to a new trial under RCW 71.09.090 because he met his burden to show that he had so changed that an evidentiary hearing was merited to determine whether he still met the criteria for confinement. CP 89. The State filed for and was granted discretionary review of this ruling and subsequently obtained a stay to await the Supreme Court's decision in *State v. McCuiston*, 174 Wn.2d 369, 275 P.3d 1092 (2012). The subsequent annual reviewing hearings were also stayed. 11/26/13 RP 4. Mr. Stout's matter was returned to the superior court after the opinion in *McCuiston* was issued. CP 1. The next hearing took place on November 26, 2013, which is the subject of this appeal.

<sup>3</sup> CP 132-43, which are attached as Appendix A.

<sup>4</sup> CP 244-56, which are attached as Appendix B.

dated January 31, 2013 (October 2011 to September 2012 review period);<sup>5</sup> and (4) Dr. Wollert's psychological evaluation of Mr. Stout dated May 7, 2013.<sup>6</sup> The relevant portions of these reports are discussed in detail below.

The superior court determined that the State had met its prima facie burden to show that Mr. Stout continued to meet the criteria for confinement for each review period and denied his request for an evidentiary hearing. CP 441-43, 445-47, 448-50.

#### D. ARGUMENT

##### **1. The superior court abused its discretion when it denied Mr. Stout's motion for relief from judgment.**

CR 60(b) provides a number of reasons upon which a trial court may relieve a party from final judgment, order, or proceeding. In addition to those reasons specifically listed, a trial court may grant this same relief for "any other reason justifying relief from the operation of judgment." CR 60(b)(11). A motion for relief from judgment for any other reason justifying relief is the catch all provision of the rule, by which trial courts may vacate judgments for reasons not identified in

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<sup>5</sup> CP 218-27, which are attached as Appendix C.

<sup>6</sup> CP 302-37, which are attached as Appendix D.

the rule's more specific subsections. *Tatham v. Rogers*, 170 Wn. App. 76, 100, 283 P.3d 583 (2012). This rule applies to situations involving extraordinary circumstances caused by irregularities unrelated to the action of the court. *Id.* at 100 (citing *Flannagan v. Flannagan*, 42 Wn. App. 214, 221, 709 P.2d 1247 (1985)).

A trial court's denial of a motion to vacate judgment is reviewed for abuse of discretion. *DeYoung v. Cenex Ltd.*, 100 Wn. App. 885, 894, 1 P.3d 587 (2000). A trial court abuses its discretion by exercising it on untenable grounds or for untenable reasons. *State ex rel. Campbell v. Cook*, 86 Wn. App. 761, 766, 938 P.2d 345 (1997).

Here, there are three independent bases upon which Mr. Stout should have been granted relief from judgment. While each basis alone necessitates relief from judgment, cumulatively these extraordinary circumstances make clear that the trial court abused its discretion when it denied Mr. Stout's CR 60(b)(11) motion.

- a. Since Mr. Stout's initial commitment trial in 2003, the psychiatric community has definitively rejected the concept of rape as a mental disorder.

Mr. Stout was initially committed in 2003 based on a combination of paraphilia NOS non-consent and antisocial personality disorder. CP 360. Paraphilia NOS non-consent is regarded by many in

the psychiatric community as the most controversial concept in sexually violent predator evaluations.<sup>7</sup> The paraphilia NOS non-consent diagnosis has a long and very misunderstood history. Frances et al., *supra* note 7. Recent literature in the field of forensic psychiatry outlines the past misapplication of this diagnosis. *See id.*

- i. *Members of the DSM Task Force and Work Groups have clarified the paraphilia NOS non-consent diagnosis and advocated against its misapplication.*

One source of misunderstanding was the DSM wording for “paraphilia.” *Id.* The source of this misinterpretation was the following language from the opening sentence of the paraphilia section in the DSM-IV-TR:

The essential features of a paraphilia are recurrent, intense, sexually arousing fantasies, sexual urges, or behaviors general involving (1) nonhuman objects, (2) the suffering or humiliation of oneself or one’s partner, or (3) children or other nonconsenting persons.<sup>8</sup>

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<sup>7</sup> Allen Frances, Shoba Sreenivasan, & Linda E. Weinberger, *Defining Mental Disorder When It Really Counts: DSM-IV-TR and SVP/SDP Statutes*, 36 J. Am. Acad. Psychiatry Law, Sept. 2008, at 375, 380. This article is attached as Appendix E.

<sup>8</sup> Allen Frances & Michael B. First, *Paraphilia NOS, Nonconsent: Not Ready for the Courtroom*, 39 J. Am. Acad. Psychiatry Law, Dec. 2011, at 555, 556.

This sentence has been inaccurately interpreted to justify the diagnosis of paraphilia NOS non-consent based on the non-consenting nature of sexual behaviors. Frances & First, *supra* note 8.

Rather, the term “nonconsenting persons” as used in the DSM was not intended to include rape. *Id.* at 557. Instead, the term describes only the victims of exhibitionism, voyeurism, frotteurism, and pedophilia. *Id.* In reality, it was the deliberate intent of the DSM-IV drafters to exclude any reference to rape as a paraphilia. *Id.* Rape was neither included as a coded diagnosis nor provided as an example of paraphilia. Frances et al., *supra* note 7. This prior misinterpretation of the phrase “nonconsenting person” resulted in clinicians treating rape as a mental disorder despite the fact that the DSM drafters’ objective was just the opposite. *Id.*

Another misconception among clinicians concerning paraphilia NOS non-consent was that it could be assigned based on rape behaviors alone. *Id.* It is now well understood that acts alone can never be paraphilic. *Id.* The essential features of paraphilia are “recurrent, intense sexually arousing fantasies, sexual urges, or behaviors.” *Id.* “Behaviors” may signify the culmination of urges and fantasies, but they are insufficient on their own to warrant a diagnosis of paraphilia

NOS non-consent. Frances et al., *supra* note 7. This distinction is necessary to separate paraphilia from opportunistic criminality. *Id.* “Some rapes may be triggered by opportunity, others may occur in the context of intoxication-related disinhibition, and some may reflect character disorder or other nonparaphilic pathology.” *Id.*

The confusion regarding paraphilia NOS non-consent has recently been clarified in the psychiatric community. *See id.* In order for a paraphilia NOS non-consent diagnosis to be merited, it requires “considerable evidence documenting that the rapes reflected paraphilic urges and fantasies linking the coercion to the arousal.” *Id.* Paraphilia NOS non-consent has been deemed an inherently weak construct because of its lack of a defined set of criteria. *Id.* at 381. The psychiatric community expressed serious concern about the danger that clinicians would misuse the DSM by applying an idiosyncratic interpretation of behaviors to shoehorn individuals for the purpose of justifying civil commitment. *Id.*

The inference that a rapist is motivated by paraphilia should never be made entirely on the fact that he committed rape. Frances & First, *supra* note 8, at 558. However, state evaluators continue to “widely misapply the concept that rape signifies mental disorder and to

inappropriately use NOS categories where they do not belong in forensic hearings.” *Id.* at 559. Paraphilia NOS non-consent is not a legitimate mental disorder diagnosis according to the drafters of the DSM. *Id.* at 560.

At Mr. Stout’s motion for relief from judgment, the State argued that paraphilia NOS had previously been unsuccessfully challenged in *In re Det. of Young*, 122 Wn.2d 1, 857 P.2d 989 (1993). 11/6/13 RP 16. However, *Young* was decided when “pathologically driven rape” was not *yet* included in the DSM-III-R. 122 Wn.2d at 28. At the time of Mr. Stout’s motion for relief from judgment, paraphilia characterized by rape behavior had been specifically *rejected* by the DSM. Frances & First, *supra* note 8. “What is critical for our purposes is that the psychiatric and psychological clinicians who testify in good faith as to the mental abnormality are able to identify sexual pathologies that are as real and meaningful as the other pathologies already listed in the DSM.” *Id.* (citing Alexander D. Brooks, *The Constitutionality and Morality of Civilly Committing Violent Sexual Predators*, 15 U. Puget Sound L. Rev. 709, 733 (1992)).

The State’s reliance on *Young* is misplaced. The *Young* decision stands for the principle that just because a pathology has not yet been

included in the DSM does not necessarily mean that the diagnosis should be rejected. *See id.* *Young* does not promote the notion that once the DSM and psychiatric community has explicitly and overwhelmingly rejected a pathology, such as rape as a mental disorder, it still may be used to indefinitely confine someone. The literature and research demonstrates that paraphilia NOS non-consent is regarded drastically differently today than it was in 2003.

Mr. Stout did not have the benefit of presenting this reexamination and rebuff of rape as a mental disorder to the fact finder in his initial commitment trial. Homosexuality was once considered a mental disorder and included in the DSM.<sup>9</sup> Homosexuality was removed from the DSM in 1973 and is no longer considered a mental disorder. Spitzer, *supra* note 9. As the Supreme Court has recognized, “The DSM is, after all, an evolving and imperfect document.” *Young*, 122 Wn.2d at 28. Denying Mr. Stout’s motion for a new trial is the equivalent of denying a new trial to an individual civilly committed for homosexuality in the 1970s.

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<sup>9</sup> R.L. Spitzer, *The Diagnostic Status of Homosexuality in DSM-III: A Reformulation of the Issues*, Am. J. Psychiatry, Feb. 1981, at 210.

The scrutiny, skepticism, and ultimate rejection of paraphilia NOS non-consent and its past misapplication illustrates the extraordinary circumstances that justify Mr. Stout's relief from the initial commitment order.

ii. *The refusal to include paraphilic coercive disorder in the DSM-5 further confirms that rape is not a mental disorder.*

Rape as a paraphilia was first suggested as paraphilic coercive disorder. Frances & First, *supra* note 8, at 558. A recent proposal to include paraphilic coercive disorder as an official diagnosis in the DSM-5 was rejected. *Id.* In a recent article, the chair of the DSM-IV Task Force and the editor and co-chair of the DSM-IV commented on this rejection:

That the proposal to include coercive paraphilia as an official diagnosis in the main body of the DSM-5 has recently been rejected confirms the previous decisions to reject paraphilic rape that were made for DSM-III, DSM-III-R, and DSM-IV. It is unanimous: a rapist is not someone who has a mental disorder and psychiatric commitment of rapists is not justified. This is an important message to everyone who is involved in approving psychiatric commitment under sexually violent predator (SVP) statutes. The evaluators, prosecutors, public defenders, judges, and juries must all recognize that the act of being a rapist is almost always an aspect of simple criminality and that rapists should receive longer prison sentences, not psychiatric hospitalizations.

*Id.* at 558-59.

Paraphilic coercive disorder's rejection from the DSM-5, reflecting the psychiatric community's refusal to classify rape as a mental disorder, further demonstrates the shift that has occurred since Mr. Stout's initial commitment trial in 2003. The fact that Mr. Stout remains indefinitely confined based on a diagnosis that was controversial in the past and fully rejected today is an extraordinary circumstance that justifies relief from his original commitment order. As such, the superior court abused its discretion when it denied Mr. Stout's CR 60(b)(11) motion.

- b. The meager three percent agreement rate regarding Mr. Stout's diagnoses among the State's experts constitutes an extraordinary circumstance that merits relief from judgment.

The erratic diagnoses offered by the State's experts over the years further substantiates the flawed nature of the paraphilia NOS non-consent diagnosis. At Mr. Stout's initial commitment trial, the State's expert, Dr. Packard, testified that the combination of paraphilia NOS non-consent and antisocial personality disorder caused Mr. Stout difficulty controlling his behavior. CP 126. Dr. Wollert, an expert who conducted a psychological evaluation of Mr. Stout in 2013 and

reviewed all of his prior diagnoses, concluded that Dr. Packard's diagnosis was based on two erroneous assumptions. CP 307-08.

Dr. Packard's first inaccurate assumption was that the relevant professional community accepted paraphilia NOS non-consent as a reliable mental disorder. CP 308. This assumption was mistaken because of the rejection of paraphilic coercive disorder, and by extension of paraphilia NOS non-consent when diagnosed on the basis of behaviors alone, as an authorized DSM diagnosis. CP 309; *see supra* Section D(1)(a). Rape is no longer considered a reliable mental disorder by the psychiatric community. *Id.*

The second incorrect assumption was that members of the relevant professional community would be able to reliably diagnose Mr. Stout with a combination of paraphilia NOS non-consent and antisocial personality disorder. CP 307. There has been only a three percent agreement rate among State's experts regarding Mr. Stout's diagnoses. CP 308. This agreement rate is far below a reasonable degree of professional certainty. *Id.* Mental health professionals have been unable to reliably identify diagnoses in Mr. Stout's case. *Id.*

The inability to reliably diagnose Mr. Stout is most dramatically illustrated by Dr. Spizman's annual reports. CP 137-38, 250-51. In his

2011 report, Dr. Spizman acknowledged that while he previously diagnosed Mr. Stout with paraphilia NOS non-consent, he subsequently became uncertain because “the assaults did not clearly indicate a desire for non-consensual sexual activity.” CP 250. The fact that the same evaluator could one year render the diagnosis and retract that diagnosis the following year based on the exact same facts exposes the problematic nature of Mr. Stout’s indefinite confinement based on these prior diagnoses. This further evidences the extraordinary circumstances that merit relief from judgment.

- c. It is unconstitutional to continue to detain Mr. Stout without a trial where the basis for his commitment has changed.<sup>10</sup>

At the initial commitment trial, the superior court concluded that “the combination of paraphilia (NOS) non-consent with anti-social personality disorder causes [Mr. Stout] serious difficulty in controlling his behavior of engaging in sex with non-consenting others.” CP 126. Mr. Stout’s mental abnormality was therefore regarded as the product of a combined diagnosis. *See id.*

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<sup>10</sup> On May 8, 2014, the Supreme Court heard oral argument in *In re Det. of Meirhofer*, Supreme Court No. 892512. The Supreme Court’s opinion in *Meirhofer* may be dispositive here. One of the issues of contention between the parties in *Meirhofer* is whether an individual committed under RCW 71.09 may continue to be detained on a different basis than that under which he was initially committed.

Since his commitment, the State's experts have expressed uncertainty regarding the applicability of a paraphilia NOS non-consent diagnosis by indicating that it should be ruled out (i.e., additional information must be considered before the diagnosis can be made or ruled out). CP 224, 250. The antisocial personality disorder diagnosis also came under question when Dr. Spizman characterized it as provisional (i.e., further information may indicate that this diagnosis is not warranted). CP 251. The only diagnosis remaining is Dr. Yanisch's antisocial personality disorder diagnosis from the most recent annual report.<sup>11</sup> CP 224.

At best, the most recent report shows that Dr. Yanisch was doubtful about the applicability of one of the two diagnoses that make up Mr. Stout's compound diagnosis. CP 224. This creates uncertainty regarding whether the full combination of diagnoses necessary to Mr. Stout's "mental abnormality" are currently active.

Mr. Stout is thus being detained for a mental abnormality other than that for which he was initially committed. At a minimum, this

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<sup>11</sup> As previously discussed, Dr. Yanisch asserted that he saw no compelling reason to change Mr. Stout's prior diagnosis. CP 224. He then refers the "interested reader" to Dr. Spizman's 2011 annual review report, which did not contain an antisocial personality disorder diagnosis. *Id.*; CP 251.

change in diagnosis warrants a full trial on the merits of Mr. Stout's continued confinement. A jury must have the opportunity to weigh the experts' competing claims regarding the validity of this new diagnosis and, as such, Mr. Stout should be granted a new trial.

**2. The State failed to present prima facie evidence that Mr. Stout continued to suffer from a mental abnormality which made him likely to engage in predatory acts of sexual violence and thus an evidentiary hearing was required.**

Even where an initial commitment is proper, the State violates due process when it continues to confine a person who is no longer both mentally ill and dangerous. U.S. Const. amend. XIV; *Foucha v. Louisiana*, 504 U.S. 71, 77, 112 S. Ct. 1780, 118 L. Ed. 2d 437 (1992) (reversing where individual was dangerous but no longer suffered from psychosis). "Periodic review of the patient's suitability for release" is required to render commitment constitutional. *Jones v. United States*, 463 U.S. 354, 368, 103 S. Ct. 3043, 77 L. Ed. 2d 694 (1984). Due process mandates that the State release a committed person "when the basis for holding him or her in the psychiatric facility disappears." *State v. Sommerville*, 86 Wn. App. 700, 710, 937 P.2d 1317 (1997).

Because commitment under RCW 71.09 is indefinite, the due process requirement that a detainee be mentally ill and dangerous is ongoing. *In re Det. of Cherry*, 166 Wn. App. 70, 75, 271 P.3d 259

(2011). To comply with this due process requirement, involuntarily committed individuals have a right to an annual examination to determine whether they still have the mental abnormality that they cannot control and which renders them unsafe to be free from total confinement. RCW 71.09.070; *Young*, 122 Wn.2d at 38-39, *superseded by statute*, Laws of 1995, ch. 216, §2, 9, *as recognized in In re Det. of Thorell*, 149 Wn.2d 724, 746, 72 P.3d 708 (2003).

By statute in Washington, involuntarily committed individuals have a right to an annual examination to determine whether they remain mentally ill and dangerous. RCW 71.09.070. Each individual also has the right to an annual show cause hearing at which the court decides whether probable cause exists to warrant a full trial to determine if the individual continues to meet the criteria for confinement. RCW 71.09.090. The State bears the burden of proof at the show cause hearing. *In re Det. of Petersen*, 145 Wn.2d 789, 796, 42 P.3d 952 (2002).

RCW 71.09.070(1) dictates the scope of annual review. The State must provide the court with a written report prepared by a qualified professional and submitted under the penalty of perjury. RCW 71.09.070(1). The report's content is mandated by statute:

The annual report shall include consideration of whether the committed person *currently* meets the definition of a sexually violent predator and whether conditional release to a less restrictive alternative is in the best interest of the person and conditions can be imposed that would adequately protect the community.

*Id.* (emphasis added).

After a show cause hearing, the court must grant a full evidentiary hearing if “[t]he state has failed to present prima facie evidence that the committed person continues to meet the definition of a sexually violent predator and that no proposed less restrictive alternative is in the best interest of the person and conditions cannot be imposed that would adequately protect the community.” RCW 71.09.090(2)(c)(i); *see Petersen*, 145 Wn.2d at 798 (State must prove “the prisoner still has a mental abnormality or personality disorder” which is likely to cause the prisoner to engage in predatory acts of sexual violence if released).

The prima facie evidence standard required by RCW 71.09.090(2)(c) is the legal equivalent of probable cause. *Petersen*, 145 Wn.2d at 797. Probable cause is based on an objective analysis of the facts presented from which a neutral and detached person would find the conclusion to be more probable than not; that is, the facts must be objectively demonstrated and must be sufficient to satisfy a

reasonable person. *Id.* (citing, *inter alia*, *Aguilar v. Texas*, 378 U.S. 108, 84 S. Ct. 1509, 12 L. Ed. 2d 723 (1964); *Spinelli v. United States*, 393 U.S. 410, 89 S. Ct. 584, 21 L. Ed. 2d 637 (1969)).

This Court reviews a superior court's decision following a show cause hearing de novo. *Petersen*, 145 Wn.2d at 799. The question on review is whether the evidence, or lack thereof, suffices to establish probable cause for an evidentiary hearing. *In re Det. of Elmore*, 162 Wn.2d 27, 37, 168 P.3d 1285 (2007).

- a. Where the State's expert was uncertain whether Mr. Stout would be likely to reoffend if released unconditionally, the State did not meet its burden to establish the required "dangerousness" for the July 2009 through August 2010 review period.

A person does not meet the criteria for commitment under RCW 71.09 unless he has a mental abnormality or personality disorder that makes him more likely than not to commit predatory acts of sexual violence. RCW 71.09.020(7), (18). If the State's evidence does not establish that the detainee is sufficiently dangerous, continued detention is not authorized. *Cherry*, 166 Wn. App. at 76.

The State must show a greater than 50 percent likelihood of re-offense to meet the more likely than not threshold that a person will reoffend if not confined. *In re Det. of Brooks*, 145 Wn.2d 275, 295-96,

36 P.3d 1034 (2001), *overruled on other grounds*, *Thorell*, 149 Wn.2d at 753. The fact to be proved with respect to civil commitment under RCW 71.09 is expressed in terms of statistical probability. *Id.* at 296. The question “is not whether the defendant will reoffend, but whether the probability of the defendant’s reoffending exceeds 50 percent.” *Id.*

In making this determination, actuarial models are more reliable than clinical judgment. *Thorell*, 149 Wn.2d at 753, 757. The probative value of actuarial assessments is high and directly relevant to whether an individual meets the criteria of confinement. *Id.* at 758; *see also In re Det. of Fox*, 138 Wn. App. 374, 395 n.14, 158 P.3d 69 (2007) (research suggests that actuarial risk assessments are more reliable than clinical analyses).

Dr. Spizman, the State’s expert for the July 2009 to August 2010 review period, used the Static-99R, an actuarial risk assessment tool, to estimate Mr. Stout’s risk of re-offense. CP 138-39. Dr. Spizman calculated Mr. Stout’s score at five on the Static-99R, resulting in a 25.2 percent risk to reoffend within five years and a 35.5 percent risk to reoffend within ten years. CP 139.

In addition to the Static-99R results, Dr. Spizman analyzed Mr. Stout’s dynamic risk factors. CP 139. Dr. Spizman listed seventeen

dynamic risk factors in his report. CP 139-41. There was no evidence of any risk, or inadequate information to assess risk, on all but 11 of these 17 factors.<sup>12</sup> *Id.* Of the six remaining factors, Mr. Stout had made improvements or had learned to effectively manage risk for three of these factors.<sup>13</sup> CP 140-41. Mr. Stout's capacity for relationship stability and cooperation with supervision were both deemed "moderate" risk factors in Dr. Spizman's report. CP 139, 141. With regard to the impulsive acts risk factor, Dr. Spizman concluded that Mr. Stout appeared to largely be able to control his impulsivity. CP 141. Dr. Spizman never articulated whether or how any of these dynamic risk factors made Mr. Stout more than 50 percent likely to commit a crime of sexual violence. *See* CP 139-41.

On the contrary, Dr. Spizman concluded, "Thus, there is some

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<sup>12</sup> The factors for which there was no evidence or inadequate information to assess were the following: (1) significant social influences; (2) intimacy deficits – emotional identification with children; (3) intimacy deficits – hostility toward women; (4) intimacy deficits – general social rejection/loneliness; (5) sexual self-regulation – sexual preoccupation; (6) sexual self-regulation – sex as coping; (7) sexual self-regulation – deviant sexual interests; (8) attitudes supportive of sexual assault – sexual entitlement; (9) attitudes supportive of sexual assault – rape attitudes; (10) attitudes supportive of sexual assault – child molester attitudes; and (11) substance abuse.

<sup>13</sup> These factors included: (1) intimacy deficits – lack of concern for others; (2) general self-regulation – poor cognitive problem solving skills; and (3) general self-regulation – negative emotionality/hostility.

uncertainty regarding whether or not [Mr. Stout] would be more likely than not to reoffend sexually if released unconditionally.” CP 142. He noted that there was relatively little information available regarding Mr. Stout’s mental or personality disorder. *Id.* However, Dr. Spizman then stated that based on the “typically chronic pattern” of these disorders, Mr. Stout continued to meet the criteria for confinement. *Id.*

A court must look beyond an expert’s stated conclusion to determine whether it is supported by sufficient facts. *In re Det. Jacobson*, 120 Wn. App. 770, 780, 86 P.3d 1202 (2004). The uncertainty that permeates Dr. Spizman’s opinion concerning Mr. Stout’s dangerousness demonstrates that the State failed to sufficiently show that Mr. Stout was more likely than not a risk to commit a predatory crime of sexual violence, which is required for his continued confinement without further hearing. *See id.* Mr. Stout was entitled to receive an individualized analysis regarding his risk to reoffend. *See RCW 71.09.070.* It is unconstitutional to detain him based on the “typically chronic pattern” of his diagnoses alone. CP 142; *see Foucha*, 504 U.S. at 77.

Because the evidence showed that Mr. Stout is less than 50 percent likely to reoffend, his continued confinement is

unconstitutional absent a full trial on the merits. U.S. Const. amends. V, XIV; *see Foucha*, 504 U.S. at 77; *Jones*, 463 U.S. at 368; *O'Connor v. Donaldson*, 422 U.S. 563, 575, 95 S. Ct. 2486, 45 L. Ed. 2d 396 (1975). The superior court's denial of Mr. Stout's request for an evidentiary hearing despite his lack of risk to reoffend was statutorily and constitutionally impermissible.

- b. The State failed to establish that Mr. Stout continued to meet the criteria for confinement during the August 2010 through September 2011 review period.

Dr. Spizman also generated the annual report for the next review period: August 2010 through September 2011. CP 244-56. Similarly, this report failed to meet the State's probable cause burden to establish that Mr. Stout continued to require indefinite confinement.

- i. Where the State's expert was uncertain whether Mr. Stout met the criteria for his prior diagnoses, the State did not meet its prima facie burden to show that Mr. Stout currently suffered from a mental abnormality or personality disorder.

Contrary to his previous report, Dr. Spizman did not diagnose Mr. Stout with a mental abnormality or personality disorder during the August 2010 to September 2011 review period. *See* CP 250-51. Instead, Dr. Spizman indicated a "rule out" for paraphilia NOS non-consent, which necessitates collection and consideration of additional

information before the diagnosis can be made or “ruled out.” CP 250. He explained, “I am providing this diagnosis as a rule out, to indicate the uncertainty in whether or not Mr. Stout continues to meet the criteria for this disorder.” *Id.*

Dr. Spizman emphasized that rape of an adult female by a man over fifty years old is very uncommon in the sex offender population. *Id.* To further illustrate his reasoning regarding the “rule out” specifier, Dr. Spizman emphasized that Mr. Stout’s prior offenses did not clearly evidence a desire for non-consensual sexual activity. *Id.* Instead, Mr. Stout often sought consent, but when it was not obtained, he was undeterred and continued pursuing the woman. CP 250. Dr. Spizman asserted, “Thus, there is some uncertainty as to how strong a desire he initially had for nonconsensual sex, with even greater uncertainty now caused by his advanced age.” *Id.* Dr. Spizman had insufficient evidence to warrant a diagnosis of paraphilia NOS non-consent. *See id.*

Dr. Spizman also did not provide an antisocial personality disorder diagnosis. CP 251. Rather, he rendered the diagnosis “provisional,” signifying that further information may indicate that this diagnosis is no longer warranted. *Id.* Dr. Spizman explained that research shows that as a man reaches his fifties, antisocial traits will

“burnout.” *Id.* Dr. Spizman found limited demonstration of antisocial behavior in Mr. Stout and thus did not diagnose antisocial personality.

CP 251. He concluded with regard to Mr. Stout:

I previously rendered a diagnosis of Paraphilia, NOS, Nonconsent. However, as noted above, I am now uncertain in this diagnosis. Furthermore, I have some questions regarding whether an antisocial personality diagnosis is warranted. Thus, there is a degree of uncertainty whether or not Mr. Stout has an underlying mental abnormality or personality disorder that meets the criteria for civil commitment.

CP 255.

Nevertheless, Dr. Spizman then offered his opinion that Mr. Stout continued to meet the criteria for civil commitment. *Id.* This conclusion is unsupported by sufficient facts and thus the superior court should not have relied upon it. *See Jacobson*, 120 Wn. App. at 780. Despite the fact that Dr. Spizman inserted a conclusory sentence near the end of his report that Mr. Stout should continue to be confined, the facts preceding this incongruous conclusion do not support this assertion.

The State’s evidence for the August 2010 through September 2011 period is insufficient to establish probable cause that Mr. Stout continued to suffer from a mental abnormality. The State’s own expert clearly articulated his uncertainty regarding Mr. Stout’s diagnosis or

lack thereof. CP 250. As such, the superior court was required to grant Mr. Stout an evidentiary hearing.

ii. Where the State's expert again expressed uncertainty regarding whether Mr. Stout would reoffend if released, the State also failed to establish the dangerousness prong required for continued confinement.

Mr. Stout's score on the Static-99R was five, the same as during his previous review period. CP 139, 252. This resulted in the same risk of re-offense of 25.2 percent within five years and 35.5 percent within ten years. CP 139, 252. Dr. Spizman concluded:

Regarding risk of reoffense, Mr. Stout did not score in a particularly high range on a commonly used actuarial risk measure (after accounting for his advancing age). Thus, there is some uncertainty regarding whether or not he would be more likely than not to reoffend sexually if released unconditionally.

CP 255. Dr. Spizman analyzed the same 17 dynamic risk factors that were discussed during his previous report with similar results. CP 252-55. Again, Dr. Spizman does not articulate whether or how these dynamic risk factors make Mr. Stout more likely to commit a predatory act of sexual violence. *See id.*

The State failed to establish through the annual review report that Mr. Stout was more likely than not to commit a violent sexual

offense. As such, he was entitled to an evidentiary hearing to determine whether continued confinement is justified.

- c. The State did not establish that Mr. Stout continued to meet the criteria for confinement during the October 2011 through September 2012 review period.

A different State's expert, Dr. Yanisch, generated the annual report for the October 2011 through September 2012 review period. CP 218-27. Once more, this report provided insufficient evidence for both the mental abnormality and dangerousness prongs.

- i. The State did not meet its prima facie burden to show that Mr. Stout continued to suffer from a mental abnormality or personality disorder.

The State's annual report for this review period contained nearly no analysis regarding Mr. Stout's mental abnormality. *See* CP 224. Rather, Dr. Yanisch opined that Mr. Stout has "carried essentially the same diagnosis since at least 2006, and I see no compelling reason to alter it at this time." CP 224. He then directed the "interested reader" to review the annual report generated a year earlier by Dr. Spizman. *Id.* As previously discussed, this report specified paraphilia NOS non-consent as a rule out and antisocial personality disorder as provisional, thus containing no diagnosis. *See* 250-51. Dr. Yanisch then provided a different diagnosis than that given the previous year by Dr. Spizman.

*Id.*; CP 224.

While Dr. Yanisch maintained the rule out specifier regarding paraphilia NOS non-consent, he diagnosed Mr. Stout with antisocial personality disorder. CP 224. He failed to provide any updated facts or analysis to support his opinion that Mr. Stout *currently* suffered from this mental abnormality, as constitutionally and statutorily required. *See id.* He also ignored Dr. Spizman's doubts concerning the antisocial personality diagnosis, even though Dr. Yanisch referred the "interested reader" to Dr. Spizman's 2011 report. *Id.* Dr. Yanisch's report failed to establish that Mr. Stout currently suffered from a mental abnormality or personality disorder. Consequently, the State failed to meet its burden regarding the first prong of commitment criteria.

*ii. The annual report also failed to establish that Mr. Stout would more likely than not commit a predatory act of sexual violence if released.*

Mr. Stout maintained his score of five on the Static-99R and Dr. Yanisch estimated his risk of re-offense based on application of this actuarial risk assessment tool at 25.2 percent within five years and 35.5 percent within ten years. CP 225. As previously discussed, this evidence is insufficient to meet the State's *prima facie* burden with

regard to the second prong of dangerousness required for continued confinement.

The superior court erred when it concluded that the State had carried its burden at each show cause hearing. This Court should reverse and remand for an evidentiary hearing to determine whether Mr. Stout continues to meet the criteria for confinement.

E. CONCLUSION

This Court should reverse the superior court's ruling denying Mr. Stout an evidentiary hearing and remand for such proceedings.

DATED this 5th day of June, 2014.

Respectfully submitted,



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WHITNEY RIVERA, WSBA No. 38139  
Washington Appellate Project  
Attorneys for Appellant

# APPENDIX A

**SPECIAL COMMITMENT CENTER  
ANNUAL REVIEW  
(July 2009 – August 2010)**

RECEIVED

OCT 22 2010

CRIMINAL JUSTICE DIVISION  
ATTORNEY GENERAL'S OFFICE

Name: Roy Stout  
Date of birth: 06.14.59  
Jurisdiction: Skagit County Superior Court  
Cause #: 01-2-01307-9  
Commitment date: 10.29.03  
Evaluated by: Paul Spizman, Psy.D.  
Date of report: 10/2/10

### Reason for Referral

Mr. Roy Stout is a 51-year-old Caucasian man whose history includes recurrent sexually coercive and violent offenses against adult women with whom he had no meaningful prior relationship. On 10.29.03 Mr. Stout was committed to the Special Commitment Center (SCC) for care, control, and treatment of his sexually violent behaviors and mental abnormality in accordance with RCW 71.09.060 (1). Pursuant to RCW 71.09.070, the purpose of this report is to evaluate whether Mr. Stout continues to meet the definition of a sexually violent predator and to assess whether conditional release to a less restrictive alternative is in his best interest and conditions can be imposed that would adequately protect the community.

### Evaluation Process

At the Special Commitment Center, the annual review of a resident's treatment progress is a multi-disciplinary process in which clinical information is synthesized from multiple data sources. Previous evaluations are reviewed, especially those conducted pursuant to RCW 71.09.040 (4). The evaluation includes a review of treatment participation and progress in order to determine whether the resident's risk for criminal sexual acts has been mitigated through sex offender treatment. Documentation and clinical impressions on the extent and quality of the resident's involvement in activities such as sex offender group therapy, psycho-educational classes, and individual therapy are also reviewed. The evaluator discusses treatment progress with the resident and discusses the resident's progress with other SCC staff. The resident is given the opportunity to participate in a clinical interview to assess his mental condition and answer questions about his experience and perceptions of his sex offender treatment.

### Relevant Background

The background information for this report was compiled from previous clinical and legal documents. Reviewing such evaluations to obtain historical information is an accepted standard of practice among mental health professionals. Please note that the historical information compiled in evaluation reports is often from a variety of sources and its presentation here is not intended to represent it as fact. Histories usually contain inaccurate and sometimes contradictory information. The information is presented to inform the reader of the information that was reported to the evaluator and to indicate this evaluator's understanding of the relevant history. The residents also have the opportunity to provide information regarding their history. This can occur during the clinical interview or by providing information to staff, who can then forward it to the forensic unit. If information in this report is found to be incorrect, it can be corrected in subsequent reports, or if needed an addendum can be written to the court.

Material for the historical sections of this report was taken mostly verbatim from the SCC Annual Review completed by Daniel Yanisch, 8/29/06, who cited a prior Annual Review completed by Mark McClung, M.D., SCC Consulting Psychiatrist as his primary source. Other information that may be included is from the End of Sentence Review report, completed by Carla van Dam, Ph.D., 7/9/01. This information is included at the end of this report.

Records reviewed for this report included those available at the Records Center as of 8/19/10. However, at times records may come to the SCC Records Center past that date, which occurred prior to 8/19/10, and would be included in next year's Annual Review.

### **Treatment Progress at the Special Commitment Center**

#### **Medical and Psychiatric Treatment**

On 3/29/10 Mr. Stout reported having pinkish/red urine, which medical staff noted might be a kidney stone (further noted below).

#### *Dr. Randall Griffith, ARNP*

Dr. Griffith discussed Mr. Stout's health and medical status. He noted that Mr. Stout does not attend the clinic often or discuss his concerns with Dr. Griffith. Regarding any substantial medical concerns, he is a smoker and has slight high blood pressure. Mr. Stout also agreed to undergo exam for possible prostate cancer, and he was diagnosed on biopsy with the cancer. He is seeing a urologist for the cancer, and he has elected to proceed with radiation treatment. Regarding the pinkish color of his urine Mr. Stout complained of at the end of 3/10 there was no evidence of blood in the urinalysis (and thus the cause seems to be unknown). Regarding strength, mobility, and endurance, it is difficult for Dr. Griffith to comment on, as he does not attend appointments at the clinic. Regarding erectile functioning, at his age there would be some expected dysfunction, which could be further impaired by the smoking, but there are no complaints at this time (of course, again, he does not attend the clinic).

#### **Extracurricular SCC Activities (Employment, Recreation, Education)**

Residents at the SCC are eligible for paid employment if they complete a required Industrial Safety course that is offered through the SCC Vocational Department. Their work is evaluated by supervisors on a regular basis, and they receive regular Job Performance Reports. Mr. Stout received feedback for his efforts as a custodian for the period of 5/09-11/09. He received primarily moderate ratings, with one positive rating for attendance, and it was noted he was always on time and never missed a day of work. On 8/26/09 it was noted he was 'meticulous' in his cleaning. Feedback for the period of 11/09-5/10 gave moderate to positive ratings, with comments including he was 'among the best' for his quality of work.

The SCC has a Recreation Department that residents can attend to participate in individual or group activities, hobbies, etc. Documentation did not reflect Mr. Stout engaged in any formal recreation during the period under review.

On 10/2/09 it was noted Mr. Stout is a Seventh Day Adventist and a vegan. It was reported he 'uses' the chaplain to get his dietary needs met, but did not participate in religious activities.

Pierce College has a program established to provide services to the residents of the SCC on McNeil Island. Documentation did not reflect Mr. Stout participating in any educational pursuits during the period under review.

### Residential Functioning

Mr. Stout was able to largely maintain appropriate behavior on the living unit. However, he had a variety of outbursts toward staff, as well. A sampling of progress notes is given here.

On 8/3/09 a memo was posted, with Mr. Stout's and other resident's names, informing them of the date and time a community meeting was to be held for the living unit. Mr. Stout made several requests that his name be removed from the memo, as he had negative interactions with staff members and did not want to be associated with that living unit. Though initially agitated, and continually approaching staff about the matter, he eventually calmed himself.

On 8/5/09 it was noted Mr. Stout would isolate in his room while on the living unit, did not room visit with other residents, rarely used the phone, and rarely sat in the dayroom on that shift (dayshift). It was also rare to see him in the yard or recreation areas. However, he would interact while in the smoking area, as long as the 'smoke break' lasted. This isolative type behavior was noted at other times as well (e.g., 8/19/09, 9/9/09). However, on 8/26/09 it was noted he would frequently be asleep during the dayshift due to his work schedule (perhaps rising quite early). Though, notes of another shift (3/6/10) also noted he is typically in his room.

On 8/12/09 it was noted Mr. Stout became upset about receiving cookies in his lunch, which he could not eat (apparently due to dietary restrictions). There had been a power outage and they were placed into his lunch in error (apparently without adequate lighting to see who's lunch it was). However, he could not accept that explanation and continued with his 'rant' until staff intervened. He then sought to speak to a supervisor, but was told to simply file a grievance if he chose to do so.

On 8/19/09 it was noted Mr. Stout became upset when staff knocked on his door, because he believed the knock was too loud. While staff explained they would try to knock lightly, Mr. Stout continued with his 'rant' until he was asked to leave the staff desk.

On 9/2/09 it was noted Mr. Stout would ask staff for certain things he needed, such as to make legal calls. However, it was noted he was not very talkative with that staff member, as Mr. Stout did not get 'his way' when he was upset. Mr. Stout would occasionally 'demand' to see a supervisor, which was at the staff member's discretion. When the supervisor would not be called, Mr. Stout would become angrier. He often then tried to get other residents involved in 'his cause.'

On 9/9/09, when informed about how room inspections were changing, he described how nobody would do anything for him, but he was expected to 'jump through hoops' for others. He stated, 'fuck Walter and Willie' (the supervisors) 'they don't do shit for me I aint [sic] doing shit for them.'

On 9/17/09 when staff knocked on his door during a resident census, Mr. Stout yelled 'what?' He came to the door 'cussing,' and banged on the door twice and asked staff why don't they bang on it harder the next time.

On 10/8/09 Mr. Stout was upset about not receiving paperwork for his room inspection. When informed he would be made a copy, he 'ranted and raved' for about thirty minutes regarding the paperwork. Staff stated it would no longer be tolerated and Mr. Stout would receive the paperwork when staff had it completed.

On 11/3/09 Mr. Stout spoke to a female staff (AT) more than six times in the eight hour shift. He told her it was a 'blessing' to have her on that unit. He also told her he was 'still jealous,' that she got married, but noted 'what can I say I never asked.' He was directed away from the staff desk at that time.

On 11/6/09 Mr. Stout spoke to a staff about information she provided for his previous Annual Review. While he did not believe what she had said was untrue, he seemed upset about her report regarding difficulties he had with another staff member. A little while later he approached the staff member and stated he just wanted to express how strongly he felt about the issue.

On 11/13/09 Mr. Stout became angry at a staff member during a room inspection, as the staff was writing down what needed to be fixed. Mr. Stout escalated to shouting.

On 11/19/09 Mr. Stout approached staff and informed them another resident (RF) who had moved off the living unit wanted some of the plants he had left in the dayroom. Mr. Stout knew which plants they were and offered to deliver them to the other resident.

On 11/20/09 Mr. Stout donated his desk lamp (apparently to charity) as residents were no longer allowed to have clip-on lamps (due to being a fire hazard). He was complying with directions of administration to dispose of the lamp.

On 11/21/09 Mr. Stout asked a staff member what she thought he should change to be a better person. He believed, for example, he should change his smoking and drinking (apparently while outside confinement). Staff noted he could work on his occasional outbursts of anger. He agreed, but then explained how a particular outburst (apparently in regard to the 11/6/09 note, above) was not his fault.

On 1/21/10 Mr. Stout was reluctant to move cardboard boxes off the unit, as part of his job (he stated he needed them, but staff stated there were more boxes than he needed). Mr. Stout then threw them by the trash door, but refused to put them into the bin, stating it was not his job (which staff noted it was).

On 2/5/10 Mr. Stout discussed his computer order, which he had been waiting to receive for two months. He noted he had difficulty with the transfer of funds. However, it seems he was able to remain calm and effectively discuss his concerns.

Various notes (e.g. 3/11/10) indicated Mr. Stout would make jokes while interacting with others.

On 5/7/10 Mr. Stout mentioned to staff the price of his computer, as compared to the price of his daughter's computer (it was unclear if he had purchased it for her).

### Behavioral Incidents

Incidents at the SCC most often are documented with a progress note. However, if there is a more notable (but not necessarily negative) event, an Observation Report (OR) may be used. If the incident is specifically problematic, it will generally result in a Behavior Management Report (BMR), and possibly an Incident Report for the most serious occurrences. An Administrative Review may be held to investigate an incident or clarify sanctions against a resident who receives a Category 1 BMR. Residents may also file grievances or abuse complaints against staff and policies. For the purposes of this report, all of these sources of documentation were reviewed by the evaluator for the period under consideration.

10/12/10 OR: Mr. Stout returned to his room at approximately 8:30 and turned his music up quite loudly, with the door ajar. He did not comply with multiple directives to turn down the music. At one time, in response, he shouted that he could not sleep because of the 'damn clapping' (other residents were watching a football game in the dayroom). When reminded he had just entered his room (apparently not trying to sleep), he stated 'What are you talking about, I can't hear you!' He finally turned off his music and closed his door.

Treatment Progress Information from Documents Reviewed

Documentation reviewed did not indicate Mr. Stout had participated in any sex offender specific treatment activities during the period under review.

Resident's Strengths

Mr. Stout typically is able to relate well with others. He also demonstrated strength in his employment efforts. Finally, he is often able to comply with the rules of the institution.

Collateral Interview

*Hugh Williams, Residential Counselor*

Mr. Williams has been working on Mr. Stout's living unit over the last year and discussed his behavior. Overall, he is largely well behaved. He relates well with others and appears to get along with all his peers. However, he does not appear to be very close to anybody in particular on the living unit, but Mr. Williams thought Mr. Stout may be closer to some of his peers on other living units. Regarding any relations with people outside the facility, Mr. Stout discusses some family members that he seems close to, such as his niece and perhaps a cousin. Mr. Williams was not aware of a romantic relationship Mr. Stout may be engaged in.

Examining specific risk factors, in regard to emotional identification with children, Mr. Stout does not demonstrate specific aspects, such as viewing child oriented media or spending time with childlike peers.

Regarding hostility toward women, he does not demonstrate any particular difficulties, and relates to women as well as he relates to men.

Regarding any lack of concern toward others, Mr. Williams noted Mr. Stout does not demonstrate any particularly callous behaviors that Mr. Williams has seen.

Mr. Stout does not discuss his sexual thoughts, feelings, behaviors, or attitudes related to offending with Mr. Williams and I did not inquire about related risk factors.

Regarding cooperation with supervision, Mr. Stout was noted to follow the rules and structure of the institution, or when given a direction he complies (however, this does not seem consistent with some of the noted outbursts, above).

Mr. Stout was not noted to demonstrate any difficulties with impulsivity. Regarding problem solving skills, he is able to figure out how to accomplish tasks and does not demonstrate difficulties in his daily routine.

Regarding negative emotionality or hostility, Mr. Williams did not have evidence of Mr. Stout demonstrating such difficulties (again, contrary to some of the above noted documentation).

Finally, when asked of any particular strengths of Mr. Stout, Mr. Williams also could not generate anything specific.

However, he referred me to Mr. Moore (another staff member), who could provide additional data.

*Thyrion Moore, Residential Counselor*

As Mr. Moore had written several notes describing problematic behavior of Mr. Stout, and that Mr. Williams referred me to Mr. Moore for further information, a brief interview was conducted. Mr. Moore was specifically asked about cooperation with supervision and negative emotionality, as these were primary areas he addressed in documents. Mr. Moore reported that Mr. Stout would usually tend to 'get mad' regarding his diet, citing his upset about cookies being placed into his lunch bag (noted above). Regarding the outbursts Mr. Moore saw, he related 'it used to be almost a daily thing,' but it has 'tapered off.' Mr. Moore related two reasons for seeing fewer outbursts include less contact with Mr. Stout (he is either asleep or at work during Mr. Moore's shift) and Mr. Stout is making use of other (appropriate) routes to discuss his dietary concerns (such as use of the Ombudsman). Mr. Moore could not comment on any possible changes to other areas of complaints from Mr. Stout noted in documents (such as regarding room inspections) given their lack of contact.

**Current Mental Condition**

Mr. Stout declined to participate in the interview or physiological testing for this annual review evaluation. That Mr. Stout did not participate places certain limitations on this evaluation. In particular, he was not able to provide current first-hand information regarding his perspective on treatment, provide information that may not have been included in his records, or correct any misinformation in such records. Furthermore, diagnostic clarification was not possible, and the resulting diagnostic impressions are based solely on a review of his records.

**Diagnosis and Mental Abnormalities**

**Axis I: Paraphilia, NOS (Non-consent)**

Mr. Stout has been arrested or convicted of sexual offenses against adult women with whom he had no prior meaningful relationship. The incidents were non-consensual, and he did not stop his actions in the presence of clear signals of fear or signals to stop from the victims. Prior evaluators have commented that Mr. Stout has not had a sexual history polygraph or a penile plethysmograph to further evaluate his sexual arousal patterns, and has not been willing to participate in evaluations to discuss his own arousal and thinking patterns regarding sexual activity and sex offenses, who then rendered this diagnosis as a 'rule out' pending further clinical evaluation. However, this author believes there to be a drive toward nonconsensual sexual activity consistent with this diagnosis. For example, one documented assault did not involve any apparent interaction prior to the assault and the attempted forced sex. As with any diagnoses, if more information were provided, it could be that this diagnoses would not be warranted.

**Polysubstance Abuse, In a Controlled Environment**

Mr. Stout has reported various difficulties related to substance abuse. For example, that his first marriage ended due to his drinking, and he has admitted that alcohol was associated with his offending behaviors. He has stated that he "moved Pruno [homemade fermented beverage] around within institutional confines" and has related that once he started drinking, he just did not know when to quit. He has also reported that he used to get belligerent and violent when drinking. He has admitted to marijuana use in the past, and attributed one of his assaults to dealing marijuana. He also acknowledged heroin use over a number of years. He has reported being abstinent from alcohol and drug use since 1983.

Given the aforementioned substance abuse, the diagnosis is given. The specifier of In a Controlled Environment indicates that Mr. Stout does not have easy access to substances, and while there is no reported use during this review period, he may again engage in substance abuse in a less controlled setting.

**Axis II: Antisocial Personality Disorder**

Mr. Stout has a significant history of problematic behaviors as a juvenile. He was reported to have a significant problem with skipping school and was expelled from several schools due to truancy. Furthermore, he has a remarkable criminal history that was documented beginning at age fifteen. While these behaviors did not occur prior to that age, as is necessary for the diagnosis, it can certainly be assumed that these were part of an ongoing pattern, given the extent of the problems.

Mr. Stout's criminal behaviors continued into his adult years, clearly indicating failure to conform to norms with respect to lawful behavior. Some degree of impulsivity was apparent in his substance abuse, several of his assaults, and may have been present in other areas of his life. His irritability and aggressiveness are apparent, such as receiving infractions while incarcerated for fighting with other inmates as well as threatening staff. Currently, while typically able to relate well with others, he did engage in verbal aggression during this period under review. A degree of irresponsibility is also present, such as a sporadic work history (it was unclear to what extent incarceration may have interrupted his ability to maintain employment). Finally, it does not appear he experiences significant remorse for his assaults and other criminal behavior, given his continued offenses across time.

**Borderline Intellectual Functioning**

Dr. van Dam's IQ testing with the WAIS-III during her 07.09.01 evaluation indicated that Mr. Stout functions in the borderline range of intelligence.

In summary, my current DSM-IV-TR diagnosis of Mr. Stout includes:

- Axis I: Paraphilia, NOS (Non-consent)  
Polysubstance Abuse, In a Controlled Environment  
Axis II: Antisocial Personality Disorder  
Borderline Intellectual Functioning  
Axis III: Deferred to medical staff

**Sexual Violence Risk Assessment**

Actuarial Risk Assessment

The Static-99R is an actuarial instrument designed to estimate the probability of sexual recidivism among males who have already been convicted of at least one sexual offense against a child or non-consenting adult.

The Static-99R has shown moderate accuracy in ranking offenders according to their relative risk for sexual recidivism. Furthermore, its accuracy in assessing relative risk has been consistent across a wide variety of samples, countries, and unique settings (Helmus, 2009).

For the Static-99R, there are four groups with which evaluator's can compare an individual's score. In order to evaluate Mr. Stout, we need to consider the extent to which he resembles the typical member of the routine samples or non-routine samples, or if he is more representative of the samples preselected for treatment or the high-risk / high need samples. I have used the recidivism rates from the preselected high risk and need samples because Mr. Stout has been determined to be a sexually violent predator and the

authors of the measure, authorities within the field, recommend using these norms for those found to be SVPs unless otherwise justified.

On the Static-99R, Mr. Stout scored a 5. This yields a risk estimate of 25.2% in five years and 35.5% in ten years.

The recidivism estimates for the Static-99 are based on logistic regression. The regression curve incorporates offender recidivism at all different scores in the measure, providing an estimate of predicted recidivism rates for each score. Therefore, the estimate of 35.5% is not to indicate offenders with similar scores to Mr. Stout reoffended at that precise rate. Rather, the regression curve estimated that offenders with that score reoffended at that approximate rate.

#### Dynamic Risk Factors

The primary goal of sex offender treatment is to address those risk factors that can be modified through intervention (dynamic risk factors) so that Mr. Stout's risk can be managed to a point that he can safely transition to a less restrictive placement. In the professional literature certain dynamic risk factors have been linked to recidivism risk. They have been combined into an instrument called the STABLE-2007. The following section includes risk factors from this instrument and others that are considered pertinent. While this instrument was designed for offenders in the community, it is believed it can still provide some useful information about someone in full confinement. However, the information in this section is greatly limited, due to Mr. Stout's lack of participation in an interview, physiological testing, or treatment.

#### Significant Social Influences

There is inadequate information to gauge this risk factor, either at the time he was offending, or currently.

#### Intimacy Deficits- Capacity for Relationship Stability

Mr. Stout has been married twice. One of the relationships was of significant duration, with the other union lasting less than 30 days. However, there is no distinct evidence that these unions were positive and caring marriages. Rather, the comment that his first marriage ended due to his drinking, and the short time of the second marriage, indicate they both may have been problematic relationships. Without further information it seems he struggled to develop strong interpersonal unions, and there is no evidence of such a union at this time known to this author. Therefore this appears to be a moderate risk factor both during the time he was offending and currently.

#### Intimacy Deficits- Emotional Identification with Children

There is no significant evidence of this risk factor either in the past or currently.

#### Intimacy Deficits- Hostility Toward Women

While Mr. Stout has been married, as noted above it does not seem these were positive unions. Furthermore, his assaults appear to indicate that he views women in a manner to use them sexually. Based upon his history, this author did not find evidence of more positive relationships with women. Rather, his relationships seem to be either conflicted, such as his marriages, or an attempt to use women as sexual objects, such as during his assaults. Therefore, historically he demonstrated a moderately high risk on this factor. Currently, there is not marked evidence of this risk factor, which he may be learning to control, at least while in a controlled setting.

#### Intimacy Deficits- General Social Rejection/Loneliness

There is inadequate information to gauge this risk factor at the time he was offending.

More recently, documentation indicated Mr. Stout would isolate in his room while on the living unit, did not room visit with other residents, rarely used the phone, and rarely sat in the dayroom. While it does not appear he is specifically rejected from his peers at this time, there is not adequate information regarding whether he feels accepted and simply chooses to isolate himself, or does not feel he can truly develop intimate relationships with others. Further, the quality of relations with his family is unknown. Thus, I cannot accurately gauge the level of this risk at this time.

Intimacy Deficits- Lack of Concern for Others

Mr. Stout has a long history of assaults and threatening others, beyond just his sexual offending, both in and outside of confinement. Furthermore, he has various theft charges, including forgeries against his own mother.

There is no real evidence that Mr. Stout has a group of people that he has a strong, positive attachment to. Of course, current relations with his family are unknown.

While information is limited, it seems he was high on this risk factor at the time he was offending.

Currently, he appears to relate relatively well to others, apart from his aggressive outbursts (which appear to have decreased). He also volunteered to assist another resident by delivering plants, demonstrating some aspects of concern.

Overall, there is some information indicating he has learned to manage this risk at this time.

Sexual Self-Regulation- Sexual Pre-occupation

There is inadequate information to gauge this risk factor, either at the time he was offending, or currently.

Sexual Self-Regulation- Sex as Coping

There is inadequate information to gauge this risk factor, either at the time he was offending, or currently.

Sexual Self-Regulation- Deviant Sexual Interests

Mr. Stout's sexual assaults appear to indicate deviant sexual interest. Whether or not he was specifically driven toward nonconsensual sex, or simply did not respond to the signals to stop his sexual pursuits, his forced sexual aggression may be arousing to him, which would indicate the presence of this risk factor. Currently, there is no information to gauge this risk factor at this time.

Attitudes Supportive of Sexual Assault- Sexual Entitlement

While this author does not have specifics, it certainly appears Mr. Stout felt entitled to sex. Several of his sexual assaults began as an apparent attempt to engage in a mutual sexual encounter. However upon being rebuked, he continued his pursuit, apparently feeling entitled to sex. His current attitudes related to offending are unknown.

Attitudes Supportive of Sexual Assault- Rape Attitudes

Mr. Stout's sexual assaults indicate he held attitudes consistent with nonconsensual sexual activity. His attitudes at this time are unknown.

Attitudes Supportive of Sexual Assault- Child Molester Attitudes

There is no significant evidence of this risk factor either in the past or currently.

#### Cooperation with Supervision

Historically, Mr. Stout has done poorly cooperating with supervision. He has violated the conditions of his parole, and at one point was arrested as being a fugitive from justice. Furthermore, he has received infractions while incarcerated for fighting with other inmates as well as threatening staff. He has demonstrated a high level of this risk factor. Currently, he maintains himself to an adequate level. However, there are still some difficulties, such as his aggressive outbursts and it appears this risk factor continues to a moderate extent, despite being in confinement.

#### General Self-Regulation- Impulsive Acts

Impulsivity was apparent in his substance abuse, several of his assaults, and may have been present in other areas of his life. Given the apparently impulsive nature of several assaults, this was a key risk factor at the time of his offenses. At this time he appears largely able to control his impulsivity, at least while in a confined setting. However, some of his aggressive outbursts still demonstrate impulsivity and parallel his behavior during a prior period of confinement. Therefore, he may be able to largely contain this risk factor within the structure of an institution, however difficulties may again arise while in a less restrictive setting.

#### General Self-Regulation- Poor Cognitive Problem Solving Skills

Historically, it seems Mr. Stout has attempted to solve difficulties in his life with substance abuse and aggression. Furthermore, it seems he has attempted to solve financial difficulties with theft or forgery. His varied and extensive criminal history demonstrates rather poor problem solving skills. Thus, this is considered a strong risk factor at least during the time period he was offending. He continued to demonstrate difficulties effectively problem solving during the period under review, as evidenced by his various outbursts. While he appears to have made improvements, such as seeking assistance from the Ombudsman rather than becoming upset with staff, it remains to be seen how long he can effectively manage himself. Further, while he is able to largely maintain adequate behavior while in confinement at this time, he has been able to do so previously, to then act out again upon release. Thus, his appropriate problem solving skills appear to depend largely on being in a structured environment.

#### General Self-Regulation- Negative Emotionality/Hostility

Mr. Stout's prior threats and aggressive behavior demonstrate his hostility. This risk factor appears to have been present to a moderate extent during the time he was offending. At this time, he continues to demonstrate negative affect in his verbally aggressive behavior toward others, as noted above.

To his credit, he appears to have decreased in his emotional outbursts at this time. Perhaps he is learning to more effectively manage this risk factor.

#### Substance Abuse

Mr. Stout has a significant history of substance abuse. It seems he was drinking prior to at least one of his sexual assaults. Without further information it appears this risk factor was present to a moderate extent during the time he was offending. Currently, there is no indication of substance abuse, and Mr. Stout may be largely able to manage this risk factor at least while in a confined setting.

#### Mental Disorder and Risk for Future Sexual Violence

Mr. Stout has a diagnosis of Paraphilia NOS (Nonconsent), Antisocial personality, and substance abuse difficulties. The above noted dynamic risk factors intermingle with aspects of these diagnoses, leading to Mr. Stout's elevated risk of sexual offending. If he is unable to learn to manage these risks he will likely end up in the same cycle of assaultive behavior as before if released unconditionally into the community.

Paraphilia, NOS, Nonconsent may involve recurrent thoughts and urges for forced sexual activity. Such individuals may find forced sexual encounters more arousing than consensual sex, or simply do not find the pleas and suffering of the victim to be un-arousing. They may display a pattern of planning and preparing for forced sexual encounters, as well as taking any opportunity as it may arise. Mr. Stout's sexual assaults appear to have been largely impulsive. Perhaps not driven solely by an urge for nonconsensual sexual activity, but rather he was not dissuaded by the struggles or pleas of the victims.

People with Antisocial Personality Disorder disregard the rights, feelings, or concerns of others. They often obtain what they wish through force or deceit. Oftentimes they are impulsive, and act out with little regard for the impact of their behavior upon themselves or others. They may be aggressive either as an emotional response or to obtain what they are seeking. Such people easily justify their having hurt or mistreated someone else, for example believing that life is simply unfair, or that the offender is the true victim in the situation. They may minimize the impact of their behavior upon others or simply remain completely indifferent. Mr. Stout repeatedly assaulted women sexually as well as engaging in a variety of other antisocial and criminal behavior. It seems he had an indifference toward others that he harmed, focusing on his own needs instead.

Mr. Stout's substance abuse difficulties may have played a role in his offending in two ways. First, the substance abuse may have destabilized his life, creating risks such as interpersonal difficulties, while preventing him from effectively coping. Furthermore, substance abuse could lower any inhibitions he may have had that would have prevented a sexual assault.

Overall, Mr. Stout demonstrated a sexual drive that was not inhibited by the struggles or pleas of the victims. It seems he impulsively sought sexual relations, when rebuked he would become hostile and aggressive, at times assaulting the victim. The apparent callousness of his personality allowed him to repeatedly assault women despite the harm he was causing.

Mr. Stout did not score in a particularly high range on a commonly used actuarial risk measure (after accounting for his advancing age). Thus, there is some uncertainty regarding whether or not he would be more likely than not to reoffend sexually if released unconditionally. However, this measure only examines a ten year span, not the rest of his life, assuming Mr. Stout will be at risk longer than ten years. Furthermore, it is only assessing detected recidivism and it is well accepted that many, if not most, sexual offenses go undetected. Therefore, his risk level is assumed to be higher than the measure demonstrates.

Unfortunately, at this time, there is relatively little information available regarding Mr. Stout's mental disorder or personality disorder, due to his lack of participation in treatment, an interview, or physiological testing. Despite the score on the risk measure, given the typically chronic pattern of his disorders, without his demonstrating significant change it is assumed that this combination of mental abnormalities and personality disorder still impair Mr. Stout's ability to control his behavior and places him at high risk for sexually violent offenses in the absence of any therapeutic or other intervention.

#### **Progress toward Conditional Release to a Less Restrictive Alternative**

Mr. Stout has remained noncompliant with treatment. He has given very little information in which to determine if he has learned of what his risk factors for a sexual offending are, or if he is able to effectively manage them. Given that the chronic nature of his difficulties, it is assumed he still has much work to do in order to learn to manage his risk factors. This work would best be done in a full confinement setting with ample treatment opportunity, and a less restrictive setting is not appropriate.

Regarding the specifics of a less restrictive alternative, this author is not aware of any proposal for a less restrictive treatment alternative being put forth by Mr. Stout. To the best of my knowledge Mr. Stout has

not been accepted into treatment by an outside certified sex offender treatment provider, nor has he arranged a housing situation that would meet the criteria necessary to fulfill the requirements of the statute. This author is not aware of Mr. Stout's willingness to comply with the requirements of supervision that would be recommended by the SCC, DOC, or the Court. He therefore appears to be lacking in several areas of a less restrictive alternative, and such a placement is not recommended at this time.

### Concluding Summary

Mr. Roy Stout has been found to meet the criteria of the RCW 71.09.020 as a Sexually Violent Predator, and was committed to the Special Commitment Center on 10.29.03. Mr. Stout was committed to the SCC because it was determined that he possessed mental abnormalities and/or a personality disorder which rendered him likely to engage in acts of sexual violence if not confined in a secure facility. His civil commitment, according to 71.09.060, is to continue under the care of the Department of Social and Health Services to ensure care, control and treatment until his condition has changed such that he no longer meets the definition of sexually violent predator or conditional release to a less restrictive alternative, as set forth in RCW 71.09.092, is determined to be in Mr. Stout's best interest and conditions can be imposed that would adequately protect the community.

It is my professional opinion that Mr. Stout appears to continue to meet the definition of a sexually violent predator. Mr. Stout's present mental condition seriously impairs his ability to control his sexually violent behavior. Secondly, it is my professional opinion that, considering the less restrictive placement options currently available to him known to this author, Mr. Stout's condition has not so changed that conditions can be imposed that would adequately protect the community, and a less restrictive alternative would not, at the present time, be in his best interest. I do not recommend that the court consider a less restrictive placement for him at this time.

Respectfully submitted,



Paul Spizman, Psy.D.  
Licensed Psychologist

# APPENDIX B

## SPECIAL COMMITMENT CENTER ANNUAL REVIEW

(August 2010 – September 2011)

Name: Roy Stout  
Date of birth: 06.14.59  
Jurisdiction: Skagit County Superior Court  
Cause #: 01-2-01307-9  
Commitment date: 10.29.03  
Evaluated by: Paul Spizman, Psy.D.  
Date of report: November 8, 2011

### Reason for Referral

Mr. Roy Stout is a 52-year-old Caucasian man whose history includes recurrent sexually coercive and violent offenses against adult women with whom he had no meaningful prior relationship. On 10.29.03 Mr. Stout was committed to the Special Commitment Center (SCC) for care, control, and treatment of his sexually violent behaviors and mental abnormality in accordance with RCW 71.09.060 (1). Pursuant to RCW 71.09.070, the purpose of this report is to evaluate whether Mr. Stout continues to meet the definition of a sexually violent predator and to assess whether conditional release to a less restrictive alternative is in his best interest and conditions can be imposed that would adequately protect the community.

### Evaluation Process

At the Special Commitment Center, the annual review of a resident's treatment progress is a multi-disciplinary process in which clinical information is synthesized from multiple data sources. Previous evaluations are reviewed, especially those conducted pursuant to RCW 71.09.040 (4). The evaluation includes a review of treatment participation and progress in order to determine whether the resident's risk for criminal sexual acts has been mitigated through sex offender treatment. Documentation and clinical impressions on the extent and quality of the resident's involvement in activities such as sex offender group therapy, psycho-educational classes, and individual therapy are also reviewed. The evaluator discusses treatment progress with the resident and discusses the resident's progress with other SCC staff. The resident is given the opportunity to participate in a clinical interview to assess his mental condition and answer questions about his experience and perceptions of his sex offender treatment.

### Relevant Background

The background information for this report was compiled from previous clinical and legal documents. Reviewing such evaluations to obtain historical information is an accepted standard of practice among mental health professionals. Please note that the historical information compiled in evaluation reports is often from a variety of sources and its presentation here is not intended to represent it as fact. Histories usually contain inaccurate and sometimes contradictory information. The information is presented to inform the reader of the information that was reported to the evaluator and to indicate this evaluator's understanding of the relevant history. The residents also have the opportunity to provide information regarding their history. This can occur during the clinical interview or by providing information to staff, who can then forward it to the forensic unit. If information in this report is found to be incorrect, it can be corrected in subsequent reports, or if needed an addendum can be written to the court.

Material for the historical sections of this report was taken mostly verbatim from the SCC Annual Review completed by Daniel Yanisch, 8/29/06, who cited a prior Annual Review completed by Mark McClung, M.D., SCC Consulting Psychiatrist as his primary source. Other information that may be included is from the End of Sentence Review report, completed by Carla van Dam, Ph.D., 7/9/01. This information is included at the end of this report.

Records reviewed for this report included those available at the SCC Records Center as of 9/29/11. However, at times records may come to the SCC Records Center past that date, which occurred prior to that date, and would be included in next year's Annual Review.

## **Treatment Progress at the Special Commitment Center**

### Medical and Psychiatric Treatment

#### *Dr. Randall Griffith, ARNP*

Dr. Griffith discussed Mr. Stout's health and medical status. Regarding any substantial medical concerns, he is a smoker. Mr. Stout also was diagnosed with prostate cancer. He went through radiation treatment for the cancer and currently does not show any signs of progression of the cancer. He is also using hormone therapy, to slow down the progression of the cancer (this could potentially effect libido and erectile functioning).

Dr. Griffith then noted that Mr. Stout has also been routinely attending the medical clinic and much more involved in his healthcare than he was previously. However, his compliance with medical advice fluctuates (his willingness to proceed with recommended treatment is ambivalent at best, often driven by what his wife tells him that he should or not do).

Dr. Griffith also related that Mr. Stout agreed to a colonoscopy, in which there were some polyps found, which were not cancerous at this time. Regarding other aspects of his health, his blood pressure is in borderline need of medication, but he is resistant to treatment and medication is not being used at this time.

Regarding strength, mobility, and endurance, these characteristics may be impacted by the antiandrogen therapy and resulting loss of muscle. However, Dr. Griffith related that Mr. Stout was not particularly muscular to begin with. Regarding erectile functioning, at his age there would be some expected dysfunction, which could be further impaired by the smoking and hormone therapy, but there are no complaints at this time.

### Extracurricular SCC Activities (Employment, Recreation, Education)

Residents at the SCC are eligible for paid employment if they complete a required Industrial Safety course that is offered through the SCC Vocational Department. Their work is evaluated by supervisors on a regular basis, and they receive regular Job Performance Reports. Documents did not reflect any employment reviews during this annual review period (however, progress notes, cited below, indicate he was working).

The SCC has a Recreation Department that residents can attend to participate in individual or group activities, hobbies, etc. Documentation did not reflect Mr. Stout engaged in any formal recreation during the period under review.

Pierce College has a program established to provide services to the residents of the SCC on McNeil Island. Documentation did not reflect Mr. Stout participating in any educational pursuits during the period under review.

### Residential Functioning

While Mr. Stout was often able to maintain appropriate behavior on the living unit, he had some verbal outbursts. Furthermore, his use of the shared resident payphones later in this review period (primarily speaking to his wife) was specifically problematic. A sample of progress notes is given here.

A note of 9/19/10 described staff informing Mr. Stout he had to remove items posted to his room door. Mr. Stout needed a second reminder, at which time he tore down the items and loudly stated, 'Jesus Fucking Christ!' He was later in front of the staff desk stating 'it's all down now! Okay!' It was noted he appeared to be struggling to maintain his composure.

A note of 9/30/10 indicated Mr. Stout was working with the SCC dietician to improve the quality of the vegan meals. He was described as typically spending time in his room while on the residential unit, rarely visiting another resident's room, or speaking on the phones. He was rarely in the dayroom of the living unit, Recreation Center, or the yard area. However, he would socialize with peers at times. Other notes (e.g. 10/15/10; 12/31/10) described similar behaviors (though, it was also noted he was often in his room asleep during the day, due to his work schedule).

On 10/22/10 Mr. Stout discussed his physical discomfort with residential staff. Mr. Stout stated he had a blood draw after which he had pain and difficulty bending his arm. He requested to then obtain his meals on the living unit, rather than go to the Dining Hall. When his request was declined, he became 'angry and started yelling and cussing.'

A note of 3/4/11 indicated Mr. Stout was planning an upcoming marriage. He was spending considerable time on the phone, at times considered excessive (apparently dealing with the paperwork regarding the marriage or speaking to people about the upcoming event). On 2/17/11 it was noted the marriage was to a woman Mr. Stout had met over the phone, but no other specifics were noted.

A note of 3/31/11 described Mr. Stout as respectful toward other residents. Two residents he spends time with (DD 490100 and CR 490331) were cited. He would often greet staff and discuss his off island medical trips.

On 4/7/11 Mr. Stout was directed to remove a hand-made towel hanger from his door. He explained he had used it to cover his window while dressing. However, he adhered to staff request to remove the item.

On 4/29/11 it was noted Mr. Stout may approach the staff for needs (e.g. phone calls). However, he would seem to become upset when a situation would not go as Mr. Stout wished, at which time he would 'rant and rave' for a few minutes. No other specifics were noted about these situations, however, it seems this was the time period he was planning his wedding and may have been under stress.

On 6/22/11 Mr. Stout appeared to become a bit upset (e.g. raising his voice) when informed he would have to ship out items he owned that were in excess of what is allowed. However, he later apologized for becoming upset.

On 7/10/11 it was noted Mr. Stout's wife had recently moved into a trailer that was on the property of another resident's (RR 490384) wife's property. His wife apparently had been residing with another resident's (CM 490224) mother and it was noted these 'conditions...were not the best.'

On 7/13/11 it was noted Mr. Stout had been temporarily suspended from his employment, as he had failed to attend the Industrial Safety course in a timely manner (he subsequently completed the course).

Notes (e.g. 7/13/11) indicated other residents had spoken to Mr. Stout about his excessive phone usage.

On 7/18/11 staff spoke to Mr. Stout about his excessive phone usage (typically speaking to his wife). He then spoke to his wife on the phone and informed staff he was trying to arrange a specific calling schedule with her (which he had attempted before, but apparently this failed). In discussing the situation with staff, Mr. Stout became frustrated, and regarding the other residents' concerns about his use of the phone he stated 'fuck these guys.' Staff indicated it was apparent Mr. Stout was under stress regarding 'everything' (no specifics noted) occurring with his wife.

A note of 7/19/11 referenced Mr. Stout continuing to spend excessive time using the phone.

A note of 7/21/11 described Mr. Stout as friendly and interacting well with his peers.

On 7/24/11 Mr. Stout spoke with staff about his wife's living situation and trying to have her somewhere that she is comfortable, which he had finally apparently obtained (apparently referencing the trailer she was living in).

A note of 7/26/11 described Mr. Stout as friendly and that he enjoyed initiating conversations. He continued to spend time on extended phone calls.

Another note of 7/26/11 indicated Mr. Stout was often using the phone in the day and during the evening. This continued despite staff speaking to him about the issue.

On 8/12/11 Mr. Stout 'snapped' at staff who documented his phone call (as instructed). However, he later apologized.

A note of 9/6/11 indicated difficulties continued with his extensive phone use, including Mr. Stout apparently trying to hide from staff (behind the phone). This behavior was noted at other times (e.g. 8/31/11).

#### Behavioral Incidents

Incidents at the SCC most often are documented with a progress note. However, if there is a more notable (but not necessarily negative) event, an Observation Report (OR) may be used. If the incident is specifically problematic, it will generally result in a Behavior Management Report (BMR), and possibly an Incident Report for the most serious occurrences. An Administrative Review may be held to investigate an incident or clarify sanctions against a resident who receives a Category 1 BMR. Residents may also file grievances or abuse complaints against staff and policies. For the purposes of this report, all of these sources of documentation were reviewed by the evaluator for the period under consideration.

9/20/10 BMR: Mr. Stout was noted to continually complain about how the food serving area was set up in the Dining Hall. He complained of items being dropped or dripped into his no egg and no dairy diet. He was considered to be harassing the food service staff and was restricted from attending the Dining Hall for 90 days.

A letter of 2/4/11 from Mr. Stout requested that Don and Treva B. be removed from his approved visitor list. I did not find any indication as to why this request was made or who these people are in relation to Mr. Stout.

A memo of 4/30/11 indicated Monica W. (his future wife) was approved for visitation.

5/17/11 OR: Mr. Stout answered the resident phone (and appeared to stay a while on the phone) during an alarm and resident evacuation.

5/19/11 OR: Mr. Stout was noted to be congenial and polite and appeared 'upbeat' in his mood. It was noted he would speak to his peers for short periods of time and had no difficulties interacting with others.

7/19/11 OR: Mr. Stout yelled and cursed at another resident (DB 490189) when the phone rang. He later approached staff and apologized (but it was not noted whether he apologized to the other resident).

7/24/11 OR: Mr. Stout asked staff to phone 911, due to a situation with his wife (in Mount Vernon, WA) as someone was outside of her trailer (no other specifics were noted). Mr. Stout later indicated his wife had been able to remedy the situation. It was noted that he appeared to be dealing with issues regarding her security and safety and he stated that he may be using the phone for extended periods of time.

7/27/11 BMR: Mr. Stout had staff place a legal call, which was actually a call being made for his wife.

7/28/11 OR: Mr. Stout was using the resident payphone so often that other residents had begun to complain. It was noted there were only short intervals between the calls. Despite staff speaking to him about the concern, he had not altered his behavior.

#### Treatment Progress Information from Documents Reviewed

Documentation reviewed did not indicate Mr. Stout had participated in any sex offender specific treatment activities during the period under review.

#### Resident's Strengths

Mr. Stout often is able to relate well with others. He also has demonstrated strength in his employment efforts. Finally, he is often able to comply with the rules of the institution.

#### Collateral Interview

*Sharon Merkle, residential staff*

Mr. Stout has been residing on his current living approximately six months and Ms. Merkle discussed his behavior.

She described how he is continually on the phone with his wife, with continuing complaints from other residents (as noted above). He is being considered for a move off of his current placement (Redwood) as it is a low management housing unit and he is having ongoing difficulties with his phone usage. She stated his move would probably happen the week of our conversation.

She related that, overall, he 'does fine,' however, the 'biggest issue is the phone.' He has been spoken to numerous times about his phone use, which he says he will correct, but it has worsened.

His wife calls in quite often, but Ms. Merkle was uncertain as to why. Regarding her knowledge of Mr. Stout's wife, Ms. Merkle noted the wife reportedly has various medical concerns, due to prior abuse in a relationship, and she is on disability. Ms. Merkle related that Mr. Stout has been under stress about his wife's various concerns, such as finding her a good place to live or sending her money. Ms. Merkle noted there are continuous issues that arise with his wife. However, he does not often discuss the relationship.

In regard to his ability to relate to others on the living unit, they are very agitated due to his phone behavior, and they do not speak to him. There is constant tension with the other residents and he does not

socialize with any of them. She noted that Mr. Stout is 'basically ousted' due to the phone issue. Ms. Merkel noted that outside the facility, Mr. Stout has discussed a longtime friend, who is helping Mr. Stout's wife. Mr. Stout also has a connection to the mother of another resident CM 490224 (who his wife was living with), but Ms. Merkel noted that Mr. Stout is never seen socializing with others. She noted that he is either on the phone, in his room, outside smoking (not socializing at these times), or doing his job.

I then inquired regarding specific dynamic risk factors.

She noted he does not demonstrate any emotional identification with children, such as viewing child oriented media or spending time with childlike peers.

Regarding any hostility toward women, he does not demonstrate any specific problematic behavior toward women.

Regarding a lack of concern toward others, she cited the phone use. She noted that despite being spoken to about reducing his phone use, she stated he simply does not care about his peers being inconvenienced. However, she did not have other specific examples of callous behavior toward others, noting how little he is active with others.

Ms. Merkel indicated that Mr. Stout does not discuss his sexual thoughts, feelings, behaviors, or attitudes and I did not inquire about related risk factors.

When asked about Mr. Stout's cooperation with supervision, Ms. Merkel again cited the difficulties with the phone (as he has been spoken to by staff and still does not comply). She noted he can also be argumentative at times. For example, she stated the staff has been trying 'for some time' to get him in compliance regarding the limits of his property. However, he will argue or debate about what property he can have. While his property level has improved, he is still not in compliance. However, she noted that overall, he will typically comply with supervision.

Regarding any impulsivity, she noted he is quick to have an impulsive verbal outburst when upset (see documentation noted above, for examples). She could not cite other specific examples of impulsivity.

Regarding problem solving skills, she acknowledged he has not been able to effectively problem solve the difficulty with the phone. She also noted that instead of talking through a difficulty he will have a verbal outburst (as cited above). After an outburst, he will later apologize for the incident. However, he still has difficulty solving the problem later, as he does not integrate feedback to actually change his behavior to solve the problem. Rather, he will simply engage in the problem behavior again.

Regarding any negative emotionality or hostility, she noted she has never seen him in what appears to be a positive mood. She described the ongoing difficulties with the phone and how he keeps his distance from others. She also cited how he has a 'very short fuse' and on occasion he will 'blow up at whatever' (as noted above, he will later apologize).

*Thyrion Moore, residential staff*

As Mr. Stout was placed onto a new living unit around the time of his marriage, and much of the above noted behavior seems to be based on his new marriage (e.g. speaking to her on the phone), a staff from Mr. Stout's prior living unit was briefly interviewed. Mr. Moore stated that prior to Mr. Stout meeting his wife, he did not create a lot of difficulties and related relatively well with others. However, Mr. Moore also noted in the few instances of difficulties that did occur, it was quite remarkable. As an example Mr.

Moore commented on Mr. Stout's difficulties in the Dining Hall when he was unable to have his desires met regarding his meal (see 9/20/10 BMR). However, apart from these difficulties, he was typically compliant with supervision and was not acting in a particularly callous way toward others.

### **Current Mental Condition**

On 9/6/11 I spoke to Mr. Stout and inquired if he wished to participate in the interview or physiological testing for his Annual Review. Mr. Stout referred me to his attorney, but I stated I needed the response from him. We agreed he would be given until the beginning of the next week to reach his attorney and have a response when I phoned back. I then spoke with Mr. Stout on 9/15/11 and he had not spoken to his attorney. He declined to participate in physiological testing but sought more time to reach his attorney, prior to responding to whether or not he would participate in an interview. I then explained to him that he had been given ample time; over one week, to reach his attorney, and as such I needed a response regarding whether or not he would participate in an interview. He could not answer until speaking to his attorney. I then informed him that if he would not set an interview with me during our call, I would indicate that he was declining to participate. He stated he was not declining but sought to speak to his attorney prior to answering. I informed him that I would detail all of this in my report, but still needed an answer. He declined to set an appointment to interview and I am taking this as declining to participate.

### **Diagnosis and Mental Abnormalities**

**Axis I: Paraphilia, NOS (Non-consent), Rule Out.**

Mr. Stout has been arrested or convicted of sexual offenses against adult women with whom he had no prior meaningful relationship. The incidents were non-consensual, and he did not stop his actions in the presence of clear signals of fear or signals to stop from the victims. However, the assaults did not clearly indicate a desire for non-consensual sexual activity. Rather, it appears he often sought consent, but when it was not obtained, this did not prevent him from pursuing the woman. However, one documented assault did not involve any apparent interaction prior to the assault and the attempted forced sex. Overall, there was some uncertainty of his exact desire/drive, with one assault I believed to clearly indicate a drive for nonconsensual sex. Therefore, I previously opined that Mr. Stout met the criteria for this disorder.

At this time, Mr. Stout is over age 50, a point that I now consider him to be an older sexual offender. Research demonstrates that as a man enters his older years, his sexual interest and behavior typically decline. While I have very limited information about Mr. Stout, if he is following this typical course, it would logically follow that any sexual drive toward rape has also decreased. In the sex offender population, rape of an adult female by a man past the age of 50 is quite uncommon. Thus, there is some uncertainty as to how strong a desire he initially had for nonconsensual sex, with even greater uncertainty now caused by his advanced age. Therefore, at this time, I am providing this diagnosis as a rule out, to indicate the significant uncertainty in whether or not Mr. Stout continues to meet the criteria for this disorder. The rule out specifier indicates that further information (e.g. obtained through interview or physiological testing) could provide information that would indicate this is an appropriate diagnosis, or it is ruled out.

### **Polysubstance Abuse, In a Controlled Environment**

Mr. Stout has reported various difficulties related to substance abuse. For example, that his first marriage ended due to his drinking, and he has admitted that alcohol was associated with his offending behaviors. He has stated that he "moved Pruno [homemade fermented beverage] around within institutional confines" and has related that once he started drinking, he just did not know when to quit. He has also

reported that he used to get belligerent and violent when drinking. He has admitted to marijuana use in the past, and attributed one of his assaults to dealing marijuana. He also acknowledged heroin use over a number of years. He has reported being abstinent from alcohol and drug use since 1983.

Given the aforementioned substance abuse, the diagnosis is given. The specifier of In a Controlled Environment indicates that Mr. Stout does not have easy access to substances, and while there is no reported use during this review period, he may again engage in substance abuse in a less controlled setting.

**Axis II:                    Antisocial Personality Disorder, Provisional**

Mr. Stout has a significant history of problematic behaviors as a juvenile. He was reported to have a significant problem with skipping school and was expelled from several schools due to truancy. Furthermore, he has a remarkable criminal history that was documented beginning at age fifteen. While these behaviors did not occur prior to that age, as is necessary for the diagnosis, it may be assumed that these were part of an ongoing pattern, given the extent of the problems.

Mr. Stout's criminal behaviors continued into his adult years, clearly indicating failure to conform to norms with respect to lawful behavior. Some degree of impulsivity was apparent in his substance abuse, several of his assaults, and may have been present in other areas of his life. His irritability and aggressiveness are apparent, such as receiving infractions while incarcerated for fighting with other inmates as well as threatening staff. A degree of irresponsibility is also present, such as a sporadic work history (it was unclear to what extent incarceration may have interrupted his ability to maintain employment). Finally, it does not appear he experiences significant remorse for his assaults and other criminal behavior, given his continued offenses across time.

However, research demonstrates that as a man reaches his fifties, many of the antisocial traits will 'burnout.' With Mr. Stout, while we still see some evidence of difficulties (e.g. his apparent indifference to other residents regarding phone use), there is limited demonstration of antisocial behavior. Therefore, I have rendered this diagnosis as provisional to indicate that at this time Mr. Stout appears to still have some antisocial traits, however, further information may indicate this diagnosis is no longer warranted.

**Borderline Intellectual Functioning**

Dr. van Dam's IQ testing with the WAIS-III during her 07.09.01 evaluation indicated that Mr. Stout functions in the borderline range of intelligence.

**Axis III:                    Deferred to medical staff**

**Sexual Violence Risk Assessment**

Actuarial Risk Assessment

The Static-99R is an actuarial instrument designed to estimate the probability of sexual recidivism among males who have already been charged or convicted of at least one sexual offense against a child or non-consenting adult.

The Static-99R has shown moderate accuracy in ranking offenders according to their relative risk for sexual recidivism. Furthermore, its accuracy in assessing relative risk has been consistent across a wide variety of samples, countries, and unique settings (Helmus, 2009).

For the Static-99R, there are four groups with which evaluator's can compare an individual's score. In order to evaluate Mr. Stout, we need to consider the extent to which he resembles the typical member of the routine samples or non-routine samples, or if he is more representative of the samples preselected for treatment or the high-risk / high need samples. I have used the recidivism rates from the preselected high risk and need samples because Mr. Stout has been determined to be a sexually violent predator and the authors of the measure, authorities within the field, recommend using these norms for those found to be SVPs unless otherwise justified.

On the Static-99R, Mr. Stout scored a 5. This yields a risk estimate of 25.2% in five years and 35.5% in ten years.

The recidivism estimates for the Static-99 are based on logistic regression. The regression curve incorporates offender recidivism at all different scores in the measure, providing an estimate of predicted recidivism rates for each score. Therefore, the estimate of 35.5% is not to indicate offenders with similar scores to Mr. Stout reoffended at that precise rate. Rather, the regression curve estimated that offenders with that score reoffended at that approximate rate.

#### Dynamic Risk Factors

The primary goal of sex offender treatment is to address those risk factors that can be modified through intervention (dynamic risk factors) so that Mr. Stout's risk can be managed to a point that he can safely transition to a less restrictive placement. In the professional literature certain dynamic risk factors have been linked to recidivism risk. They have been combined into an instrument called the STABLE-2007. The following section includes risk factors from this instrument and others that are considered pertinent. While this instrument was designed for offenders in the community, it is believed it can still provide some useful information about someone in full confinement. However, the information in this section is greatly limited, due to Mr. Stout's lack of participation in an interview, physiological testing, or treatment.

#### Significant Social Influences

At this time, a key social influence appears to be his wife. While I have limited information regarding this relationship, one obvious area of concern during this review period was his use of the phone, which seemed to be primarily related to speaking to his wife. Thus, he was repeatedly engaged in a problematic behavior, despite apparent attempts to curb it (by speaking to her about the amount of time on the phone). Thus, she seems to at least have some negative influence upon him. Of course, she may also have positive influences that I am aware of.

Overall, at this time, based on limited information, I have some concerns regarding the influence of his wife.

#### Intimacy Deficits- Capacity for Relationship Stability

Mr. Stout has been married twice. One of the relationships was of significant duration, with the other union lasting less than 30 days. However, there is no distinct evidence that these unions were positive and caring marriages. Rather, the comment that his first marriage ended due to his drinking, and the short time of the second marriage, indicate they both may have been problematic relationships.

He has also recently married, but I have very limited information about this union.

At this time, I have concerns about this being an ongoing risk factor, until such time I can gather information regarding his current marriage that could possibly offset this concern.

Intimacy Deficits- Emotional Identification with Children

There is no significant evidence of this risk factor either in the past or currently.

Intimacy Deficits- Hostility Toward Women

Mr. Stout has been married previously and as noted above it does not necessarily seem these were positive unions. Furthermore, his assaults appear to indicate that he views women in a manner to use them sexually. Based upon his history, I did not find evidence of more positive relationships with women. Rather, his relationships may have been conflicted, perhaps in his marriages, or an attempt to use women as sexual objects, such as during his assaults. Therefore, historically he demonstrated a degree of risk on this factor.

However, he has again married and appears to demonstrate concern for her welfare. Furthermore, there is not marked evidence of this risk factor in his interactions with female staff. Thus, he appears to be learning to control this risk.

Intimacy Deficits- General Social Rejection/Loneliness

There is inadequate information to gauge this risk factor at the time he was offending.

Prior to his recent marriage, it seems Mr. Stout was able to relate adequately with others. However, due to his excessive phone use he has angered his peers. Unfortunately, without information from an interview, I cannot assess his reaction to the difficulties with his peers, to assess if he feels specifically rejected and lonely. Of course, his relationship with his new wife may offset any loneliness he could be experiencing.

Overall, at this time, while I have some concerns, I cannot indicate this is a notable area of risk.

Intimacy Deficits- Lack of Concern for Others

Mr. Stout has a long history of assaults and threatening others, beyond just his sexual offending, both in and outside of confinement. Furthermore, he has various theft charges, including forgeries against his own mother. While information is limited, it seems he was high on this risk factor at the time he was offending.

At this time, the only relationship he appears to demonstrate any concern in is with his wife. While he does not often appear to be specifically callous toward his peers, his apparent indifference to their concerns regarding his phone use obviously demonstrates this risk factor.

Overall, he continues to demonstrate some (albeit not particularly notable) aspects of this risk factor.

Sexual Self-Regulation- Sexual Pre-occupation

There is inadequate information to gauge this risk factor, either at the time he was offending, or currently. However, as a man enters his older adult years, there is typically a decrease in sexual interest and behavior. Thus, Mr. Stout is likely experiencing this normal decline, which would reduce this risk factor from his earlier years.

Sexual Self-Regulation- Sex as Coping

There is inadequate information to gauge this risk factor, either at the time he was offending, or currently. Similar to sexual preoccupation, as there may be a reduction in general sexual functioning, there may also be a decrease in any sexual coping.

Sexual Self-Regulation- Deviant Sexual Interests

Mr. Stout's sexual assaults appear to indicate deviant sexual interest. Whether or not he was specifically driven toward nonconsensual sex, or simply did not respond to the signals to stop his sexual pursuits, his forced sexual aggression may be arousing to him, which would indicate the presence of this risk factor. Currently, there is no information to gauge this risk factor at this time. However, as with the other sexual risk factors, age may contribute to a decline in this risk, as deviant sexual interests would assumedly decline along as sexual interest in general declines.

Attitudes Supportive of Sexual Assault- Sexual Entitlement

While I do not have specifics, it certainly appears Mr. Stout felt entitled to sex. Several of his sexual assaults began as an apparent attempt to engage in a mutual sexual encounter. However upon being rebuked, he continued his pursuit, apparently feeling entitled to sex. His current attitudes related to offending are unknown.

Attitudes Supportive of Sexual Assault- Rape Attitudes

Mr. Stout's sexual assaults indicate he held attitudes consistent with nonconsensual sexual activity. His attitudes at this time are unknown.

Attitudes Supportive of Sexual Assault- Child Molester Attitudes

There is no significant evidence of this risk factor either in the past or currently.

Cooperation with Supervision

Historically, Mr. Stout has done poorly cooperating with supervision. He has violated the conditions of his parole, and at one point was arrested as being a fugitive from justice. Furthermore, he has received infractions while incarcerated for fighting with other inmates as well as threatening staff. He has demonstrated a high level of this risk factor. Currently, he maintains himself to an adequate level. However, there are still some difficulties, such as his aggressive outbursts and problematic use of the telephone, and it appears this risk factor continues to a moderate extent, despite being in confinement.

General Self-Regulation- Impulsive Acts

Impulsivity was apparent in his substance abuse, several of his assaults, and may have been present in other areas of his life. Given the apparently impulsive nature of several assaults, this was a key risk factor at the time of his offenses. At this time he appears largely able to control his impulsivity, at least while in a confined setting.

General Self-Regulation- Poor Cognitive Problem Solving Skills

Historically, it seems Mr. Stout has attempted to solve difficulties in his life with substance abuse and aggression. Furthermore, it seems he has attempted to solve financial difficulties with theft or forgery. His varied and extensive criminal history demonstrates rather poor problem solving skills. Thus, this is considered a strong risk factor, at least during the time period he was offending.

During the current review period, staff noted Mr. Stout has been unable to effectively problem solve his use of the telephone. Staff also noted that instead of talking through a problem, he will have a verbal outburst. While he will later apologize, he still has difficulty solving the initial problem, as he does not

integrate feedback to actually change his behavior. Rather, he engages in the same problem behavior again.

Thus, this is an ongoing risk factor.

#### General Self-Regulation- Negative Emotionality/Hostility

Mr. Stout's prior threats and aggressive behavior demonstrate his hostility. This risk factor appears to have been present to a moderate extent during the time he was offending. At this time, he continues to demonstrate negative affect occasionally in his verbally aggressive behavior toward others. Staff also noted he does not often appear to be in a positive mood. Thus, this appears to be an ongoing risk factor.

#### Substance Abuse

Mr. Stout has a significant history of substance abuse. It seems he was drinking prior to at least one of his sexual assaults. Without further information it appears this risk factor was present to a moderate extent during the time he was offending. Currently, there is no indication of substance abuse, and Mr. Stout may be largely able to manage this risk factor at least while in a confined setting.

#### Mental Disorder and Risk for Future Sexual Violence

I previously rendered a diagnosis of Paraphilia, NOS, Nonconsent. However, as noted above, I am now uncertain in this diagnosis. Furthermore, I have some questions regarding whether an antisocial personality diagnosis is warranted. Thus, there is a degree of uncertainty whether or not Mr. Stout has an underlying mental abnormality or personality disorder that meets the criteria for civil commitment.

However, Mr. Stout also significantly limits the amount of information available to conduct this evaluation. He is not active in treatment, did not participate in an interview, nor did he participate in physiological testing.

Furthermore, he still demonstrates some aspects of dynamic risk factors and if he returns to substance abuse this may increase his risk.

Thus, at this time, based on available information, I believe he continues to have an underlying abnormality (based upon his ongoing personality disorder, possible aspects related to sexual deviancy, and dynamic risk factors) that meets the criteria.

Regarding risk of reoffense, Mr. Stout did not score in a particularly high range on a commonly used actuarial risk measure (after accounting for his advancing age). Thus, there is some uncertainty regarding whether or not he would be more likely than not to reoffend sexually if released unconditionally. However, it is only assessing detected recidivism and it is well accepted that many, if not most, sexual offenses go undetected. Therefore, his risk level is assumed to be higher than the measure demonstrates.

Overall, I believe Mr. Stout has a continuing abnormality that meets the criteria for civil commitment and that his risk level continues to remain more likely than not to reoffend if released unconditionally.

However, with his advanced age, this is becoming increasingly uncertain. Therefore, I encourage those involved in his case to consider placement into a less restrictive alternative setting (LRA). In that manner, Mr. Stout could be given a step-down placement, prior to reaching the point that he may be considered to no longer meet the criteria for civil commitment. I believe this could potentially be in his best interest and adequate to protect the community (of course, I would need to fully review the LRA prior to making this determination and deciding whether or not to recommend placement in a specific LRA).

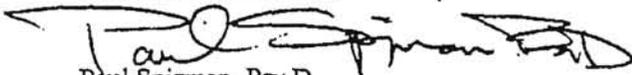
Of course, opinions and conclusions in this report could certainly change with additional information. As noted above, Mr. Stout significantly limits the information available to conduct this evaluation.

### Concluding Summary

Mr. Roy Stout has been found to meet the criteria of the RCW 71.09.020 as a Sexually Violent Predator, and was committed to the Special Commitment Center on 10.29.03. Mr. Stout was committed to the SCC because it was determined that he possessed mental abnormalities and/or a personality disorder which rendered him likely to engage in acts of sexual violence if not confined in a secure facility. His civil commitment, according to 71.09.060, is to continue under the care of the Department of Social and Health Services to ensure care, control and treatment until his condition has changed such that he no longer meets the definition of sexually violent predator or conditional release to a less restrictive alternative, as set forth in RCW 71.09.092, is determined to be in Mr. Stout's best interest and conditions can be imposed that would adequately protect the community.

It is my professional opinion that Mr. Stout appears to continue to meet the definition of a sexually violent predator. Secondly, I am currently unaware of Mr. Stout having any LRA placements potentially open to him in which I could recommend placement.

Respectfully submitted,



Paul Spizman, Psy.D.  
Licensed Psychologist

# APPENDIX C

## SPECIAL COMMITMENT CENTER ANNUAL REVIEW

*(October 2011 through September 2012)*

Name: **Roy Stout**  
Date of birth: **06.14.59**  
Jurisdiction: **Skagit County Superior Court**  
Cause #: **01-2-01307-9**  
Commitment date: **10.29.03**  
Evaluated by: **Daniel Yanisch, Psy.D., Certified Sex Offender Treatment Provider**  
Date of report: **01.31.2013**

### Reason for Referral

Mr. Roy Stout is a 53-year-old Caucasian man whose history includes recurrent sexually coercive and violent offenses against adult women with whom he had no meaningful prior relationship. On 10.29.03 Mr. Stout was committed to the Special Commitment Center (SCC) for care, control, and treatment of his sexually violent behaviors and mental abnormality in accordance with RCW 71.09.060 (1). Pursuant to RCW 71.09.070, the purpose of this report is to evaluate whether Mr. Stout continues to meet the definition of a sexually violent predator and to assess whether conditional release to a less restrictive alternative is in his best interest and conditions can be imposed that would adequately protect the community.

### Evaluation Process

At the Special Commitment Center, the annual review of a resident's treatment progress is a process in which clinical information is synthesized from multiple data sources. Previous evaluations are reviewed, especially those conducted pursuant to RCW 71.09.040 (4). The evaluation includes a review of treatment participation and progress in order to determine whether the resident's risk for criminal sexual acts has been mitigated through sex offender treatment. Documentation and clinical impressions on the extent and quality of the resident's involvement in activities such as sex offender group therapy, psycho-educational classes, and individual therapy are also reviewed. The evaluator discusses treatment progress with the resident and discusses the resident's progress with other SCC staff. The resident is given the opportunity to participate in a clinical interview to assess his mental condition and answer questions about his experience and perceptions of his sex offender treatment. As needed, psychological and / or physiological testing is requested to address specific areas. The results are incorporated into a final report to the Court. . It should be noted that this evaluator did submit a previous Annual Review of Mr. Stout in 2006, and has had no contact with him since then. Mr. Stout declined to participate in an interview as part of this evaluation.

### Relevant Background

Numerous evaluations about Mr. Stout have been submitted to the Court that provide ample data about his social, demographic, legal, and treatment history. The interested reader is referred to such documents for detailed information about him. In brief, he was born in 1959 to a military family that moved frequently. Reports from Mr. Stout have differed over the years as to the level of discord and violence in the home. Some reports indicate that when his father was drunk he would physically abuse Mr. Stout and other members of the family. However, he has denied sexual abuse occurring within the home. He was involved in Special Education classes while in school, and was regularly truant or would skip classes. He dropped out of school and left home at the age of 16, and he was quite transient. He reported driving or hitchhiking in every state within the continental United States, regularly coming back to Washington. He reports to have been employed installing telephone cables, as a telephone splicer, as a chef, as an auto

repair person, and doing general labor such as carpentry, dairy worker, or delivering firewood. In regards to substance abuse, again Mr. Stout has provided differing accounts. He denies having serious drug or alcohol problems, but has also stated that his first marriage ended due to his drinking, and that alcohol was associated with his offending behaviors. He claims not to have consumed alcohol or drugs since 1983, and he has not been involved in programming to address substance abuse through his incarcerations in DOC or the SCC.

Mr. Stout has an extensive history of illegal behaviors dating back to his teen years. These include driving violations, possession of marijuana, disorderly conduct and assault, interfering with the US Mail, truancy, arson, burglary, and violation of probation. As an adult, Mr. Stout was arrested for: theft, trespass, rape, forgery, fugitive from justice, domestic violence, indecent liberties with forcible compulsion, telephone harassment, and sexually motivated burglaries and assaults. His sexual offending behavior often involved following, isolating, and assaulting strangers with the intent of sexual contact. He would follow them on foot (from a bar), or in his vehicle, or over the telephone. Even when the woman clearly expressed resistance, Mr. Stout continued to press for sex and would take whatever sexual contact he could, including groping breasts, fondling genitals, and forced intercourse. He clearly felt entitled to sexual contacts with females, including developmentally disabled or intoxicated women. Mr. Stout has never participated in any sex offense specific treatment, even though such was recommended for him while he was in the community and in DOC. Since his arrival at the SCC in 2001 Mr. Stout has maintained a non-treatment stance in regards to participation in the therapy available to SCC residents.

### **Treatment Progress at the Special Commitment Center** (October 2011 through September 2012)

Records reviewed for the purpose of this annual review include documents from Mr. Stout's SCC file Bates numbered 002123 through 002470. In addition, prior SCC annual reviews from 2006 through 2011 were reviewed to gain a longer term perspective of his SCC involvement and activities.

An inspection of all SCC records generated about Mr. Stout for the current review period reveals that he has not taken part in any of the sex offender specific treatment groups. He has not requested or participated in any individual therapy or treatment planning sessions, despite being regularly asked via letter or memo about his interest to discuss case management issues.

The Treatment Plan dated 05.02.12 (002357) lists the following for Mr. Stout under *Responsivity Issues*:

In the past 12 months Mr. Stout has been addressed by the Treatment Team about his excessive usage of the resident telephone. During this process Mr. Stout has consistently demonstrated that he is reticent to cooperating with staff directives and SCC policies. His consistent disregard for explicit and repeated directives had resulted in his move to PA (Program Area) 2 and then to the development of a Current Conditions regarding his excessive telephone usage. Also, Mr. Stout currently rejects any involvement in sex offender specific treatment and has demonstrates (sic) low motivation for self mandated change. . . .

Intermediate Goal: Establish a working relationship with your assigned case manager. Discuss personal life goals and the internal barriers to achieving them. Overcome barriers to entering treatment.

Interventions: Meet monthly with case manager. Engage in open, honest, and respectful discussion about the PROs and CONs of entering sex offense specific treatment, specifically reducing time spent in elaborate complaints about SCC. Identify potential means of neutralizing, overcoming, or coping with the perceived negative impact of treatment participation.

OK

It should be noted that, in his almost 12 years at the SCC, Mr. Stout has consistently declined to take part in meetings that discuss treatment, and in which his treatment plan is designed. In a rare meeting with clinical staff on 05.02.12, Mr. Stout discussed his view of treatment involvement:

Mr. Stout was asked if he would consider entering treatment. He declined stating that his attorneys and his expert have advised him not to enter treatment. He states people who enter treatment are in it for years and they are still here. He asked why treatment at TRCC is done and completed, but when coming to the SCC they have to begin again. It was brought to Mr. Stout's attention that there have been a number of residents in treatment that have moved on to an LRA (less restrictive alternative) or SCTF (secure community transition facility). He still expressed no interest in the treatment process and declined. (002381)

On 07.30.12 Mr. Stout requested contact with his assigned Psychology Associate, Joe Coleman:

This writer met with Resident Stout at his request as he wanted to discuss his treatment plan, and some of the listed dynamic risk factors. Mr. Stout had questions about Substance Abuse still being listed as a risk factor for him. It was explained to resident Stout that the dynamic risk factors are assessed by an evaluator who determines if they are still a factor for him to work on. Mr. Stout argued that he has been sober a long time and that this was not a factor for him anymore. He was told that this has been in a controlled environment. Mr. Stout stated that he was hoping for an unconditional release and that he would never enter treatment. Mr. Stout was told his choices are his own and that he should read his last annual review to better understand which DRF's are still a factor for him. (002366)

### Current Medical Status

Past annual reviews indicate that Mr. Stout rarely would schedule or attend appointments with the Medical Department. He was noted to be a smoker, despite encouragement from medical staff to stop, and to have slightly elevated blood pressure. He is a long term vegan by preference. Beginning in 2010 he noticed blood in his urine, and, following a biopsy, he was diagnosed with prostate cancer. He was treated with radiation and hormone therapy in the Fall of 2011. By March of 2012, when his radiation oncologist was recommending a 6 month follow up by a urologist, Mr. Stout declined such an off island appointment / visit (002307). Mr. Stout also consulted with Medical staff about smoking cessation techniques. He reported smoking at least 1 pack per day since the age of 12. He started treatment with nicotine patches by January 2012.

It is worthy of note that Mr. Stout was unwilling to schedule appointments with medical staff to discuss his health issues at times the he was scheduled to have telephone contact with his wife (002296). He has refused to go on off-island medical appointments because it would mean he could not talk with her on the telephone. "I'm not going to go on any more off-island trips. It's an all day trip and I just sit there and talk for 20 minutes. . . I don't want to freak my wife out every time I go out. I don't want to be out for 4-6 hours for a 15-20 minute visit. You folks can monitor me here and if things change we'll see," (002295). However, he was also unwilling to have the necessary labs and checks done that would allow adequate monitoring of his prostate condition. He was similarly unwilling to participate in chest x-rays, and it was assessed that he "defers to his wife on question of medical decisions," (002456).

### Residential Functioning

As noted in the 2011 SCC Annual Review by Dr. Spizman, Mr. Stout became involved with a woman through the telephone, and eventually was married to her. Because of the extent of his telephone contacts with her, and the fact that other residents were upset about his abuse of phone privileges, Mr. Stout was moved to a different living unit in December of 2011. On one day Mr. Stout was observed making 13 telephone calls before 4:00 p.m. When staff tried to discuss this with him Mr. Stout tried to deflect the

discussion to another resident. It was noted on 12.20.11: "Resident Stout has been asked by staff over and over again to be respectful of his peers, and monitor his phone usage. Res. Stout continues to ignore staff direction and monopolize the phones all day every day." According to internal movement records (002123) he was moved from Elm unit to the higher management unit (Dogwood) on 12.21.11. Within 3 days of his arrival on Dogwood it was observed that he monopolized the phone from 6 a.m. up until 2:00 a.m., and that his peers were starting to complain.

By the end of January 2012 Mr. Stout's abuse of phone privileges resulted in treatment staff implementing a revision of his treatment plan (called a Current Condition or CC). Because he had been answering the phone for residents who were restricted from using it, and then passing on information between the parties, Mr. Stout was directed *not* to answer the telephone when it rang. He was also limited to five (5) telephone calls per day, of up to 30 minutes apiece, during specified time periods. This CC was renewed for at least the next 2 months, through April 2012. It was terminated on 05.03.12 (002355).

One residential progress note of interest is dated 02.16.12, and states: "Mr. Stout spends the majority of his time in his room. Since his marriage Mr. Stout's demeanor has changed he appears to be upset more often. I have observed him shouting and becoming very angry on the phone and when he realizes staff are aware of his anger he turns his body around so staff are unable to see his face while on the phone. He has been abiding by his phone CC," (002240). On 03.26.12 it was noted that he had synchronized his watch with the unit clock so that he and staff could more accurately time his half-hour long calls with his wife.

By the middle of June it was noted that Mr. Stout was self-monitoring his phone use much more effectively, using good judgment, and was more respectful and courteous with his peers (002377). However, by 08.05.12 he appeared to be reverting to some earlier behaviors:

I observed Mr. Stout on the phones more then (sic) any other residents on the unit, he is jumpy when the phone rings and he is not right by it, he will come out of his room every time the phone rings to see if it is for him and if he does not answer the phone he watches the person who answered it and waits for a few seconds before he will return to his room. He appears to make all his plans surrounding his phone calls and the phone calls do not always sound very pleasant. He has been changing the chair so staff are to his back while on the phone and unless we walk around him we are unable to detect if his call is upsetting or not. Also when staff walks the tier and walk past him while he is on the phone he will stop talking and wait and watch you walk by. I will continue to monitor and document any changes in routines or behaviors. (002364)

Residential progress notes and room inspection reports indicate that Mr. Stout keeps his room up to standards for the most part. On at least one occasion (002139) his personal hygiene was such that staff needed to talk to him about his body odor, but this did appear to be an isolated incident.

### Behavioral Incidents

Incidents at the SCC most often are documented with a progress note. However, if there is a more notable (but not necessarily negative) event, an Observation Report may be used. If the incident is specifically problematic, it will generally result in a Behavior Management Report (BMR), and possibly an Incident Report for the most serious occurrences. An Administrative Review may be held to investigate an incident or clarify sanctions against a resident who receives a Category 1 BMR. Residents may also file grievances or abuse complaints against staff and policies. For the purposes of this report, all of these sources of documentation were reviewed by the evaluator for the period under consideration.

An Observation Report was written on 10.24.11 when Mr. Stout was observed via camera giving another resident a cigarette butt.

When staff escorting another resident requested the pill line nurse deal with that resident before Mr. Stout so that staff could go about his other duties, Mr. Stout protested. "I asked calmly and very politely of resident Stout if I could have the resident with me step up to the pill line next. He replied, 'I mind. He can wait in line like everybody else.' His voice seemed harsh. I repeated my request respectfully and was told, 'No. There are escorts all the time, in the mail room, elsewhere. You can wait! He can go to the back of the line and wait like everybody else.'" Mr. Stout demanded "I want a supervisor right now!" when medical staff invited the other resident forward. Staff submitted an Observation Report on 11.23.11 because they believed Mr. Stout responded to a reasonable and respectful request in a way that was hostile, disrespectful, and less than compliant (002148). Mr. Stout did bring this to the attention of a unit supervisor later that same day, and another Observation Report was written about that interaction (002147). Mr. Stout was informed that staff needed to get back to their duties when they were escorting a resident, and that if he were the person being escorted he would be allowed to go ahead in line. During the conversation he continued to escalate and was informed that he "was blowing this whole thing out of proportion." He finally just walked away from staff.

The above situation was later determined to be a Category 2 BMR incident and was brought to Mr. Stout's treatment team. He was cited for Delaying Staff and Disruptive Behavior, and it was the treatment team's decision to suspend the automatic privilege level decrease for 60 days, provided he had no further BMRs in that time (002158).

An Incident Report (002150) was generated on 12.16.11 when Mr. Stout's wife contacted the unit administrator to report that another resident had threatened Mr. Stout for being on the phone too much. When Mr. Stout was asked about this by investigators, he denied being threatened and did not want to be placed in protective custody.

In June 2012 a family member notified clinical staff that Mr. Stout had been calling them collect, and indicating that he was going to be released from the SCC. This family member reported that Mr. Stout was using both the unit telephone and a cell phone. Since cell phones are considered contraband in this institution, a room search was conducted which did not reveal anything of interest, and certainly not a cell phone.

Numerous other Observation Reports were submitted by residential staff concerning Mr. Stout's telephone usage. They need not be described in detail since the information has been thoroughly covered already.

### Employment

Beginning in November 2011 Mr. Stout was working as a resident custodian, cleaning areas of the residential unit where he lived. He was regularly noted to arrive for work on time, and to complete his duties appropriately. He took a sick day on 01.01.12, and did not return to work for at least two weeks (002255). When residential staff asked him why he had stopped working on 01.16.12, Mr. Stout responded with, "I am not discussing that with you." Residential staff reported on 06.10.12 that he "just quit one day saying his wife did not want him to work anymore." (002390) Mr. Stout has not been employed since that time, yet he still appears to have money for personal items (and possibly cigarettes).

### Recreation

According to the SCC Recreation Specialist, Gordon Monk, Mr. Stout has not shown or expressed interest in any of the possible recreational activities available to him. "He meanders through the area aloof and amiable." He does not check out books or movies from the library. Periodically he may ask about special events that are coming up, and he did engage in some of those, such as the SCC Holiday party and Christmas caroling. He has also submitted entries to the Craft Sale. Sometimes he requests that

a photo be taken of him and a female visitor at the Visiting Center. There is no indication that he makes use of the music room, hobby shop, or exercise facilities.

A residential progress note from 07.04.12 states: "I observed Mr. Stout talking with his peers about going to the BBQ that SCC is providing to the resident's today. Today is the first time in a long time that Mr. Stout looked happy about anything. He was standing and waiting for the call to be made."

### Education

Pierce College Instructor Scott Mannering reported that Mr. Stout was *not* involved in any of their offerings during the current review period.

### Physiological Testing

There is no indication in the records reviewed that Mr. Stout has ever participated in a polygraph or penile plethysmograph assessment while he has been detained at the SCC or elsewhere.

### Psychological Testing

No psychological testing of Mr. Stout has been conducted during the current review period. It does not appear that he has undergone any psychological testing throughout his stay at the SCC.

### Collateral Interviews

#### Leslie Sziebert, M.D., SCC Medical Director

According to Dr. Sziebert, over the past year Mr. Stout has been treated with radiation to address prostate cancer. Prior to the radiation treatments he was placed on Lupron. The latest blood test "showed no evidence of cancer recurrence," so the Lupron medication should have been discontinued. More recently Mr. Stout is refusing to have anything to do with the Medical Department, though staff there do not know why this is. (Mr. Stout has engaged in similar refusal / resistance in the past.) Dr. Sziebert has had no psychiatric contacts with Mr. Stout to address mental health concerns.

#### Shauna Anderson, Residential Rehabilitation Counselor

Ms. Anderson has been working on Dogwood Unit where Mr. Stout resides for the past several years. She is an 11 year employee of the SCC and is very familiar with how this resident interacts with others and functions in the institution. Ms. Anderson reported that there has been little change with Mr. Stout during the current review period. She observed him while he was on the CC geared to monitor his telephone usage, and she indicated that he would "nitpick" the minutes of his phone calls to the point where it was "ridiculous." Now that the CC has been lifted, she observes that there continue to be problems. The other residents complain about the length of time he is on the phone, and those who answer the phone when she calls feel verbally harassed by his wife. (She is free in her use of profanity.)

Ms. Anderson estimated that 90% of the time that she is at work (from 9:00 a.m. to 4:00 p.m.) Mr. Stout is on the telephone. He will leave the unit for his meals, otherwise "he is absolutely just tied to that phone. Whenever a phone rings he is looking to see if it is for him. In the past he harassed people on the phone." She noted that his mood changes depending on how his phone conversations with his wife go. At times he will be shouting on the phone, then he goes to the smoking / fresh air pad where he smokes nervously, or will exhibit "just a foul attitude." She noted that Mr. Stout is no longer working because he has to be available for telephone calls with his wife. "I will say he has improved with getting off the phone when he sees that others need to use the phone."

In regards to the interactions Mr. Stout has with Ms. Anderson, again they almost always deal with issues surrounding the telephone. "He doesn't like to interact with me. It looks like he would prefer to interact with male staff. I have been here for 11-12 years. He doesn't intimidate me, and he doesn't like my

authority. He is cooperative with routine things, but when something is out of the norm he doesn't take that very well. For instance, with room inspections he is cooperative. . . . But when it is not a day to day thing he doesn't do well with change."

When questioned if she has observed any sexual preoccupation or sexualized content coming from Mr. Stout, Ms. Anderson stated, "I have never observed anything like that from him."

### Resident's Strengths

Aside from the incidents documented above, Mr. Stout is not seen as a significant behavioral management problem at the SCC. He has not acted out physically or aggressively against peers or staff. He maintains his room and hygiene adequately. He appears to have the mental ability to adequately take part in treatment groups and complete the required tasks if he decides to do so (though further testing might indicate that placement in the Special Needs track would be in his best interest).

### **Current Mental Condition**

Mr. Stout declined to participate in the interview for this annual review report, which places certain limitations on this evaluation. In particular, he declined to provide current first-hand information regarding his perspective on treatment, provide information that may not have been included in his records, or correct any misinformation in the records.

### Diagnosis and Mental Abnormalities

The following diagnostic impressions were formulated based on a review of Mr. Stout's records. He has carried essentially the same diagnosis since at least 2006, and I see no compelling reason to alter it at this time. The interested reader can review the rationale for this diagnosis as provided in the 11.08.11 SCC Annual Review submitted by Paul Spizman, Psy.D.

In summary, my current *DSM-IV-TR* diagnoses of Mr. Stout entails:

- Axis I:            302.9 Rule Out Paraphilia, NOS (Non-consent)  
                      305.00 Polysubstance Abuse, In a Controlled Environment (by history)
- Axis II:           301.7 Antisocial Personality Disorder  
                      V62.89 Borderline Intellectual Functioning
- Axis III:          Deferred to medical staff

### **Sexual Violence Risk Assessment**

#### Actuarial Risk Assessment

As Dr. Spizman noted in 2011:

The Static-99R is an actuarial instrument designed to estimate the probability of sexual recidivism among males who have already been charged or convicted of at least one sexual offense against a child or non-consenting adult.

The Static-99R has shown moderate accuracy in ranking offenders according to their relative risk for sexual recidivism. Furthermore, its accuracy in assessing relative risk has been consistent across a wide variety of samples, countries, and unique settings (Helmus, 2009).

For the Static-99R, there are four groups with which evaluator's can compare an individual's score. In order to evaluate Mr. Stout, we need to consider the extent to which he resembles the typical member of the routine samples or non-routine samples, or if he is more representative of the samples preselected for treatment or the high-risk / high need samples. I have used the

recidivism rates from the preselected high risk and need samples because Mr. Stout has been determined to be a sexually violent predator and the authors of the measure, authorities within the field, recommend using these norms for those found to be SVPs unless otherwise justified. On the Static-99R, Mr. Stout scored a 5. This yields a risk estimate of 25.2% in five years and 35.5% in ten years.

The recidivism estimates for the Static-99 are based on logistic regression. The regression curve incorporates offender recidivism at all different scores in the measure, providing an estimate of predicted recidivism rates for each score. Therefore, the estimate of 35.5% is not to indicate offenders with similar scores to Mr. Stout reoffended at that precise rate. Rather, the regression curve estimated that offenders with that score reoffended at that approximate rate.

Dynamic Risk Factors (specific risk factors noted in *italics*)

The primary goal of sex offender treatment is to address those risk factors that can be modified through intervention (dynamic risk factors) so that Mr. Stout's risk can be managed to a point that he can safely transition to a less restrictive placement. In the professional literature certain dynamic risk factors (DRFs) have been linked to recidivism risk. They have been combined into an instrument called the STABLE-2000. The following section includes risk factors from this instrument, and a few others that are considered pertinent to treatment progress at the SCC.

I outlined in his .08.29.06 annual review:

Mr. Stout appears to have significant difficulty in the area of General Self-Regulation. Records of his developmental years indicate numerous incidents of *impulsive acts* and *negative emotionality / hostility*. In addition, he has experienced difficulty with *substance abuse*, though there is not clear evidence of that occurring for his index or other more recent offenses. More likely, Mr. Stout would have difficulty due to *poor cognitive problem solving skills*. In the area of Intimacy Deficits, Mr. Stout is noteworthy for his *lack of concern for others*. He also exhibits a *lack of cooperation with supervision*. A careful review of his offenses provides evidence of a high level of *sexual preoccupation* as well as *sexual entitlement*.

Evidence of difficulty managing these dynamic risk factors has surfaced for Mr. Stout over the current review period. The preponderance of progress notes focused on Mr. Stout's use / misuse of the telephone in regards to contacts with his wife. While this may seem more an annoyance than a major concern, significant inferences can be drawn from the behaviors Mr. Stout demonstrated. Namely:

- He is significantly, and perhaps unhealthily, attached to his new wife. It is clear that Mr. Stout now structures his life around the contacts he has with her. He discontinued employment so that he can talk with her on the phone. He declines medical appointments if they cannot be scheduled around his phone calls with her. He appears to rely on her advice more than he does to the medical professionals' recommendations. This is of particular concern given that he has so recently been treated for prostate cancer, and is not getting the follow up care to monitor his current status. His emotional regulation appears to destabilize or be greatly impacted depending on the type of contact he has with his wife. (poor problem solving, lack of cooperation, negative emotionality)
- It contributes to conflicts with peers. Mr. Stout has attempted to monopolize the phones and intimidate other residents from using them when he is expecting to contact his wife. At times he would glare at his peers, pace around them while they were using the phone, or place notes "reserving" the phone for his use. Because of such conflicts he was moved from one residential unit to another more structured unit. There was also indication that he was being threatened by at least one other resident because of his phone misuse. (negative emotionality, lack of concern for others, relationship difficulties)

- Mr. Stout needed outside structure placed on him to monitor and control his use of the phone in this environment. He was not able to manage this on his own, even with immediate feedback given to him by his peers and staff. The Current Condition placed upon him for months guided not only him, but his wife, in how to limit their use of the phone. (poor problem solving,)
- When confronted about his telephone use Mr. Stout could become aggressive, angry, and disruptive. He appeared intent on doing what he felt he needed or wanted to do, regardless of how it impacted others. (negative emotionality, hostility, lack of concern for others)
- There appears to be a strong perseverative quality to Mr. Stout's need to be in contact with his wife. It is not known if this takes on a sexual aspect in their conversations together. Regardless, the strength of this need and how he puts it into practice is telling. Those contacts take precedence over all other aspects of his life. When he is restricted from free access he becomes irritable and unpleasant, anxious and demanding. (emotion regulation) .

### Mental Disorder and Risk for Future Sexual Violence

Mr. Stout has a rule out diagnosis of Paraphilia NOS (Nonconsent), coupled with Antisocial Personality Disorder and borderline intellectual functioning. The above noted dynamic risk factors intermingle with aspects of these diagnoses, leading to Mr. Stout's elevated risk of sexual offending. As I noted in the 08.29.06 SCC annual review (and as I still believe is an accurate formulation for Mr. Stout):

Mr. Stout's Antisocial Personality Disorder has manifested itself in many different ways throughout his youth and adulthood. It enabled him to engage in illegal and abusive behaviors without concern for the thoughts, feelings, or desires of the other people involved. It persisted despite numerous contacts with the legal system and significant legal and personal consequences. This mindset allowed him to take what he wanted when he wanted it without concern for his own welfare or the welfare of others. When coupled with sexual urges, it enabled Mr. Stout to aggressively pursue others that he thought might offer sexual services, even when they were clear that they were not interested and did not desire romantic or sexual contacts with Mr. Stout. When faced with rejection of his sexual advances, Mr. Stout did not step back from the moment and clearly think out his options, but impulsively responded with anger and aggression to take what he believed he deserved. . . .

His lower level of intellectual functioning also inhibits an accurate assessment of his current status, and may contribute to confusion about others' motives and intentions.

This combination of mental abnormalities and personality disorder impairs Mr. Stout's ability to control his behavior and places him at high risk for sexually violent offenses in the absence of any therapeutic or other intervention.

### **Progress toward Conditional Release to a Less Restrictive Alternative**

Mr. Stout has remained steadfast in his refusal to participate in the treatment that is available to him at the SCC. The fact that he does not provide staff information about his current sexual thoughts, urges, or behaviors does not allow for an accurate assessment of where he may be in regards to his level of risk. An evaluator is only able to proceed based on his previously documented thoughts, feelings, and behaviors. Mr. Stout has never readily given that. There is no indication that he has done anything to mitigate his level of risk through participation in treatment. It is telling that in one of his few contacts with clinical staff this past year he was clear that he hoped for an unconditional release, and was adamant that he would "never enter treatment."

I am not aware of any proposal for a less restrictive treatment alternative being put forth by Mr. Stout. To the best of my knowledge Mr. Stout has not been accepted into treatment by an outside certified sex offender treatment provider. He has not arranged a housing situation that would meet the criteria

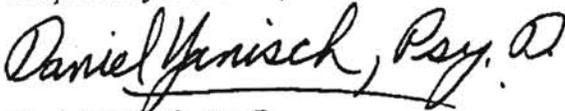
necessary to fulfill the requirements of the statute regarding placement of SVP's. I am not aware of his willingness to comply with the requirements of supervision that would be recommended by the DOC, the DSHS, or the Court. He therefore appears to be lacking in several areas of a less restrictive alternative, and such a placement is not recommended at this time.

### Concluding Summary

Mr. Roy Stout has been found to meet the criteria of the RCW 71.09.020 as a Sexually Violent Predator, and was committed to the Special Commitment Center on 10.29.03. Mr. Stout was committed to the SCC because it was determined that he possessed mental abnormalities and/or a personality disorder which rendered him likely to engage in acts of sexual violence if not confined in a secure facility. His civil commitment, according to 71.09.060, is to continue under the care of the Department of Social and Health Services to ensure care, control and treatment until his condition has changed such that he no longer meets the definition of sexually violent predator or conditional release to a less restrictive alternative, as set forth in RCW 71.09.092, is determined to be in Mr. Stout's best interest and conditions can be imposed that would adequately protect the community.

It is my professional opinion that Mr. Stout appears to continue to meet the definition of a sexually violent predator. Mr. Stout's present mental condition seriously impairs his ability to control his sexually violent behavior. Secondly, it is my professional opinion that Mr. Stout's condition has not so changed that conditions can be imposed that would adequately protect the community, and a less restrictive alternative would not, at the present time, be in his best interest. I do not recommend that the court consider a less restrictive placement for him at this time.

Respectfully submitted,



Daniel Yanisch, Psy.D.  
Licensed Psychologist  
Certified Sex Offender Treatment Provider  
Special Commitment Center  
253-756-3996

# APPENDIX D

**Richard Wollert, Ph.D.**  
Licensed Clinical Psychologist  
Oregon and Washington  
P. O. Box 61849  
Vancouver, WA 98666  
360.737.7712

May 7, 2013

Ms. Kelli Armstrong-Smith, Attorney at Law  
P.O. Box 13443  
Mill Creek, WA 98102

Psychological Evaluation of Mr. Roy Stout  
Skagit County Superior Court Case Number 01-2-01307-9

Dear Ms. Armstrong-Smith:

As you know, your office recently retained me to undertake a psychological assessment/evaluation of Mr. Roy Stout's current status on the sexually violent predator (SVP) criteria adopted by the Washington State Legislature. I understand that Mr. Stout, who is now 53 years old (date of birth: June 14, 1959), was adjudged to meet the sexually violent criteria and committed to Washington's Sex Offender Special Commitment Center (SCC) in October of 2003 and that the reason for evaluating him now is to determine whether he has so changed that he no longer meets the criteria.

Before the present evaluation I evaluated Mr. Stout in 2008, 2009, 2011, and 2012. I concluded that he no longer met Washington's SVP criteria in each evaluation.

After implementing the procedures below I have concluded in the present evaluation that Mr. Stout no longer meets the SVP criteria. My evaluation is set forth in the following sections.

**I. Expert's Assignment and Procedures Regarding Mr. Stout's Case**

To carry out my first two evaluations I examined many documents your office sent me, including Findings of Legal Fact made by Judge Susan Cook in October of 2003, a deposition by psychologist Dr. Richard Packard, Ph.D. (dated March 11, 2003), copies of evaluations of Mr. Stout by psychologists Dr. Betty Richardson, Ph.D. (dated February 22, 2001) and Dr. Carla van Dam, Ph.D. (one dated July 9, 2001 and a revision dated July 28, 2001), handwritten notes describing an interview Dr. Packard had with Mr. Stout on September 12, 2002, and Annual SCC Reviews completed by Dr. Jason Dunham, Ph.D. (October 10, 2004), Dr. Mark McClung, M.D. (January 25, 2006), Dr. Daniel Yanisch, Psy.D. (August 29, 2006), Dr. Paul Spizman, Psy.D. (October 10, 2007;

September 2, 2009; October 2, 2010; and November 8, 2011), Dr. Christopher North, Ph.D. (October 15, 2008), and Dr. Henry Richards, Ph.D. (September 12, 2011). I also reviewed SVP evaluations of Mr. Stout I completed in September of 2008, December of 2009, January of 2011, and February 2011 (an addendum to my January 2011 evaluation), interviews I completed with Mr. Stout in August of 2008 (in person), December of 2009 (in person), and January of 2011 (by telephone), and an interview I completed with his fiancé Ms. Monica Wolfe in January of 2011. I also completed a new interview of Mr. Stout by telephone on March 17, 2012 and a new telephone interview of Monica, who married Mr. Stout in June of 2012, on March 14, 2012. Then I scored Mr. Stout on the MATS-I actuarial instrument and answered your referral questions.

To carry out my present assignment I reviewed some of the foregoing documents, my 2012 evaluation of Mr. Stout, and about 2550 pages of file materials your office sent me on a CD. The CD contained Bates-stamped documents 0001-1959 and SCC-stamped documents 1950-2564. These documents included Mr. Stout's most recent Annual Review, dated January 31, 2013, by Dr. Daniel Yanisch, Psy.D. I also completed a new in-person interview with Mr. Stout on April 10, 2013, and he called me a couple of times to give me the numbers of some possible collateral informants. After carrying out these procedures and summarizing Mr. Stout's case history, I answered your referral questions. I have emphasized some observations and facts in the following sections by putting them in bold typeface.

## II. A Chronological History of Mr. Stout's Case Based on File and Interview Data

From my examination of the file materials pertaining to Mr. Stout and my interviews with him I compiled the following case history. The sources of the events in this history are included in parentheses so that, for example, "CVD" means an event that was reported in Dr. Van Dam's evaluation, "RP" refers to Dr. Packard's evaluation, "FOF" refers to Judge Cook's Finding of Legal Facts, "PS07" and "PS09" refer to Dr. Spizman's Annual Reviews for 2007 and 2009, respectively, and DY13 refers to Dr. Daniel Yanisch's 2013 evaluation. The page or pages on which an event is reported in a reference has been cited after the reference's abbreviation.

Mr. Stout was born in 1959, and grew up with two brothers and three sisters. His father was in the military and his family moved frequently. Although he denied ever being sexually abused he has told one investigator that "when dad was drunk he was violent." (PS09-15).

He took some beer from his family's refrigerator and drank it when he was 6 years old, but "was severely punished and did not try beer again until about age 16" (PS10-14).

He completed the eleventh grade but was assigned to Special Education classes and was expelled because of truancy problems (PS10-13). During our interviews he told me that "I was put in a Special Education class because I wouldn't do the homework. I was 7 or 8. I went back to the regular class room about 6 months later."

The following bullet points summarize his juvenile criminal history:

- His first legal difficulties occurred in June of 1974, when he was 15 years old, after he took his uncle's car without permission and had an accident: He was cited for Operating a Vehicle Without a Valid Driver's License (PS10-14).
- In July of 1974 he was arrested for Possession of Marijuana.
- In September of 1974 he was declared a Delinquent Ward of the State and assigned special supervision after he assaulted two individuals who did not pay him for drugs he had sold them (PS10-14).
- In September of 1974 he was convicted of Truancy and ordered to see a psychiatrist.
- In February of 1975 he was convicted of Arson and given 12 days of detention after he threw a lighted book of matches into a mail slot at a Post Office.
- In February of 1976 he was given two days of detention after he was convicted of Burglary and Incurability.
- In July of 1976 he was given three days of detention after he violated his probation by running away from home.

During our interviews Mr. Stout also told me that he was placed in juvenile detention for three months when he was 13 or 14 years old after "I threw a book of matches into the Post Office mail slot ... my parents were getting a divorce and I was angry."

He was involved in 3 or 4 heterosexual relationships that involved kissing girls his own age when he was in high school. He did not have sexual intercourse until he married his first wife Patricia in 1978. They separated in 1981 after having two daughters. When I asked about the circumstances under which they separated he told me that

*Patricia and I separated because of my drinking. We never had any arguments and I didn't do anything physically harmful. But she was afraid that something might happen. She gave me an ultimatum and I chose the alcohol over my family.*

He married his second wife Tanya in June of 1989 and separated from her in December of 1989. During our interviews he told me that he did so because he found her cheating on him. He has also lived with two other adult women for several months. He has denied ever sexually assaulting any of his wives or girlfriends, and there does not appear to be any evidence to the contrary (RP notes – 2189 to 2194; RP notes – 2152 to 2154). He also indicated that this was the case during our interviews.

During our interviews Mr. Stout consistently denied being compulsively aroused to fantasies of nonconsensual sexual interactions or ever collecting any pornography that depicted nonconsensual sexual interactions. He also indicated that he has never behaved

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During our interviews Mr. Stout consistently denied being compulsively aroused to fantasies of nonconsensual sexual interactions or ever collecting any pornography that depicted nonconsensual sexual interactions. He also indicated that he has never behaved

in a sexually inappropriate manner towards female staff members during any of his several incarcerations or while he has been committed at the SCC.

Between 1982 and 1992 Mr. Stout was charged with or convicted of 3 contact sex offenses. The following bullet points summarize these events:

- In January of 1982 he was arrested for rape, but he was acquitted of the charge.
- In August of 1990 he was convicted of Third Degree Assault after he was initially charged with rape. During our interviews he told me that "I think I was released in late 1990 or early 1991."
- In August of 1992 a jury convicted him of Indecent Liberties by Forcible Compulsion. During our interviews he told me that "they gave me five years ... my prison release date was in late 1996."

In November of 1996 he was charged with Telephone Harassment after a woman complained that he called her in an attempt to solicit sexual favors for money. Although he was referred to the End of Sentence Review Board for evaluation as a SVP after this, he was not found guilty of harassment and further action on the referral was not taken.

In December of 1997 he was convicted of First Degree Burglary after he was initially charged with First Degree Burglary and Indecent Liberties. (PS09-17 to 19). During our interviews he told me that "I was sentenced to 75 months in prison ... I was transported to the SCC sometime around November of 2001."

**In 2001 Mr. Stout's status on the SVP criteria was evaluated by Dr. Richardson (BR-1202-1210) and Dr. Van Dam (CVD - 1211 to 1239 and CVD - 1227 to 1239). In September of 2002 a third SVP evaluation was completed by Dr. Packard (RP - 2135). In October of 2002 the Washington State Attorney General's Office filed a civil commitment petition alleging that Mr. Stout met the criteria for being classified as a SVP.**

Mr. Stout subsequently elected to have his case tried by the bench rather than a jury. (FOF - 1).

**In his pre-commitment trial evaluation of Mr. Stout Dr. Packard opined that Mr. Stout met the criteria for a diagnosis he referred to as "Paraphilia Not Otherwise Specified Nonconsent" (PNOSN). He acknowledged, however, that "there's been controversy about whether or not certain syndromes or diagnoses should or should not be considered in the DSM" and, with respect to a particularly controversial issue, Dr. Packard stated that "there's been considerable discussion regarding paraphilic rape or coercive sexual disorder," and that Paraphilia NOS Nonconsent "would be very similar" to paraphiliccoercive sexual disorder in its conceptualization (RP Deposition - 15). Dr. Packard also testified that Mr. Stout met the criteria for a diagnosis known as "Antisocial Personality Disorder" (ASPD) (RP Deposition - 11).As far as**

psychological testing was concerned, he scored Mr. Stout on the revised version of the **Psychopathy Checklist (PCL-R)** and obtained an overall score of 26, a Factor 1 score of 7, and a Factor 2 score of 13. Actuarially, he scored Mr. Stout on three actuarial instruments - the **Static-99** (total score = 6), the revised version of the **Minnesota Sex Offender Screening Tool (MnSOST-R)**; total = 8); the **Sex Offender Risk Appraisal Guide (SORAG)**; total =13). On the basis of his procedures, Dr. Packard opined that Mr. Stout “would be more likely to commit future acts of predatory sexual violence if not confined to a secure facility” (RP Deposition - 126).

After hearing the evidence the Court provided a detailed and individualized description as to how Mr. Stout met Washington’s SVP criteria. It stated that:

*Mr. Stout suffers from a mental disorder. That disorder is paraphilia not otherwise specified nonconsent ... A paraphilia of this kind is a mental disorder that causes recurrent intense sexually arousing fantasies, urges, and behaviors involving non-consenting adults, that lasts for more than six months, and results in negative consequences to the individual ... Mr. Stout’s paraphilia is a congenital or acquired condition that affects his volitional capacity and predisposes him to the commission of criminal sexual acts such that he is a menace to the health and safety of others ... Mr. Stout also suffers from anti-social personality disorder ... Mr. Stout’s anti-social personality disorder is manifested by a disregard for the rights of others and the rules of society ... Dr. Packard utilized three assessment tools to evaluate Mr. Stout’s risk of reoffense: the Static 99, the MnSOST-R, and the SORAG...all three tools used by Dr. Packard provide support for his opinion that Mr. Stout is more likely than not to reoffend sexually if not confined ... In Mr. Stout, the combination of paraphilia (NOS) non-consent with antisocial personality disorder makes him more likely than not to reoffend ... In Mr. Stout the combination of paraphilia (NOS) non-consent with anti-social personality disorder causes him serious difficulty in controlling his behavior of engaging in sex with non-consenting others ... Based on the testing and Mr. Stout’s history of offending ... Mr. Stout is more likely than not to engage in acts of sexual violence against those same kinds of people if not confined in a secure facility. (FOF – 8 to 10).*

To be rational Dr. Packard’s diagnostic opinions must have been premised on at least two assumptions. The first is that Dr. Packard must have assumed that members of the relevant professional community had the ability to reliably classify Mr. Stout with the combination of PNOSN and ASPD using whatever diagnostic criteria they associated with these concepts. The second is that at the time of his evaluation Dr. Packard must have assumed the relevant professional community accepted both Paraphilia Not Otherwise Specified Nonconsent/“Paraphilic Coercive Disorder” and Antisocial Personality Disorder (ASPD) as reliable mental disorders.

The pattern of diagnoses assigned to Mr. Stout by many different state evaluators indicates that Dr. Packard’s first assumption was wrong. Table 1, below, reports the agreement rate for the presence or absence of both PNOSN and ASPD among state-employed or state-retained doctoral level professionals who evaluated Mr. Stout after his

last conviction. Only the most recent set of diagnostic opinions has been included for each evaluator, but the earliest set precedes Mr. Stout's commitment trial. From the data in this table it is apparent that **there is only a 3% agreement rate between evaluators that Mr. Stout met whatever criteria they were using to identify PNOSN and ASPD.** This agreement rate is far below a reasonable degree of certainty, which must surely be greater than 3%. **Mental health professionals have therefore been unable to reliably identify diagnoses in Mr. Stout's case.**

Table 1. Thirty-six pairs of diagnostic ratings about Mr. Stout were made by state-employed or state-retained evaluators whose identities have been abbreviated in the left column and the top row. The 36 boxes above the diagonal marked by blank cells shows the agreement rate for the presence (3%) and absence (47%) of PNOSN (50% of the raters did not agree on whether PNOSN was present or absent). The 36 boxes below the diagonal shows the agreement rate for the presence (75%) and absence (0%) of ASPD (25% of the raters did not agree on whether ASPD was present or absent). Only 1 pair of raters (footnoted as JD and RP) agreed Mr. Stout met whatever criteria they were using to identify both PNOSN and ASPD. Only 3% of all raters have therefore agreed on Mr. Stout's commitment diagnoses. Entries after "DY" refer to Dr. Yanisch's 2011 report.

Top Triangle: Agreement Rate for the Presence or Absence of PNOSN

	JD	MM	CN	RP	BR	PS11	CVD	DY	HR
JD		+-	+-	(++) <sup>1</sup>	+-	+-	+-	+-	+-
MM	++		--	-+	--	--	--	--	--
CN	++	++		-+	--	--	--	--	--
RP	(++) <sup>1</sup>	++	++		+-	+-	+-	+-	+-
BR	++	++	++	++		--	--	--	--
PS11	-+	-+	-+	-+	-+		+-	+-	+-
CVD	++	++	++	++	++	+-		--	--
DY	++	++	++	++	++	+-	++		+-
HR	++	++	++	++	++	+-	++	+-	

Bottom Triangle: Agreement Rate for the Presence or Absence of ASPD

Note. A "+" stands for an endorsement of a diagnosis. A "-" stands for a non-endorsement. "++" stands for rater agreement on the presence of a disorder while "--" stands for rater agreement on its absence. "+-" means the rater in the row concluded the disorder was present and the rater in the column concluded it was absent. "-+" means the rater in the row concluded the disorder was absent and the rater in the column concluded it was present.

**Recent events in the realm of psychiatric science indicates that Dr. Packard's second assumption must now be regarded as wrong.** In about 2011 Paraphilic Coercive Disorder (PCD) was proposed for inclusion in the upcoming fifth edition of the

Diagnostic and Statistical Manual of the American Psychiatric Association. The DSM is invariably relied upon by psychologists and psychologists for diagnostic classification when they undertake SVP evaluations. Starting in 2007, a groundswell of opposition arose in the psychological and psychiatric communities to the use of PNOSN or PCD for the purposes of diagnostic classification for use in SVP cases. Opposition increased during the pendency of the proposal to adopt PCD as a DSM diagnosis and included a petition against PCD that was submitted to the President of the American Psychiatric Association by almost 125 mental health professionals from around the world. In December of 2012 the Trustees of the American Psychiatric Association rejected the proposal to include PCD – and by extension a PNOS diagnosis qualified by “nonconsent” – as an authorized DSM diagnosis. The rejection was so complete that PCD was not even included in the section of the DSM that includes criteria that have not been adopted as authorized diagnoses but have been deemed worthy of further study.

**Paraphilia Not Otherwise Specified Nonconsent is therefore not considered a reliable mental disorder by the relevant community.** This is not the appropriate place to describe the extensive body of literature published in scientific journals that bears on this result, but I would easily be able to submit a substantial compendium of articles on this issue if asked to do so. I am also confident that a fair review of these articles and the APA’s ultimate decision would confirm the foregoing assestion. For probable cause purposes I have attached to the present document the petition submitted to the APA’s President and a very brief article (Wollert, 2012) that summarizes many of the major objections against treating PCD as a mental disorder.

Regarding Mr. Stout’s level of functioning at the SCC from 2008 to 2009 Dr. Spizman indicated that

*In 12/08 and 5/09 Mr. Stout received feedback for his work as a custodian. He received moderate to positive ratings, with comments including he never missed work and did an excellent job (PS09-2) ... While frequently pleasant with staff, documentation reflected ongoing complaints and verbal aggression from Mr. Stout. Several of these focused on his dietary restrictions, such as being a vegan, and he would be served a meal with an aspect he could not eat (PS09-2) ... Documentation reviewed did not indicate that Mr. Stout had participated in any sex offender specific treatment activities during the period under review (PS09-5) ... Mr. Stout typically is able to relate well with others. He also demonstrated considerable strength in his employment efforts. Finally, he is often able to comply with the rules of the institution (PS09-5) ... He will go out of his way to assist (others) (PS09-6) ... He does not discuss any sexual thoughts, feeling, behavior, or attitudes (PS09-6) ... He is co-operative for the most part (PS09-6) ... he holds grudges for an extended period of time (PS09-7).*

**Mr. Stout’s third to most recent SCC Annual Review was completed by Dr. Spizman on October 10, 2010.** Regarding Mr. Stout’s SCC functioning, Dr. Spizman’s description of Mr. Stout’s behavior was similar to his 2009 description. No incidents of sexual misconduct were noted. Although Dr. Spizman did not indicate that Mr. Stout

received any Behavior Management Reports in his review, Mr. Stout told me during our 2011 interviews that

*I received a Category 2 BMR after I complained about how the food was being handled in the kitchen. I didn't throw anything at them or swear at them, but I was insistent about the problems of contamination that their food handling procedures created for vegans like myself.*

The following bullet points allude to other important portions of Dr. Spizman's report:

- Regarding Mr. Stout's health status, Dr. Spizman reported that Mr. Stout was diagnosed with prostate cancer and had decided to proceed with radiation treatment.

When I asked him about this issue during our 2011 interviews Mr. Stout told me that

*I don't know how the radiation treatments I've just completed have worked out, and I won't know for another five years. I think the treatments have affected my sexual functioning. I get a shot once a month. It causes impotency. The doctors will re-evaluate my status in September of this year. They might give me the shots for another year, but they don't like to administer them for more than two years. There are other drugs they can use if they take me off the medication I'm currently on.*

- Regarding Mr. Stout's diagnostic status, Dr. Spizman opined that Mr. Stout met the criteria for Paraphilia Not Otherwise Specified (Nonconsent), Polysubstance Abuse (In a Controlled Environment), Antisocial Personality Disorder, and Borderline Intellectual Functioning.
- Regarding Mr. Stout's risk status, Dr. Spizman did not score Mr. Stout on any of the risk assessments that were used by Dr. Packard. Instead, he used a new actuarial risk assessment instrument known as Static-99R and several dynamic risk factors from an "instrument designed for use in the community" that he thought could "still provide some useful information about someone in full confinement." Referring to Static-99R, Dr. Spizman observed that "Mr. Stout did not score in a particularly high level on a commonly used actuarial measure (after accounting for his advancing age)" ... thus there is some uncertainty regarding whether or not he would be more likely than not to reoffend sexually if released unconditionally" (PS10-11). Nonetheless, he stated that the "dynamic risk factors intermingle with aspects" of the first three of Mr. Stout's diagnoses to produce "an elevated risk of sexual offending" (PS10-10) and that "it is assumed that this combination of mental abnormalities and personality disorder still impair Mr. Stout's ability to control his behavior" (PS10-11). Dr. Spizman did not articulate how the intermingling process worked or what aspects of Mr. Stout's diagnoses were specifically involved in the process.

Regarding Mr. Stout's status on Washington's SVP risk criteria, Dr. Spizman opined that

"Mr. Stout appears to continue to meet the definition of a sexually violent predator" (PS10-12).

When I asked Mr. Stout about whether he intended to use alcohol if he were released during our 2011 interviews he told me that

*If I'm released I'm not going to be doing any drinking at all. I have no use for it. I've done a lot of urinalyses since I quit drinking in 1983. All of them have come up clean. I did get a write-up on one occasion when I was unable to urinate after I was asked for a urine sample.*

He also told me that

*My fiancé and I are going to get married at some point, depending in part on how things work out regarding my release petition. I met Monica last December. One of the guys here was dating her and introduced her to me. Then things didn't work out between them, and we hit it off. She was able to shatter the wall of isolation I had around me. I get along with people OK, but I wouldn't let anybody in because I didn't want to make a commitment because of my being on the inside and the problems that others have to deal with when that is the case.*

*I don't like it here at the SCC but I wouldn't have met Monica otherwise, and being with her makes my whole stay worthwhile. I've also completed a lot of Christian training and have nine certificates on issues like metaphysics and soul therapy.*

After my last 2011 interview with Mr. Stout I interviewed his then fiancé Ms. Monica Wolfe. Ms. Wolfe told me that

*I was dating his adopted son but we didn't get along. I started talking with Roy after Halloween of 2009 ("Halloween of 2009" is a typo; it should have read "Halloween of 2010"). We discussed marriage over the holidays. If he is released we'll get married in February. Otherwise we'll get married in April. He told me about his offenses in 1990, 1992, and 1997. I'm OK with that because the past is the past. He's trying to start a fresh life and so am I. He treats me good. He treats me with respect. He doesn't yell at me and he's been there for me when I've had my ups and downs. He calls me and he listens to me when I tell him what's going on.*

**Mr. Stout's second to most recent SCC Annual Review was completed by Dr. Spizman on November 8, 2011. Regarding Mr. Stout's SCC functioning, Dr. Spizman stated that**

While Mr. Stout was often able to maintain appropriate behavior on the living unit, he had some verbal outbursts (PS11-3) ... (he) often is able to relate well with others. He also has demonstrated strength in his employment efforts (PS11-5).

Mr. Stout was also apparently married to his fiancé Monica about midway through the

year. No incidents of sexual misconduct were noted and during our 2012 interview Mr. Stout denied receiving any Behavior Management Reports during this review period. He also indicated that he has maintained a Privilege Level of a "4," which is the highest level attainable by a resident who is not participating in the sex offender counseling program that is offered at the SCC. When I talked with him about his relationship with his wife Mr. Stout told me that

*Monica and I are doing very good, really good. She comes out here about once a month. I wish it were more often but she has to take a bus if she wants to visit. She's living with JoAnne. This is a whole lot better than where she was living the last time you talked with me. At that time she was living in Bremerton. This is 110% better.*

Mrs. Stout's interview comments were consistent with this view. She told me that

*We were married on June 22<sup>nd</sup>, 2011. We are doing just great. We're succeeding in our relationship. Roy's on phone restriction but we talk with each other 5 times a day. We talk for up to 30 minutes a call.*

The following bullet points allude to other important portions of Dr. Spizman's report:

- Regarding Mr. Stout's health status, Dr. Spizman's report included the following passages.

**He went through radiation treatment for the (prostate) cancer and currently does not show any signs of progression of the cancer. He is also using hormone therapy, to slow down the progression of the cancer (this could potentially effect libido and erectile functioning ... Regarding erectile functioning, at his age there would be some expected dysfunction, which could be further impaired by the smoking and hormone therapy, but there are no complaints at this time.**

When I asked him about this issue during our interview Mr. Stout told me that

*As far as my prostate radiation treatment is concerned, there's no evidence of cancer. The PSL test is as low as you can go. I got the treatments in November of 2010. I am taking Lupron as part of my post-radiation plan. Some side effects of this are minimal libido, hot and cold flashes, and mood swings. The mood swings come on after the administration of the Lupron. I anticipate this reaction so I monitor myself closely during this period. I attribute my mood changes in large part during this time to the effects of the Lupron.*

- Regarding Mr. Stout's diagnostic status, **the only entries included in this Review were Paraphilia Not Otherwise Specified (Nonconsent) Rule Out, Antisocial Personality Disorder - Provisional, Polysubstance Abuse (In a Controlled Environment), and Borderline Intellectual Functioning (PSII-7).** Therefore, **unlike**

previous reviews, Dr. Spizman did not conclude that Mr. Stout suffered from a Mental Abnormality to a reasonable degree of certainty.

Explaining the first entry (PS11-7), Dr. Spizman stated that

Mr. Stout has been arrested or convicted of sexual offenses against adult women with whom he had no prior meaningful relationship. The incidents were nonconsensual, and he did not stop his action in the presence of clear signals of fear or signals to stop from the victims. However, the assaults did not clearly indicate a desire for non-consensual sexual activity. Rather, it appears he often sought consent, but when it was not obtained, this did not prevent him from pursuing the woman. However, one documented assault did not involve any apparent interaction prior to the assault and the attempted forced sex. Overall, there was some uncertainty of his exact desire/drive, with one assault I believed to clearly indicate a drive for nonconsensual sex. I previously opined that Mr. Stout met the criteria for this disorder.

At this time, Mr. Stout is over age 50, a point that I now consider him to be an older sexual offender. Research demonstrates that as a man enters his older years, his sexual interest and behavior typically decline. While I have very limited information about Mr. Stout, if he is following this typical course, it would logically follow that any sexual drive toward rape has also decreased. In the sex offender population, rape of an adult female by a man past the age of 50 is quite uncommon. Thus, there is some uncertainty as to how strong a desire he initially had for nonconsensual sex, with even greater uncertainty now caused by his advanced age. Therefore, at this time, I am providing this diagnosis as a rule out, to indicate the significant uncertainty as to whether or not Mr. Stout continues to meet the criteria for this disorder. The rule out specifier indicates that further information (e.g., obtained through interview or physiological testing) could provide information that would indicate this is an appropriate diagnosis, or if it is ruled out.

Explaining his characterization of Antisocial Personality Disorder as "provisional," (PS11-8), Dr. Spizman stated

Research demonstrates that as a man reaches his fifties, many of the antisocial traits will "burn out." With Mr. Stout, while we still see some evidence of difficulties (e.g., his apparent indifference to other residents regarding phone use), there is limited demonstration of antisocial behavior. Therefore, I have rendered this diagnosis as provisional to indicate that at this time Mr. Stout appears to still have some antisocial traits, however, further information may indicate this diagnosis is no longer warranted.

- Regarding Mr. Stout's risk status, Dr. Spizman did not score Mr. Stout on any of the risk assessment instruments used by Dr. Packard. Instead he used the Static-99R and several dynamic risk factors from an "instrument designed for use in the

community” that he thought could “still provide some useful information about someone in full confinement.” Referring to Static-99R, Dr. Spizman observed that “Mr. Stout scored a 5 ... this yields a risk estimate of 25.2% in five years and 35.5% in ten years” (PS11-9).

- Regarding Mr. Stout’s status on Washington’s SVP risk criteria Dr. Spizman stated (PS11-12) that “there is a degree of uncertainty whether or not Mr. Stout has an underlying mental abnormality or personality disorder that meets the criteria for civil commitment.” He also stated that “there is some uncertainty regarding whether or not he would be more likely than not to reoffend sexually if released unconditionally.” Yet, after these assertions he concluded that “I believe Mr. Stout has a continuing abnormality that meets the criteria for civil commitment and that his risk level continues to remain more likely than not to reoffend if released unconditionally.”

Dr. Spizman therefore asserted that he was both certain and uncertain regarding Mr. Stout’s status, which is equivalent to saying that he is and he isn’t a sexually violent predator. This is illogical and indicates that Dr. Spizman is too uncertain to take a position on the SVP issue. Mr. Stout should not be considered to meet the SVP criteria under such a high level of uncertainty.

Mr. Stout was also evaluated by Dr. Richards after he was evaluated by Dr. Spizman. Dr. Richards claimed that he suffered from a Mental Abnormality after he listed the following entries as “listed in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR)”: Alcohol Abuse in a Controlled Environment, Polysubstance Dependence in a Controlled Environment, Antisocial Personality Disorder (Severe Psychopathy) with Paranoid Personality Traits, and Borderline Intellectual Functioning. On the Static-99R he assigned Mr. Stout a total of 6 points. This is one point too many because Mr. Stout’s “first marriage lasted two and a half years” (HR11-6). On both the Static-2002R and the MnSOST-R he scored Mr. Stout as in the third highest risk category. He also assessed his status on various risk factors.

Dr. Richards concluded that “it is my opinion that Mr. Donald Roy Stout, Jr., does meet the criteria as a Sexually Violent Predator.” Although he stated that he believed that Mr. Stout “is more likely than not to commit a new crime of sexual violence” Dr. Richards did not agree that Mr. Stout continued to suffer from this original commitment diagnoses of Paraphilia NOS Nonconsent and Antisocial Personality Disorder. Furthermore, the diagnosis that he discussed at greatest length – Antisocial Personality Disorder/Psychopathy – is not accepted as a legitimate diagnosis in DSM-IV-TR.

**Mr. Stout’s most recent SCC Annual Review was completed by Dr. Daniel Yanisch on January 31, 2013.** Regarding that range of treatment activities that Mr. Stout might have accessed at the SCC during the current review period, Dr. Yanisch at one point reported that

An inspection of all SCC records generated about Mr. Stout for the current review

period reveals that **(Mr. Stout) has not taken part in any of the sex offender specific treatment groups.** He has not requested or participated in any individual therapy or treatment planning sessions, despite being regularly asked via letter or memo about his interest to discuss case management issues (DY13-2).

At a later point, however, Dr. Yanisch indicated that **"Mr. Stout requested contact with his assigned Psychology Associate, Joe Coleman ... as he wanted to discuss his treatment plan, and some of the listed dynamic risk factors ...** Mr. Stout argued that he had been sober a long time and that (Substance Abuse) was not a factor for him anymore" (DY13-3).

Regarding Mr. Stout's current medical status Dr. Yanisch reported that "In 2010 ... following a biopsy, he was diagnosed with prostate cancer. He was treated with radiation and hormone therapy in the Fall of 2011" (DY13-3).

Dr. Yanisch did not indicate that Mr. Stout is still being treated with Depo-Lupron (2544, 2553). When I asked Mr. Stout about his current sex drive he indicated that he did not have any. He also told me he has not had an erection for over 3 years, that he does not masturbate, and that he has not had any nocturnal emissions.

Regarding Mr. Stout's residential functioning Dr. Yanisch reported that

As noted in the 2011 SCC Annual Review by Dr. Spizman, Mr. Stout became involved with a woman ... and eventually was married to her. Because of the extent of his telephone contacts with her, and the fact that other residents were upset (by this) ... Mr. Stout was moved to a different living unit ... By the end of January 2012 (these issues) resulted in treatment staff implementing a revision of his treatment plan ... Mr. Stout was directed not to answer the phone when it rang ... By the middle of June it was noted that Mr. Stout was monitoring his phone use much more effectively ... However, by 08.05.12 he appeared to be reverting to some earlier behaviors ... Residential progress notes and room inspection reports indicate that Mr. Stout ... keeps his room up to standards ... (DY13-4).

Regarding behavioral management issues Dr. Yanisch reported that

When staff escorting another resident requested the pill line nurse deal with that resident before Mr. Stout ... Mr. Stout protested ... He continued to escalate and was informed that "he was blowing this whole thing out of proportion." He finally just walked away from staff ... The above situation was later determined to be a Category 2 BMR incident and was brought to Mr. Stout's treatment team. He was cited for "Delaying Staff and Disruptive Behavior" (DY13-5).

(Residential Rehabilitation Counselor Shauna Anderson) noted that Mr. Stout is no longer working because "he has to be available for telephone calls from his wife" ... When questioned if she had observed any sexual preoccupation or

sexualized content coming from Mr. Stout, Ms. Anderson stated, "I have never observed anything like that from him." (DY13-6 to 7).

Mr. Stout also received a Category 1 BMR for Computer Violations after Dr. Yanisch's report. According to the "Treatment Plan Addendum" describing this incident "Mr. Stout possessed on his computer a lewd story describing an ultimate sexual act ... he was also in possession of 17 software/computer related items which is a violation of SCC Policy 212" (2502). A February 26, 2013 memorandum by Investigator Joseph Henderson indicated that Mr. Stout told him that "He had allowed another resident ... to complete legal work on his computer in the past. Mr. Stout stated that this resident must have written the story. Mr. Stout did admit that his computer was ultimately his responsibility" (2510).

When I asked Mr. Stout about the content of the story he told me that "it was a graphic story about Batman ... I didn't put it on there."

Regarding Mr. Stout's diagnostic status, **the entries included in Dr. Yanisch's Review were Paraphilia Not Otherwise Specified (Nonconsent) Rule Out, Antisocial Personality Disorder, Polysubstance Abuse, In a Controlled Environment (by history), and Borderline Intellectual Functioning (DY13-7).**

Regarding Mr. Stout's risk status, Dr. Yanisch did not score Mr. Stout on any of the risk assessments used by Dr. Packard. Instead **he used the Static-99R.** Like Dr. Spizman in his 2011 Review, **Dr. Yanisch observed in his 2012 Review that "Mr. Stout scored a 5 ... this yields a risk estimate of 25.2% in five years and 35.5% in ten years"** (DY13-7 to 8). Like Dr. Spizman he also assessed Mr. Stout on risk factors from the Stable "and a few others that are considered pertinent to treatment progress at the SCC" (DY13-8).

Overall, Dr. Yanisch concluded that

**Mr. Stout has a Rule Out Diagnosis of Paraphilia NOS (Nonconsent), coupled with Antisocial Personality Disorder and Borderline Intellectual Functioning.** The above noted dynamic risk factors intermingle with aspects of these diagnoses, leading to Mr. Stout's elevated risk of sexual offending ... **The combination of mental disorders and personality disorder impairs Mr. Stout's ability to control his behavior** and places him at high risk for sexually violent offenses in the absence of any therapeutic or other intervention ... It is my professional opinion that Mr. Stout appears to continue to meet the definition of a sexually violent predator. Mr. Stout's present mental condition seriously impairs his ability to control his sexually violent behavior.

In his deposition as part of his trial testimony Dr. Packard indicated that he was reasonably certain that the diagnoses of Paraphilia NOS (Nonconsent) and Antisocial Personality were applicable to Mr. Stout. The trial court subsequently concluded that "***In Mr. Stout the combination of paraphilia (NOS) non-consent with anti-social***

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*personality disorder causes him serious difficulty in controlling his behavior of engaging in sex with non-consenting others.*” Mr. Stout’s Mental Abnormality was therefore regarded as the product of a compound diagnosis. Diagnosticians indicate that they are uncertain about the applicability of a diagnosis by stating that it should be “Ruled Out.” Dr. Yanisch, like Dr. Spizman, indicated in his most recent Annual Review that “Mr. Stout has a Rule Out Diagnosis of Paraphilia (Nonconsent).” Both Dr. Yanisch and Dr. Spizman are therefore uncertain that this alleged disorder, even if assumed to be accepted by the relevant community, is currently active in Mr. Stout’s case. Since they are both doubtful about the applicability of one of the two diagnoses that make up Mr. Stout’s compound diagnosis they must also be uncertain as to whether the full combination of diagnoses necessary to Mr. Stout’s Mental Abnormality are currently active. The reports by Dr. Spizman and Dr. Yanisch therefore indicate that Mr. Stout’s diagnostic status has so changed that he no longer meets Washington’s SVP criteria.

In his deposition before Mr. Stout’s commitment trial Dr. Packard also testified that the risk assessment methodologies he used left him with the opinion that Mr. Stout “would be more likely to commit predatory acts of sexual violence.” Both Dr. Yanisch and Dr. Spizman reported that their scoring of Mr. Stout “yields a risk estimate of 25.2% in five years and 35.5% in ten years.” The top end of the range of these estimates does not exceed Washington’s “more likely than not” SVP criterion. Dr. Spizman explicitly acknowledged this, pointing out that “there is some uncertainty regarding whether or not (Mr. Stout) would be more likely than not to reoffend sexually if released unconditionally.” Dr. Yanisch referred to Mr. Stout’s risk as being “elevated” and “high” but did not specifically opine that Mr. Stout met Washington’s SVP criterion of being “more likely than not” to commit new predatory crimes of sexual violence. The reports by both Dr. Spizman and Dr. Yanisch therefore indicate that Mr. Stout’s risk status has so changed that he no longer meets Washington’s SVP criteria.

At the end of their Reviews both Dr. Spizman and Dr. Yanisch concluded that it was their opinion that Mr. Stout continued to meet the criteria for civil commitment. The foregoing paragraphs indicate that, prior to these statements, neither Dr. Spizman nor Dr. Yanisch laid out any foundation for coming to this conclusion. Because of this I believe their “ultimate opinions” are simply dispositive and thus do not make a “prima facie case” that Mr. Stout continues to meet Washington’s SVP criteria.

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### III. Expert's Training, Clinical Experience, Academic Experience, and Research Experience

I was awarded a Ph.D. in clinical psychology by Indiana University in 1978. While I was in residence there I was mentored at the Kinsey Institute for Sex Research by its director, Dr. Paul Gebhard. From 1977 to 1993 I was a professor at four universities (Florida State University, Portland State University, University of Saskatchewan, and Lewis & Clark College) and received \$563,000 in research grants from the U.S. and Canadian governments for various projects that related to studying sex offenders, self-help groups, and aspects of the third edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. I am currently a nonsalaried adjunct/research professor at Washington State University Vancouver. A copy of my vita has been attached.

Over the last 30 years I have personally evaluated about 1,000 sex offenders and personally treated about 3,000. Clinical staff under my supervision treated another 5,000. I have provided extensive clinical services to sex offenders in both Oregon and Canada. In Oregon, from 1990 to 2002, I initiated a sex offender program, Wollert and Associates, based on relapse prevention principles. In the course of developing it I generated many descriptive materials, wrote my own treatment manual (now in its third edition), implemented an array of computerized client-tracking systems, and developed a systematic, thorough, and cost-effective approach to intake evaluations. At one point this program served a census of over 300 clients and provided services under separate contracts with the federal government and Community Justice Departments from Multnomah, Marion, Clackamas, and Washington Counties. I have worked with dozens of parole and probation officers who supervised my clients while they were living in their own residences or in work release centers. The annual contact sexual recidivism rate for supervisees adhering to the rules of my program was found to be ½ of 1%.

In June of 2002 I transferred the ownership of my clinic serving Multnomah County to my colleague Casey Weber, MS, LPC. I thereafter continued in practice as a sole practitioner, providing evaluation and treatment services pursuant to a contract I held with the federal government from 1999 until November of 2009. During that time I treated about 50 child pornography offenders and about 25 other federal offenders who either physically contacted or attempted to physically contact minors they had met via the internet. Other federal offenders I have treated include men who have committed rape or molested children on either a Native American reservation or while they were serving in the United States military.

I moved my office to its present Vancouver location and discontinued providing treatment services in November of 2009. My practice now revolves around consultations related to sex offender litigation and sex offender evaluations.

I have been qualified to testify and provide expert testimony about sexual offending and/or sex offender risk assessment in federal courts in the United States (North Carolina and Oregon) and Canada (Saskatchewan) and in superior courts in various states (Oregon, Washington, California, Massachusetts, Iowa, and Wisconsin). I have also provided reports or evaluations in other states (Alaska, Illinois, and New Jersey) where I was not retained to testify. Overall, I have testified in about 100 adult sex offender sentencing proceedings for

contact offenses, about 25 adult child pornography offender sentencing proceedings, 25 adult probation or parole revocation proceedings, and 10 child placement proceedings. I submitted reports but did not testify in about 40 adult sentencing proceedings for contact sex offenses, 25 juvenile sentencing proceedings for contact sex offenses, and 25 sexually violent predator (SVP) cases. I have been retained in 200 sexually violent predator cases in seven states (Washington, California, Iowa, Wisconsin, Illinois, New Jersey, and Massachusetts), *testifying in about 100 cases where respondents committed index offenses as adults and in about 25 cases where respondents committed index offenses as minors.*

Since 2001 I have published 11 peer-reviewed articles, 1 book chapter, and 1 other manuscript on sex offenders. About half of these documents focused on diagnostic issues such as the reliability of authorized paraphilic diagnoses in the Diagnostic and Statistical Manual of the American Psychiatric Association (e.g., Pedophilia, Sexual Sadism; see Wollert, 2006, and Frances & Wollert, 2012) and proposed diagnoses that the APA rejected in 2012 (Hebephilia and Paraphilia Not Otherwise Specified, Rape; see Wollert, 2007; Wollert & Cramer, 2011; Wollert, 2011). My other articles focused on describing a new instrument – the “MATS-1” – that my colleagues and I developed for the purpose of sex offender risk assessment (e.g., Wollert, Cramer, Waggoner, Skelton, & Vess, 2010).

During this same period I provided 20 trainings and conference presentations on sex offender diagnosis, risk assessment, and treatment. In October of 2012 I participated as an invited expert witness in a mock SVP trial on the diagnostic adequacy of Hebephilia at the Annual Meeting of the American Academy of Psychiatry and the Law in Montreal. A description of the trial may be accessed at <http://forensicpsychologist.blogspot.com>. The United States Sentencing Commission also invited me to provide testimony at a two-day hearing on child pornography offenders that the Commission held at the Washington, D.C., Thurgood Marshall Justice Building in February of 2012. My testimony is summarized as part of a 468-page report which the Commission submitted to Congress on February 27, 2013. Several sections of the Commission’s Report also cited to research I have published on federal child pornography offenders.

#### IV. Washington Statutes and Court Decisions About SVP Proceedings

A. I have read sections of RCW Chapter 71.09 and Court Decisions that set forth (1) legislative findings regarding the prevalence of sexually violent predators (SVPs) and their resistance to change; (2) those characteristics that define SVPs; (3) the conditions that must be satisfied to determine whether a respondent to a civil commitment petition is a SVP; and (4) the conditions that must be met to set a hearing to determine whether a person once classified as a SVP continues to merit this classification.

1. Regarding issue (1) under section III.A., RCW 71.09.010 states that the legislature for the State of Washington *"finds that a small but extremely dangerous group of sexually violent predators exist"* and that they *"are unamenable to existing mental illness treatment modalities."*
2. Regarding issue (2) under section III.A., RCW 71.09.020 (16) states that a *"'sexually violent predator' means any person who has been convicted of or charged with a crime of sexual violence and who suffers from a mental abnormality or personality disorder which makes the person likely to engage in predatory acts of sexual violence if not confined in a secure setting."*

RCW 71.09.020 (8) provides some elaboration on this definition by stating that *"'mental abnormality' means 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."*

Although RCW 71.09.020 (8) links the term "Mental Abnormality" to a condition that presumably impairs emotional or volitional capacity it does not further clarify the meaning of an emotional or volitional impairment.

3. Regarding issue (3) under section III.A., RCW 71.09.060 (1) states that *"the court or jury shall determine whether, beyond a reasonable doubt, the person is a sexually violent predator."*
4. Regarding issue (4) under section III.A., RCW 71.09.090 (2) (c) states that if *"probable cause exists to believe that the person's condition has so changed that: (A) the person no longer meets the definition of a sexually violent predator; or (B) release to a less restrictive alternative would be in the best interest of the person and conditions can be imposed that would adequately protect the community, then the court shall set a hearing on either or both issues."*

Further clarification of the procedures referenced under RCW 71.09.090 (2) have been provided in various decisions. In *State of Washington v. David McCuiston* (2012), in particular, the Washington Supreme Court stated that:

*At the show cause hearing, the State bears the burden to present prima facie*

*evidence that the individual continues to meet the definition of a SVP and that conditional release to a less restrictive alternative would be inappropriate. The court must order an evidentiary hearing if the State fails to meet its burden or, alternatively, the individual establishes probable cause to believe his "condition has so changed" that he no longer meets the definition of a SVP or that conditional release to a less restrictive placement would be appropriate ... "there are two possible statutory ways for a court to determine there is probable cause to proceed to an evidentiary hearing ... (1) by deficiency in the proof submitted by the State, or (2) by sufficiency of proof by the prisoner."*

5. Also regarding issue (4) under section III.A., RCW 71.09.090 (4) states

*(4) (a) Probable cause exists to believe a person's condition has 'so changed' under subsection (2) of this section, only when evidence exists, since the person's last commitment trial, or less restrictive alternative revocation proceeding, of a substantial change in the person's physical or mental condition such that the person either no longer meets the definition of a sexually violent predator or that a condition ...*

*(b) A new trial under subsection (3) of this section may be ordered, or a trial proceeding may be held, only when there is current evidence from a licensed professional of one of the following and the evidence presents a change in condition since the person's last commitment trial proceeding:*

- i. An identified physiological change to the person, such as paralysis, stroke, or dementia, that renders the committed person unable to commit a sexually violent act and this change is permanent; or*
- ii. A change in the person's mental condition brought about through positive response to continuing participation in treatment which indicates that the person meets the standard for conditional release to a less restrictive alternative such that the person would be safe at large if unconditionally released from commitment.*

*(c) For purposes of this section, a change in a single demographic factor, without more, does not establish probable cause for a new trial proceeding under subsection (3) of this section. As used in this section, a single demographic factor includes, but is not limited to, a change in chronological age, marital status, or gender of the committed person.*

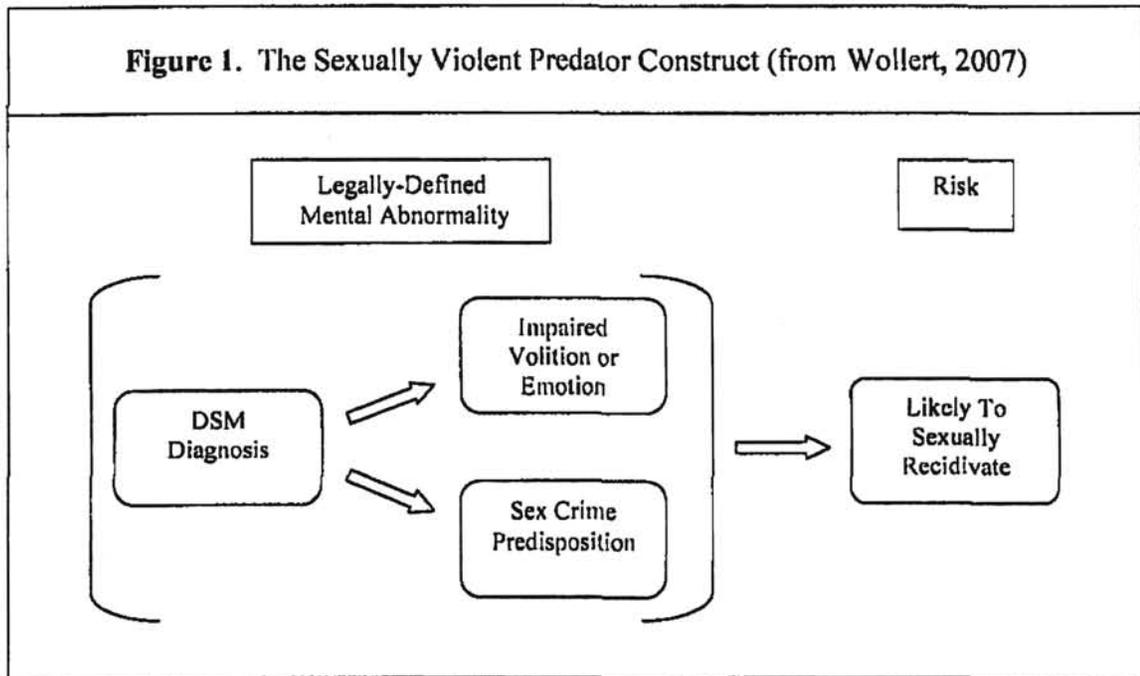
Although RCW 71.09.090 (4) refers to the concept of "change" as necessary to a new trial it does not specify the conditions under which the requisite change must be entirely produced by processes or factors that are internal to a person, the conditions under which change may be a product of an interaction between internal and external factors, and the conditions under which it may be due entirely to external factors. It also does not define three terms in the phrase "brought about through positive

response to continuing participation in treatment" (underlined terms remain undefined).

V. Definitions of Vague Terms in Washington's SVP Laws That Were Applied in the Present Review

- A. Many of the terms cited in section IV. have not been clearly defined. Further definition is useful, however, for the completion of a meaningful sexually violent predator evaluation. I believe that various potentially important sources of information sources should be consulted to provide useful guidance to SVP evaluators on the questions that need to be addressed to formulate an adequate evaluation. The following items enumerate the questions that are currently most important to me.
1. Which disorders are typically considered "congenital or acquired conditions"?
  2. Should experts assume that diagnoses from the current Diagnostic and Statistical Manual of the American Psychiatric Association (DSM-IV-TR) constitute congenital or acquired conditions?
  3. What is the best way to identify emotional or volitional impairments which predispose individuals to the commission of criminal sexual acts?
  4. What is the appropriate timeframe for applying the Mental Abnormality criterion?
  5. What is the appropriate scope of application of the SVP criteria to Washington's sex offender population?
  6. What standard of consistency should be followed in determining whether a person who has been found to be an SVP remains an SVP?
  7. What standard should be used to determine whether a person who was found to be a SVP has "changed" so that he no longer meets the criteria that define a SVP?
  8. What is the definition of "change ... brought about through ... continuing participation in treatment"?
- B. The following items enumerate my views on the foregoing questions based on my publications, reading of relevant materials, discussions with colleagues, and experience.
- BI. Acquired or Congenital Conditions. Figure 1 is a schematic that was published in two different peer-reviewed journals that depicts how I believe that experts (see, for example, Doren, 2002, and First & Halon, 2008) typically conceptualize SVPs. It shows that experts usually equate a DSM diagnosis with an "acquired or congenital condition." Most of these diagnoses fall in the categories referred to as "Paraphilias."

**Figure 1. The Sexually Violent Predator Construct (from Wollert, 2007)**



A comparison of the content of the DSMs since the first “modern” DSM (DSM-III) was published in 1980 strongly implies that stringent levels of evidence must be met before any of the Paraphilias may be assigned to a respondent (Frances & Wollert, 2012). The following passages describing the Paraphilias, for example, were included in DSM-III.

*The essential feature of disorders in this subclass is that unusual or bizarre imagery or acts are necessary for sexual excitement. Such imagery or acts tend to be insistently and involuntarily repetitive and generally involve either (1) preference for use of a nonhuman object sexual arousal, (2) repetitive sexual activity with humans involving real or simulated suffering or humiliation, or (3) repetitive sexual activity with nonconsenting partners.*

*The imagery in a Paraphilia, such as simulated bondage, may be playful and harmless and acted out with a mutually consenting partner. More likely it is not reciprocated by the partner, who consequently feels erotically excluded or superfluous to some degree. In more extreme form, paraphiliac imagery is acted out with a nonconsenting partner, and is noxious and injurious to the partner (as in severe Sexual Sadism) or to the self (as in Sexual Masochism).*

*Since paraphiliac imagery is necessary for erotic arousal, it must be included in masturbatory fantasies if not actually acted out alone or with a partner and supporting cast or paraphernalia. In the absence of paraphilic imagery there is no relief from nonerotic tension, and sexual excitement or orgasm is not attained.*

*Frequently these individuals assert that the behavior causes them no distress and that*

*their only problem is the reaction of others to their behavior. Others admit to guilt, shame, and depression at having to engage in an unusual sexual activity is socially unacceptable. There is often impairment in the capacity for reciprocal affectionate sexual activity, and psychosexual dysfunction are common.*

*Social and sexual relationships may suffer if others, such as a spouse (many of these individuals are married), become aware of the unusual sexual behavior. In addition, if the individual engages in sexual activity with a partner who refuses to cooperate in the unusual behavior, such as fetishistic or sadistic behavior, sexual excitement may be inhibited and the relationship may suffer.*

*Complications(may occur, including) physical harm ... serious damage (to oneself) ... (and) incarceration.*

The current version of the DSM (DSM-IV-TR) describes the Paraphilias in the following terms.

*The essential features of a Paraphilia are recurrent, intense sexually arousing fantasies, sexual urges, or behaviors generally involving 1) nonhuman objects, 2) the suffering or humiliation of oneself or one's partner, or 3) children or other nonconsenting persons that occur over a period of at least 6 months (Criterion A). For some individuals, paraphilic fantasies are obligatory for erotic arousal and are always included in sexual activity. In other cases, the paraphilic preferences occur only episodically (e.g., perhaps during periods of stress), whereas other times the person is able to function without paraphilic fantasies or stimuli. For Pedophilia, Voyeurism, Exhibitionism, the diagnosis is made if the person has acted on these urges or the urges or sexual fantasies cause marked distress or interpersonal difficulty. For Sexual Sadism, the diagnosis is made if the person has acted on these urges with a nonconsenting person or the urges, sexual fantasies, or behaviors cause marked distress or interpersonal difficulty. For the remaining Paraphilias, the diagnosis is made if the behavior, sexual urges, or fantasies cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.*

*Paraphilic imagery may be acted out ... in a way that may be injurious to the partner (as in Sexual Sadism) ... the individual may be subject to arrest or incarceration (Exhibitionism, Pedophilia, and Voyeurism make up the majority of apprehended sex offenders) ... self-injury (as in Sexual Masochism) ... social and sexual relationships may suffer if others find the unusual sexual behavior shameful or repugnant, or if the individual's sexual partner refuses to cooperate.*

*Many individuals with these disorders assert that the behavior causes them no distress and that their only problem is social dysfunction as a result of the reaction of others to their behavior. Others report extreme guilt, shame, and depression at having to engage in an unusual sexual activity that is socially unacceptable or that they regard as immoral. There is often impairment in the capacity for reciprocal, affectionate sexual activity, and Sexual Dysfunctions may be present.*

Considering the description of the Paraphilias presented in the current DSM within the historical context of previous definitions, and giving heavy weight to the passages I have put in bold type, I believe the following elements must be satisfied to conclude that a mature adult meets the criteria for a Paraphilia.

- a) There must be a six-month period during which the person experiences paraphilic imagery that is so recurrent and intense that it is necessary for sexual excitement (this is the meaning of the A, or essential, criterion).
- b) The person must be severely distressed during this six month period by his paraphilic urges, or experience serious interpersonal difficulties or an impairment in his daily routine due to these urges, or act on them in way that is harmful (this is the meaning of the B, or threshold, criterion).
- c) The paraphilias do not apply to acts of rape that are perpetrated by those who do not meet the criteria for Pedophilia or Sexual Sadism (there is no mention of a diagnosis that is reserved for rape in general).

The DSM also requires a high level of evidence stringency in order to assign a Personality Disorder to a respondent. In the case of Antisocial Personality Disorder, which is the specific Personality Disorder most commonly assigned in SVP cases, a person must be found to show evidence of a Conduct Disorder before his fifteenth birthday.

- B2. DSM Diagnoses and Acquired or Congenital Conditions. Three facts point to the conclusion that experts should not assume that any diagnosis from the DSM constitutes an acquired or congenital condition.

First, no research has ever confirmed that any DSM diagnosis affects "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, the DSM diagnoses that are invoked in SVP cases are widely regarded as error-ridden (First & Frances, 2008; First & Halon, 2008; Frances, Sreenivasan & Weinberger, 2008), invalid or unreliable (Brody & Green, 1994; Green, 2002; Kingston, Firestone, Moulden, & Bradford, 2007; Levenson, 2004; Marshall, 1997; Marshall & Kennedy, 2003; Marshall, Kennedy, & Yates, 2002; Marshall, Kennedy, Yates, & Serran, 2002; O'Donohue, Regev, & Hagstrom, 2000; Prentky, Coward, & Gabriel, 2008; Wilson, Abracen, Looman, Picheca, & Ferguson, 2010), associated with high rates of misdiagnoses (Wollert, 2007; Wollert & Waggoner, 2009), or dubious labels that may facilitate "shoe-horning" respondents into the SVP criteria (Frances, Sreenivasan, & Weinberger, 2008; Frances, September 1, 2010; Franklin, 2010; Green, 2010; Knight, 2010; Wollert & Cramer, 2011; Zander, 2005; Zander, 2008).

Finally, the American Psychiatric Association and those who authored the most recent manual of DSM diagnoses insist that no diagnosis is sufficient to determine that a person

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has a mental illness which warrants civil commitment (American Psychiatric Association, 1994, 1996, 2000, 2001; First & Halon, 2008). As I have also mentioned, the APA has rejected the inclusion of Paraphilia Not Otherwise Specified (Nonconsent) in the 2013 edition of DSM-5 when the criteria for PNOSN were referred to as Paraphilic Coercive Disorder.

- B3. Impairment. The validity of the concept of volitional impairment has been widely criticized and there is no agreement among evaluators as to what the best method is for identifying emotional or volitional impairments which predispose individuals to the commission of criminal sexual acts (American Bar Association, 1986; American Psychiatric Association, 1983; LaFond, 2000; Jackson, Rogers, & Shuman, 2004; First & Halon, 2008; Prentky, Janus, Barbaree, Schwartz, & Kafka, 2006; Prentky et al., 2008; Wollert & Waggoner, 2009).

From the information in V.B.2. we know that DSM diagnoses are inadequate for identifying volitional impairments. Common-sense also tells us that examples are usually inadequate for this purpose because examples almost never differentiate SVP recidivists from typical sex offender recidivists.

It is therefore most likely impossible for experts to accurately assess the impairment requirement of the SVP construct without intentionally and carefully defining what it means.

I believe there are two approaches that might be adopted to address this problem.

One would be to assess whether respondents meet the criteria for insanity, which involves answering the following questions: (1) Is the respondent aware of the nature and quality of his actions? and (2) Does the respondent know right from wrong with respect to his actions? This approach has the advantage of clarity in that the "notion of volitional impairment generally collapses into the more operationally useful notion of *rationality defects*" (APA, 2001, p. 28, footnote 11; Morse, 1994).

A broader approach would be to evaluate respondents in terms of the severity to which they are sexually impaired. Abel and Rouleau (1990), for example, have suggested that *a severe cycle of deviant sexual compulsivity* exists among a specific class of sex offenders who

*Report having recurrent, repetitive, and compulsive urges and fantasies to commit rapes. These offenders attempt to control their urges, but the urges eventually become so strong that they act upon them, commit rapes, and then feel guilty afterwards with a temporary reduction of urges, only to have the cycle repeat again. This cycle of ongoing urges, attempts to control them, breakdown of those attempts, and recurrence of the sex crime is similar to the clinical picture presented by exhibitionists, voyeurs, pedophiles, and other traditionally recognized categories of paraphiliacs.*

Although rejection of Paraphilic Coercive Disorder by the APA means that the foregoing conceptualization does not apply to rapists, a number of considerations recommend it as an

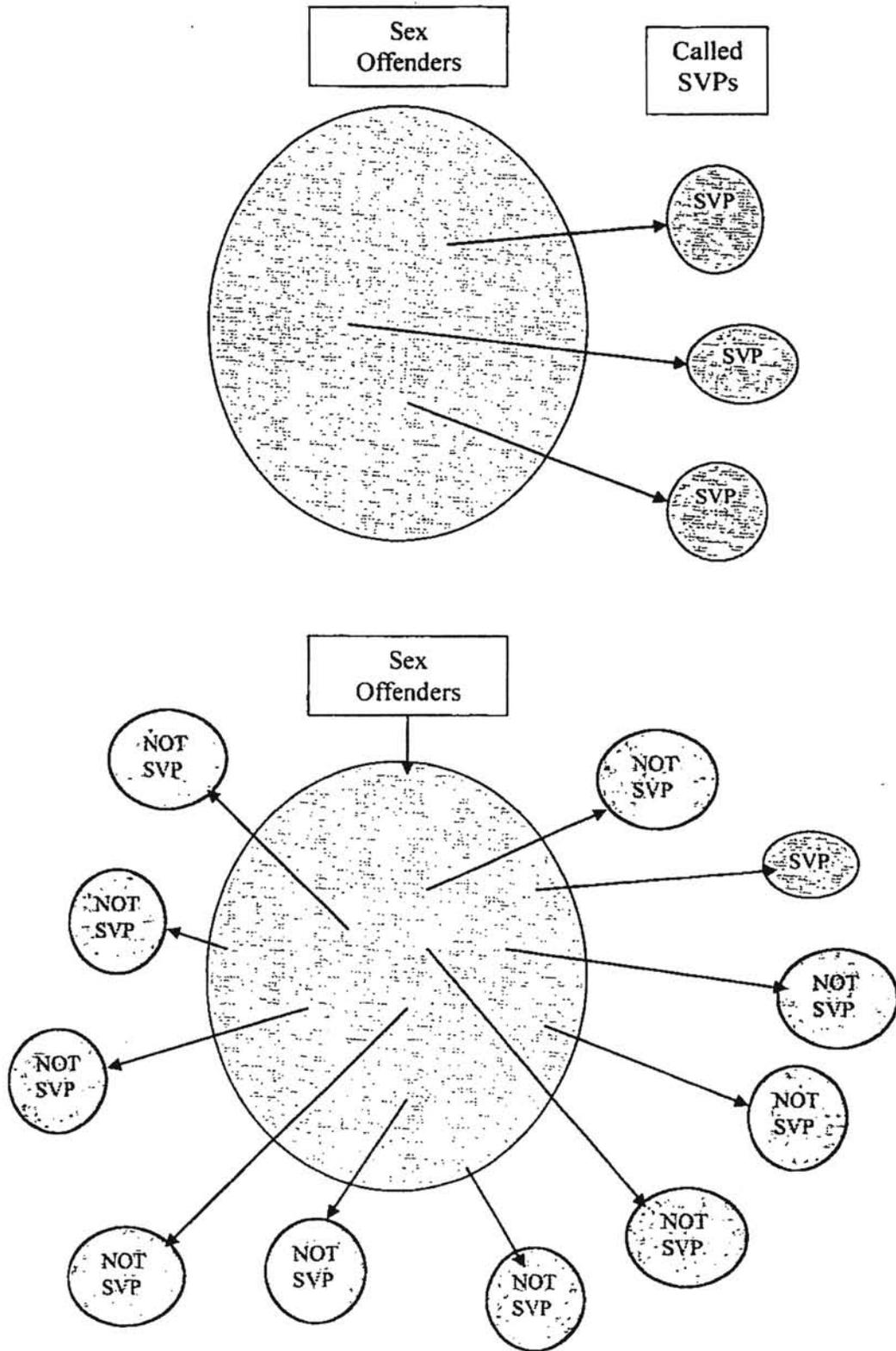
approach to conceptualizing Mental Abnormality among those with authorized paraphilias – particularly Pedophilia and Sexual Sadism – that are most relevant to Washington’s SVP statutes. One is that it covers all of the elements of a Mental Abnormality by combining the Paraphilic criteria from the DSM with predispositional, emotional, and volitional concepts. Another is that the Washington State Supreme Court has referred to the Abel and Rouleau article that includes the foregoing passage as being of “seminal” importance in a SVP case [In re Young, 857 P. 2d 989, 1002 (Wash. 1993)]. Still another advantage is that a multifaceted and extensive program of research (Carnes & Delmonico, 1996; Coleman, Minor, Ohlerking, & Raymond; Coleman-Kennedy & Pendley, 2002; Galbreath, Berlin, & Sawyer, 2002; Goodman, 2004; Goodman, May 26, 2009; Kafka, 2009; Kalichman & Rompa, 1995, 2001; Wines, 1997) and testing (e.g., the Sexual Addictions Screening Scale, the Sexual Compulsivity Scale, the Compulsive Sexual Behavior Inventory) has applied a somewhat less stringent conception of this view to various clinical and nonclinical populations.

- B4. Timeframe. The timeframe for applying the Mental Abnormality criterion to a person being evaluated on the SVP criterion must reflect his “current” status on the criterion (APA, 2000; *State of Washington vs. David McCuiston*). Extrapolating from past observations is therefore insufficient to render a meaningful opinion.
- B5. Scope. The appropriate scope for the application of Washington’s SVP criteria is one that is narrow [*Kansas v. Hendricks*, 521 U.S. 346 (1997); *Kansas v. Crane*, 534 U.S. 407 (2002); Jackson & Richards, 2007, p. 191]. The criteria, in other words, should apply to a very small percentage of sex offenders: Stern (2010), for example, has estimated that only 1.5% of all incarcerated sex offenders in Washington are thought to meet the SVP criteria.

It is hoped, as illustrated in the top circles of **Figure 2** (modeled after Figure 2 from Wollert & Waggoner, 2009), that some methods of evaluation processes will be reliable enough to identify offenders who fall in this group to a reasonable degree of certainty. But it is also almost certain, as illustrated in the bottom circles of **Figure 2** (after Figure 3 from Wollert & Waggoner, 2009), that this will not be the case for all methods of SVP evaluation and that caution must be exercised to avoid “false positives.”

Regarding the issue of scope, it is also the case that a respondent must be positive for all of the elements that define a SVP to be classified as one. Adopting an electrical metaphor for descriptive purposes, I believe that all of the “switches” depicted in **Figure 1** must be in the “on” position. This is denoted in **Figure 3** by a lack of shading. Someone who is a typical criminal or typical criminal recidivist but not an SVP will therefore be negative for one or more of the components. Using shading to represent switches that are in the “off” position, and then crossing out these elements, **Figure 3** presents a conceptual illustration of a non-SVP. As **Figure 3** indicates, an offender does not have to be negative for each and every feature to be a non-SVP.

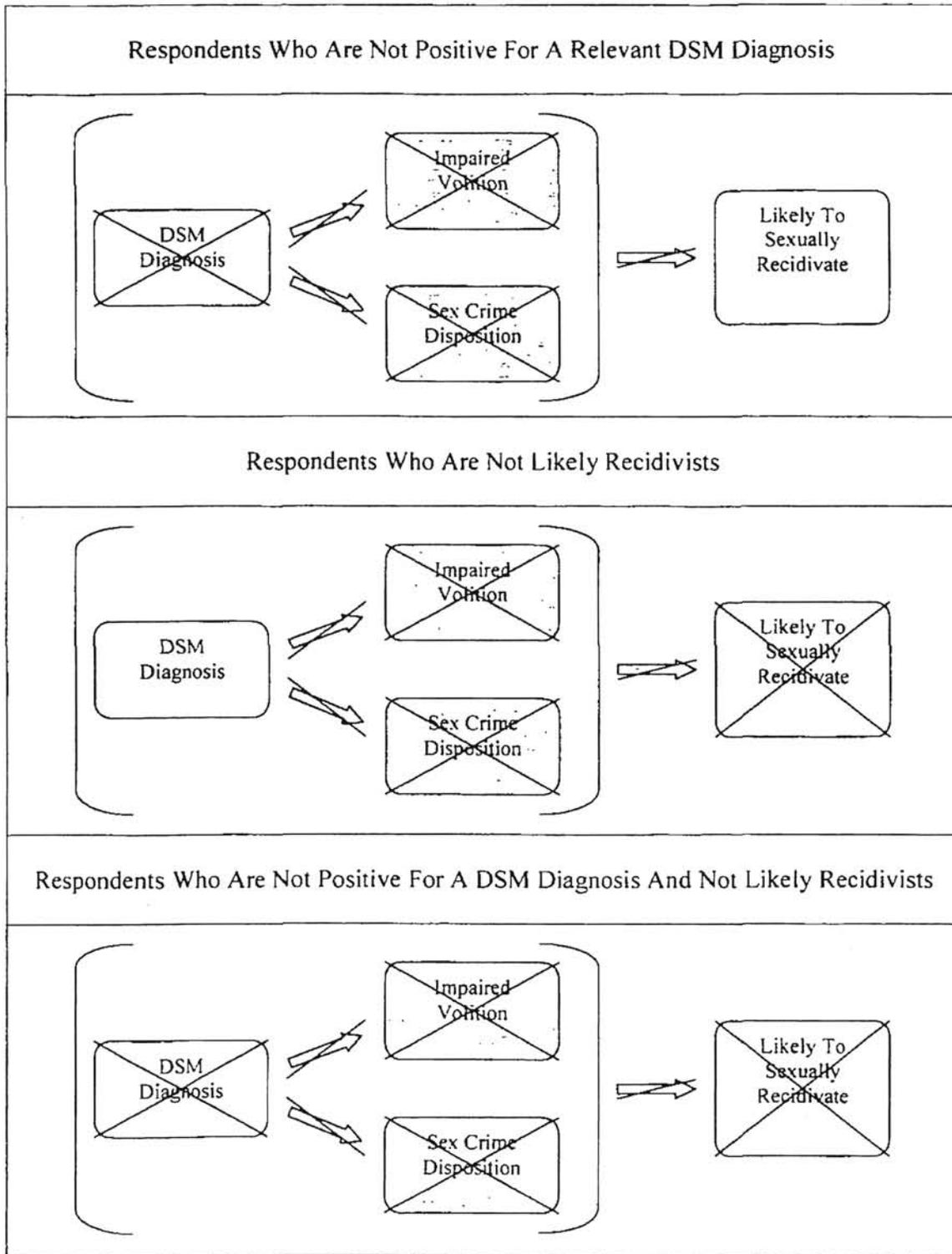
**Figure 2.** The Problem With SVPs Is Differentiating Them From Non-SVPs  
(The Top Panel Works Well; The Bottom Panel Does Not)



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**Figure 3.** Three Classes of Respondents Who Would Not Qualify as SVPs



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- B6. Consistency of standard of proof. The SVP criteria should be consistently applied so that evaluators apply the same standard of proof in both pre-commitment evaluations and annual review evaluations. [see *State of Washington v. David McCuiston* (2012) for a more general discussion of this issue]. Evaluators should not, in other words, apply a stricter set of standards in making a release recommendation than they would apply if they were making a commitment recommendation.
- B7. Definitions of change. The most widely-accepted philosophical perspective on the nature of science and how this perspective defines the meaning of “change” revolves around a cumulative and ever-evolving process of conceptualization and hypothesis testing. Pursuing the first objective, the scientific enterprise conceptualizes objects and processes that have a bearing on human existence, properties associated with these constructs, the mechanisms by which they operate, and the results of these operations. Pursuing the second, it tests the validity of these conceptualizations by attempting to show that they are false.

Another fundamental tenet is that common sense indicates that a physical universe exists, but the sciences of biology and sensory psychology indicate that direct knowledge of that universe is beyond human capability. Scientists therefore construct and test their conceptualizations of the physical universe by collecting indirect observations and using logic to interpret the meaning of these observations.

This “constructivist” perspective on the nature of science holds a number of implications. One is that the properties of the physical universe do not precisely correspond to the universe of scientific constructs. Another is that the world that scientists “see” at any given point in time is determined by the scientific conceptualizations through which they are viewing it. Still another is that **scientists will see an object as having “changed” if their conceptualizations about the object change as a result of developing new conceptualizations or combining previous conceptualizations that advance understanding, means-ends operations, or predictive power.** This is logical and coherent in that any other reaction on their part would involve the continued application of inferior conceptions.

Conclusions that were considered “facts” at one time are therefore often revised as a scientific discipline evolves. This is particularly the case for psychiatric and psychological constructs that are relevant for SVP evaluations, which the Supreme Court alluded to as “ever-advancing” rather than unchanging in *Kansas v. Crane* (2002). Regarding the diagnosis of mental disorders, for example, homosexuality was considered a mental disorder in an early version of the Diagnostic and Statistical Manual of the American Psychiatric Association but was removed from later versions (Zander, 2005). This change, in turn, necessitated a change in the mental health status of many who had previously been thought of as mentally disordered. Regarding the prediction of violent behavior, a professor of forensic psychiatry named Caesar Lombroso promoted the theory in the late 1800s that criminality was often inherited and

that evaluatees who were affected by this congenital disorder could be identified by measuring their skull and other features of their *physiognomy*. A corollary of this theory was that people of color were physiognomically predisposed to criminality because "only we white people have reached ... the ultimate bodily form" (Herman, 1997). Following the discreditation of the theory of physiognomy, it was incumbent on professionals who had once adhered to it to change their opinions about the criminological predispositions they had previously "seen" in persons who came from ethnic backgrounds that differed from their own. Any other response would simply have amounted to argumentation for the sake of argumentation, which runs counter to scientific tradition.

The foregoing position and examples indicated to me that **there are two pathways by which a civilly committed person's "condition" may be found to have "changed"** so that the person no longer meets the definition of a sexually violent predator. **One is that he has changed with respect to scientific conceptualizations that have withstood the test of time and attempts at scientific falsification. The other is that scientific conceptualizations that were once thought to identify him as a sexually violent predator have either been discredited or re-interpreted** in such a way that his continued classification as a sexually violent predator would be inconsistent with the status of science.

- B8. Change Brought About Through Continuing Participation in Treatment. Regarding the definition of "treatment," it is self-evident that (1) the *raison d'être* for Washington's Special Commitment Center is to provide continuous care and treatment to all who are placed there. Treatment therefore includes, but is not limited to, such different interventions as psychotherapy, skills training, pharmacotherapy, social support, inspirational modeling, maturation, response inhibition, rest, recreation, reflection, adequate health care, and scientific advances that inform the processes by which SVPs and non-SVPs are identified. This position is supported by court testimony from former SCC Superintendent Henry Richards indicating in one hearing (In re the Detention of Gale West) held on January 31, 2007 that

all of the offenders who are at ... the SCC are in treatment (p. 182),

and then elaborating on this position in a later hearing (In re the Detention of Toney Bates, January 18, 2008) by stating that

the SCC is responsible for ... a milieu therapy where the entire environment is in the treatment process through structure, through ongoing interaction with the staff, vocational training, education, and also through more specialized interventions (p. 14) ... once a detainee has been committed, we see the whole process as a treatment process (p. 71).

Since those who have been committed to the SCC are not released until they are eligible for release it also follows that all SVPs are continuously in treatment while they are in residence at the SCC.

The counter to the foregoing line of reasoning is that what the legislature meant by "treatment" when it amended RCW 71.09.090 was "sex offender-specific counseling." This, of course, would be useful to know. However, if this was the legislature's intent it would have been a simple matter for it to qualify the term "treatment" in RCW 71.09.090 (4) by inserting the term "sex offender-specific counseling treatment" in its place. It did not do this, so my assumption is that it meant to refer to "treatment" in a very broad sense. A narrower release specification may also have exposed RCW 71.09.090 (4) to more scrutiny by higher courts [see the majority decision in *State of Washington v. David McCuiston* (2011) and the dissent in *State of Washington v. David McCuiston* (2012) for a discussion of this issue]. Whatever the legislature's intent, the current language in RCW 71.09.090 (4) increases evaluator uncertainty because it creates a situation where the term "treatment" may be represented as sex offender-specific counseling in lower courts and as a broader process in higher courts.

Regarding the definition of "change through treatment," the ultimate goal of placing an individual at the SCC is to transform him from being a SVP into being a non-SVP. Considering this purpose within the context of the broad definition of treatment, and also considering that the legislature has apparently found that SVPs are very unlikely to change unless they are exposed to the unique treatment offered at the SCC, it follows that any person who was committed to the SCC in the past but does not meet the SVP criteria at the present time must have undergone a "change" in his "mental condition brought about through positive response to continuing participation" in the unique type of treatment offered at the SCC.

## VI. Statement of Questions That Bear on Determining Whether Mr. Stout is an SVP

- A. The following questions are of paramount relevance for determining Mr. Stout's status on the SVP criteria:
1. Does the current SCC Annual Review for Mr. Stout provide prima facie evidence that he continues to meet Washington's SVP criteria?
  2. Can Mr. Stout present evidence that, if believed, would be sufficient to plausibly argue that he does not have a "Mental Abnormality"?
  3. Can Mr. Stout present evidence that, if believed, would be sufficient to plausibly argue that he is unlikely to commit sexually violent offenses of a predatory nature because of a current Mental Abnormality if he were released?
  4. Can Mr. Stout present evidence that, if believed, would be sufficient to plausibly argue that he has "so changed" as a result of continuous participation in treatment that he would be safe to be at large if unconditionally released?
  5. Has Mr. Stout undergone an identified and permanent physiological change that renders him unable to commit a sexually violent act?

VII. Procedures That Were Followed to Address the Questions at Issue

- A. To address the questions raised under sections VI.A.1. through VI.A.5., I first carried out the procedures described under section I.
- B. After completing these preliminary steps I addressed each of the five preceding questions by considering the relevant data. My conclusions are presented in the following sections.

VIII. Testing Question VI.A.1. Indicates That The Current SCC Annual Review Does Not Provide Prima Facie Evidence That Mr. Stout Currently Continues to Meet Washington's SVP Criteria.

My reasons for reaching this conclusion are presented in Section II. The last three paragraphs, in particular, indicate that recent State evaluations advance opinions that are dispositive rather than substantive. The State has therefore not made a prima facie case that Mr. Stout currently meets the SVP criteria for having a Mental Abnormality. A prima facie case has also not been made that he is more likely than not to sexually recidivate.

IX. Testing Question VI.A.2. Indicates That Mr. Stout Can Present Evidence In Support of a Plausible Argument that He Does Not Currently Have a Mental Abnormality.

- A. The following reasons, grounded in the content of Mr. Stout's chronological case history, point to this conclusion.
  - 1. There is no indication in his Annual Review that he suffers from a rationality defect. He also did not show a rationality defect in any of my interviews with him.
  - 2. There is no indication in his Annual Review or in my present evaluation that he suffers from a severe cycle of sexual compulsivity.
  - 3. The assumption that Mr. Stout has a Mental Abnormality has been predicated on the underlying assumption that he meets the criteria for an alleged disorder referred to as Paraphilia Not Otherwise Specified Nonconsent (PNOSN). The criteria for this disorder are the same as the criteria for another alleged disorder referred to as Paraphilic Coercive Disorder. Paraphilic Coercive Disorder is not accepted by the relevant professional community because it was proposed for inclusion in DSM-5 but was rejected in 2012 by the Board of Trustees of the American Psychiatric Association. PNOSN is therefore also not accepted by the relevant professional community.
  - 4. Mr. Stout would not currently meet the criteria for PNOSN even if it were believed that PNOSN is accepted by the relevant professional community. The reason for this is that his current Annual Review indicates that PNOSN may well not apply to him

because its "Rule-Out" status signifies diagnostic uncertainty. This conclusion is consistent with evaluator results presented in Table 1 of Section II, where only 3% of 36 pairs of ratings indicated that state evaluators agreed on his compound commitment diagnoses of PNOSN and ASPD.

X. A Framework For Testing Question VII.A.3.

- A. **The goal of sex offender risk assessment in SVP cases is to evaluate the probability that the State's theory that an evaluatee is a future recidivist is true.** A respondent meets the SVP risk criterion if the likelihood that this theory is true exceeds 50%. A respondent does not meet the risk criterion if the likelihood does not exceed 50%.
- B. The most accurate approach to evaluating the state's "recidivism theory", according to empirical research, is based on actuarial procedures (Dix, 1976; Hall, 1988; Hanson & Thornton, 2000; Hanson, 2006; Kahn & Chambers, 1991; Skelton & Vess, 2008; Smith & Monastersky, 1986; Sturgeon & Taylor, 1980; Waggoner, Wollert, & Cramer, 2008; Wollert, 2006). An actuarial system includes 1) a battery of risk items (e.g., whether or not an evaluatee has been married, whether or not he has ever been convicted of a violent offense, how many times he has been convicted of a sex offense); 2) a manual for assigning numerical ratings to risk items (e.g., an evaluatee who has committed a violent crime may be given a "1" on this risk item whereas an evaluatee who has not may be given a "0") and combining the ratings into a total score; and 3) an experience table that lists the percentage of offenders with each score who have recidivated in the past.
- C. A number of different risk item batteries have been disseminated. The most well-known are referred to as Static-99, Static-99R("R" means "Revised" in this case), Static 2002R, the RRASOR, the MnSOST-R, and the SORAG. At least one experience table has been formulated for each of these batteries and more than one experience table has been formulated for Static-99.
- D. It has been found that the percentage of sex offenders who commit new sex offenses, known as the base recidivism rate, has gone down over the last several decades (Wollert & Waggoner, 2009; Harris, Helmus, Hanson, & Thornton, October 2008). It has also been found that the base recidivism rate is most elevated for the youngest offenders and steadily decreases with age (Barbaree & Blanchard, 2008; Barbaree, Blanchard, & Langton, 2003; Hanson, 2002; Skelton & Vess, 2008; Wollert, 2006; Waggoner et al., 2008). Evaluators therefore need to use actuarial systems that take these factors into account as fully as possible in order to estimate the risk of sexual recidivism. This criterion rules out the use of the MnSOST-R and the SORAG. It also rules out the use of miscellaneous risk factors that are not corrected for age or recidivism reduction.
- E. Two actuarial systems have been developed, however, that take both recidivism decline and the effects of age on recidivism into account. One is the "MATS-1", which is based on the Static-99 risk item battery and an age-stratified experience table disseminated by Hanson (2006) that was corrected by Waggoner, Wollert, and Cramer (2008) in one peer-reviewed article and expanded in a second article (Wollert, Cramer, Waggoner, Skelton,

& Vess, 2010). The other is based on the Static-99 and Static-2002 risk item batteries and nonstratified tables disseminated by the Static-99 research team (Helmus, Thornton, and Hanson, October 2009; Hanson, Helmus, & Thornton, 2010; Helmus, Thornton, Hanson, & Babchshin, 2011). Both systems have been shown to be reasonably reliable (Helmus, Thornton, & Hanson, October 2009; Hanson, Helmus, & Thornton, 2010; Wollert, August 2007; Wollert et al., 2010). They also overlap one another because they are based on recidivism data collected on some of the same offenders.

F. I scored Mr. Stout on both the MATS-1 and the Static-99R because both have now been published and either one or the other was used by all of the experts who evaluated Mr. Stout most recently. This is redundant in most cases because the published actuarial tables generally point to similar findings.

XI. Testing Question VI.A.3. Indicates That Mr. Stout Can Present Evidence In Support of a Plausible Argument that He Is Unlikely To Sexually Recidivate.

A. The following observations point to this conclusion:

1. I gave Mr. Stout a high range score of "4" on the "ASRS version" of the MATS-1 battery. This score is based on the fact that he has been convicted of 2 sex offenses prior to his index sex offense, has been sentenced on five occasions, and was convicted of a violent nonsexual crime prior to his index offense. The highest score in the high range is an 8. The eight-year sexual recidivism rate for those with scores of 4 more on the MATS-1 who are 50 to 60 years old is 23%.
2. Like Drs. Spizman and Yanisch I gave Mr. Stout a moderately high score of "5" on Static-99R. This score is based on the fact that he has been convicted of 2 sex offenses prior to his index sex offense, has been sentenced on five occasions, was convicted of a violent nonsexual crime prior to his index offense, has committed a sex offense against a nonrelative, and has committed a sex offense against a stranger. One point is subtracted from the total of these scores because Mr. Stout is over 40 years old. The highest score in the high range is a 12. The only published actuarial table for the Static-99R indicates that the five-year sexual recidivism rate for those with scores of 5 is 13.5%.
3. The foregoing results are inconsistent with the state's theory that Mr. Stout is a likely recidivist.

One objection that is sometimes raised in response to this type of negative finding is that it is possible to generate higher recidivism estimates by scoring a respondent on multiple actuarials or attempting to add the effects of "dynamic risk factors" other than age to the scores from multiple actuarials. Studies that have assessed the merits of this hypothesis for evaluating SVPs (Seto, 2005; Vrieze & Grove, 2010; Nunes et al., 2006), however, have consistently rejected it on the grounds that it does not satisfy the "total relevant evidence requirement," which is a fundamental principle of inductive logic (Vrieze & Grove, 2010). As applied to SVP risk

evaluations it requires evaluators who claim that multiple actuarials and dynamic factors can be combined to derive valid risk estimates to produce mathematical evidence in the form of likelihood ratios that supports their practice.

I am unaware of any evidence for an approach that combines multiple actuarials with dynamic risk factors, or for an approach that combines a single actuarial with dynamic risk factors, that meets the total relevant evidence requirement. In contrast, the age stratification approach used in the MATS-1 does meet this requirement (Wollert et al., 2010).

I therefore believe the risk estimate I have advanced for Mr. Stout includes all total relevant evidence. The consideration of other factors would therefore amount to nothing more than clinical judgment, which is notoriously speculative and unreliable.

XII. Testing Question VI.A.4. Indicates That Mr. Stout Can Present Evidence In Support of a Plausible Argument that He Has "So Changed" As A Result of Continuous Participation in Treatment That He Would Be Safe To Be At Large If Unconditionally Released

Mr. Stout has been continuously confined at the SCC since 2001. He was committed in 2003 after it was determined that he had a Mental Abnormality that caused him to be sexually dangerous. He no longer has a Mental Abnormality and is no longer sexually dangerous. Conceptualizing treatment in the least restrictive sense, it is most reasonable to conclude that his current changed condition is attributable to continuously participating in treatment as a result of being in treatment on an ongoing basis. Any other interpretation would make the conditions for being released from civil confinement more restrictive than the conditions for being placed in civil confinement.

XIII. Testing Question VI.A.5. Indicates That Mr. Stout Can Present Evidence In Support of a Plausible Argument that He Has Undergone an Identified and Permanent Physiological Change that Renders Him Unable to Commit a Sexually Violent Act?

Mr. Stout underwent radiation treatments after being diagnosed with prostate cancer in 2010. He has been treated with Depo-Lupron injections for over two years. His self-reported capacity for sexual arousal is minimal. Very few sex offenders over the age of 50 commit new rape offenses. Mr. Stout's physiological changes as a result of cancer, pharmacological treatment, and advancing age have greatly disabled his capacity for sexual arousal. These developments make it very unlikely that he has the libido to commit sexually violent acts in the future.

XIV. Conclusions Regarding the Questions at Issue

- A. Mr. Stout does not currently suffer from a Mental Abnormality.
- B. It is unlikely that he will sexually recidivate as a result of a Mental Abnormality if he is released from confinement.
- C. He has experienced physiological changes as a result of cancer, pharmacological treatment, and advancing age that have greatly disabled his capacity for sexual arousal. It is unlikely that he has the libido to commit sexually violent acts in the future.

I certify and declare under penalty of perjury of the laws of the State of Washington that the foregoing is true and correct to the best of my knowledge.

Executed at Vancouver, Washington, this 7<sup>th</sup> day of May, 2013.

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Richard Wollert, Ph.D.

OR

# APPENDIX E

# Defining Mental Disorder When It Really Counts: DSM-IV-TR and SVP/SDP Statutes

Allen Frances, MD, Shoba Sreenivasan, PhD, and Linda E. Weinberger, PhD

Civil commitment under the sexually violent predator (SVP) statutes requires the presence of a statutorily defined diagnosed mental disorder linked to sexual offending. As a consequence of broad statutory definitions and ambiguously written court decisions, a bright line separating an SVP mental disorder from ordinary criminal behavior is difficult to draw. Some forensic evaluators reject whole categories of DSM-IV-TR (Diagnostic and Statistical Manual of Mental Disorders: Text Revision) diagnoses as qualifying disorders (e.g., personality and substance abuse disorders), while others debate whether recurrent rape constitutes a paraphilic disorder. We argue that the ramifications of the SVP process, in representing both the balancing of public safety and the protection of an individual's right to liberty, demand that decisions about what is a legally defined mental disorder not be made in an arbitrary and idiosyncratic manner. Greater clarity and standardization must come from both sides: the legalists who interpret the law and the clinicians who apply and work under it.

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Perhaps one of the most controversial areas in forensic mental health is the civil commitment of sex offenders upon completion of their prison sentences. Several states have enacted either Sexually Violent Predator (SVP) or Sexually Dangerous Person (SDP) provisions.<sup>1,2</sup> The SVP/SDP laws are meant to protect society from the relatively small group of sex offenders who have both a mental disorder and a high risk of recidivism. The criteria necessary for categorizing an individual as an SVP/SDP include findings that the person was convicted of offenses determined by the state to constitute a sexually violent crime; the person has a diagnosed mental disorder;

and as a result of that disorder, the person is likely to engage in sexually violent offenses. Individuals identified as an SVP/SDP are civilly committed for treatment in designated mental health facilities after serving their prison terms. The period for an SVP/SDP commitment is indefinite.

SVP/SDP statutes exist because of legislatures' concern about the release of known dangerous sex offenders from prison into the community. Notorious sex crimes committed by released offenders serve to reinforce society's acceptance of laws designed to identify extremely dangerous incarcerated sexual offenders who represent a threat to public safety. However, these laws have not been without controversy.

As civil commitment can only be initiated if the individual is determined to harbor a mental disorder, some in the psychiatric community view the SVP/SDP laws as an inappropriate use of psychiatry to promote preventive detention.<sup>3</sup> Those who oppose the laws worry that in pursuing the worthwhile effort to reduce sexual crime, these laws violate individual civil rights and could provide a slippery slope toward

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psychiatric commitment for whatever behaviors society deems deviant at any given time.

On the other hand, the U.S. Supreme Court has considered these concerns and has held the SVP process to be constitutional, fulfilling the intent of civil commitment. Those who support the statutes view them as a necessary way of protecting potential victims from a small group of highly dangerous predators.

The conceptual debate between these camps is likely to continue as long as SVP/SDP laws exist, and cannot be settled easily. Even among those who do not oppose the SVP/SDP civil commitment statutes, there is much debate about what is meant by a diagnosed mental disorder and what disorders should qualify.<sup>1,4-6</sup>

The rationale for SVP/SDP commitment is the presence of a statutorily defined "diagnosed mental disorder," which is linked to sexual offending. But what is meant by that term? The ramifications of the SVP/SDP process, in representing both the balancing of public safety and the protection of an individual's right to liberty, demand that decisions about what is a legally defined mental disorder should not be made in an arbitrary and idiosyncratic manner. The purposes of this article are to discuss the statutory and case law definitions of diagnosed mental disorder and what guidelines are offered as to who qualifies for an SVP/SDP civil commitment; to examine what the Diagnostic and Statistical Manual of Mental Disorders: Text Revision (DSM-IV TR)<sup>7</sup> can and cannot offer to the process and what disorders may qualify; and to propose a conceptual template toward developing expert consensus in rendering SVP/SDP diagnoses.

### Definition of SVP/SDP Mental Disorder by State Statutes

The current SVP/SDP statutory laws must not be confused with the earlier sexual psychopath laws (enacted in the 1930s and repealed by the 1980s). A brief historical overview serves to place the implementation of the current SVP/SDP statutes in context.

The intent of the sexual psychopath laws was to identify convicted sex offenders amenable to treatment who would then be placed in a psychiatric hospital in lieu of prison. These sexual psychopath laws were formulated during a period of optimism that mental health interventions could cure offenders<sup>3</sup>

and that hospitals were both more humane and more effective than prisons. The laws fell into disfavor in the 1980s in reaction to well-publicized cases of sex offenders who committed heinous acts after purportedly successful completion of their hospital treatment.

Another important contextual factor occurred at approximately the same time. There was a trend away from indeterminate prison sentences that gave judges and parole boards considerable discretion. Instead, courts applied fixed sentencing for similar crimes. Determinate sentencing reflected, in part, a shift in the criminal justice system from rehabilitation to incapacitation. The purpose of determinate sentences was to increase fairness and reduce possible bias. An unintended consequence was that some high-risk sex offenders served shorter sentences than they would have under an indeterminate scheme.

Despite the move to repeal sexual psychopath laws, civil commitment statutes emerged in the 1990s for a subpopulation of dangerous sex offenders. Earl K. Shriner was such an individual.<sup>3</sup> Mr. Shriner served a 10-year term for the kidnap and assault of two teenaged girls. Two years after his release from custody, he sodomized a seven-year-old boy and cut off his penis. This case and the public outcry that ensued led the state of Washington to be the first to enact an SVP law. The purpose was to identify sex offenders who should be civilly committed because of their mental disorder, which predisposes them to dangerous sexual behavior.

Currently, most states with SVP/SDP laws define the qualifying mental disorders in very similar terms. The common definition of a diagnosed mental disorder 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. 1, p 473).

This legal definition is remarkably vague and difficult to apply in specific cases. For example, it is not clear why both congenital and acquired conditions are specified, as these together cover the territory of all conditions. The terms "emotional and volitional capacity" seem to form an important part of the definition but are not defined further. Nor do these terms have clear definitions within psychology or psychiatry. The term predisposes is never defined precisely, so it is not clear what degree is required before the statutory definition is met.

Perhaps absent most in the definition is any indication of which mental disorders might warrant an SVP/SDP civil commitment. Case law emerging in the various states has also been ambiguous on this question.<sup>1</sup> Moreover, the legal reasoning provided in the states' case decisions is not usually clear, specific, or clinically helpful. In summary, the statutory definitions across the states are so broad that they defy precise guidance as to what warrants a designation of an SVP/SDP mental disorder.

### Definition of Mental Disorder: U.S. Supreme Court

The U.S. Supreme Court twice reviewed SVP matters, in *Kansas v. Hendricks*<sup>8</sup> and *Kansas v. Crane*.<sup>9</sup> On each occasion, the Court found the process to be constitutional. In both cases, the requirement of a mental abnormality coupled with dangerousness was cited as a predicate for civil commitment. Moreover, the Court recognized the historical view that restraining dangerous mentally ill persons for treatment via civil commitment has not been considered punishment (as articulated in *Jones v. U.S.*<sup>10</sup>).

In *Kansas v. Hendricks*, Mr. Hendricks had a long history of sexual molestation of children. He admitted to having sexual desires for children, urges that he could not control when he was under stress. Mr. Hendricks was given the diagnosis of pedophilia, a disorder that the Kansas trial court qualified as a mental abnormality under the Kansas SVP Act. However, the Kansas State Supreme Court invalidated the SVP Act on the grounds that mental abnormality did not satisfy due process, in that involuntary civil commitment must be predicated on a mental illness. The U.S. Supreme Court reversed the State Supreme Court's ruling, noting that states were left to define terms that were of a medical nature that have legal significance. The Court ruled that mental abnormality, as defined by the Kansas SVP statute, satisfied substantive due process requirements for civil commitment: "it couples proof of dangerousness with proof of some additional factor, such as 'mental illness' or 'mental abnormality'" (Ref. 8, p 346).

What was this mental abnormality according to the U.S. Supreme Court? The Court, in the majority opinion, stated that involuntary commitment statutes have been upheld consistently to detain people who are "unable to control their behavior and

thereby pose a danger to the public health and safety" (Ref. 8, p 346), provided that proper procedures and evidentiary standards were followed. The Court underscored that state legislatures were not required to use the term "mental illness," and that the states were free to use any similar term. In reviewing the Kansas statute, the Court noted that there must be "a finding of future dangerousness" that then "links that finding to the existence of a 'mental abnormality' or 'personality disorder' that makes it difficult, if not impossible, for the person to control his dangerous behavior" (Ref. 8, p 358).

How would this U.S. Supreme Court ruling fit with contemporary DSM-IV-TR<sup>7</sup> nomenclature? In the *Hendricks* case, the DSM-IV<sup>11</sup> diagnosis at issue was pedophilia, and was one found to correspond with the legally defined mental disorder. But would other disorders qualify or comport within the broad meaning offered by the Court?

In *Kansas v. Crane*,<sup>9</sup> the Court had an opportunity to rule on this issue. Mr. Crane, a previously convicted sex offender, was diagnosed as having exhibitionism and antisocial personality disorder. While the experts believed that exhibitionism alone would not support a classification as an SVP, they opined that the combination of the disorders would meet SVP criteria. Mr. Crane was declared an SVP, and the case was appealed.

The Kansas State Supreme Court reversed the lower court's finding and interpreted the *Hendricks* case as requiring, "a finding that the defendant cannot control his dangerous behavior"—even if (as provided by Kansas law) problems of 'emotional capacity' and not 'volitional capacity' prove the 'source of bad behavior' warranting commitment" (Ref. 9, p 411). The case was then appealed to the U.S. Supreme Court. Kansas argued that the State Supreme Court wrongly interpreted *Hendricks* as requiring that it must always be proved that a dangerous individual is "completely unable to control his behavior" (Ref. 9, p 411).

The U.S. Supreme Court held that there was no requirement for a total or complete lack of control. The Court wrote that lack of control was not absolute, and if such an approach were used it would, "risk barring the civil commitment of highly dangerous persons with severe mental abnormalities" (Ref. 9, p 407).

The Court recognized the important distinction between the civil commitment of dangerous sex of-

fenders from other dangerous persons, for whom criminal proceedings would be more proper. The Court reasoned that such a distinction was necessary; otherwise, civil commitment would become a "mechanism for retribution or general deterrence" (Ref. 9, p 407). However, the Court never specified how to make this differentiation. Nor did the Court define its own conception of a qualifying "mental disorder."

In *Crane*, the Court acknowledged that no precise meaning was given to the phrase, "lack of control." The Court wrote:

[I]n cases where lack of control is at issue, "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. 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 sexual 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. 9, p 413].

In both *Hendricks*<sup>8</sup> and *Crane*,<sup>9</sup> the Court avoided offering specific guidance as to what mental condition would support "proof of serious difficulty in controlling behavior." Rather, the Court acknowledged that states should have "considerable leeway in defining the mental abnormalities and personality disorders that make an individual eligible for commitment" (Ref. 9, p 413). While such allowance has been granted to the states, as mentioned, the states have remained equally nonspecific on this point.

In *Crane*, the Court considered whether an SVP mental abnormality could be justified solely on the basis of emotional as opposed to volitional impairment. Mr. Crane carried the dual diagnoses of exhibitionism and antisocial personality disorder (with the Court citing the DSM-IV<sup>11</sup> for reference); the experts believed that these diagnoses impacted his emotional capacity. The Court acknowledged that in *Hendricks*, the discussion was limited to volitional disabilities, such as pedophilia (referencing the DSM-IV criterion), which involved what the layperson might describe as a lack of control. The Court wrote that they had not drawn a clear distinction between a purely emotional versus volitional sexually related mental abnormality. They further noted that there might be considerable overlap between defective understanding and appreciation, and the inability to control behavior. The Court stated that they had no occasion to consider in either *Hendricks* or

*Crane* whether civil commitment on the basis of emotional abnormality would be constitutional.

Ultimately, the Court's commentary on the terms volitional and emotional impairment is not particularly useful to those who conduct SVP/SDP evaluations. Nonetheless, even in *Kansas v. Hendricks*, an egregiously clear case of sexual deviance, in which a man asserted that the only barrier that could keep him from sexually assaulting children was death, the U.S. Supreme Court filed a narrowly ruled decision. In the five-to-four decision, the swing voter, Justice Kennedy, wrote a separate opinion cautioning against overly broad interpretations of the boundaries of suitable mental disorders.

The U.S. Supreme Court holdings are largely silent and unhelpful in defining clearly what constitutes an SVP/SDP mental disorder. There is the instruction to consider the features of the case to determine the mental abnormality. Can a personality disorder qualify as an SVP/SDP mental disorder alone, or must it be coupled with a sexual deviancy disorder? Moreover, what mental abnormality is sufficient to distinguish between the cases of a dangerous sex offender and an ordinary criminal?

### Definition of Diagnosed Mental Disorder: DSM-IV-TR

Given the vagueness of the Supreme Court's decisions coupled with the states' broad and ambiguous definitions encompassed in the SVP/SDP statutes, one might hope that the DSM-IV-TR<sup>7</sup> would provide clearer guidelines on what constitutes a mental disorder. Unfortunately, the introduction of the DSM-IV-TR openly states that it is unable to provide a precise definition of a mental disorder:

Although this manual provides a classification of mental disorders, it must be admitted that no definition adequately specifies the precise boundaries for the concept of "mental disorder." The concept of mental disorder, like many other concepts in medicine and science, lacks a consistent operational definition that covers all situations. All medical conditions are defined on various levels of abstraction—for example, structural pathology (e.g., ulcerative colitis), symptom presentation (e.g., migraine), deviance from physiological norm (e.g., hypertension), and etiology (e.g., pneumococcal pneumonia). Mental disorders have also been defined by a variety of concepts (e.g., distress, dysfunction, dyscontrol, disadvantage, disability, inflexibility, irrationality, syndromal pattern, etiology, and statistical deviation). Each is a useful indicator for a mental disorder, but none is equivalent to the concept, and different situations call for different definitions [Ref. 7, pp xxx-xxxi].

Although the concept of mental disorder is crucial to both psychiatry and to the SVP/SDP laws, it is impossible to define well in the abstract. In practice, forensic clinicians use the DSM-IV-TR to describe mental disorders present in an individual. The courts, however, have not provided clear indications about which of these are applicable to the SVP/SDP statutes.

In the introduction, the DSM-IV-TR addresses its use in forensic settings:

In most situations, the clinical diagnosis of a DSM-IV mental disorder is not sufficient to establish the existence for legal purposes of a "mental disorder," "mental disability," "mental disease," or "mental defect." In determining whether an individual meets a specified legal standard (e.g., for competence, criminal responsibility, or disability), additional information is usually required beyond that contained in the DSM-IV diagnosis. This might include information about the individual's functional impairments and how these impairments affect the particular abilities in question. It is precisely because impairments, abilities, and disabilities vary widely within each diagnostic category that assignment of a particular diagnosis does not imply a specific level of impairment or disability [Ref. 7, p xxxiii].

This caution in the introduction emphasizes the need for a case-by-case analysis of the elements present in the individual and its correspondence to the legal definition of an SVP/SDP diagnosed mental disorder. Moreover, the cautionary statement does not imply that the DSM-IV-TR cannot be used to justify SVP/SDP civil commitment, as may be concluded erroneously if no further review of the caution were undertaken. The DSM-IV-TR offers a widely accepted method of defining and diagnosing mental disorders and provides the means of conveying to the trier of fact the best information available on psychiatric disorders. In both *Hendricks*<sup>8</sup> and *Crane*,<sup>9</sup> the U.S. Supreme Court recognized the DSM-IV<sup>11</sup> classification system when referring to the diagnoses rendered.

Another potential misinterpretation of the DSM-IV-TR is that the mere presence of a specific disorder in an individual is equivalent to that person's having met the legally defined mental disorder. The introduction states explicitly:

Moreover, the fact that an individual's presentation meets the criteria for a DSM-IV diagnosis does not carry any necessary implication regarding the individual's degree of control over the behaviors that may be associated with the disorder. Even when diminished control over one's behavior is a feature of the disorder, having the diagnosis in itself does not demonstrate that a particular individual is (or was) unable to control his or her behavior at a particular time [Ref. 7, p. xxxiii].

Bearing this caution in mind, a clinician conducting an SVP/SDP evaluation should not rely on the diagnosis alone to conclude that all persons with such a diagnosis are predisposed to reoffend sexually.

### **DSM-IV TR Mental Disorders: Which Qualify for an SVP/SDP Mental Disorder?**

As indicated earlier, the statutes and the U.S. Supreme Court have not delineated what specific mental disorders do or do not qualify for an SVP/SDP commitment. Therefore, it may follow that any DSM-IV-TR diagnosis could render a person eligible for commitment as long as it can be demonstrated that such a condition predisposes the person to committing dangerous sexual acts. But which ones should count for an SVP/SDP commitment?

#### **Pedophilia**

This disorder is probably the most easily identified and supported mental disorder in SVP/SDP cases. Pedophilia is widely recognized as sexual deviance, and the DSM-IV-TR criterion sets for this disorder are well defined. Those who meet the diagnosis of pedophilia engage in deviant urges, fantasies, and behaviors over an extended period. Such individuals are distinguished from those who engage in sexual activity with children that may be short-term and situational (e.g., incestual context during divorce or other stress, influenced by intoxication).

One area of debate is whether diagnosed pedophilia can ever be in remission. Some evaluators believe that a prior remote pattern of pedophilic behavior does not mean that the disorder is current. Such evaluators may argue that the remoteness of the acts and the individual's lack of endorsement of current pedophilic urges and fantasies justify an in-remission categorization. However, DSM-IV-TR describes pedophilia as tending to be chronic and lifelong, with the expression of sexual deviancy waxing and waning in response to opportunity, stressors, or interaction with comorbid disorders. In addition, those who are in custody do not have the opportunity to engage in deviant sexual behavior with children, nor are they very likely to endorse pedophilic urges and sexual fantasies in an adversarial context. Thus, a conclusion that the disorder is in remission would be weak in such circumstances. Careful consideration of the case facts and other data (e.g., treatment variables, physical debilitation) is necessary before a conclusion that the pedophilia is in remission can be justified for

those who have been in custody with the lack of opportunity to reoffend.

### **Paraphilia NOS**

The disorder, paraphilia not otherwise specified (NOS), nonconsenting person, has been used most frequently to diagnose the presence of sexual deviancy in the form of coercive sexual contact, primarily for the crime of rape. This diagnosis is given to distinguish the criminally inclined individual who rapes as a part of a broad repertoire of illegal activities from the rapist driven by deviant sexual urges—namely, arousal to coercion.

This is probably the most controversial concept in SVP/SDP evaluations and one that has a long and much misunderstood history. During construction of the DSM-III-R<sup>12</sup> in 1985, the suggestion was made to add paraphilic coercive disorder as a separate category in the paraphilia section. Researchers in the area supported this suggestion; however, there had been little systematic research on the usefulness, reliability, validity, or definition of the proposed disorder. Moreover, significant debate ensued in a 1985 DSM conference about categorizing rape behavior as a mental disorder. There was considerable concern that such a disorder could be used in forensic settings to exculpate rapists. Consequently, the disorder was not included in the DSM-III-R. In the DSM-IV,<sup>11</sup> new disorders for inclusion had to demonstrate a high degree of empirical support. There was no suggestion for including a category for coercive sexual disorder in the DSM-IV, nor in the Text Revision.<sup>7</sup> Paraphilic coercive disorder is not mentioned in the examples of paraphilia NOS, and it is not included in an appendix of suggested diagnoses for further study. The basis for the exclusion of a separate coercive sexual disorder in the DSM-IV was that there were insufficient data to support this disorder.

Unfortunately, the DSM IV wording of paraphilia was not thought out carefully, which has led to much misinterpretation, nor was it corrected in the Text Revision. In DSM-III-R, Criterion B included distress or acts. In DSM-IV, the acts element was referred to as behaviors under Criterion A and remained so in DSM-IV-TR. The DSM-IV-TR describes the essential features of a paraphilia as, "recurrent, intense sexually arousing fantasies, sexual urges, or behaviors . . ." (Ref. 7, p 566). The use of "or behaviors" was an inadvertent placement and in no way meant to signify that a paraphilia could be

diagnosed based on acts alone. Rather, the behaviors were meant to signify the culmination of urges and fantasies. This distinction is necessary to separate paraphilia from opportunistic criminality. The other misleading aspect was the narrative in the introduction of the paraphilias that one type was nonconsent. The term nonconsenting persons was meant to apply only to exhibitionism, voyeurism, and sadism. It was not meant to signify rapism specifically; rape was not included as a coded diagnosis nor as an example of NOS. While there may be cases where the diagnosis is justified purely on the basis of rape behavior, it was never intended to convey that the acts alone would be paraphilic. Some rapes may be triggered by opportunity, others may occur in the context of intoxication-related disinhibition, and some may reflect character disorder or other nonparaphilic pathology.

The discussion regarding paraphilic coercive disorder was not widely promulgated to the general clinical community, and the confusion regarding paraphilia NOS is understandable. However, now that this information is disclosed in a public forum, SVP/SDP evaluators should take notice of the current clarification and of the meaning of "or behaviors" in the narrative descriptor of this set of disorders. The use of paraphilia NOS to describe repetitive rape cannot be justified on the basis of the term "or behaviors" alone.

This distinction does not mean that paraphilia NOS cannot or should not be used to describe some individuals who commit coercive sexual acts. However, such diagnosis would require considerable evidence documenting that the rapes reflected paraphilic urges and fantasies linking the coercion to arousal. One acceptable standard for using it may be to demonstrate clear substantiation of urges and fantasies, either as inferred by the acts perpetrated on the victim or by the interview information, so as to distinguish it from criminal behavior that is not rooted in sexual psychopathology.

The term rape does appear within the DSM-IV-TR<sup>7</sup> in the context of sexual sadism. It is possible that the repetitive expression of sadistic behaviors (e.g., domination, strangulation, beatings) in a particular case of a serial rapist may well warrant the diagnosis of paraphilia NOS, with sadistic traits, when there is insufficient evidence to support the criteria for sexual sadism. The DSM-IV-TR Casebook<sup>13</sup> provides an illustration of paraphilia NOS, for a serial rapist (Jim) without antisocial traits. The narrative in the

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Casebook states, "During the development of DSM-III-R, the term *Paraphilic Coercive Disorder* was suggested for this particular kind of Paraphilia, but the category has never been officially recognized. Therefore, Jim's disorder would be coded as Paraphilia Not Otherwise Specified (DSM-IV-TR, p.579)" (Ref. 13, p 173). However, reliance on the Casebook to buttress an argument for using paraphilia NOS to signify paraphilic coercive disorder may be a weak avenue; particularly, in a forensic context. The Casebook, unlike the DSM-IV, does not reflect the work or endorsement of the DSM-IV Task Force; therefore, it is not authoritative.

The sexual disorder section does include an NOS category. Throughout the DSM-IV, the NOS diagnosis reflected the Task Force's intent to include generic residual categories for patients with clinical problems that did not fit into one of the more specific definitions of disorders. As with the specific criteria sets, the intent for NOS was to allow clinicians to use their judgment for each individual as to whether the symptom cluster caused enough distress and/or impairment to be a mental disorder. There were no guidelines as to how such judgments should be made and no hard and fast rules; it was left to the clinician to make the determination on a case-by-case basis. This vagueness in guidelines was intentional so as to permit the clinician flexibility in using the Manual.

Nonetheless, paraphilia NOS, nonconsenting partners, is an inherently weak construct, given the lack of a set of defined criteria. There is a danger of misusing DSM-IV TR<sup>7</sup> mental disorders by applying an idiosyncratic interpretation of case facts to shoe-horn individuals, so as to justify an SVP/SDP commitment. Paraphilia, NOS has the potential to be a catch-all diagnosis for persons accused of sexual offenses and for whom the clinician cannot identify criteria for a specific clinical diagnostic category.

Attempts to describe rape-related paraphilia is a difficult diagnostic endeavor.<sup>6,14,15</sup> Identifying the behavior as paraphilic as opposed to criminal is complicated by the often comorbid disorder of antisocial personality disorder. The line between personality disorder and sexual disorder may not be drawn easily in certain instances, nor may one disorder exclude the other. In some instances, the behaviors demonstrated can be articulated to reflect paraphilic urges and fantasies; in other instances, it may be more accurate diagnostically to render only the antisocial personality disorder.

### Antisocial Personality Disorder

The position that antisocial personality disorder (ASPD) is a qualifying mental disorder has generated much debate in recent articles.<sup>1,4-6</sup> It has been argued that ASPD should be excluded on the grounds that SVP/SDP commitment should require the presence of a sexual deviancy disorder. ASPD has been viewed as triggering rape or other deviant sexual behaviors because of criminal rather than sexual motives. Further, it is argued, that most prisoners in custody would qualify for ASPD, and no one is suggesting that they be transferred from a prison to a psychiatric hospital. In this view, the use of ASPD to trigger SVP/SDP commitment is not justified and would represent preventive detention.

The other view argues that there has been no prescription on the use of ASPD in the SVP/SDP statutes or the U.S. Supreme Court rulings.<sup>8,9</sup> This position maintains that the application of ASPD or any other diagnosis as a qualifying mental disorder should be formulated on a case-by-case basis, rather than excluding *pro forma* entire categories of diagnoses. The core distinction between these views is that those who oppose the use of ASPD base their position on group analysis. Those who support the use of ASPD base their position on conducting an analysis of a specific individual's predisposition to engage specifically in repetitive sexual criminal behavior.

The U.S. Supreme Court has not drawn the bright line of what is a diagnosed mental disorder; instead, the Court has noted that there should be a distinction between the repetitive criminal and those whose behaviors are driven by a mental disorder.<sup>9</sup> The Court discussed the need to consider the features of the case to determine if the individual has a mental abnormality, and if so, whether that condition renders the person distinguishable from an individual who is an ordinary criminal offender. The case characteristics of a particular offender should be the guideposts for the clinician. For example, the clinician's rationale should articulate how the failure to conform to social norms with respect to lawful behaviors relates to this person's proclivity toward dangerous sexual behavior toward others.

Clinicians who categorically exclude ASPD as a qualifying diagnosis may be criticized for ignoring the statutory language and Supreme Court guidance. Unless there is legal instruction to the contrary, either through statutory or case law, ASPD should be a

viable SVP/SDP mental disorder if it can be demonstrated that it leads specifically to a pattern of sexual offenses.

**Other Disorders: Psychosis, Mood, Substance Abuse, and Cognitive Conditions**

Generally, the SVP/SDP process has been based predominantly on a showing that the individual has a sexual deviancy disorder. There is no premise in the law to include only sexual deviancy disorders. Therefore, examiners should not be reluctant to use diagnoses other than the paraphilias as a qualifying SVP/SDP mental disorder if it can be demonstrated that such disorders are causally linked to the individual engaging in sexual crimes.

There may be cases of persons who have schizophrenia, in which an aspect of their disorder is recurrent sexual impulsiveness and aggression. While the general population of those who have schizophrenia may not be predisposed to committing criminal sexual offenses, a particular individual's psychosis may manifest repeatedly in a sexually aggressive manner. For example, a person's delusion may be that he is a deity who must impregnate all available females to save the world and produce perfect beings. Consequently, he rapes adult women. His psychosis predisposes him to engage repeatedly in sexual behavior with nonconsenting partners to fulfill the requirements of the delusion.

In addition, there may be cases of individuals with intellectual disabilities who commit sexual offenses. On a case-by-case basis, the clinician can examine how that specific person's limited cognitive capacity (e.g., impaired judgment, limited coping resources, poor frustration tolerance) impairs the person's ability to understand what is appropriate sexual behavior and what is not. Such impairment may, in some persons, result in repetitive pedophilic or rape behavior.

Mania and attendant hypersexuality may be a driving element in repetitive sexually assaultive behavior. An individual in a manic state may consistently become sexually disinhibited and force others into sexual activity or choose children as sexual targets. In such instances, bipolar disorder could be argued as representing a qualifying mental disorder for an SVP/SDP commitment.

Substance abuse and intoxication represent another class of disorders that may warrant a designation as an SVP/SDP mental disorder diagnosis. For example, an individual who rapes repetitively under

the influence of stimulants may warrant an SVP/SDP civil commitment. Intoxication may be uncovering an underlying sexual deviancy disorder or may represent an aberrant reaction to the stimulant. As with ASPD, it is important to emphasize that while substance abuse as an SVP/SDP designated mental disorder may represent an unusual case, the presence of a clear pattern connecting substance abuse to sexual offending in that individual should be the basis of determining whether it is a qualifying mental disorder.

**Comorbid Conditions**

Comorbid conditions are both common and important for evaluators to consider in their interviews. Coexisting disorders may be associated with a worse outcome than if the individual presents with only one disorder. The cumulative impact of comorbid mental conditions such as sexual deviancy, personality disorder, and substance abuse may be the underlying mechanism for driving the individual to have a predisposition to commit deviant sexual acts. Therefore, we strongly encourage examiners to explore disorders present in the individual, in addition to paraphilias, that may drive repetitive sexual deviant behavior.

**Developing an Expert Consensus**

Forensic applications of DSM diagnoses are left largely to the individual clinician. As the SVP/SDP process demonstrates, there is no good fit between criteria sets in the DSM-IV-TR and the legal standards of mental disorder. However, clinicians have to apply these psychiatric and legal concepts to the individual being examined and then explain them to the trier of fact. If experts disagree as to what constitutes a diagnosed mental disorder, how will the lay trier of fact make this legal determination? Therefore, it would be of value if clinical examiners in the SVP/SDP field attempted to establish a consensus in several different areas of their work. Such a consensus would increase the reliability and credibility of the evaluations and facilitate communication across the psychiatric/legal interface. We suggest the following areas that need review and consideration.

First, there should be a consensus regarding which diagnoses qualify for an SVP/SDP commitment, and under what circumstances. The two areas of controversy, paraphilia NOS and antisocial personality disorder, may be appropriate in some circumstances and

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inappropriate in others. These should be clarified and detailed to avoid idiosyncratic determinations.

For Paraphilia NOS, one approach may be to demonstrate that there are sufficient case data regarding the individual's underlying deviant fantasies and urges upon which he has acted, so as to conclude that he is predisposed to commit dangerous sexual offenses. These may include identifying the presence of ritualistic behaviors (e.g., always uses duct tape to bind victims), statements, or behaviors that demean the victim (e.g., forces her to say she enjoys being raped), and behaviors that demonstrate arousal in controlling the victim (e.g., sustains an erection while victim is pleading for his or her life, crying, or making statements that he or she is being hurt).

For antisocial personality disorder, this would involve demonstrating how the disorder, based on the case facts, leads to repetitive sexual offenses as opposed to illegal acts of a general nature. This method of reporting the data and how they relate to the SVP/SDP criteria enhances the thoroughness and rigor of the reasoning, which ultimately makes the opinions easier to understand and defend in court.

Second, there should be agreement on the use of semistructured interviews for diagnostic evaluations in SVP/SDP cases. One of the more difficult, consequential, and scrutinized settings for psychiatric diagnosis is the SVP/SDP evaluation. The interviews afford no confidentiality. In addition, the findings pose risks for both the inmate and society, and will be challenged before a jury. Under these circumstances, it would be highly desirable to have the interviews be as standardized as possible on questions meant to tap the most common disorders likely to be present (viz., antisocial personality disorder, paraphilia, and substance abuse or dependence). Other possible but much less frequently encountered diagnoses (e.g., bipolar disorder, schizophrenia) would not routinely be the subject of semistructured interviewing, unless they seemed pertinent to the particular case. Semistructured interviewing will increase the reliability, transparency, and credibility of diagnosis with little or no increased interview time or effort.

Third, there should be consensus on the appropriate rationales that demonstrate convincingly that the diagnosed mental disorder qualifies for an SVP/SDP civil commitment. It is recommended that forensic clinicians attempt to achieve greater transparency by reporting the rationale they used to justify the presence of an SVP/SDP diagnosed mental disorder or

the reasons why such a disorder is not present. It is not enough to base a conclusion that an individual does or does not have a qualifying SVP/SDP mental disorder solely on the presence or absence of a listed DSM-IV-TR disorder. By demanding the rationale for the clinician's opinion, there is less risk that the trier of fact will accept unknowingly idiosyncratic and/or ill-defined conclusions about whether a diagnosed mental disorder is or is not present. This assurance would provide additional quality control, reliability, and credibility to controversial diagnoses. The more detailed the documentation regarding an evaluator's opinion on whether a diagnosis does or does not represent an SVP/SDP mental disorder, the more clarity is provided for the trier of fact to consider fully the expert's opinion. Clear articulation of the reasoning on how a particular DSM-IV-TR disorder or set of disorders qualifies could serve to reduce an inclination toward overinclusiveness as well as underinclusiveness.

## Conclusion

As a consequence of U.S. Supreme Court decisions that are written ambiguously and tentatively, the bright line separating an SVP/SDP mental disorder from ordinary criminal behavior is difficult to draw and tests a no-man's land between psychiatry and the law. One way to resolve this dilemma is to discuss the existing definitions of the legally qualifying mental disorder and call for more specificity. Legislative and/or judicial review may force the legal system to be more explicit as to the kind and degree of mental disorder that is constitutionally sufficient to deprive individuals of their right to freedom as well as support the need for public safety. As for forensic clinicians, their role demands a careful examination and articulation of the fit between DSM-IV-TR diagnoses and qualifying SVP/SDP mental disorders. Greater clarity and standardization must come from both sides: the legalists who interpret the law and the clinicians who apply and work under it.

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