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No. 69061-2-I

IN THE COURT OF APPEALS OF THE STATE OF WASHINGTON

DIVISION ONE

IN RE THE DETENTION OF RICHARD ALLEN RUDE

STATE OF WASHINGTON,

Respondent,

v.

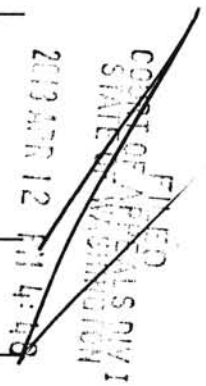
RICHARD ALLEN RUDE,

Petitioner/Appellant.

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

The Honorable John Meyer

BRIEF OF PETITIONER/APPELLANT



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A. ASSIGNMENTS OF ERROR

1. Mr. Rude's diagnoses of paraphilia NOS (nonconsent) and anti-social personality disorder and resulting commitment violated his Fourteenth Amendment right to due process of law.

2. The admission of prejudicial and unreliable hearsay, ostensibly to explain the basis for the State expert's opinion, but used by the State as substantive evidence of dangerousness, violated Mr. Rude's right to due process.

3. The assistant attorney general committed misconduct that violated due process when she urged the jury that they could commit Mr. Rude based on any abnormality, not just the diagnosis relied upon by the State's expert.

4. Mr. Rude's right to a unanimous jury verdict was violated when the assistant attorney general urged the jury that they could commit based on any abnormality, not just the diagnosis relied upon by the State's expert.

B. ISSUES PERTANING TO ASSIGNMENTS OF ERROR

1. Under the due process clauses of the Fourteenth Amendment and article I, section 3, a person may only be civilly committed against his will upon proof of current mental illness and dangerousness. The Supreme Court has emphasized that this fundamental requirement

precludes the commitment of an individual unless he suffers from a mental abnormality sufficient to distinguish him from the "dangerous but typical" recividist convicted in a criminal case. The controversial diagnosis of paraphilia not otherwise specified (nonconsent) has been rejected by the American Psychiatric Association, roundly criticized within the profession, and lacks diagnostic criteria necessary to ensure the diagnosis is reliable. Did the use of the diagnosis to support Mr. Rude's commitment violate due process?

2. Principles of due process preclude the State from committing an individual simply because he suffers from a disorder that may lead to criminal conduct. A general disposition towards criminality is at the foundation of the diagnosis of anti-social personality disorder; indeed, a substantial majority of prisoners, and most male prisoners, suffer from this disorder. Did Mr. Rude's commitment on this basis violate due process?

3. Under ER 703 and ER 705, hearsay that forms the basis of an expert's opinion may only be introduced at trial if (a) the evidence is tied to a specific opinion, and (b) a limiting instruction is issued to the jury. Even where a limiting instruction is given, the United States Supreme Court recognizes that in some instances, the prejudicial impact of hearsay testimony may be too great for the jury to withstand. Did multiple instances of hearsay, introduced into evidence by the State's expert, but

not tied to specific professional opinions, violate Mr. Rude's Fourteenth Amendment right to a fair trial?

4. Due process protects against involuntary commitment except upon proof of mental illness and dangerousness. The terms "mental abnormality" and "personality disorder" have been found to be sufficiently precise to support commitment provided they are specifically defined for the jury. In her closing argument, the assistant attorney general in effect told the jury to ignore its obligation to find that Mr. Rude suffers from a mental illness and commit him if they found the existence of any "condition" that predisposed him to engage in acts of predatory violence. She told them that the diagnoses and DSM-IV definitions were "just a guide." Did the argument urge the jury to commit without finding Mr. Rude was mentally ill, in violation of his right to due process?

5. A respondent in SVP commitment proceedings has the right to a unanimous jury verdict on each element of the commitment statute. Where the State presented evidence of several "conditions" at trial, only one of which was claimed to predispose him to have serious difficulty in controlling his behavior, did the improper argument also deny Mr. Rude a unanimous jury verdict?

C. STATEMENT OF THE CASE

1. Mr. Rude's substance abuse and criminal behavior.

As an adolescent and young man, Richard Rude had a troubled relationship with his family, particular his abusive father, and a substance abuse problem. 6/13/12 20, 26; 6/20/12 RP 65.[1] In 1979, when he was still a juvenile, Mr. Rude was convicted of indecent liberties based upon a game that he played with other boys in which they would grab at or slap adult women in parking lots. 6/18/12 RP 105-06. Mr. Rude also was convicted in connection with sexually obscene prank phone calls he made with other boys. 6/18/12 RP 109; 6/21/12 RP 34. A year later, in 1981, Mr. Rude was prosecuted for rape, based on an offense committed with another man while both were high on amphetamines. 6/18/12 RP 113. Mr. Rude pled guilty to rape in the second degree based on this conduct. 6/18/12 RP 115.

Mr. Rude was referred to the sexual psychopathy treatment program at Western State Hospital ("WSH"). While he was out of custody on his own recognizance pending admission to the program, he started drinking heavily again. 6/18/12 RP 11. He committed another

[1] The verbatim report of pretrial and trial proceedings was transcribed in multiple volumes and is referenced herein by date followed by page number, e.g., 6/20/12 RP 65.

offense, and pled guilty to attempted rape. 6/18/12 RP 118. Mr. Rude was eighteen years old when he commenced the WSH program.

At WSH, Mr. Rude was accused of fondling and trying to force another young man to orally copulate him. 6/18/12 RP 120. Mr. Rude vehemently denied the allegation, and asserted that instead the complainant, who was gay, had made a sexual advance on Mr. Rude. Id. at 121. Nineteen other men, all participants in the treatment program, grilled Mr. Rude about the allegation for three straight days in a closed room without a therapist present. 6/19/12 RP 90-92. With the exception of one man, all the men questioning Mr. Rude were older than him. 6/19/12 RP 89. Following this intense questioning, Mr. Rude admitted to the assault. 6/18/12 RP 121. This was the only time that Mr. Rude admitted to the allegation; at all other times, Mr. Rude maintained that the complainant was gay and came onto him. 6/19/12 RP 92. Mr. Rude nevertheless was discharged from the program and sent to prison.

Prisons in Washington were more racially divided in the 1980s than they are now. 6/20/12 RP 58, 74. In prison, Mr. Rude became affiliated with white supremacist gangs. 6/13/12 RP 14; 6/20/12 RP 74. He continued to abuse drugs, using cocaine while incarcerated. CP 402.[2] Upon his release, Mr. Rude was still disaffected, estranged from his

[2] Excerpts of Mr. Rude's deposition testimony were played for the jury but were not transcribed.

family, and addicted to drugs and alcohol. CP 403-04. He obtained a job as a bouncer, which he enjoyed because he could hit people, and could use the job as a cover to sell cocaine and heroin. 6/13/12 RP 20.

In June of 1994, Mr. Rude committed another rape. 6/12/12 RP 68. The crime occurred during the Dirt Cup races at the Skagit Speedway. 6/12/12 RP 71-72. According to the victim, she was at the speedway with a friend, but they became separated. 6/12/12 RP 73. She said Mr. Rude offered to drive her around so she could look for her friend, but that once she got into his pickup truck, he sped out of the parking lot and drove her to a gravel pit. 6/12/12 RP 76. There, he raped her orally, vaginally, and anally, and then offered her a ride home. 6/12/12 RP 77, 80.

Mr. Rude's account of the offense differed from the victim's. He explained that he had previously met the victim and used drugs with her. 6/13/12 RP 24. He said that prior to the rape, they were smoking crack naked together. 6/13/12 RP 24. He was angry because he had engaged in a drugs-for-sex transaction with her, and she did not deliver. 6/13/12 RP 22, 25. He acknowledged that she said "no" to the sex, but he did not stop. 6/13/12 RP 26. He said that he was in a drug and alcohol stupor, and the victim could have been any female. 6/13/12 RP 22. Mr. Rude pled guilty to rape in the second degree in 1995, and was returned to prison. 6/12/12 RP 50.

2. The sea change in Mr. Rude's attitude.

Mr. Rude's initial adjustment in prison was not very good; he returned to his previous prison lifestyle, earning an infraction in 1997 for possession of heroin. Then, as he put it, the "lightbulb clicked on." CP 407. The major catalyst for change was Mr. Rude's newfound religious faith. CP 409-410. Mr. Rude became actively involved in church programs in prison, attending Promise Keepers[3] classes on Sundays and taking leadership roles in Kairos, a semi-annual retreat and religious renewal program. 6/20/12 RP 106-110. He became first assistant group director and then group leader of the Kairos program, both positions that carried substantial responsibility. 6/20/12 RP 112-13. He earned the respect, trust, and praise of prison chaplain Henry Fischer, who worked with Mr. Rude for 18 months between 2009 and 2010. 6/20/12 RP 121.

Mr. Rude also entered sex offender treatment with treatment provider Shandra Carter. 6/13/12 RP 7, 13. While in treatment, Mr. Rude attended two-hour group sessions four times weekly, and individual sessions twice a month. 6/13/12 RP 38-39. Ms. Carter believed that Mr. Rude was sincere in his engagement with treatment and stated that he made significant progress. 6/13/12 RP 22, 40. He opened up about his past offending behavior and gained insight into the causes. 6/13/12 RP 49.

[3] Promise Keepers was described at the commitment trial as a nationwide men's oriented Christian program. 6/20/12 RP 115.

He acknowledged that his previous attitude regarding women was one of entitlement – that he was entitled to sex from women – and that these beliefs were oppressive. 6/13/12 RP 52.

Ms. Carter opined that in the time leading up to his offenses, Mr. Rude's lifestyle was chaotic. 6/13/12 RP 52. Mr. Rude engaged in violence, drug use, and thrill-seeking behavior. Id. While he was involved in church activities, he met and fell in love with a volunteer, Michelle, and they were married. 6/20/12 RP 117-18. Aware of Mr. Rude's prior convictions, Michelle was nevertheless supportive of Mr. Rude and of his progress through sex offender treatment. 6/13/12 RP 42; 6/20/12 RP 119-120, 137.

Heather Rude, Mr. Rude's daughter from a previous marriage, was also supportive of her father. 6/20/12 RP 132. She learned of Mr. Rude's three rape convictions from her mother when she was twelve or thirteen. 6/20/12 RP 131. She nevertheless reconnected with him when she was eighteen, in response to his efforts to reach out to her. 6/20/12 RP 134-35. Over the next seven years,[4] Ms. Rude became very close to her father, to the point where she considered him her "best friend." 6/20/12 RP 134. She went to visit him as frequently as she was able, bringing her young son with her. 6/20/12 RP 135. She said that he had "changed so much,"

[4] Ms. Rude was 25 when she testified at the commitment trial. 6/20/12 RP 135.

showing newfound sensitivity to the feelings of others, and empathy for his victims and the effect his crimes had on them. 6/20/12 RP 132. He served as a mentor for Ms. Rude's six-and-a-half-year-old son, talking to him and counseling him when he misbehaved. 6/20/12 RP 135.

Ms. Rude offered herself as a housing resource for her father, indicating that she had saved money so that she could obtain an apartment in an area where he would be permitted to live. 6/20/12 RP 135. Mr. Rude would have two years of community supervision upon his release, and, although not obligated by his judgment and sentence to engage in sex offender treatment, would be eligible to enter Phase Three outpatient treatment. 6/22/12 RP 7-8.

3. The State's petition to involuntarily commit Mr. Rude as a sexually violent predator.

In August 2008, Mr. Rude's cellmate, John Frost, also a sex offender, reported that Mr. Rude had assaulted him. 6/18/12 RP 14-15. Mr. Frost claimed that they had an altercation in which Mr. Rude ended up shadow-boxing him. 6/18/12 RP 47. According to Mr. Frost, as Mr. Frost tried to push Mr. Rude away, Mr. Rude pulled Mr. Frost onto his bed and shoved his fingers into Mr. Frost's rectum through his shorts. 6/18/12 RP 46-47. Mr. Frost struggled and kicked Mr. Rude's television over,

breaking it. 6/18/12 RP 48-49. Mr. Rude then became angry at Mr. Frost and punched him in the face. 6/18/12 RP 49.

Mr. Frost acknowledged that his relationship with Mr. Rude had been deteriorating for some time prior to the alleged assault. 6/18/12 RP 65. Also before the alleged assault, Mr. Frost had submitted a transfer request that was not granted. 6/18/12 RP 66. Mr. Frost admitted that an assault allegation might not persuade prison authorities to approve a transfer, but a sexual assault allegation definitely would. Id. John Padilla, who investigated the incident, concluded that an assault of Mr. Frost's face had occurred, but not a sexual assault, and infracted Mr. Rude on this basis only. 6/18/12 RP 67-68.

On August 12, 2010, the State filed a petition to have Mr. Rude involuntarily committed as a sexually violent predator. CP 1-2. The State's petition was supported largely by the testimony of psychologist Kathleen Longwell. Dr. Longwell made the controversial diagnosis of Paraphilia NOS (nonconsent).[5] 6/18/12 RP 132, 138. She saw a pattern in the fact that all of Mr. Rude's offenses involved forced sexual activity on non-consenting persons, 6/18/12 RP 143, even while she acknowledged that this is, in fact, the definition of rape. Dr. Longwell also diagnosed

[5] Dr. Longwell also diagnosed Mr. Rude with Frotteurism and alcohol and cocaine dependence in remission. 6/18/12 RP 138.

Mr. Rude with anti-social personality disorder ("ASPD") and psychopathy. 6/18/12 RP 156, 161-62.

Dr. Longwell testified that she believed Mr. Rude suffered from mental abnormalities which caused significant difficulties in controlling his sexually violent behavior. 6/18/12 RP 169. She stated that her conclusion was based upon Mr. Rude's diagnoses "as a whole," explaining that each diagnosis impaired Mr. Rude's emotional and volitional control, and that they interacted with each other. 6/18/12 RP 171-72.

Dr. Longwell conceded that the editors of the DSM-IV have expressed that the inclusion of the diagnosis of paraphilia NOS in the manual was a mistake. 6/19/12 RP 65. She agreed that the editors rejected the concept of rape as a mental disorder, but that by misreading the poorly-worded paraphilia NOS section of the DSM-IV, practitioners formed the opposite view. Id. at 70. She additionally acknowledged that they believe that the use of the diagnosis in a forensic context is a misuse of psychiatry; in fact, it was never anticipated that the diagnosis would be utilized in court proceedings as a forensic definition to determine the suitability of long-term incarceration. Id. at 68, 71; 6/20/12 RP 37-38.

Using the problematic and poorly-weighted actuarial instruments, the Static 99, SORAG, and SRAFV, Dr. Longwell predicted that Mr. Rude

was in the very high range for sexual recidivism. 6/19/12 RP 14-15, 28-30.

4. Defense expert's opinion.

The defense presented several witnesses to talk about Mr. Rude's personal transformation, including prison chaplain Henri Fischer, two fellow inmates who, over the course of many years of incarceration, witnessed Mr. Rude undergo real, substantive change, and his daughter. The defense also called an expert witness, Dr. Daniel Fisher, a California-based psychologist working with "mentally disordered sex offenders." 6/20/12 RP 151-53.

Dr. Fisher is a sex offender treatment provider, and estimated that at the time of trial he had treated about 200 sex offenders, using a relapse prevention model. 6/20/12 RP 157. According to Dr. Fisher, sex offender treatment has only become effective in the past 15-20 years; the treatment that Mr. Rude received at WSH was likely to have been "pretty typical" of the 1980s, and not effective. 6/20/12 RP 161.

In addition to reviewing many thousands of pages of records, including the records reviewed by Dr. Longwell, Dr. Fisher interviewed Mr. Rude for four hours, and also spoke with his father, wife, and daughter. 6/20/12 RP 165-66. Dr. Fisher stated that Mr. Rude had committed his offenses when he was a younger man, and at the time was a

"real hell-raiser." 6/20/12 RP 166. The claim was that Mr. Rude had changed; Dr. Fisher wanted to verify this. Id.

Dr. Fisher said that the "research is clear" that ASPD and some other personality disorders go into remission and are expressed less and less as people age. 6/20/12 RP 175. Dr. Fisher diagnosed Mr. Rude with ASPD based on his past behaviors, but emphasized that according to the DSM-IV, ASPD remits in the fourth decade of life. 6/20/12 RP 178. He said that had he been basing his diagnosis on the past five to eight years, he would not have diagnosed ASPD. 6/20/12 RP 179.

Dr. Fisher also diagnosed Mr. Rude with alcohol and substance dependence. 6/20/12 RP 186. It was clear, Dr. Fisher testified, that Mr. Rude had been abusing alcohol and substances for a long time, and that both were "common denominators" in his offending behavior. 6/20/12 RP 186-88.

Dr. Fisher also diagnosed Mr. Rude with sexual abuse of an adult. 6/20/12 RP 188. He explained that this is not a mental illness, but rather a reason why a person might go to see a psychologist. 6/20/12 RP 189. Dr. Fisher flatly disagreed with Dr. Longwell's diagnosis of paraphilia NOS (nonconsent). 6/20/12 RP 189; 6/21/12 RP 10. He noted that at the time that the DSM-IV was published, there was a controversy as to whether rape was a paraphilia, with the editors ultimately concluding that it was

not. 6/20/12 RP 191. Dr. Fisher stated that the DSM-V was slated to be released in 2012, however the publication date was delayed due, in part, to an outcry over whether paraphilic coercive disorder should be included as a mental illness.[6] 6/20/12 RP 192. He described the "NOS" category as a "wastebasket diagnosis", generated primarily for purposes of insurance billing. 6/20/12 RP 190.

Dr. Fisher explained that the focus of the DSM-IV in diagnosing paraphilias used to be upon sexual fantasies or urges. 6/20/12 RP 195. The shift to basing a diagnosis on behaviors alone "blurs the distinction between mental illness and ordinary criminality," Dr. Fisher stated. Id. Dr. Fisher believed that decisions regarding possibly life-long psychiatric commitment should not be based on the misreading of a poorly worded criterion item. Id. In his view, a paraphilia should not be diagnosed without evidence of sexually deviant fantasies or urges. 6/20/12 RP 196.

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[6] Dr. Fisher testified that according to the DSM-V website, paraphilic coercive disorder would be included in the appendix as a condition that requires further research. 6/20/12 RP 193. The website now indicates:

> Because the draft diagnostic criteria posted most recently on www.dsm5.org are undergoing revisions and are no longer current, the specific criteria text has been removed from the website to avoid confusion or use of outdated categories and definitions. Changes to disorders and diagnostic criteria, based in part on the latest comments received, will be made through the fall.

Available at http://www.dsm5.org/Pages/Default.aspx, last visited April 11, 2013.

Dr. Fisher described Mr. Rude's offending behavior as "situational and opportunistic," rather than predatory. 6/21/12 RP 16. He saw no evidence that Mr. Rude was having intrusive sexual thoughts that were disturbing to him. Id. Dr. Fisher believed that Mr. Rude initially sought consensual sex with the women he raped. 6/21/12 RP 28. When his victims resisted, Mr. Rude's anger and rage took over, along with his sense of entitlement, and the sex became violent and forceful. Id. at 29. Dr. Fisher stated that the fact that Mr. Rude ejaculated during intercourse was indicative not of arousal to the non-consensual aspect of the sex, but simply of his arousal during the sex act itself. Id. at 30.

Dr. Fisher also took issue with Dr. Longwell's actuarial predictions. 6/21/12 RP 49-90. The actuarial instruments that Dr. Longwell used, as well as the way that she scored them, artificially inflated Mr. Rude's reoffense risk. 6/21/12 RP 54, 58-61. Using the MATS-1 (the "Multisample Age-Stratified Table of Sexual Recidivism Rates"), an instrument which does not make a "risk estimate," but rather provides an observed recidivism rate based on over 1000 offenders, Dr. Fisher calculated Mr. Rude's risk level at 15.95% over a five-year period, and 25.5% over eight years. 6/21/12 RP 84-88.

Dr. Fisher stated that he had read approximately 300 pages of Mr. Rude's sex offender treatment homework. 6/21/12 RP 21. He found Mr.

Rude's work thoughtful and individualized, and stated that Mr. Rude had evidently put a lot of thought and energy into it, and was addressing the issues that applied to him. Id. He said the work was "thoroughly and genuinely done." Id.

Dr. Fisher said that one of the issues processed by Mr. Rude was the components of an offense cycle. 6/21/12 RP 22. Mr. Rude's included low self-esteem, being angry, bitter, hurt, and hateful to other persons, resentment of his mother, rejection of his father, being isolated, having to live up to others' expectations, objectifying women, and grooming himself and others. 6/21/12 RP 22. Dr. Fisher explained that the basis of the relapse-prevention model of sex offender treatment was identification of these components so that in the future, it would be possible to intervene and prevent someone else from being hurt. 6/21/12 RP 23. Dr. Fisher believed that Mr. Rude's relapse prevention plan was very good: it was complete, individualized, and relevant to his offending. 6/21/12 RP 23. Dr. Fisher did not believe that Mr. Rude would commit future acts of sexual violence. 6/21/12 RP 106.

5. Government misconduct and jury verdict.

In rebuttal closing argument, the assistant attorney general ("AAG") told the jury,

> [the defense attorney] told you that what you had to find beyond a reasonable doubt was that Dr. Longwell had diagnosed Mr. Rude with Paraphilia Not Otherwise Specified, that that diagnosis had to be found beyond a reasonable doubt. That's not what the law says.

6/22/12 RP 60.

Mr. Rude objected. Id. The court overruled the objection, stating that the AAG's argument was a "fair comment on the evidence." Id. The AAG continued her argument:

> What you have to find is that Mr. Rude has a condition, a condition that predisposes him. And you remember, we put up the slide with [the] definition of mental abnormality. The DSM, the testimony of the experts, the diagnoses, they're all just a guide.

6/22/12 RP 60-61.

Mr. Rude objected and argued, "what the State is essentially suggesting is they can make up their own mental abnormality." 6/22/12 RP 61. He argued that permitting the jury to commit Mr. Rude based on any mental abnormality would violate substantive due process. 6/22/12 RP 63-64. The court overruled his objection, and stated,

> If there has been error, there has been error. And we're going to have to let the chips fall where it may [sic], depending on what the verdict is, but I think I'm not going to prevent [the AAG] from arguing what she believes the law to be, and what she believes the jury has the right to do.

6/22/12 RP 66.

The jury returned a verdict finding that the State had proven Mr. Rude was a sexually violent predator beyond a reasonable doubt. CP 678. Mr. Rude appeals.

D. ARGUMENT

1. Mr. Rude's involuntary commitment violates due process because it is premised upon diagnoses that are not accepted by the psychiatric profession, are overbroad, and insufficiently precise.

The diagnosis of paraphilia NOS (nonconsent), explicitly rejected by the American Psychiatric Association (APA) and the publishers of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), and roundly criticized within the profession, lacks medical recognition and due process prohibits its use as a predicate for involuntary commitment.

a. Due process requires the State prove an involuntary civil commitment is based upon a valid, medically recognized mental disorder.

The state and federal constitutions guarantee the right to due process of law. U.S. Const. amend XIV; Const. art. I, § 3. A person's right to be free from physical restraint "has always been at the core of the liberty protected by the Due Process Clause from arbitrary government action." Foucha v. Louisiana, 504 U.S. 71, 80, 112 S. Ct. 1780, 118 L. Ed. 2d 437 (1992). The indefinite commitment of sexually violent predators is a restriction on the fundamental right of liberty, and

consequently, the State may only commit persons who are both currently dangerous and have a mental abnormality. Id. at 77; Kansas v. Hendricks, 521 U.S. 346, 357-58, 117 S. Ct. 2072, 138 L. Ed. 2d 501 (1997); In re Det. of Thorell, 149 Wn.2d 724, 731-32, 72 P.3d 708 (2003). Current mental illness is a constitutional requirement of continued detention. O'Connor v. Donaldson, 422 U.S. 563, 574-75, 95 S. Ct. 2486, 45 L. Ed. 2d 396 (1975).

Involuntary civil commitment may not be based on a diagnosis that is not medically recognized or is too imprecise to distinguish the truly mentally ill from typical recidivists who must be dealt with by criminal prosecution alone. Foucha, 504 U.S. 71; Hendricks, 521 U.S. 346; Kansas v. Crane, 534 U.S. 407, 413, 122 S. Ct. 867, 151 L. Ed. 2d 856 (2002). If a supposedly dangerous person with a personality disorder "commit[s] criminal acts," then "the State [should] vindicate [its interests through] the ordinary criminal processes . . . , the use of enhanced sentences for recidivists, and other permissible ways of dealing with patterns of criminal conduct"—that is, "the normal means of dealing with persistent criminal conduct." Foucha, 504 U.S. at 82; accord id. at 88 (O'Connor, J., concurring in part and concurring in the judgment) (It is "clear that acquittees could not be confined as mental patients absent some medical justification for doing so.").

"Dangerousness, standing alone, is ordinarily not a sufficient ground upon which to justify indefinite involuntary commitment." Hendricks, 521 U.S. at 358. "Proof of dangerousness [must be coupled] with the proof of some additional factor, such as a 'mental illness' or 'mental abnormality.'" Id. (affirming commitment where "diagnosis as a pedophile . . . suffice[d] for due process purposes" and admitted inability to control his pedophilic urges "adequately distinguishe[d] [respondent] from other dangerous persons who are perhaps more properly dealt with exclusively through criminal proceedings").[7]

Most recently, the Court reemphasized that an individual cannot be involuntarily committed unless he suffers from a mental abnormality "sufficient to distinguish . . . him . . . from the dangerous but typical recidivist convicted in an ordinary criminal case." Crane, 534 U.S at 413. The Washington Supreme Court similarly recognizes that in sexually violent predator proceedings, due process requires the State to prove the detainee has a serious, diagnosed mental disorder that causes him difficulty controlling his sexually violent behavior. Thorell, 149 Wn.2d at

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[7] Justice Kennedy, who provided the fifth vote in support of the majority opinion in Hendricks, emphasized that Hendricks' "mental abnormality—pedophilia—is at least described in the DSM-IV." 521 U.S. at 372 (Kennedy, J., concurring). He therefore concluded that, "[o]n the record before [the Court], [Hendricks' commitment] conform[ed] to [the Court's] precedents." Id. at 373. He continued, "however, . . . [that] if it were shown that mental abnormality," as defined by state law, "is too imprecise a category to offer a solid basis for concluding that civil detention is justified, our precedents would not suffice to validate it." Id.

736, 740-41. "Lack of control" requires proof "'sufficient to distinguish the dangerous sexual offender whose serious mental illness, abnormality, or disorder subjects him [or her] to civil commitment from the dangerous but typical recidivist convicted in an ordinary criminal case.'" Id. at 723 (quoting Crane, 534 U.S. at 413). Expert testimony is essential to tie a lack of control to a diagnosed mental abnormality or personality disorder. Id. at 740-41. This proof must rise to the level of proof beyond a reasonable doubt. Id. at 744.

Although states have considerable leeway to define when a mental abnormality or personality disorder makes an individual eligible for commitment as a sexually violent person, see Crane, 534 U.S. at 413, the diagnosis must nonetheless be medically justified. See Hendricks, 521 U.S. at 358 (explaining that states must prove not only dangerousness but also mental illness in order to "limit involuntary civil confinement to those who suffer from a volitional impairment rendering them dangerous beyond their control"); Thorell, 149 Wn.2d at 732, 740-41 (explaining that State must present expert testimony and proof beyond a reasonable doubt that offender has serious, diagnosed mental illness that causes him difficulty controlling his behavior).

b. Mr. Rude's commitment based on a diagnosis of paraphilia NOS (nonconsent) violates due process because it is an invalid diagnosis not accepted by the profession.

Dr. Longwell's diagnosis of paraphilia NOS (nonconsent) is invalid, and its use as predicate for Mr. Rude's involuntary civil commitment therefore violates due process.

The Supreme Court has upheld involuntary civil commitment only in cases in which the diagnosed disorder was one that "the psychiatric profession itself classifies as a serious mental disorder." Hendricks, 521 U.S. at 360; id. at 372 (Kennedy, J., concurring); id. at 375 (Breyer, J., dissenting); Crane, 534 U.S. at 410, 412.

The disorder referred to by Dr. Longwell as paraphilia NOS (nonconsent) fails the Supreme Court's "medical recognition" or "medical justification" test, because it is not recognized by either the psychiatric profession in general, or the APA or the DSM-IV-TR in particular. Put simply, it is a wholly unreliable and invalid diagnosis that fails to distinguish Mr. Rude from any "dangerous but typical recidivist" who cannot be civilly committed under the Due Process Clause. Crane, 534 U.S. at 413.

The diagnosis of paraphilia NOS (nonconsent) was essentially invented by Dr. Dennis Doren, a Wisconsin psychologist who is the evaluation director for Wisconsin's SVP commitment program. See

Dennis Doren, Evaluating Sex Offenders: A Manual For Civil Commitments and Beyond (2002). Doren has acknowledged, though, that the DSM has "no separately listed paraphilia of this type." Id. at 63.

Every category of diagnosis in the DSM-IV-TR contains an "NOS" diagnosis. The DSM-IV-TR, in explaining the purpose of "NOS" diagnoses, states "[n]o classification of mental disorders can have a sufficient number of specific categories to encompass every conceivable clinical presentation. The Not Otherwise Specified categories are provided to cover the not infrequent presentations that are at the boundary of specific categorical definitions." DSM-IV-TR at 576. As Dr. Fisher stated, the "NOS" designation is a "wastebasket diagnosis," essentially created for purposes of insurance billing. 6/20/12 RP 190.

Thus the DSM-IV-TR at least nominally recognizes a general diagnosis of "Paraphilia Not Otherwise Specified." American Psychiatric Association, The Diagnostic and Statistical Manual of Mental Disorders, IV-Text Revision 576 (4th ed.-text rev. 2000) ("DSM-IV-TR"). The category provides a code for paraphilias that do not meet the criteria for any of the specific categories; including, for example, pedophilia, exhibitionism, and sexual sadism. See id. at 566-75. The DSM-IV-TR explains that examples of paraphilia NOS "include, but are not limited to, telephone scatologia (obscene phone calls), necrophilia (corpses),

partialism (exclusive focus on part of body), zoophilia (animals), coprophilia (feces), klismaphilia (enemas), and urophilia (urine)." Id. at 576.

By its terms, this diagnosis "is not limited to" the variants specifically listed. However, it would be hard to imagine that the DSM-IV-TR would list such "relatively rare" and "inherently nonviolent" disorders, such as urophilia, while omitting a valid diagnosis of nonconsent, which would be "more common and certainly more socially problematic" than the disorders specifically identified. Thomas K. Zander, Civil Commitment Without Psychosis: The Law's Reliance on the Weakest Links in Psychodiagnosis, 1 Journal of Sexual Offender Civil Commitment: Science and the Law 17, 43 (2005), available at http://www.soccjournal.org; see also, e.g., Marilyn Price, et al., Redefining Telephone Scatologia: Comorbidity and Theories of Etiology, 31 Psychiatric Annals 226, 226 (2001) (describing the paraphilia NOS category as "reserved for sexual disorders that are either so uncommon or have been so inadequately described in the literature that a separate category is not warranted"). The logical inference is that the modifier (and diagnosis) "nonconsent" was deliberately omitted.

This inference is supported by the treatment of non-consensual sexual conduct in other sections of the DSM-IV-TR. For example, sexual

abuse of a child is mentioned in the section of the DSM that covers "other conditions or problems" that may merit "clinical attention" but are not independently diagnosable mental disorders. See DSM-IV-TR at 731, 738-39; Zander, Civil Commitment Without Psychosis, supra, at 43-44.

Further, the APA trustees have rejected the diagnosis, in part because of the preliminary nature of the data and the difficulty physicians have in differentiating the disorder from other disorders. Zander, Civil Commitment Without Psychosis, supra at 46 (2005). A subsequent APA task force similarly concluded, "[t]he ability to make such a diagnosis with a sufficient degree of validity and reliability remains problematic." Howard V. Zonna, et al., Dangerous Sex Offenders: A Task Force Report of the American Psychiatric Association, 170 (1990).

In addition to the APA's rejection of the diagnosis of paraphilia NOS (nonconsent), a number of professionals and commentators in the field continue to conclude that it is invalid and diagnostically unreliable. See e.g., 12/19/12 RP 68 (Dr. Longwell concedes diagnosis was termed a "misuse of psychiatry" by the editors of the DSM-IV); 12/20/12 RP 195 (Dr. Fisher warns of danger of basing diagnosis upon behaviors alone); Richard Wollert, Poor Diagnostic Reliability, the Null-Bayes Logic Model, And Their Implications For Sexually Violent Predator Evaluations, 13 Psychology, Public Policy, and Law, 167, 185 (2007) (concluding,

based on analysis of results of independent evaluations in 295 SVP cases, that "psychologists who undertake [SVP] evaluations should no longer diagnose any [individual] as suffering from [Paraphilia NOS (nonconsent)]" because the diagnosis is "so unreliable . . . that it is impossible to attain a reasonable degree of certainty as to [its] presence" and therefore its "only function" is to provide a "pretext" for "preventive detection"); Robert A. Prentky, et al., Sexually Violent Predators in the Courtroom, 12 Psychology, Public Policy And Law, 357, 370 (2006) ("because by definition all victims of sexual crimes are nonconsenting, all sexual offenders with multiple offenses . . . could be diagnosed with paraphilia NOS-nonconsent," thus, the "category becomes a wastebasket for sex offenders" and is "taxonomically useless"); Holly A. Miller, et al., Sexually Violent Predator Evaluations: Empirical Evidence, Strategies For Professionals And Research Directions, 20 Law and Human Behavior, 29, 39 (2005) ("[T]he definition of [Paraphilia NOS (nonconsent)] is so amorphous that no research has ever been conducted to establish its validity"); Stephen D. Hart & Randall Kropp, Sexual Deviance and the Law, Sexual Deviance Theory, Assessment And Treatment, 557, 568 (Richard Laws & William T. O'Donohue eds., 2d ed. 2008) (paraphilia NOS (nonconsent) is "an idiosyncratic diagnosis . . . that is not generally accepted or recognized in the field"); Jill S. Levenson, Reliability Of

Sexually Violent Predator Civil Commitment in Florida, 28 Law and Human Behavior, 357, 365 (2004) ("Since none of [Doren's] criteria [for diagnosing paraphilia NOS (nonconsent)] are stated or implied in the DSM-IV, it is not surprising that, in practice, the diagnosis is . . . widely variable"); Zander, supra, at 44-45, 49-50 (summarizing research studies and academic opinion).

The diagnosis of paraphilia NOS (nonconsent), invented by a single psychiatrist, explicitly rejected by the APA, and roundly criticized within the profession, lacks medical recognition and due process prohibits its use as a predicate for involuntary commitment.

c. Basing Mr. Rude's commitment on a diagnosis of antisocial personality disorder violates due process because it is too imprecise a diagnosis.

Mr. Rude's involuntary commitment also violates due process insomuch as it is based on a diagnosis of antisocial personality disorder. To begin with, the Supreme Court's decision in Foucha strongly implies that due process prohibits involuntary commitment on the basis of such a diagnosis. See 504 U.S. at 78, 82-83 (State may not commit person indefinitely merely because he is determined to have "a personality disorder that may lead to criminal conduct").

Antisocial personality disorder is simply "too imprecise a category to offer a solid basis for concluding that civil detention is justified."

Hendricks, 521 U.S. at 373 (Kennedy, J., concurring). For this reason, the diagnosis is fatally "[in]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." Crane, 534 U.S. at 413. For example, in Crane, the Court cited a study that found that 40 to 60 percent of the male prison population is diagnosable with antisocial personality disorder. Id. at 412. In reality, this number is probably 75 to 80 percent. See, e.g., Eric S. Janus, Foreshadowing the Future of Kansas v. Hendricks: Lessons from Minnesota's Sex Offender Commitment Litigation, 92 N.W. U. L. Rev. 1279, 1291 & n.59 (1998) (collecting studies indicating that 75 to 80 percent of all prisoners are diagnosable with antisocial personality disorder). The State's expert, Dr. Longwell, agreed that as much as sixty percent of the male prison population suffers from antisocial personality disorder, and that the diagnosis is suggestive simply of general criminality. 6/19/12 RP 133-34. Indeed, an estimated seven million Americans—including more than six million men—are diagnosable with antisocial personality disorder. Harriet Barovick, Bad to the Bone, Time, Dec. 27, 1999.

That millions of Americans and an overwhelming majority of the male prison population are diagnosable with antisocial personality

disorder is not surprising. The core of an antisocial personality disorder diagnosis is the existence of any three of the following seven behaviors:

> (1) failure to conform to social norms with respect to lawful behaviors as indicated by repeatedly performing acts that are grounds for arrest;
>
> (2) deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure;
>
> (3) impulsivity or failure to plan ahead;
>
> (4) irritability and aggressiveness, as indicated by repeated physical fights or assaults;
>
> (5) reckless disregard for the safety of self or others;
>
> (6) consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations;
>
> (7) lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another.

DSM-IV-TR at 706; accord RP 705.[8]

Far from "distinguish[ing] . . . the dangerous but typical recidivist convicted in an ordinary criminal case," Crane, 534 U.S. at 413, these criteria essentially describe a typical recidivist (as well as millions of non-

[8] The remaining "diagnostic criteria" of antisocial personality disorder are that the individual must be at least 18 years of age, there must be some "evidence" of a "Conduct Disorder" before age 15, and the antisocial conduct underlying the diagnosis must not relate exclusively to schizophrenia or a manic episode. DSM-IV-TR at 706. An actual diagnosis of conduct disorder is not required; rather, "a history of some symptoms of Conduct Disorder before age 15" will suffice. DSM-IV-TR at 702; Zander, Civil Commitment Without Psychosis, supra, at 55.

criminals). Accord Sentencing Guidelines Commission, Recidivism of Adult Felons 2007 at 1 (April 2008) (recidivism rate among adult males is 63.3 percent).[9]

The APA also has taken the position that antisocial personality disorder is an over-inclusive and inappropriate basis for civil commitment. For instance, in Crane, the APA appeared as amicus curiae and argued "the presence of 'antisocial personality disorder' as the condition causing the danger provides no meaningful limiting principle" for civil commitment statutes. Brief for the American Psychiatric Association and American Academy of Psychiatry and the Law as Amici Curiae in Support of Respondent, 2001 WL 873316, at *18.[10]

In addition to the APA's opposition to the use of antisocial personality disorder as a predicate for involuntary commitment, numerous individual mental health professionals and commentators have leveled similar criticisms. See, e.g., Daniel F. Montaldi, The Logic of Sexually Violent Predator Status in the United States of America, 2(1) Sexual

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[9] Available at http://www.cfc.wa.gov/PublicationSentencing/Recidivism/Adult_Recidivism_FY2007.pdf (last visited April 8, 2013).

[10] The APA opposes the use of an antisocial personality disorder diagnosis as a basis for civil commitment despite the disorder's inclusion in the APA-published DSM-IV-TR. As the DSM explains (at xxxvii): "It is to be understood that inclusion here, for clinical and research purposes, of a diagnostic category . . . does not imply that the condition meets legal . . . criteria for what constitutes a mental disease, mental disorder, or mental disability." Thus, while consensus professional recognition, as reflected by the DSM, should be seen as a necessary condition for civil commitment under the Due Process Clause, it should not be viewed as a sufficient condition.

Offender Treatment (2007), available at http://www.sexual-offender-treatment.org/57.0.html (last visited April 8, 2013); Bruce Winick et al., Should Psychopathy Qualify for Preventive Outpatient Commitment?, in International Handbook on Psychopathic Disorders and the Law 8 (Alan Felthous and Henning Sass, eds., 2007) (antisocial personality disorder does not justify involuntary civil commitment because it "does not impair cognitive processes or otherwise interfere with rational decision making" and "does not make it difficult for [the individual] to control [his] conduct"), available at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=984938 (last visited April 8, 2013); Zander, Civil Commitment Without Psychosis, supra, at 52-62 (summarizing studies and scholarly opinion).

Even a prominent article espousing the minority view in the profession that involuntary commitment based on antisocial personality disorder may be appropriate in some cases concedes that "[t]he use of [antisocial personality disorder] to justify civil commitment is unlikely to find general acceptance among mental health professional groups." Shoba Sreenivasan et al., Expert Testimony in Sexually Violent Predator Commitments: Conceptualizing Legal Standards of "Mental Disorder" and "Likely to Reoffend," 31 J. Am. Acad. Psychiatry & L. 471, 477 (2003).

In sum, as the Supreme Court has twice suggested (and perhaps once concluded), and consistent with the APA's official position, antisocial personality disorder is simply too imprecise and overbroad a diagnosis to survive constitutional scrutiny. See Foucha, 504 U.S. at 82-83; Crane, 534 U.S. at 412-13. The diagnosis does not satisfy the State's constitutional obligation to differentiate "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." Crane, 534 U.S. at 413. To the contrary, as numerous studies indicate, it comes perilously close to justifying the civil commitment of "any convicted criminal." Foucha, 504 U.S. at 82-83. Consequently, antisocial personality disorder is not a valid basis for civil commitment, and Mr. Rude's continued detention on that ground violates due process.

2. **The admission of unreliable hearsay at trial regarding Mr. Rude's alleged past conduct to supply a "foundation" for the State expert's opinion violated Mr. Rude's right to due process.**

a. Mr. Rude moved to exclude hearsay evidence at the commitment trial unless it could be tied to a specific expert opinion.

Prior to trial, Mr. Rude moved to bar Dr. Longwell from testifying regarding hearsay opinions of non-testifying experts and hearsay about

Mr. Rude's alleged past conduct without expressly tying each hearsay fact to a specific opinion. CP 59-61. Mr. Rude agreed that ER 703 permits an expert to rely upon hearsay or other inadmissible data in forming her opinions. CP 60. He noted, however, that much of the information that Dr. Longwell cited as the basis for her opinions had never been tested through the criminal process, the declarants were unavailable for confrontation, and, that given the prejudicial nature of the evidence, the substantial risk existed the jury would consider it for substantive purposes. 6/1/12 RP 70-74. The court denied the motion, instructing Mr. Rude to "make your objections when you need to." 6/1/12 RP 75. The court issued a limiting instruction telling the jury to consider the information Dr. Longwell relied upon "only in deciding what credibility and weight to give the opinions of Dr. Longwell" and not "as evidence that the information relied upon by the witness is true or that events described actually occurred." 6/18/12 RP 103-04; CP 664.

During Dr. Longwell's testimony, Mr. Rude objected repeatedly to her failure to tie her recounting of hearsay to a specific opinion. 6/18/12 RP 107-08, 114, 120, 121, 124. He ultimately argued that "there's no foundation as to why any of these things are relevant to her opinion other than one generic question: Did you rely on this material in forming your opinion." 6/18/12 RP 124.

b. In violation of ER 703, the prejudicial hearsay recounted by Dr. Longwell was untied to any specific opinion, and its admission violated due process.

ER 703 permits an expert to base his or her expert opinion on facts or data that are not otherwise admissible provided that they are of a type reasonably relied on by experts in the particular field. ER 703. Under the rule, an expert is thus permitted to offer an opinion based on hearsay data that would otherwise be inadmissible in evidence. In re the Det. of Marshall, 156 Wn.2d 150, 162, 125 P.3d 111 (2005); ER 705. But, while the rule allows an expert witness "to take into account matters which are unadmitted and inadmissible, it does not follow that such a witness may simply report such matters to the trier of fact: The Rule was not designed to enable a witness to summarize and reiterate all manner of inadmissible evidence." State v. DeVries, 149 Wn.2d 842, 848 n. 2, 72 P.3d 748 (2003) (citations omitted)).

In SVP commitment proceedings, the rule imposes a substantive limitation upon expert testimony: the expert is permitted to relate inadmissible hearsay so long as the evidence is to explain the underlying basis of her expert opinion. In re Det. of Coe, 175 Wn.2d 482, 512-513, 286 P.3d 29 (2012). In Coe, the State's expert relied in part on hearsay reports regarding Coe's prior conduct. 175 Wn.2d at 488, 511-12. The Washington Supreme Court concluded that any prejudicial effect from the

admission of the hearsay testimony was mitigated by the issuance of a limiting instruction. 175 Wn.2d at 514.

The United States Supreme Court recognizes that in some instances, however, a limiting instruction will be insufficient to ameliorate the prejudice from the admission of inflammatory hearsay, resulting in a violation of the right to a fair trial. Bruton v. United States, 391 U.S. 123, 132-35, 88 S.Ct. 1620, 20 L.Ed.2d 476 (1968); U.S. Const. amend. XIV. The Court in Coe attempted to distinguish Bruton on the basis that it involved "a narrow exception to the general rule that juries follow instructions." Coe, 175 Wn.2d at 514. This is an incorrect reading of Bruton. See Bruton, 391 U.S. at 132 n. 8 (quoting with approval Judge Learned Hand's characterization of limiting instructions as "a 'recommendation to the jury of a mental gymnastic which is beyond, not only their powers, but anybody's else'") and at 135 (warning, "there are some contexts in which the risk that the jury will not, or cannot, follow instructions is so great, and the consequences of failure so vital to the defendant, that the practical and human limitations of the jury system cannot be ignored"). Far from outlining a precise "exception" to the general presumption that juries follow instructions including instructions to consider highly inflammatory evidence for a limited purpose, the Court

in Bruton candidly recognized that in some instances, a limiting instruction is a type of placebo, a "judicial lie." 391 U.S. at 132 n. 8.

In this case, Dr. Longwell's hearsay testimony was extensive and primarily uncorroborated by other testimony or evidence. Although Dr. Longwell loosely claimed that the materials she reviewed supported her diagnosis, she failed to correlate many specific pieces of information to her opinions. Instead, she broadly recounted detailed, unsubstantiated, unconfronted reports at length for the jury's consideration.

For example, Dr. Longwell related allegations regarding a supposed incident in Texas, where Mr. Rude was said to have cornered a woman in a laundromat. 6/18/12 RP 111. That incident did not result in the filing of any criminal charges. Id. Mr. Rude remembered the incident but denied having threatened or cornered the woman. 6/18/12 RP 112.

Dr. Longwell also relayed to the jury the substance of the police reports from Mr. Rude's first rape conviction, in which Mr. Rude was alleged to have raped a 16-year-old girl with a companion. 6/18/12 RP 113-15, 117. The victim did not testify at trial, but Dr. Longwell told the jury what she told police had occurred. Id. Mr. Rude disputed her version of what happened. 6/18/12 RP 116.

Dr. Longwell likewise recounted the allegations underlying Mr. Rude's subsequent conviction for attempted rape in the first degree.

6/18/12 RP 118. She told the jury that Mr. Rude actually raped the victim at knifepoint, even though Mr. Rude disputed her version and at the time, the State did not determine the incident merited a prosecution for first-degree rape. Id. Dr. Longwell also told the jury about the substantive allegations underlying Mr. Rude's ejection from the WSH treatment program. 6/18/12 RP 120.

All of these details recounted by Dr. Longwell were untied to any specific professional opinion. Their admission therefore was contrary to ER 703 and 705, and violated Mr. Rude's right to a fair trial.

3. **The prosecutor's argument telling the jury that they could commit Mr. Rude if they found beyond a reasonable doubt that he suffered from any "condition" that caused him serious difficulty in controlling his sexually violent behavior was misconduct that violated his right to due process and jury unanimity.**

a. Due process requires that civil commitment be based upon mental illness and dangerousness; a commitment order violates due process where the verdict is not based on a mental abnormality that distinguishes him from the "dangerous but typical" recividist.

As established in argument 1, supra, civil commitment violates due process if it is based on too imprecise a diagnosis. The mental abnormality or illness that forms the basis of SVP commitment must be identified with sufficient specificity to differentiate the SVP respondent "from other dangerous persons who are perhaps more properly dealt with

exclusively through criminal proceedings." Hendricks, 521 U.S. at 360; accord Crane, 534 U.S. at 413; Thorell, 149 Wn.2d at 732-33. It is the finding of a link between the mental abnormality or personality disorder and the serious difficulty controlling behavior that supplies the predicate for commitment. Thorell, 149 Wn.2d at 736.

The constitutional demand that commitment be based upon a legitimate diagnosis requires the terms of art "mental abnormality" and "personality disorder" to be defined for the jury. In re Det. of Pouncy, 168 Wn.2d 382, 229 P.3d 678 (2010). In Pouncy, the Supreme Court held,

> The phrase "personality disorder" is not one in common usage and is beyond the experience of the average juror. It is a term of art under the DSM that requires definition to ensure jurors are not "forced to find a common denominator among each member's individual understanding" of the term.

168 Wn.2d at 391 (citation omitted).

The mental abnormality identified by the State, via Dr. Longwell, was the paraphilia NOS (nonconsent) diagnosis. She identified Mr. Rude as meeting the criteria for civil commitment viewing Mr. Rude's circumstances "as a whole"; i.e., the conjunction of the paraphilia NOS (nonconsent) diagnosis with his ASPD (a personality disorder) and substance abuse (a "condition"). 6/18/12 RP 172. She explained that the paraphilia would predispose him to reoffend, and that even if he had the best intentions when he was released from custody, the ASPD would

impair his ability to conform his actions to his will, particularly if he were to start abusing substances again. 6/18/12 RP 173.

Thus, according to Dr. Longwell, the paraphilia NOS (nonconsent) was a necessary predicate and condition precedent for him to reoffend. By arguing that the jury should base its decision whether to grant the State's commitment petition upon any "condition that predisposes him," and telling the jury that the slides explaining mental abnormality, the DSM-IV – in effect, the jury instructions – were "just a guide," the AAG urged the jury to disregard the medical evidence. The AAG's argument amounted to an exhortation to the jury to commit Mr. Rude if they simply were afraid of him and believed he might reoffend.

Pouncy is instructive. There, the Court reversed the commitment order based upon the court's failure to supply a definition of the term, "personality disorder":

> We have no way of knowing from the verdict whether the jury found that Pouncy was an SVP because he suffered from a mental abnormality or a personality disorder ... And, if the jury agreed Pouncy suffered from a personality disorder, we have no way of knowing what definition the jury used in reaching this conclusion. It is not sufficient that counsel were able to argue to the jury their respective understandings of the term based on expert testimony; lawyers have a hard enough time convincing jurors of facts without also having to convince them what the applicable law is.

Pouncy, 168 Wn.2d at 391-92 (internal citation omitted).

By arguing to the jury that the DSM criteria and expert testimony were merely a "guide" and that any "condition" could support commitment, the AAG created an impermissible risk that Mr. Rude's commitment order was based not on mental illness but on some amorphous "condition", using any definition they chose. The "condition" that the jurors may have determined supported the commitment order could have been anything. It could have been drug addiction, low self-esteem, lack of respect for women, or an overactive sex drive. The AAG thus urged the jurors to commit Mr. Rude if they found that he was a "dangerous but typical" recidivist. The commitment order violated due process.

b. The AAG's argument violated Mr. Rude's right to jury unanimity.

A person subject to SVP commitment proceedings has the right to a unanimous jury verdict. In re Personal Restraint of Young, 122 Wn.2d 1, 48, 857 P.2d 989 (1993); RCW 71.09.060. Washington law also requires the State to prove each element of the civil commitment statute beyond a reasonable doubt. Where a charge is defined by the Legislature as subject to proof by alternative means, then an accused person's right to jury unanimity instruction is not violated by a court's failure to instruct the jury that they must be unanimous provided that each of the alternative

means is supported by substantial evidence. State v. Arndt, 87 Wn.2d 374, 377, 553 P.2d 1328 (1976). In the context of SVP proceedings, the Washington Supreme Court has applied this rule to hold that the right to jury unanimity is not violated by allegations that an SVP respondent suffers from both a mental abnormality and personality disorder so long as substantial evidence supports both alternative means. In re Det. of Halgren, 156 Wn.2d 795, 810-11, 132 P.3d 714 (2006).

Here, substantial evidence did not support each of the alternative means alleged by the State. Specifically, although the State presented substantial evidence that Mr. Rude had been diagnosed with paraphilia NOS (nonconsent), ASPD, and substance abuse, the State did not prove that the ASPD or substance abuse, on their own, predisposed him to commit sexually violent acts such that he would have serious difficulty controlling his behavior if not confined in a secure facility.

Coupled with the State's improper argument urging the jury to commit Mr. Rude if they found any "condition", regardless of the expert testimony, the jury was led to believe they could commit Mr. Rude by picking and choosing among the State's evidence. The argument thus urged the jury to commit Mr. Rude even if they were not convinced that the diagnosis of paraphilia NOS (nonconsent) was legitimate. Since substantial evidence did not support commitment based on the other

alternative means alleged by the State, the commitment order violated Mr. Rude's right to jury unanimity.

E. CONCLUSION

For the foregoing reasons, this Court should conclude that the commitment order violated due process. The remedy is reversal and remand for a new trial.

DATED this 12th day of April, 2013.

Respectfully submitted:

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

IN RE THE DETENTION OF	)	
	)	
	)	
RICHARD RUDE,	)	NO. 69061-2-I
	)	
	)	
APPELLANT.	)	

DECLARATION OF DOCUMENT FILING AND SERVICE

I, MARIA ARRANZA RILEY, DECLARE THAT ON THE 12TH DAY OF APRIL, 2013, I CAUSED THE ORIGINAL **OPENING BRIEF OF APPELLANT** TO BE FILED IN THE **COURT OF APPEALS – DIVISION ONE** AND A TRUE COPY OF THE SAME TO BE SERVED ON THE FOLLOWING IN THE MANNER INDICATED BELOW:

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