FILED
Clerk of the Superior Court
APR 25 2011
By: D. ZOLEZZI, Deputy

SUPERIOR COURT OF THE STATE OF CALIFORNIA

FOR THE COUNTY OF SAN DIEGO

THE PEOPLE OF THE STATE OF CALIFORNIA, Petitioner, v. RICHARD McKEE, Respondent.	Case No. MH 97-752 D 050554 S 162823 **STATEMENT OF DECISION** Judge: Michael D. Wellington Dept.: 59

This case examines the question whether changes to the length of commitment and the standard and burden of proof brought to the Sexually Violent Predator Act in 2006 violate the Equal Protection Clause of the Fourteenth Amendment to the United States Constitution. (See *People v. McKee* (2010) 47 Cal.4th 1172.) It has been remanded to this court from the California Supreme Court for an evidentiary hearing on that issue.

Specifically, the issue focuses on three classes of persons civilly committed: those committed under the Sexually Violent Predator Act (Welf. & Inst. Code § 6600 et seq., hereafter "SVP's"), those committed under the Mentally Disordered Offenders Act (Penal Code § 2960 et seq., hereafter "MDO's") and those committed after being found not guilty by reason of insanity (Penal Code § 1026.5(a), hereafter "NGI's.") Under all these civil

commitment schemes, the subjects have been previously found guilty of criminal offenses, and then have been found to suffer from mental disorders which render them a danger to others.[1] Members of each class have either served their prison sentences (SVP's and MDO's) or have been under commitment for a period of time equal to the maximum time they could have been sentenced to state prison.

Prior to 2006, MDO's and SVP's were initially committed for periods of one and two years, respectively, following their prison terms. NGI's, could be held for the amount of time they could have served in state prison and thereafter could have their commitments extended for periods of two years at a time. All of these commitments could then be extended only by the State periodically filing new petitions and proving beyond a reasonable doubt that the patients still qualify for commitment. Any recommitments would be for determinate terms of only one year (MDO's) or two years (SVP's and NGI's). (*McKee*, *supra*, at 1185, 1201, 1207.)

In November 2003 the voters passed Proposition 83, known as "Jessica's law" which, among other changes, made SVP commitments indeterminate, potentially lasting for life. (Welf. & Inst. Code § 6604.) The patients are now subject to annual reviews in the hospital to address the question whether they still qualify for continued commitment, and there are statutory procedures for hospital staff to recommend release. (Welf. & Inst. Code § 6605 (a)(b).) [2] However, absent authorization from the Director of Mental Health under Welfare & Institutions Code § 6605(b), the only way for them to seek release is by filing their own petitions in court and bearing the burden to prove by a preponderance of the evidence that they can be safely released to an outpatient program. (Welf. & Inst.

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[1] MDO's and NGI's are found to be a "substantial danger of physical harm to others" as a result of their mental disorders. (Penal Code §§ 1026.5 (b)(1), 2970.) SVP's are found to be likely to "engage in sexually violent criminal behavior" as a result of their mental disorders. (Welf. & Inst. Code § 6600.)

[2] If, at this annual review, the DMH concludes the patient is no longer an SVP, or that conditional release is appropriate, then the Director of Mental Health "shall" authorize the patient to file a petition in the Superior Court. The District Attorney may oppose the petition, but will bear the burden of proof beyond a reasonable doubt. (Welf. & Inst. Code § 6605 (b)(d).)

Code § 6608 (a)(d)(i).)[3] As a result, SVP's are the only ex-felons who are subject to an indeterminate civil commitment on these terms.

McKee argues that this differential treatment is unjustified and constitutes an equal protection violation. As will be seen, this court concludes the People have met their burden to justify the differential treatment on the terms set out by the California Supreme Court.

I. Procedural Background

A petition alleging that respondent Richard McKee is a sexually violent predator was filed in the San Diego Superior Court November 8, 2004. The petition alleged McKee had been convicted of two separate violations of Penal Code § 288(a). On February 16, 2007, after the passage of Proposition 83, McKee demurred to the petition on the grounds that the amendments made by Proposition 83 were unconstitutional. The demurrer was overruled. On March 5, 2007, an amended petition was filed making the same factual allegations as the previous petition and requesting an indeterminate commitment pursuant to the amended statutes.

On March 12, 2007, McKee was found by a jury to be an SVP within the meaning of the law. The court issued an order committing him to the custody of the Department of Mental Health (DMH) for an indeterminate term. He appealed, raising, among other issues, the equal protection claim addressed here. His arguments were rejected by the Court of Appeal, and the California Supreme Court granted review. The Supreme Court rejected McKee's arguments under the Due Process and Ex Post Facto clauses of the United States Constitution. However, as to his Equal Protection claim, the court concluded the People had not yet met their burden to show justification for providing a different term and a different standard and burden of proof for SVP's than for MDO's and NGI's. The court found that the People might still be able to meet that burden and so

[3] While the patient may gain unconditional release on a petition authorized by the Director of Mental Health under Welf. & Inst. Code § 6605 (b), the patient's petition under Welf. & Inst. Code § 6608 only allows for conditional release. The patient must remain in conditional release for a year before being eligible for unconditional release. (Welf. & Inst. Code § 6608 (d).)

remanded the cause to the trial court for the People to be given an opportunity to do so. (*McKee*, *supra* at 1208-1211.)

II. The Issue

In the *McKee* opinion, the Supreme Court expressly found that MDO's, NGI's and SVP's are all "similarly situated" for the initial purpose of shifting the burden of proof to the People to justify the "differential treatment." (*McKee*, *supra*, at 1203, 1207.) This is so because all three classes have demonstrated some level of dangerousness by their criminal convictions, and all are civilly committed for a time beyond the period provided for punishment as a result of a finding of a mental disorder disposing them to commit future dangerous acts. (*McKee*, *supra* at 1203, 1207.) The court also made clear that, since McKee's liberty interest is at stake, the statutory provisions involved must withstand the "strict scrutiny" standard of equal protection analysis. Relying on and quoting from *In re Moye* (1978) 22 Cal.3d 457, 465-466, the court held, "the state must establish both that it has a 'compelling interest' which justifies the challenged procedure and that the distinctions drawn by the procedure are necessary to further that interest." (*McKee*, *supra*, at 1197-1198.) There being little question that protection of the public and humane treatment of the mentally ill are compelling state interests (*McKee*, *supra*, at 1210), the central issue is whether the distinctions drawn for SVP's are necessary to the pursuit of those interests.

The court recognized that the "necessity" aspect of an equal protection analysis takes on a special context when it is applied to civil mental health commitments. In light of this, the court conducted an extensive examination of the case law surrounding such issues and set out at length to frame the specific issue as clearly as possible for this remand hearing. The language of the *McKee* decision bears extensive quoting because it precisely defines the issue now before this court.

The court made it clear that some differences between civil commitment schemes, including term length, may be perfectly appropriate if justified by a reasonable perception of danger presented by a special class. The court said,

> [The state] may adopt more than one procedure for isolating, treating, and restraining dangerous persons; and differences will be upheld if justified. [Citations.] Variation of the length and conditions of confinement, *depending on degrees of danger reasonably perceived* as to special classes of persons, is a valid exercise of state power. (*Mckee*, *supra* at 1200, emphasis added in *McKee*, quoting *Conservatorship of Hofferber* (1980) 28 Cal.3d 161, 172.)

While "the reasons for differential treatment are not immediately obvious from the face of the . . . statutory schemes" in the present case (*McKee*, *supra*, at 1205), the court emphasized that,

> the Legislature may make reasonable distinctions between its civil commitment statutes based on a showing "that those who are reasonably determined to represent a greater danger may be treated differently from the general population." (*McKee*, *supra*, at 1204, quoting *In re Smith* (2008) 42 Cal.4th 1251, 1266)

and added,

> This differential treatment may result at least initially in imposing a greater burden of proof in order to be released from involuntary commitment. (*McKee*, *supra*, at 1204.)

Because the goals of the MDO and SVP programs are similar, the court concluded that,

> [t]he differentiation between MDO's and SVP's must be made with reference to the goals of the statutes, i.e. treatment of the mentally disordered or public protection. (*McKee*, *supra*, at 1203-1204.)

Noting that the distinctions between the statutory schemes in part consisted of varied standards and burdens of proof, the court found this too directs our attention to the question whether the more burdened class can reasonably be seen as representing a greater danger than the other classes. Finding that "standards and burdens of proof represent societal determinations of who should bear the risk that a court's or jury's judgment will be in error," (*McKee*, *supra*, at 1203, citing *Addington v. Texas* (1979) 441 U.S. 418), the court said,

> [b]ecause MDO's and SVP's have the same interest at stake—the loss of liberty through involuntary civil commitment—it must be the case that when society varies the standard and burden of proof for SVP's in the manner in which Proposition 83 did, it does so because of the belief that the risks involved with erroneously freeing SVP's from their commitment are significantly greater than the risks involved with freeing MDO's. [Citation] A substantial question is raised about the basis for this belief. (*McKee*, *supra*, at 1204.)

In addressing these questions in the context of a strict scrutiny analysis, the usual judicial deference to legislative findings "gives way to an exercise of independent judgment of the facts to ascertain whether the legislative body 'has drawn reasonable inferences based on substantial evidence.' [Citations]" (*McKee*, *supra*, at 1206.) To justify the distinctions drawn,

> It must be shown that . . . SVP's . . . as a class bear a substantially greater risk to society, and that therefore imposing on them a greater burden before they can be released from commitment is needed to protect society. (*McKee*, *supra*, at 1208.)

The court specified that such a showing could be made in a variety of ways such as evidence that recidivism is more likely for SVP's or that they pose a greater risk to a particularly vulnerable class, such as children. "Or, the People may produce some other justification." (*McKee*, *supra*, at 1209.)

Reemphasizing the precise focus of the remand hearing and the scope of the inquiry this court is directed to make, the Supreme Court closed with a summary of the relevant principles.

> In remanding the case, we make clear that different classes of individuals civilly committed need not be treated identically. In *Hofferber*, *supra*, 28 Cal.3d 161, *even as we affirmed that fundamental distinctions between classes of individuals subject to civil commitment are subject to strict scrutiny (id. at p. 171, fn. 8), we also acknowledged the government's legitimate capacity to make reasonable distinctions*: "The state has compelling interests in public safety and in humane treatment of the mentally disturbed. [Citation.] It may adopt more than one procedure for isolating, treating, and restraining dangerous persons; and differences will be upheld if justified. [Citations.] *Variation of the length and conditions of confinement, depending on degrees of danger reasonably perceived as to special classes of persons, is a valid exercise of state power.*" (*Id.* at pp. 171–172, fn. omitted.) *Moreover, we*

have recognized "the importance of deferring to the legislative branch in an area which is analytically nuanced and dependent upon medical science." (Hubbart [v. Superior Court], supra, 19 Cal.4th [1138] at p. 1156.) But the government has not yet shown that the special treatment of SVP's is validly based on the degree of danger reasonably perceived as to that group, nor whether it arises from any medical or scientific evidence. On remand, the government will have an opportunity to justify Proposition 83's indefinite commitment provisions, at least as applied to McKee, and demonstrate that they are based on a reasonable perception of the unique dangers that SVP's pose rather than a special stigma that SVP's may bear in the eyes of California's electorate.

Moreover, *we emphasize that mere disagreement among experts will not suffice to overturn the Proposition 83 amendments. The trial court must determine whether the legislative distinctions in classes of persons subject to civil commitment are reasonable and factually based—not whether they are incontrovertible or uncontroversial.* The trial court is to determine not whether the statute is wise, but whether it is constitutional. (*McKee*, *supra*, at 1210-1211, emphasis added.)

III. The Evidence

The burden is on the People to present substantial evidence that there are differences between SVP's on the one hand and MDO's and NGI's on the other which give rise to a reasonable perception that SVP's pose a greater danger to society. An extensive hearing was held at which the People presented the testimony of eight witnesses intended to show: (1) the harm caused by sexual crimes is complex, significant, pervasive, and unique, (2) overwhelmingly, SVP's are diagnostically different from MDO's and NGI's, (3) those different diagnoses lead to significantly different treatment plans, challenges, and different levels of danger for society, and (4) that indeterminate terms are necessary to support the unique treatment needs and meet the greater challenges and dangers. Respondent presented eleven witnesses, intended to show: (1) sexual trauma does not differ dramatically from other forms of trauma, (2) there is significant overlap between the diagnoses for SVP's, MDO's and NGI's, making distinctions between the classes unclear, (3) both diagnosis and risk assessment are still developing sciences which remain

imprecise and untrustworthy, (4) indeterminate terms hinder rather than help the treatment process and (5) there are other, less restrictive, alternatives available to treat SVP's.

Recidivism Statistics

As the Supreme Court has noted, the purpose of the SVP and MDO laws is to protect the public and to provide treatment for the offender's mental disorder. (*McKee*, *supra*, at 1203-1204.) The legislature has made it clear the purpose of the SVP law is more specifically to protect the public from the commission of sexually violent offenses. This is apparent from the fact that the act only applies to individuals who have committed such crimes and are found to have a mental disorder which makes it likely that they will do so again. (Welf. & Inst. Code § 6600 (a)(1).) In deciding whether SVP's are reasonably perceived to represent a greater danger than MDO's or NGI's, an obvious first inquiry would be whether they represent a greater danger of recidivism in general or, more specifically, sexual recidivism.

Unfortunately, the currently available statistical data is of limited help. The court has taken judicial notice of several statistical studies and has heard testimony regarding others. The central problem is the lack of studies specifically examining the subset of sex offenders actually committed as SVP's. There are a number of statistical studies comparing the recidivism of the broad class of all sex offenders generally to non-sex offenders. The relevant class in this case, however, is not all sex offenders, but the particular subclass represented by SVP's; that is, individuals who have been sentenced to prison for one of a statutory list of "sexually violent crimes" and have been found to have a mental disorder making it likely that they will commit such crimes again.

SVP's represent a very small and specific subclass of sex offenders generally. Evidence presented at the hearing shows that, of all state prisoners referred to the Department of Mental Health by the Department of Corrections and Rehabilitation as possible SVP's under Welf. & Inst. Code § 6601, less than 2% are ultimately committed as SVP's. (Hearing Exh. 5.) As testified to by David Thornton, Treatment Director for Wisconsin's highly respected Sand Ridge SVP program, whenever you create a subset of

the general sex offender population by selecting those who have committed past serious sex crimes, those with mental disorders, and those for whom a finding has been made that their mental disorders make them likely to reoffend sexually, that subset can be expected to reoffend at a higher rate. Specifically, it is Dr. Thornton's opinion that for sex offenders generally one might expect a 20% rate of recidivism over a five-year period, while with SVP's one might expect a rate closer to 50%. Dr. Rebecca Jackson, Chief Psychologist for the South Carolina SVP program, noted that an SVP program necessarily screens out the low risk sex offenders and screens in the high risk offenders. This makes the general sex offender population unrepresentative of the subclass of SVP's and puts sharp limits on the value of statistics taken from the general sex offender population.

Specifically, the court took judicial notice of a pair of studies done by the U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics. One examined prisoners released from prison in 11 states in 1983. (Respondent's First Judicial Notice Request, Exh. A.) It showed sex offenders generally reoffending more often than homicide defendants and less often than property crime defendants. But it did not examine the particular subset represented by SVP's. In looking at general sex offenders, however, it did show that they were more likely to reoffend sexually than non-sex offenders. Specifically, released rapists were 10.5 times more likely than non-rapists to have a subsequent arrest for rape. Furthermore, prisoners who had served time for other sexual assaults were 7.5 times more likely to be arrested for a new sexual assault than those who did not serve time for sexual assault.

Another U.S. Department of Justice study examined prisoners released from prison in 15 states in 1994. (Respondent's First Judicial Notice Request, Exh. B.) That study too compared general sex offenders with non-sex offenders. It showed that general sex offenders were rearrested at a lower rate than non-sex offenders, but again the comparison group there was general sex offenders and not SVP's. On the other hand, that study concluded that, compared to non-sex offenders, released sex offenders were four times more likely to be rearrested for a new sex crime.

The court also took judicial notice of a 2010 study done by the California Department of Corrections and Rehabilitation comparing the rate of return to prison for adult felons released from prison. It showed the overall return to prison rate was 67.5% with the return rate slightly higher for property crime defendants and slightly lower for those required to register as sex offenders under Penal Code § 290. There were no SVP's, MDO's or NGI's in the study and no showing of what percentage of either class reoffended with a new sex crime. Little of value to this case can be drawn from this.

Two "near neighbor" studies were also the subject of testimony. One was conducted in California at Atascadero State Hospital in an effort to evaluate the success of the SVP treatment program. It followed 93 subjects who had come to Atascadero on referral from state prison under Welf. & Inst. Code § 6601, but who were either never committed as SVP's or were subsequently found not to qualify for continued commitment. This study was stopped by the Department of Mental Health before it was completed. The frustrating and troubling circumstances under which the study was stopped were testified to in some detail by Dr. Jesus Padilla, the clinical psychologist who designed the study, but was not allowed to complete it. Before the study was halted, it showed a lower than expected recidivism rate for the subjects over an average 4.7 year period. (see Hearing Exh. 15.) Even if completed, this study would have shed relatively little light on the current issue since it examined only people determined *not* to be SVP's and provided no comparison to MDO's or NGI's. The second study, conducted in the State of Washington, examined a number of subjects who had received evaluations suggesting they qualified for commitment to that state's SVP program, but for whom petitions for commitment were never filed. (Hearing Exh. 16.) It suffers the same relevance issues as the Padilla study. It only examines subjects who were not found to be SVP's, and provides no comparisons with MDO's or NGI's.

Thus, the bottom line of the available recidivism studies is that none directly show how SVP's compare to MDO's or NGI's in terms of recidivism generally. As Dr. Jackson testified, it cannot be known exactly what the recidivism rate is for sex offenders because

they are overwhelmingly confined and therefore not "at risk." The two U.S. Department of Justice studies however, do support the conclusion that sex offenders in general are substantially more likely to reoffend sexually than are non-sex offenders. This fact was made even more relevant to this case by Dr. Thornton from the Sand Ridge SVP program, and Dr. Robert Prentke, a recognized expert on sexual violence, both of whom testified that SVP's would be expected to reoffend sexually at an even higher rate than the general sex offender population. This is significant, given that the goal of the SVP Act is specifically to protect society from particularly serious sexual offenses, and in light of the additional evidence presented that sexual crimes cause a different and more severe harm than most other crimes.

The Trauma of Sexual Crime

The Supreme Court has framed the current question as whether SVP's are "reasonably determined to represent a greater danger" than MDO's and NGI's. (*McKee*, *supra*, at 1204.) This raises the question whether the trauma caused by sexually violent offenses is greater than the trauma caused by other crimes. There was significant expert testimony supporting the view that the nature of the trauma occasioned by sex crimes is, in most cases, more intense than other traumas and is, in many instances, unique to sexual trauma.

Dr. Robert Geffner, a licensed clinical psychologist and diplomate in both family psychology and neuropsychology testified regarding the harm caused by sexual trauma. He has written and taught widely on the subject of sexual abuse and has spoken to hundreds of victims of sexual abuse. He expressed the view that the trauma from sexual assault is qualitatively different from any other trauma. It expresses itself psychologically, physiologically, socially, and neuropsychologically.

Examples of such trauma include obesity at very high rates in both child and adult victims, in part the consequence of a subconscious effort to make themselves unattractive as a defense against future attacks. A traumatic shock reaction is common in which the victim becomes either numb or hypervigilant. The victim suffers from an array of

internalized feelings including helplessness, reduced self-worth, and guilt arising from a belief the attack was somehow his or her own fault. These internalized feelings are unique to sexual assault in their strength and duration. The psychological consequences of social attitudes towards sex can externally exacerbate the victim's internal guilt with implied questions as to why the victim put him or herself in a vulnerable position. This social reaction operates to make others feel safer because it allows them to believe they would not make themselves vulnerable in the same way. It also operates to magnify the traumatic effects on the victim and contributes to the victim's reluctance to report the crime.

All these factors can also lead to what is referred to as "acquired vulnerability" which occurs when the victim feels so much more vulnerable that he or she actually becomes more vulnerable, by appearing as a "weak" and relatively easy prey to offenders. This is supported by studies showing that prior victims are at statistically greater risk for additional victimization. This acquired vulnerability puts victims at risk for illness and suicide at a rate far higher than occurs to victims of other crimes.

Self-medication through alcohol, drugs or hypersexuality is also far more prevalent with such victims as are marital intimacy problems. Dissociation is a common coping reaction in which the victim, in an effort to blunt the emotional elements of the attack, also blunts the emotional content of much of his or her life. This dissociation sometimes leads to self-harm, such as cutting, or other self-mutilation, done in an effort to "feel something" again. Neuropsychologically, sexual trauma changes the production of neurotransmitters and, especially in children, actually disrupts the structural development of the brain in a way that may well be permanent. Male victims suffer particularized versions of this trauma as their masculine identity is challenged, even if the perpetrator is a woman. And if the abuse was male on male, a whole range of additional sexual identity issues are implicated.

The degree of harm in any particular case can vary based on a variety of traumatic and protective factors. The degree of intrusion occasioned by the crime, the closeness of the perpetrator to the victim, the duration and frequency of the abuse all add to the harm.

On the other hand, factors such as the victim's family background, religious practices, and intellect may facilitate recovery. Nonetheless, Dr. Geffner's view is that sexual trauma is qualitatively different than other trauma. It reduces the victim's resiliency. It lasts longer, particularly if, as is common, the victim fails to report it and get treatment. Even with treatment, recovery is slower. Furthermore, some aspects of the trauma, such as the extreme violation of boundaries represented by the intrusion, the internalized self-blame, the external social attitudes and pressures, and the acquired vulnerability are either unique to sex crimes or are present to an extent far more pronounced than with other trauma.

Dr. Anthony Urquiza, a licensed clinical psychologist, also testified on the topic of sexual trauma. He is a professor of pediatrics at the University of California at Davis and is the Director of Mental Health Services and Clinical Research there. He has treated "several thousand" abused children. He agreed with much of what Dr. Geffner stated regarding sexual trauma and made some additional observations.

Sexual abuse of children, according to Dr. Urquiza, fundamentally disrupts the victim's position in society. Psychological development is based on a foundation of relationships and unabused children learn from healthy relationships. But sexually abused children adopt a skewed way of "making sense" of the abuse experience, leading to a variety of self-image problems that may cause chronic, long-term harm. For example, a sexualized child may develop a sense of self-worth dependent on his or her sexuality, making them vulnerable to promiscuity and more abuse.

For adult survivors of sexual assault, a common reaction is the dysfunctional avoidance of any stimuli that might retrigger the emotions surrounding the attack. This can result in trust issues, intimacy avoidance, or avoidance of people of the same gender, profession or race as the perpetrator. A variety of somatic consequences are documented in the literature. These include headaches, stomach aches, various illnesses, and obesity.

Sexual dysfunction is also a common consequence for abused children as they are much more likely to display developmentally inappropriate sexual behavior such as oral

copulation or sodomy. Long-term sexual problems include promiscuity, prostitution, teen pregnancy and sexually transmitted diseases. Statistically, abused children go on to have many times more sex partners than children who were not abused. This is a consequence of a self-image based disproportionately on sexuality. These sexual distortions and the dissociation and avoidance reactions after sexual trauma are not seen in the wake of physical abuse, domestic violence or neglect. They are unique to sexual abuse.

Exacerbating these problems is the fact that sexual crimes are dramatically under-reported. Multiple studies suggest that even when such crimes are reported, the victims often delay many months before reporting. Failure to report or delay in reporting is usually the result of threats, fear, and shame. The result is the victim does not get treatment and the emotional and physical consequences continue unchecked.

Dr. John Conte also testified. He is a professor of social work at the University of Washington who has interviewed "thousands" of victims of sexual abuse as a therapist or evaluator. His testimony was consistent with Dr. Geffner and Dr. Urquiza. It is his opinion that the history of studies shows that sexual abuse is a major cause of a wide variety of mental health issues. (See Hearing Exh. 9.) He adds that one of the most significant impacts of sexual assault is a profoundly reduced quality of life that never goes away. Specific examples of this are depression, nightmares, phobias and many other psychological maladies.

Each of these three experts agreed that some victims are more resilient than others and the factors exacerbating the trauma or protecting the victim from it vary with each individual victim. While the witnesses agreed that most examples of trauma can be observed to one degree or another in victims of nonsexual crimes, they held to the view that most examples are present in a more intense manner with sexual crimes and that many of them, such as sexual dysfunctions, are unique to sex crimes.

Dr. Vincent Felitti, an internist at Kaiser Permanente testified about the Adverse Childhood Experiences (ACE) study he designed and continues to follow and write about. He was the founding chairman of Kaiser's Department of Preventive Medicine. As part of

an obesity study, he began to notice that many of his obese patients had a history of traumatic events. In concert with the Center for Disease Control, he designed a study to track the medical conditions of 17,337 Kaiser patients, half male, half female, who agreed to complete a special questionnaire addressing a list of 10 adverse childhood experiences, such as physical, emotional or sexual abuse, alcoholic or imprisoned parents, or emotional and physical neglect. With the information about the presence or absence of these experiences for each patient noted, the patients' medical histories have been tracked and continue to be tracked today.

The study finds that a wide range of physical and emotional problems are powerfully correlated to adverse childhood experiences and that the more such experiences a patient has, the more adverse the consequences. A patient with six of the ten adverse experiences is 47 times more likely to be an intravenous drug user and has his or her life expectancy reduced by 20 years. The presence of any one factor increases by 87% the likelihood of a second one and by 55% the likelihood of three others. However, no single factor has shown itself to be any more impactful than any other, with the exception of severe emotional abuse which is correlated to a 15% increase in negative consequences.

Dr. Felitti agreed with Drs. Geffner, Urquiza and Conte as to many of the kinds of physical and emotional consequences that flow from sexual crimes and that childhood sexual abuse is very underreported. He also notes that his patients are a "distinctly middle-class population," though he doubts the results would be much different with a less affluent population.

It appears to this court that the testimony of Drs. Geffner, Urquiza and Conte provides substantial evidence supporting a reasonable perception that the harm done by child sexual abuse and adult sexual attack is a greater harm, deserving of more protection than trauma caused by other crimes. While Dr. Felitti's ACE study does not support this conclusion, it was not intended for this purpose. In any event, Dr. Felitti's testimony at

most constitutes a disagreement among the experts which is not sufficient to overturn the distinctions drawn in Proposition 83.

Are SVP's Clinically Different Than MDO's and NGI's?

A significant amount of evidence was presented on the question whether there are clinical differences separating SVP's from MDO's and NGI's in ways relevant to the equal protection issue here. Substantial evidence was presented tending to show that SVP's, as a class, have clinical diagnoses that are markedly different from the diagnoses for MDO's and NGI's. The evidence also tended to show that along with these diagnostic differences come differences in treatment plans, patient cooperation, and other obstacles to treatment.

Diagnostic Differences

The People presented statistical data from the Department of Mental Health showing diagnoses given to patients under all three commitment schemes for each of five fiscal years, 2005-2010. (Hearing Exh. 5.) While the specific numbers vary slightly from year to year, overall they present a reasonably uniform diagnostic picture. The data shows that approximately 95% of MDO's and 90% of NGI's suffer from major mental illnesses such as schizophrenia, bipolar disorder, major depression or some other psychosis. For each of those same two groups, less than 2% suffer from pedophilia or any other paraphilia. On the other hand, the data shows that, with the exception of two years, over 90% of SVP's are diagnosed with pedophilia or other paraphilias.[4] Less than 10% of SVP's had major mental illness diagnoses in 2005-2006 and less than 2% had such diagnoses in fiscal years 2006-2010.

While these numbers appear to present a stark contrast between the classes, the real picture may not be quite so clear. Several witnesses testified that it is common for such patients to have multiple diagnoses. A representative from DMH testified that the computer process that provided the data in Hearing Exh. 5 can only list one diagnosis per patient, which is the initial diagnosis on admission. Furthermore, some testimony called

[4] The two exceptional years are 2006-2007 and 2007-2008 in which there were an unusually high number (29% and 15% respectively) of "deferred" diagnosis cases.

into question the accuracy of psychiatric diagnoses generally. Dr. Alan Abrams, Chief Psychiatrist at the California Medical Facility at Vacaville testified that there is a great deal of imprecision in psychiatric diagnoses. While he does not doubt that Hearing Exh. 5 represents the diagnoses actually assigned to patients in DMH custody, he has little confidence in the accuracy of those diagnoses. Noting that Hearing Exh. 5 purports to list the patient's "qualifying mental disorder," Dr. Abrams said there is no such concept in psychiatry, making it hard to draw conclusions from that data. Dr. Abrams did say that DMH staff have used the phrases "qualifying diagnosis" or "qualifying mental disorder," typically to refer to the "primary diagnosis" which typically would be the one requiring the most urgent attention. Dr. Prentke testified that the Diagnostic and Statistical Manual (DSM), which is intended to provide a common language for mental health diagnostics, is not well designed to classify sex offenders. Bemoaning what he called a "fundamental lack of research" in this area, he testified that pedophilia and other paraphilias are "orphans of the DSM."

Whatever may be said about the DMH diagnostic statistics in Hearing Exh. 5, the general picture from that data is supported by the testimony of a number of expert witnesses. Dr. David Fennell is a psychiatrist who is the Chief of Forensics at Atascadero State Hospital. He has been at Atascadero since 1998. In his experience, approximately 90% of MDO patients suffer from a psychotic disorder and the diagnostic profile for NGI's is nearly identical to that for MDO's. Approximately 66% of SVP's, on the other hand, are diagnosed as pedophiles, and another 33% are diagnosed with some other paraphilia. Only 1-3% of SVP's suffer from psychoses. Dr. Jackson from South Carolina also agrees that SVP's are overwhelmingly diagnosed with paraphilias and not psychoses. She noted the diagnostic profiles in Hearing Exh. 5 and testified that they are roughly similar to the SVP diagnoses in other states, such as Wisconsin where 80% of the SVP's are diagnosed with paraphilias and Washington where 99% are. Also, Dr. Robert Withrow, Acting Medical Director at Coalinga State Hospital, testified that of the SVP's at Coalinga, 60% are diagnosed with pedophilia and 40% with some other paraphilia.

The significance of the differential diagnoses between the classes examined here lies in the different treatment plans required for them, any obstacles to successful treatment, the speed and likelihood of successful treatment and the risk for sexual reoffending that they represent.

Dr. Fennell from Atascadero spoke to some of these issues, particularly with regard to MDO's, most of whom are housed at Atascadero. According to him the treatment for MDO's is mostly with psychiatric medications, aiming to stabilize the patients so that meaningful psychosocial treatment can begin. Such psychosocial treatment focuses on education of the patient, especially on the importance of continuing to take medication. It also includes relapse management skills and independent living skills. The treatment is not focused on the crime that led to the patient's commitment. It is focused on his mental disorder. Treatment compliance is quite high for taking medications and ranges from 65% to 75% regarding other forms of treatment. Treatment and treatment compliance is about the same for NGI's as it is for MDO's. In Dr. Fennell's view, an MDO is no more likely to commit a sexual offense than he is to commit any other offense. The nature of their disorders makes them disorganized and unpredictable. The same is true for NGI's. Unlike sex offenders generally, neither of these classes, even when they have committed sexual crimes previously, is more likely to re-offend sexually in the future.

SVP's, on the other hand, present a different profile. Their treatment is not based on medications, rather it is based on an effort to give them the tools to limit their risk of re-offense. Participation in treatment is low (20-30%) for a variety of reasons. At least initially in the development of the program, many SVP's were advised by their attorneys not to participate for fear they might make admissions that could jeopardize their cases or subject them to additional prosecution. Resistant SVP's also put peer pressure on other SVP's not to participate. And many patients, on being transferred to DMH, brought with

them the prison "mindset" of never admitting anything. Even so, there is a relatively small core of 20-30% who do participate. [5]

Dr. Jill Stinson, a licensed clinical psychologist who is the Sex Offender Treatment Coordinator for Fulton State Hospital in Missouri, testified in some detail about the clinical differences between pedophiles and paraphiles on the one hand and those with severe mental illnesses on the other.[6] Severe mental illnesses can be more or less acute and are marked by greater impulsivity, auditory hallucinations, delusions, responses to internal stimuli, withdrawal from the external world, tangential speech and potential breaks with reality. Such patients commonly recognize that something is wrong with them. Treatment for such patients typically begins with medications to stabilize them and some standard *psychosocial* therapy for the deficits resulting from their mental illnesses. This therapy is largely focused on helping them learn how to live with their illness. Their amenability to treatment is generally good and, with the right medications, they may be stabilized in a week or so, with a good chance at long-term stability.

Those with paraphilias are not as easy to identify externally, according to Dr. Stinson. They tend to think nothing is wrong with their sexual interests and are commonly not bothered by their disorder. The paraphilias tend to remain stable throughout the patient's life. Some "age out" of it, although it is unclear whether their actual fantasies dim with age or merely their actions in pursuit of them. Like severe mental illnesses, paraphilias can have a wide range of intensities. Treatment for paraphiles is essentially psychosocial therapy. There are no medications available except for those that dim arousal or stabilize mood. But these do not alter the paraphilia, they just help control the patient's actions.

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[5] Drs. Kasdorf and Withrow from Coalinga both testified that approximately 80% of SVP's participate to some extent in non-sex offender specific treatment which can be helpful. Dr. Kasdorf indicated that some of them participate sincerely while others participate merely for "entertainment".

[6] Several of the expert witnesses used phrases such as "major mental illness," "serious mental disorder" and "severe mental illness" as interchangeable ways to refer to a category of illnesses typically including schizophrenia, schizoaffective disorder, bipolar disorder, and major depression. This is not necessarily the same as the "severe mental disorder" identified and defined in Penal Code § 2962(a).

Paraphiles face barriers to treatment that are not commonly experienced by those with severe mental disorders. Often those with paraphilias do not want to be in treatment. They may wish to avoid the stigma attached to the diagnosis. Many are in denial that a problem exists and see nothing wrong with their behavior. Few come to the commitment ready for treatment. An additional obstacle to treatment for paraphiles is the common presence of personality disorders such as antisocial personality or borderline personality. While these sometimes occur in the severely mentally ill population, they are much more common among paraphiles. The presence of such personality disorders makes treatment substantially more difficult. Antisocial personalities tend to be skilled liars and the borderline personalities tend to be too instable for easy treatment. All these factors make treatment for paraphiles more difficult than those with severe mental illnesses.

Another distinction between paraphiles and the severely mentally ill is the connection between their mental illness and reoffending. Dr. Stinson testified that the criminal acts of the severely mentally ill tend to be random and unpredictable. They tend not to be focused on a particular crime or victim and they are not inherently dangerous. Some may be violent, but only 5% to 10% commit violent crimes. They may offend sexually, but usually don't. With paraphiles, however, there is a direct causal connection between the disorder and potential future sexual offenses. The paraphile is driven by his disorder to a particular type of behavior and usually targets a particular victim type. Paraphiles demonstrate better planning in their crimes, for example by "grooming" a victim. And they are better able to evolve and refine their offending with an eye to greater success, including the planning of strategic cover-ups. Summing up the differences in danger represented by SVP's as opposed to those with severe mental illnesses, Dr. Stinson testified that SVP's are more sexually dangerous than the severely mentally ill if not more generally dangerous.

Dr. Thornton from Wisconsin agreed that SVP's present a different set of treatment challenges than the severely mentally ill. Particularly, he noted that the combination of a paraphilia with antisocial personality disorder represents the highest risk level because

they do not believe anything is wrong with them and they like to control their environment, making treatment quite difficult. Their emotional shallowness may lead them to fake emotions, providing another obstacle to treatment.

Dr. Jackson from South Carolina also emphasized the dangerous link between paraphilias and personality disorders. She testified that among SVP's generally, 77%-80% also have personality disorders. This link is of special concern because the personality disorder, especially antisocial personality disorder, supports and facilitates the acting out of the paraphilia.

Dr. Padilla also drew sharp distinctions between SVP's and MDO's based on his experiences at Atascadero. He agreed that many SVP's have antisocial personality disorder and few are medicated. The antisocial personality disorder can facilitate attempts at deception presenting challenges for treatment. As a general matter, he testified that SVP's are more organized than MDO's, making them more effective in their criminal behavior. As an example of this distinction in organizational ability, he said that SVP's publish an underground newsletter in the hospital called "Tales of the Gulag." It reflects their anger at being committed after completing their prison sentences. No such newsletter is produced by MDO's.

Projected Length of Treatment

Given the particular issues underlying the treatment of SVP's, many of the experts were asked their opinion how long it would be expected for a highly motivated, hardworking SVP to complete treatment and be ready for release. Not surprisingly, the answers varied. Dr. Fennell from Atascadero said the fastest would be 30 months. But he believed that an average for such an exceptional patient would be more like three and a half to five years. Furthermore, only about 1% of the SVP population was sufficiently motivated to do it in that time. Dr. Thornton from Wisconsin believed such a particularly motivated patient could complete the Sand Ridge program in approximately six years. However, only 10% to 20% of the SVP population fit into this highly motivated category. Dr. Stinson from Missouri expressed the opinion that a motivated patient might complete

custodial treatment in five years, but only about 10% of SVP's are so motivated. Dr. Kasdorf from Coalinga State Hospital estimated a three to eight year range for a highly motivated SVP to complete the program. His estimate was that about 25% of the SVP's are so motivated. Dr. Withrow from Coalinga estimated that a perfectly motivated patient could complete the program in three years, though he had no opinion what percent of the SVP's could do this. He did say that range for completion would be two to ten years, with some SVP's never completing treatment.

A handful of the experts also offered opinions as to the utility of the indeterminate term for SVP's in the context of treatment. These views were also mixed. Dr. Fennell from Atascadero expressed the strong view that when SVP's had two year commitments, that period significantly damaged the treatment process. The presence of an upcoming court hearing caused patients to put their treatment "on hold" pending the court date. Furthermore, the court process would cause patients to be absent from the hospital and therefore absent from treatment for periods of eight to nine months at a time which was particularly harmful to treatment. This damage was exacerbated when the patients returned to the hospital after being recommitted because typically they were angry and resentful which made them resistant to treatment, setting the treatment process back further. The treatment for MDO's and NGI's is not harmed significantly by court hearings in his view. Largely this is because relatively few of them (approximately one-third) actually go out to court to contest recommitment. Those that do, however, often go off their medications while in local custody which does set their treatment back.

Dr. Thornton from Wisconsin's Sand Ridge program believes that bi-annual recommitment hearings would be a distraction to treatment which would interject counterproductive motivational issues into the process. Specifically, he expressed concern that upcoming court hearings would cause patients to become "cautious" about what they said in treatment for fear of what the court might think of their statements. He has heard these concerns expressed by colleagues in California based on their experience with the SVP program when it used two-year commitments. He further

commented that two years is an unrealistic period of time for a patient to complete treatment and that a two-year commitment reflects a lack of confidence in the original commitment decision.

Dr. Kasdorf from Coalinga State Hospital, on the other hand, believes that an indeterminate term is not generally helpful in getting patients into treatment, although it does encourage some patients. He expressed the view that two-year terms encourage hard work to achieve goals in time for an upcoming hearing. He also thought that having an "external review" every two years increases trust by the patients who are wary of the opinions expressed by evaluators seen by them as hospital employees. In his opinion, two-year reviews are "not that disruptive." Dr. Withrow, also from Coalinga, also believes that indeterminate terms are not helpful. In his opinion they reduce hope in the patients, lead staff to believe their recommendations are not valued, and discourage the patients from committing themselves to treatment. He thinks that "time goals," as represented by two-year court reviews, are useful in treatment and he used them in a variety of ways in his private practice.[7]

Risk Assessment

Members of the criminal justice community have long looked for reliable ways to predict recidivism for criminal offenders. This search is particularly intense in efforts to assess the risk that a sex offender will commit further sex offenses. Evaluators have traditionally used their independent clinical judgment to assess the risk of recidivism in individual cases. But the highly subjective nature of such assessments has led psychologists and psychometrics specialists to develop more objective actuarial instruments to balance out the subjectivity of clinical judgment. Currently, the most commonly used of these for sex offenders is the Static-99 or the newly revised Static-99R. It has been adopted by the State of California as the State Authorized Risk Assessment

[7] Dr. Withrow testified that he was not speaking as a representative of DMH and that DMH had asked him to make that clear.

Tool for Sex Offenders (SARATSO). (Penal Code § 290.04 et seq.[8]) It uses relatively objective data on a series of unchanging ("static") topics to create a score. (see Hearing Exh. 8.) This score is then correlated with the scores of a larger population of sexual offenders whose re-offense record is known to determine what percentage of offenders with a similar score have reoffended within a particular time period. In theory, groups with higher scores reoffend sexually at higher rates. The score is not intended to show the specific likelihood of sexual recidivism for a particular individual. Rather, it is intended to show what the recidivism rates are generally for people with such scores and whether people with such scores can generally be considered "low," "moderate-low," "moderate-high," or "high" risk. (see Hearing Exh. 8.) The Static-99R has amended that process by adding one changeable ("dynamic") factor – age, and adjusting the score to reflect the apparent fact that beyond a certain age, sexual offending tends to drop. Although widely used, the Static-99 and Static-99R are not without controversy.

The People offered data from DMH reflecting the Static-99 scores of groups of patients on the issue whether SVP's, as a class, represent a greater risk of sexual reoffending than do MDO's and NGI's. As a result of limitations imposed by the computer records at DMH as well as the fact that only some MDO's and NGI's (those required to register as sex offenders under Penal Code § 290) have Static-99 scores, the results provide a less than perfect comparison of the groups. Furthermore, the expert testimony raised additional questions about what conclusions can be drawn from the data.

The DMH data (Hearing Exh. 5) suggests a sharp distinction between SVP's on the one hand and MDO's and NGI's on the other. The average Static-99 score for all SVP's referred to DMH and committed under Welfare & Institutions Code § 6604 since September 20, 2006, is 6.19. According to the Static-99 coding form (Hearing Exh. 8) this

[8] Penal Code § 290.04 identified the Static-99 as the SARATSO and required the creation of a SARATSO Review Committee to decide whether it should continue to be the SARATSO. That committee has subsequently selected the newer Static-99R to be the SARATSO. (See http://www.cdcr.ca.gov/Parole/SARATSO_Committee/SARATSO.html.)

places the average SVP in the "high" risk category.[9] By comparison, the average Static-99R score for male MDO's housed at Patton State Hospital who have been committed under Penal Code § 2972 after the expiration of their parole and who are subject to the registration requirements of Penal Code § 290 in the year 2010 is 3.6. This suggests an average score for MDO's with a sex crime history is in the "moderate-low" risk category. Finally, the average Static-99R score for all patients discharged from Atascadero State Hospital since January 1, 2010, who are required to register under Penal Code § 290 is 4.6. This group includes both MDO's and NGI's (Hearing Exh. 6B) and puts the combined risk as "moderate-high". [10]

Dr. Jackson from South Carolina testified that other states had similar Static-99 scores for SVP's, with Washington averaging 5.4 and Wisconsin averaging 6.17. These are markedly different from the Static-99R scores for general sex offenders which average a score of 3. Not all SVP's have Static-99 scores indicating "high" risk, however. Dr. Kasdorf from Coalinga testified that 20% of California SVP's score 3 or less ("moderate-low"), 40% score 4-5 ("moderate-high") and another 40% score 6 or more ("high") on the Static-99.

The experts vary widely in their opinions about the value of the Static-99 in risk assessment. Dr. Mark Boccaccini teaches psychometrics and psychology and law at Sam Houston State University in Texas. The Static-99 is used in Texas for all SVP's and anyone who has to register as a sex offender. He conducted a study of 2000 males screened for civil commitment in Texas. In his view, the Static-99 has only marginal to moderate predictive reliability, little greater than chance. One problem he sees is that rater agreement is not high, with the raters disagreeing by at least one point 45% of the time. He testified that the Static-99 has a "confidence interval" or margin for error of 1.5,

[9] Coalinga State Hospital began using the Static-99R on SVP's in 2010. Hearing Exh. 5 shows that the average Static-99R scores were approximately one point lower than the average Static-99 score, dropping from 6.3 to 5.3. Presumably this reflects the adjustment the Static-99R makes for age in light of the relatively older SVP population.

[10] While SVP's generally scored lower on the Static-99R than the Static-99, this appears to reflect the generally older SVP population. Dr. Frennell testified that the average age of MDO's and NGI's was younger than SVP's. It is unclear whether MDO's and NGI's would score differently on the Static-99.

meaning that a score of 6 actually covers a range between 4.5 and 7.5. Thus, they are not as precise as they might seem. Nonetheless, it is his opinion that such actuarial tools are better predictors of future risk than clinical judgment. He believes the research shows that use of a single good actuarial tool is a better predictor than the use of multiple tools.

Dr. Prentke strongly disagreed, saying that the best risk assessments are "comprehensive," using all data available, including the patient's history, testing, and actuarial tools. The controversy, he said, is how to integrate the data. He agreed that clinical judgment is problematic, believing it must be balanced by actuarial input such as the Static-99. However he believes the Static-99 has only "moderate" predictive accuracy, concluding that it is "indefensible" to base a risk assessment entirely on an actuarial assessment. Overall, he referred to risk assessment in general as "the mother of all uncertainty."

Dr. Padilla from Atascadero believes the Static-99R is the best actuarial tool available. However, he too believes an actuarial tool by itself is not a sufficient basis for a risk assessment. He says that professional thinking is shifting towards an increased emphasis on dynamic risk factors, although this is itself controversial. According to Dr. Jackson, such dynamic factors include; intimacy deficits, sexual preoccupation, self-regulation failures, negative affect and noncompliance with supervision. She says it is these factors that sex offender treatment is designed to change. Dr. Withrow from Coalinga added that the state of the art of diagnosis, assessment of dynamic risk factors and treatment is steadily improving. Other experts expressed little faith in the use of dynamic risk factors in risk assessment. Dr. Boccaccini is unaware of any studies showing that dynamic factors substantially impact risk levels. Dr. Brian abbot, a licensed clinical psychologist who has published widely on topics related to SVP'S, statistics and the Static-99 uses the Static-99R in his own evaluations and agrees with Dr. Boccaccini that the best risk assessments are done with actuarial instruments alone. He does not consider dynamic factors at all in his evaluations because he believes they are not predictive.

Dr. Abbot testified extensively to a statistical analysis of the Static-99 scores reported in Hearing Exh. 5 and reached the conclusion that while such scores may demonstrate "relative" risk levels for SVP's, MDO's and NGI's, they cannot say much about the "absolute" risk levels of each class. The problem, in his view, is the lack of trustworthy "base rates" which would be necessary to a reliable prediction of what percent of patients with a given score can be expected to reoffend within a given time frame.

IV. Analysis

The traditional constitutional analysis for legislative distinctions subject to a "strict scrutiny" analysis is whether the challenged distinctions are necessary to the pursuit of a compelling governmental interest. (*D'Amico v. Board of Medical Examiners* (1974) 11 Cal.3d 1.) The purpose of the challenged SVP provisions here is protection of the public from sexual recidivism and treatment of the offender's mental disorders. It is settled that the state has a compelling interest in pursuing these goals. (*McKee*, *supra*, at 1210.) Therefore, in this case, the question is whether making an SVP commitment indeterminate and placing the burden of proof on the patient to show by a preponderance of the evidence that he no longer qualifies for commitment is "necessary" to the securing of that interest, while it is not for MDO's and NGI's. In the specific context of the civil commitment schemes examined here, the California Supreme Court refined this pivotal issue to the question whether the legislative body "has drawn reasonable inferences based on substantial evidence" in concluding that SVP's as a class "bear a substantially greater risk to society [than MDO's and NGI's], and that therefore imposing on them a greater burden before they can be released from commitment is needed to protect society." (*McKee*, *supra*, at 1206, 1208.) The court was pointed in emphasizing:

> [M]ere disagreement among experts will not suffice to overturn the Proposition 83 amendments. The trial court must determine whether the legislative distinctions in classes of persons subject to civil commitment are reasonable and factually based – not whether they are incontrovertible or uncontroversial. The trial court is to determine not whether the statute is wise, but whether it is constitutional.

If anything is clear from the evidence presented in this case, it is that key factual matters are controversial. It is also apparent that the evidence of the relative danger the classes represent is analytically nuanced and deeply rooted in developing medical and psychological science.

While all three civil commitment schemes seek "to protect the public from dangerous felony offenders with mental disorders and to provide mental health treatment for their disorders" (*McKee*, *supra*, at 1203), it is worth noting that the legislature actually defined the goals more distinctly. In the SVP Act, the legislature sought to protect the public from a specific class of "sexually violent offenses." They demonstrated this focused intent by limiting commitment to individuals who suffer from mental disorders which make it likely that they will *commit future sexually violent crimes.* (Welf. & Inst. Code § 6600 (a)(1).) On the other hand, the commitments of MDO's and NGI's focus on the question whether, by reason of their mental disorders, they "represent a *substantial danger of physical harm to others.*" (Penal Code §§ 1026.5 (b)(1), 2972 (c), emphasis added.) The evidence presented by the people supports the conclusion that the harm caused by sexually violent offenses is a greater harm than that caused by mere physical harm. It also supports the conclusion that, as a class, SVP's are clinically distinct from MDO's and NGI's and that those distinctions make SVP's more difficult to treat and more likely to commit additional sexual offenses than are MDO's and NGI's.

Multiple experts have testified at length about the physical and psychological harm that results from sexual crime. There was testimony that trauma from many causes can produce sustained harm and that resilience to trauma, whatever its cause, can vary due to individual factors making some victims more resilient than others. But the People's witnesses credibly testified that several aspects of long-term harm from sexual crime are unique to sexual victims and that many other aspects of such harm are found to a markedly greater degree with sexual victims than with other trauma victims.

Data from DMH (Hearing Exh. 5) suggests that SVP's to an overwhelming extent (over 90%) have as their most pressing diagnosis a sexual disorder such as pedophilia or

some other paraphilia, while only a very small number (less than 3%) primarily suffer from a major mental illness such as schizophrenia, bipolar disorder or major depression. That data also suggests that MDO's and NGI's present a virtual mirror image of that profile, with approximately 90% of them having as their most pressing diagnosis a major mental disorder and only a very small number (less than 2%) suffering from pedophilia or some other paraphilia. Other witnesses raised generalized questions about the precision of psychiatric diagnoses, especially when it comes to pedophilia and other paraphilias. But even adjusted for imprecision, these cold numbers seem stark and significant. Their significance lies, in part, in the additional testimony supporting the conclusion that SVP's are more resistant to treatment than are MDO's and NGI's. Since treatment is designed to reduce the danger these patients represent, their greater resistance to treatment leaves them more dangerous.

The DMH data also spoke to the question of risk analysis as represented by the Static-99 actuarial risk assessment tool. The Static-99 (and Static-99R) have been embraced by the State of California both legislatively and administratively as the State Authorized Risk Assessment Tool for Sex Offenders. There was significant testimony from the experts that a Static-99 score is not precise and has limits as a predictive tool. However, the consensus of the experts was that it is a key assessment tool that deserves to be a part of the risk assessment process. The DMH data suffers further imprecision because of the limits imposed by the computer record system producing it and the shifting of the various commitment populations among the state hospitals. Furthermore, no complete "head to head" comparison is possible between SVP's and the other classes for the simple reason that, while all SVP's have Static-99 scores, MDO's and NGI's only have them if they are required to register under Penal Code § 290. While this makes the comparisons incomplete, at least they are comparisons of SVP's to MDO's and NGI's who have a sexual offense history, somewhat increasing the relevance. The data contained in Hearing Exh. 5 shows that the SVP's committed since the passage of Proposition 83 have an average Static-99 score of 6.19, putting them in the "high" risk category. The subset of

MDO's that could be measured have an average Static-99R score of 3.6, putting them in the "moderate-low" risk category. Finally, a group from Atascadero State Hospital comprised of both MDO's and NGI's had a combined average Static-99R score of 4.6, putting them in the "moderate-high" risk category.

Apart from the DMH data, expert testimony also addressed the question of differential diagnoses and risk assessment. While the experts were not in complete agreement, there was substantial expert testimony that SVP's overwhelmingly tend to be pedophiles or other paraphiles while MDO's and NGI's overwhelmingly tend to have major mental illnesses. (Drs. Fennell, Jackson, Padilla.) Expert testimony also credibly supports the conclusion that SVP's are much more likely to reoffend sexually than are MDO's and NGI's and are more likely to sexually reoffend than general sex offenders. (Drs. Fennell, Thornton, Stinson, Jackson.) As Dr. Fennell testified, an MDO with a sex offense in his background is no more likely to commit a new sexual offense than he is to commit any other crime because MDO's are typically psychotic, disorganized, and unpredictable.

Considerable attention was given to statistical studies of recidivism but with unimpressive results. As Dr. Jackson pointed out, we just don't know about the recidivism rate for the subset of sexual criminals represented by SVP's because they are in custody and therefore not free to reoffend. So, the only data we have is for people who are not SVP's, either because they never were or because they no longer are. As was noted in oral argument in this case, the only way to generate useful data on this would be to release a large number of SVP's who are otherwise not ready for release, something no one has been willing to do. While the statistics we do have are of little direct value in comparing SVP's to MDO's and NGI's, two of the studies did show that sex offenders generally are much likely to reoffend sexually than are other classes of criminals. When coupled with the evidence that SVP's are substantially more likely to reoffend sexually than are sex offenders generally, this data underscores the view that SVP's are substantially more likely to reoffend sexually than are any other class of criminals.

The expert testimony in this case also provides credible support for the conclusion that SVP's are confronted with internal barriers to their treatment that MDO's and NGI's

don't face. Expert testimony supports the view that SVP's are less likely to enter treatment in the first place, less likely to embrace the idea that there is anything wrong with them in need of treatment, and more likely to be deceptive, manipulative, and controlling. According to several of the experts, the large majority of SVP's simply are not motivated to enter treatment or to succeed in it if they do begin it.

Several of the experts addressed the issue of how long it would take a hypothetical highly motivated SVP to complete hospital treatment and what percentage of SVP's meet that definition. The numbers varied widely from two and half to ten years with the understanding that some would never complete it. The estimates varied from 1% to 25% of the population being motivated enough to fit into these time ranges. In contrast, MDO's and NGI's are said to respond relatively quickly to psychiatric medications and then, largely willingly, enter traditional psychosocial therapy. Most of them know something is wrong with them and are relatively cooperative with treatment. To be sure, there was also testimony that MDO's and NGI's struggle with treatment too and stay in treatment for a considerable period of time. But it appears to this court that the weight of the evidence supports the conclusion that the course of treatment is rockier and the prognosis for successful treatment is poorer for SVP's than it is for MDO's and NGI's. To the extent this is so, it seems obvious that obstacles to their treatment constitute obstacles to neutralizing the danger represented by their mental disorder.

Finally, several of the witnesses expressed opinions whether an indeterminate term is an essential part of the treatment for SVP's. Not surprisingly, the opinions here also were mixed. Two witnesses (Drs. Fennell and Thornton) believed that a two-year term inflicted significant harm on the treatment process by exacerbating the patients' motivational issues, presenting a prolonged distraction which elevated the patients' resentful resistance to treatment. Dr. Thornton concluded that a two-year commitment represented a fundamental lack of faith in the original commitment. Dr. Fennell specifically believes these problems are not present to the same extent for MDO's or NGI's as classes, largely because of their greater degree of cooperation with treatment. Two other

witnesses (Drs. Kasdorf and Withrow) believed that an indeterminate term was unhelpful, though Dr. Kasdorf agreed that it did encourage some to enter treatment. His view was that two-year terms were "not that disruptive" and both witnesses believed that regular external reviews helpfully increased trust and hope on the part of the patients.

As the Supreme Court has pointed out, the usual great deference to legislative findings gives way to an exercise of independent judgment "whether the legislative body has drawn reasonable inferences based on substantial evidence" when statutory distinctions are subjected to a strict scrutiny analysis. (*McKee*, *supra*, at 1206.) However not all deference is banished. In summing up the principles applicable in this case, the Supreme Court specifically acknowledged "'the importance of deferring to the legislative branch in an area which is analytically nuanced and dependent upon medical science.'" (*McKee*, *supra*, at 1210, quoting from *Hubbart v. Superior Court* (1999) 19 Cal.4th 1138, 1156.) *Hubbart*, in turn, cited the United States Supreme Court for the proposition that "the legislature, not the judiciary, is best suited to weighing the scientific evidence . . . ." (*Hubbart*, *supra*, at 1156, citing *Kansas v. Hendricks* (1997) 521 U.S. 346, 359.)

In light of this, the California Supreme Court expressly invited the People to demonstrate at this hearing that "the special treatment of SVP's is validly based on the degree of danger reasonably perceived as to that group" and "whether it arises from any medical or scientific evidence." The People have, at length, presented evidence based in medical and psychological science showing that, on several levels, SVP's may reasonably be seen to represent a uniquely greater danger of sexual trauma, and that sexual trauma constitutes a unique quality and quantity of harm to victims. The extent and complexity of the evidence presented at this hearing clearly qualifies it as "analytically nuanced," and demonstrates the wisdom of our Supreme Court's conclusion that, even in a strict scrutiny context, some deference is due to the legislative branch in weighing such scientific evidence.

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It is this court's conclusion that the evidence presented satisfies the People's burden of establishing, by a preponderance of the evidence, that the different treatment given to SVP's under Proposition 83 is "based on a reasonable perception of the unique dangers that SVP's pose rather than a special stigma that SVP's bear in the eyes of California's electorate." (*McKee*, *supra*, at 1210.) The fact that the evidence supporting this may be subject to controversy does not detract from its reasonableness or from the validity of the legislative distinctions based on it.

At oral argument in this case, McKee raised several additional objections to the People's position that bear examination here. On his behalf it was argued that the diagnostic and risk level distinctions between the classes are not as sharp as they must be to survive an equal protection examination. In support of this McKee points out evidence that there are MDO's and NGI's who have paraphilias and SVP's who have major mental illnesses. Likewise, they point to evidence that there are SVP's whose Static-99 scores would rate them as low risk. In fact, a small number of patients are simultaneously committed as SVP's and MDO's. He points to these "overlaps" as fatal to the equal protection analysis. Citing *Loving v. Virginia* (1967) 388 U.S. 1, he argues that even if only one member of a class is subject to an unjustified differential burden the statutory distinctions must fail as to the entire class. This seems a misplaced reliance on *Loving*, in which an interracial couple was convicted and sentenced for being married. That case did not involve two largely distinct classes some of whose members might qualify for membership in both. No cases are cited to the court for the proposition that such potential overlaps constitute a violation of equal protection. In fact, the People cite *Vance v. Bradley* (1979) 440 U.S. 93, 108.) There a foreign service mandatory retirement age was attacked as being unjustifiably different from the mandatory retirement age for federal employees generally. Finding relevant differences between the two classes, the Supreme Court acknowledged that the differences may not apply uniformly throughout the two classes. But this did not lead to an equal protection violation.

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> Even if the classification involved here is to some extent both underinclusive and overinclusive, and hence the line drawn by Congress imperfect, it is nevertheless the rule that, in a case like this, "perfection is by no means required." [Citations.] The provision "does not offend the Constitution simply because the classification 'is not made with mathematical nicety. . . .'" [Citations.] (*Vance v. Bradley*, *supra*, at 108.)

While *Vance v. Bradley* was a "rational basis" case rather than a "strict scrutiny" case, it still seems on point. In human experience distinctions between classes seldom lend themselves to mathematical purity. The inquiry must be into the characteristics of a class "as a class." To the extent a particular individual is burdened by a distinction appropriate to his class generally, but not as to him specifically, the proper course of action might be for him to object to the statute as overbroad as applied to him. However, no evidence was presented in this case suggesting that in any respect relating to McKee personally the application of the SVP Act is overbroad as applied to him.

It is also argued on behalf of McKee that, in practice, the SVP laws essentially lock the patient up and "throw away the key". They say this because relatively few SVP's have progressed to outpatient status and none have been recommended for release by the Director of Mental Health. The People counter that the key is not thrown away, but actually put in the patient's hands, inviting him to participate in treatment and show that he is ready for release. This argument is simply not a component of an equal protection analysis.

McKee was allowed to present evidence of two sex offender programs in other states. Texas has a program that houses patients under substantial supervision in halfway houses after prison. It is "voluntary," although failure to "volunteer" subjects a patient to a felony prosecution, prison sentence and return to the "volunteer" program. The Texas representative who testified said that patients are reviewed every two years and no one has ever been recommended for release. Evidence was also received of a program begun in Canada called Circles of Support and Accountability, in which volunteers from faith-based organizations join with a recently released sexual offender to provide him support in rejoining the community. The representative who testified

presented an impressive picture of a successful community-based program. While this evidence was offered to show that less restrictive alternatives exist to SVP treatment, it fails to gain traction in an equal protection context. The focus of the issue here is to compare treatment of California SVP's with California MDO's and NGI's in light of the equal protection claim. California is not obligated to follow Texas or Canada's examples however much more enlightened they may seem.

Finally, at oral argument, McKee pointed to the evidence that diagnostics, risk assessment and treatment are all enterprises which are still developing and controversial. From this he argued that we simply do not know enough yet about these areas to be able to draw any reasonable distinctions between the classes based on them. It appears true that each of these areas continues to develop. We know more today than we did five or ten years ago. We will undoubtedly know more in five or ten years than we do now. But California has made a legislative determination that it faces an identifiable danger today from SVP's. The evidence available today supports the reasonable conclusion that SVP's present a greater danger of sexual reoffending than do MDO's or NGI's and that sexual reoffending represents a greater danger and a greater harm to victims than do most other crimes. It appears to this court that the government is entitled to make the best choices it can today with the information available to it today.

V. Disposition

For the foregoing reasons, this court concludes that the People have met their burden to establish a justification for the disparate treatment of SVP's under the standards set out by the Supreme Court in this case. The March 13, 2007, order committing him to the custody of the Department of Mental Health for an indeterminate term is confirmed.

Dated: 4/25/11

MICHAEL D. WELLINGTON
Judge of the Superior Court (Ret.)