Diagnostic Trends and *Donald DD.*: Has the Watershed Case Changed How State Doctors Diagnose Sex Offenders?

MAXIMILIAN J. AUERBACH*

Twenty states currently have laws providing for the civil management of sex offenders through involuntary confinement or outpatient supervision. These "SVP statutes" unanimously require a finding of a "mental abnormality," a legal standard that has generated significant debate since the Supreme Court affirmed the standard's constitutionality in Kansas v. Hendricks. *Proving the existence of a mental abnormality requires psychiatrists to diagnose sex offenders, and much of the aforementioned criticism focuses on the reliability of these predicate diagnoses. The New York Court of Appeals, in* State v. Donald DD.*, interpreted these cases to mean a sole diagnosis of antisocial personality disorder is insufficient to find a mental abnormality.*

This Note investigates whether, and to what extent, the Donald DD. *decision has affected New York's ability to civilly manage sex offenders and changed the diagnoses used in those civil management proceedings. Part II explores the constitutional requirements for SVP statutes established by the Supreme Court in* Kansas v. Hendricks *and* Kansas v. Crane. *Part III details the civil commitment scheme in New York, with particular focus on the diagnostic stages of a case. Part IV summarizes a review of civil management cases in New York since 2007 in order to determine whether* Donald DD.*'s holding affected New York's ability to civilly manage sex offenders, or the diagnoses offered by state experts when seeking civil management. This review includes analyses of whether* Donald DD. *has changed how frequently New York recommends sex offenders for civil*

* Managing Editor, Colum. J.L. & Soc. Probs., 2019–2020. J.D. 2020, Columbia Law School. The author thanks the attorneys at Mental Hygiene Legal Service, First Judicial Department, for introducing him to this area of law. In addition, the author would like to thank the staff of the *Columbia Journal of Law and Social Problems* for their feedback, insight, and edits. The author also thanks Professor Bert Huang for serving as the author's advisor.

management, and how frequently the State succeeds at trial. This Note observes that, while the case may have had some effect on referral, it has not affected trial success rates. Additionally, this Note finds some evidence that Donald DD. *may have led to increased psychopathy diagnoses, unspecified and other specified paraphilic disorder diagnoses, and the number of diagnoses assigned to individual respondents.*

I. INTRODUCTION

In 2006, Jerome A. pled guilty to attempted first degree rape at the age of fifty.[1] That offense was neither his first violent crime nor his first sex crime. In fact, Jerome A.'s extensive criminal record began developing at fifteen years old, accumulating charges for robbery, assault, and rape.[2] Since then, Jerome A. continued to accrue similar charges: around 1990, a Virginia court convicted him for maiming an individual;[3] in 1992, Jerome A. stabbed a man;[4] and in 1997, he pled guilty to first degree sexual abuse after threatening and raping his victim.[5] Given Jerome A.'s considerably violent and, more specifically, sexually violent history, few would struggle to label Jerome A. as a bad man. Yet, the more interesting question, and one that presently remains unanswered,[6] is whether Jerome A. qualifies as a mad man.[7]

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1. State v. Jerome A., No. 30261-2014, 2015 N.Y. Misc. LEXIS 3243, at *5 (Sup. Ct. Sept. 8, 2015). Case names in Article 10 proceedings are usually anonymized by abbreviating the respondent's last name to an initial. *See, e.g.*, State v. Timothy R., 89 N.Y.S.3d 678 (App. Div. 2018); State v. Jamaal A., 90 N.Y.S.3d 772 (App. Div. 2018); State v. David J., 90 N.Y.S.3d 347 (App. Div. 2018). The statute does not expressly require this anonymization; it merely permits parties to request "closure of the courtroom, or sealing of papers, for good cause shown." *See* N.Y. MENTAL HYG. LAW § 10.08(g) (McKinney 2011). Only two available cases have directly addressed the decision to grant respondents anonymity. *See* State v. J.R.C., No. CA 16-00168, 2017 N.Y. App. Div. LEXIS 6396, at *1–*2 (2017) (granting respondents motion for anonymity); State v. John T., 79 N.Y.S.3d 761, 763 (App. Div. 2018) (noting that the trial court granted anonymity to respondent).

2. *Jerome A.*, 2015 N.Y. Misc. LEXIS 3243, at *4.

3. *Id.*

4. *Id.* at *9.

5. *Id.* at *4.

6. As of the writing of this Note, the most recent development in Jerome A.'s case was the vacatur and remand of the decision to release him. *See* State v. Jerome A., 98 N.Y.S.3d 191, 191 (App. Div. May 7, 2019).

7. The "mad versus bad" dichotomy appears frequently in literature on criminal psychology. If someone is "mad" their behavior is attributable to a personality disorder or other mental illness, but if a person is "bad" their criminal behavior is attributed to their immorality. *See, e.g.*, Alan A. Stone, *The Line Between Mad and Bad*, PSYCHIATRIC TIMES (Aug. 1, 2005), https://www.psychiatrictimes.com/forensic-psychiatry/line-between-mad-and-bad [https://perma.cc/E659-9UN4]; Donna L. Hall et al., *The Increasingly Blurred Line Between 'Mad' and 'Bad': Treating Personality Disorders in the Prison Setting*, 74 ALB. L. REV. 1277 (2010); Alexander I.F. Simpson & Christopher D. Webster, *Contesting Mad versus Bad: The*

On October 3, 2014, Dr. Frances Charder, a psychologist for the New York State Office of Mental Health (OMH), first attempted to answer this question.[8] The State of New York (the State) had determined that Jerome A. required "civil management" under New York Mental Hygiene Law Article 10 (Article 10),[9] but forcing this civil management on Jerome A. first required proving in court that Jerome A. suffered from a "mental abnormality."[10] Two weeks later, on October 17, 2014, Dr. Charder authored a report concluding that Jerome A. indeed suffered from a mental abnormality, a conclusion she reached by diagnosing Jerome A. with antisocial personality disorder (ASPD) with psychopathy.[11]

Upon receiving Dr. Charder's report, the State decided to proceed with its efforts to civilly manage Jerome A., which would require the State to first prove there was "probable cause to believe" Jerome A. qualified for such management.[12] However, a significant legal development occurred between the publication of Dr. Charder's report and the probable cause hearing that would pull the brakes on the mad man inquiry.[13] Following Dr. Charder's report, the New York Court of Appeals held in *Matter of State of*

Evolution of Forensic Mental Health Services and Law at Toronto, 21 PSYCHIATRY, PSYCHOL. & L. 918 (2014); ANDREAS VOSSLER ET AL., MAD OR BAD?: A CRITICAL APPROACH TO COUNSELLING AND FORENSIC PSYCHOLOGY (2017); HL Kröber & S. Lau, *Bad or Mad? Personality Disorders and Legal Responsibility-the German Situation*, 18 BEHAV. SCI. L. 679 (2000).

8. *See* State v. Jerome A., No. 30261-2014, 2015 N.Y. Misc. LEXIS 3243, at *2–*3 (Sup. Ct. Sept. 8, 2015).

9. *See* N.Y. MENTAL HYG. LAW §§ 10.00–10.17. (McKinney 2011). Under Article 10, "civil management" means either confinement — sometimes referred to as "civil commitment" — or strict and intensive supervision and treatment (SIST), which amounts to a sex-offender-specific form of parole. *See id.* § 10.04(q) ("'Sex offender requiring civil management' means a detained sex offender who suffers from a mental abnormality. A sex offender requiring civil management can, as determined by procedures set forth in this article, be either (1) a dangerous sex offender requiring confinement or (2) a sex offender requiring strict and intensive supervision.").

10. *See* N.Y. MENTAL HYG. LAW § 10.03(q) (McKinney 2011) ("'Sex offender requiring civil management' means a detained sex offender who suffers from a mental abnormality."); *see id.* § 10.03(i) ("'Mental abnormality' means a congenital or acquired condition, disease or disorder that affects the emotional, cognitive, or volitional capacity of a person in a manner that predisposes him or her to the commission of conduct constituting a sex offense and that results in that person having serious difficulty in controlling such conduct."). For a more detailed discussion of Article 10 procedure, *see infra* Part III.A.

11. *Jerome A.*, 2015 N.Y. Misc. LEXIS 3243, at *3.

12. *See* N.Y. MENTAL HYG. LAW § 10.06(g) (McKinney 2011) ("Within thirty days after the sex offender civil management petition is filed . . . the supreme court or county court before which the petition is pending shall conduct a hearing without a jury to determine whether there is probable cause to believe that the respondent is a sex offender requiring civil management.").

13. *Jerome A.*, 2015 N.Y. Misc. LEXIS 3243, at *1.

New York v. Donald DD. that a diagnosis of ASPD, standing alone, was insufficient to establish a mental abnormality under Article 10.[14] While Jerome A.'s ASPD diagnosis did not stand alone, the New York County Supreme Court nonetheless held that "'ASPD with psychopathy' is not materially different" from a lone ASPD diagnosis, and therefore the State had not carried its burden at the probable cause stage.[15] In other words, as bad as Jerome A. might be, the State had ultimately failed to demonstrate his madness, rendering him ineligible for civil management; i.e., Jerome A. would become free, given the expiration of his prison sentence and ineligibility for civil management.

The State then appealed this decision, and the Appellate Division reversed, finding the addition of psychopathy sufficient to overcome the hurdle put in place by *Donald DD.*[16] Jerome A.'s case thus proceeded to the mental abnormality trial stage, at which point the State would attempt to prove by clear and convincing evidence that Jerome A. suffered a mental abnormality.[17] In its effort to carry this burden, the State abandoned ASPD with psychopathy, a diagnosis that had narrowly survived the lower evidentiary bar at the probable cause stage, and instead proffered new diagnoses detected by another psychologist, Dr. Kostas Katsavdakis.[18] This psychologist had already participated in Jerome A.'s probable cause hearing, primarily to bolster Dr. Charder's assertions. Specifically, Dr. Katsavdakis argued that Jerome A. "had 'psychopathic character pathology,'" and went on to support the notion initially rejected by the court that ASPD and psychopathy differ sufficiently to overcome *Donald DD.*[19] Despite these assertions,

14. State v. Donald DD., 21 N.E.3d 239, 250 (N.Y. 2014). For a more detailed discussion of *Donald DD.*, *see infra* Part III.B.

15. *See* State v. Jerome A., No. 30261-2014, 2015 N.Y. Misc. LEXIS 3243, at *1 (Sup. Ct. Sept. 8, 2015).

16. State v. Jerome A., 27 N.Y.S.3d 150, 151 (App. Div. 2016).

17. *See* N.Y. MENTAL HYG. LAW § 10.07(a) (McKinney 2011) ("[W]ithin sixty days after the court determines . . . that there is probable cause to believe that the respondent is a sex offender requiring civil management, the court shall conduct a jury trial to determine whether the respondent is a detained sex offender who suffers from a mental abnormality."); *see id.* § 10.07(d) ("[T]he jury, or the court if a jury trial is waived, shall determine by clear and convincing evidence whether the respondent is a detained sex offender who suffers from a mental abnormality."). For a more detailed discussion of the stages of an Article 10 petition, *see infra* Part III.A.

18. State v. Jerome A., No. 30261/2014, 2017 N.Y. Misc. LEXIS 4880, at *2 (Sup. Ct. Dec. 21, 2017).

19. *See State v. Jerome A.*, 2015 N.Y. Misc. LEXIS 3243, at *16.

Dr. Katsavdakis ultimately concluded only that Jerome A. suffered from ASPD with narcissistic features at the probable cause stage.[20]

This diagnosis, unlike Dr. Charder's, subsequently survived to the mental abnormality trial stage, but not without supplementation. In addition to ASPD with narcissistic features, Dr. Katsavdakis further diagnosed Jerome A. with unspecified paraphilic disorder (USPD), various substance abuse disorders, and a provisional diagnosis of sexual sadism disorder.[21] Despite these additional diagnoses, the court ultimately found that the State had not proven a mental abnormality by clear and convincing evidence.[22] It appeared that Jerome A. was just a bad man, not mad; however, the State appealed the verdict, the Appellate Division sided with the State and, as of the writing of this Note, the ultimate result in Jerome A.'s case remains unknown.[23]

Jerome A.'s saga reveals several relevant features of New York's civil management system. For one, it previews the general legal process of, and issues in, bringing an Article 10 action. It also serves as a useful illustration of the various stages of an Article 10 case. Most importantly, however, the case of *Jerome A.* represents potentially shaky diagnostic practices implemented in response to the *Donald DD.* decision. *Jerome A.* is unique by virtue of its straddling of *Donald DD.*: Jerome A. received his first diagnosis before

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20. *See id.*

21. *See Jerome A.*, 2017 N.Y. Misc. LEXIS 4880, at *2–*3.

22. *See* State v. Jerome A., 98 N.Y.S.3d 191, 191–92 (App. Div. 2019). Unlike the other diagnoses, which were found unproven, USPD was precluded in a *Frye* hearing. *See* State v. Nicholas T., 78 N.Y.S.3d 650, 651 n.1 (Sup. Ct. 2018). New York courts apply the *Frye* evidentiary test in order to determine the admissibility of expert testimony. *See* People v. Wesley, 633 N.E.2d 451, 454 (N.Y. 1994). Under *Frye*, "expert testimony based on scientific principles or procedures is admissible, but only after a principle or procedure has 'gained general acceptance' in its specified field." *Id.* (quoting Frye v. United States, 293 F. 1013, 1014 (D.C. Cir. 1923)). Thus, the question in Jerome A.'s case was whether "USPD is generally accepted in the relevant psychiatric community." *Jerome A.*, 2017 N.Y. Misc. LEXIS 4880, at *1. Initially, the court found that USPD had achieved general acceptance, and was therefore admissible. *See id.* However, following an appellate decision in the Second Department finding USPD did not satisfy *Frye*, the trial court reversed its initial decision. *See Nicholas T.*, 78 N.Y.S.3d at 651–52. The trial court reasoned that, even though it was generally only bound by First Department decisions, the court had to follow the Second Department's decision since it was the only available appellate law. *See id.* The issue of USPD's admissibility under *Frye* eventually reached the First Department, who concluded that the diagnosis passed *Frye*, despite the Second Department's conclusion to the contrary. *See Jerome A.*, 98 N.Y.S.3d 191, 191–92. In light of this conclusion, the First Department reversed the decision to release Jerome A., and remanded the case to proceed with evidence of USPD. *See id.*

23. *See Jerome A.*, 98 N.Y.S.3d at 191 (vacating the trial court's decision to release Jerome A. and remanding for a new trial). For a more thorough description of this appeal, *see supra* note 22.

Donald DD., nearly went free because of *Donald DD.*, and then received an amplified diagnosis after *Donald DD.* This Note investigates whether *Jerome A.* represents a mere coincidence or if state psychologists have instead adjusted their diagnoses to cater to the law.

Viewed differently, it could be argued that *Jerome A.* represents a success story: the State managed to protect society from a dangerous individual despite barriers put in place by the New York Court of Appeals. One taking such a view likely opposes *Donald DD.* and worries that it could lead to more Jerome A.'s roaming the streets. For this reason, this Note also assesses whether *Donald DD.* has hamstrung efforts to civilly manage sex offenders. This assessment also relates to the diagnostic inquiry described above, as it is possible that *Donald DD.* has had a diminished effect on civil management efforts due to adjustments in the diagnoses.

While this Note does not reach any definitive conclusions on these questions, given the limited data available, it does provide preliminary efforts toward answering what effects *Donald DD.* has had on the diagnoses used in, and the ultimate results of, Article 10 proceedings. Specifically, the data presented herein indicate that *Donald DD.* has not substantially hampered New York's ability to civilly manage its sex offenders, but that this lack of effect may stem from a change in diagnostic practices following *Donald DD.*

Part II of this Note begins by outlining the relevant constitutional background of Article 10 and similar laws. The central cases of *Kansas v. Hendricks*[24] and *Kansas v. Crane*[25] highlighted in this Part explain why Article 10 and similar laws place such a significant emphasis on psychiatric testimony, which in turn explains the grave constitutional implications of that testimony's reliability. These cases also provide the backdrop for understanding the decision in *Donald DD.* Part III then details the civil commitment scheme in New York, which includes an analysis of both relevant case law, like *Donald DD.*, and an outline of the Article 10 process. This Part also demonstrates the centrality of psychiatric testimony, further emphasizing the importance of that testimony's accuracy. Part IV summarizes the findings of a review of civil commitment cases in New York since 2007, and how predicate

24. 521 U.S. 346 (1997).
25. 534 U.S. 407 (2002).

diagnoses and trial success rates have changed following the New York Court of Appeals' decision to preclude a lone diagnosis of ASPD.

From this data, this Note concludes that *Donald DD.* has not significantly hampered the State's ability to civilly manage sex offenders, which lends support to the *Donald DD.* decision on practical grounds. This Note also found evidence that (1) questionable diagnoses are often used in connection with civil commitment in New York, and (2) the State may have changed some of its diagnostic practices in order to circumvent *Donald DD.* These preliminary findings support further, more rigorous investigation into Article 10 diagnoses, given the constitutional significance of those diagnoses.

II. THE CONSTITUTIONAL ROLE OF PSYCHIATRIC DIAGNOSES IN SEXUALLY VIOLENT PREDATOR LAWS AS DETERMINED BY *KANSAS V. HENDRICKS* AND *KANSAS V. CRANE*

Article 10 falls into a broader category of laws known as sexually violent predator (SVP) laws, which permit states to civilly commit sex offenders.[26] Two Supreme Court cases, *Kansas v. Hendricks* and *Kansas v. Crane*, discussed in Part II.A and Part II.B, respectively, set forth the constitutional conditions for SVP laws. Essentially, these cases established that states must prove that an offender possesses some feature distinguishing him from "the dangerous but typical recidivist."[27] This distinguishing feature manifests in the mental abnormality requirement found in SVP statutes, supplemented with a related lack-of-control requirement imposed by *Crane*.[28]

Following *Hendricks* and *Crane*, the constitutionality of SVP laws has been widely considered a settled matter.[29] However,

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26. *See* CHARLES PATRICK EWING, JUSTICE PERVERTED: SEX OFFENSE LAW, PSYCHOLOGY, AND PUBLIC POLICY 9–10 (2011) (describing the shift in nomenclature from "sexual psychopath laws" to the current "SVP statutes"). Although Ewing only describes civil commitment, New York's law goes beyond civil commitment, as it also allows the State to supervise the offender in the community. *See supra* note 9. For this reason, Article 10 frames its statute in terms of civil management, but this feature does not affect the relevance of the cases discussed in this Part of the Note.

27. Kansas v. Crane, 534 U.S. 407, 413 (2002).

28. *Id.* at 412.

29. *See* Deirdre M. Smith, *Dangerous Diagnoses, Risky Assumptions, and the Failed Experiment of 'Sexually Violent Predator' Commitment*, 67 OKLA. L. REV. 619, 624 (2015) (noting that commentators seem to agree that the constitutionality issue is settled).

these cases still require attention as they form the basis for New York courts' analysis of Article 10. Specifically, this Part of the Note focuses on how these cases have created a substantial role for psychiatric testimony in the SVP context.[30] Because this reliance on psychiatric testimony stems from the constitutionally required distinction described above, *Hendricks* and *Crane* set up questionable diagnoses as a constitutionally charged issue.[31]

A. *KANSAS V. HENDRICKS* AND THE REQUIREMENT THAT SVP LAWS DISTINGUISH SVPS FROM TYPICAL RECIDIVISTS

The first[32] constitutional challenge to an SVP statute in the U.S. Supreme Court occurred in *Kansas v. Hendricks*. Leroy Hendricks was civilly committed under Kansas' SVP statute after a jury found that he suffered from a mental abnormality.[33] This finding relied on a state physician's diagnosing Hendricks with pedophilia, as well as Hendricks' own admissions that "he can't control the urge to molest children."[34] The Kansas statute defined a mental abnormality as "[a] congenital or acquired condition affecting the emotional or volitional capacity which predisposes the person to commit sexual offenses in such a degree constituting the person a menace to the health and safety of others."[35] Hendricks challenged the statute as violating substantive due process, the Double Jeopardy Clause, and the Ex Post Facto Clause.[36]

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30. *See id.* at 646–47 (describing an "indispensable role for the psychiatric community" in identifying those eligible for commitment as one of the core assumptions of *Hendricks* and *Crane*).

31. *See id.* ("The constitutionality of SVP laws and their consistency with core U.S. values hangs entirely on the finding of a mental condition so severe that it deprives the person of the ability to exercise volition.").

32. The designation of "first" here relies on a distinction between SVP laws and their predecessors, the sexual psychopath laws. For discussion of the history of sexual psychopath laws and their evolution into SVP laws, *see* Smith, *supra* note 29, at 629–30; Kaitlyn Walsh, Note, *Antisocial Personality Disorder and* Donald DD*.: Distinguishing the Sex Offender from the Typical Recidivist in the Civil Commitment of Sex Offenders*, 44 FORDHAM URB. L.J. 867, 880–84. Sexual psychopath laws withstood constitutional scrutiny in Minnesota *ex rel.* Pearson v. Probate Court of Ramsey County, 309 U.S. 270, 274 (1940).

33. Kansas v. Hendricks, 521 U.S. 346, 355–56 (1997).

34. *Id.* at 355.

35. KAN. STAT. ANN. § 59-29a02(b).

36. *Hendricks*, 521 U.S. at 350. Because the due process holding is the most relevant to the structure and development of Article 10, this Note will not focus on the ex post facto and double jeopardy holdings. Essentially, the Court found that neither clause was violated because civil confinement does not qualify as punishment. *See id.* 361–70. The four-Justice dissent disagreed only as to the majority's ex post facto holding. *See id.* at 373.

In a five-to-four opinion authored by Justice Clarence Thomas, the Court rejected all of Hendricks' constitutional challenges.[37] With respect to due process, Justice Thomas noted that, while states retain significant leeway in setting the parameters for civil commitment, due process still requires states to sufficiently narrow the class of individuals eligible for commitment.[38] Kansas' statute accomplished this distinction through its requiring a mental abnormality, and by "set[ting] forth criteria relating to an individual's ability to control his dangerousness."[39] Justice Thomas went on to conclude that Hendricks readily met these criteria: Hendricks had a mental abnormality in his diagnosed pedophilia, and had admitted to an inability to control his pedophilic urges.[40]

Justice Anthony Kennedy wrote separately in order to add words of caution on the constitutionality of civil commitment schemes. Specifically, Justice Kennedy focused on the term mental abnormality, which the Court had just validated. Justice Kennedy warned that "if it were shown that mental abnormality 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."[41] Despite these concerns about imprecision, the *Crane* decision, discussed below, served only to further confuse the definition of mental abnormality.

B. *KANSAS V. CRANE* AND THE REQUIREMENT THAT SVPS EXHIBIT A LACK OF SELF-CONTROL

While *Hendricks* made clear that lack of control was a key constitutional feature of SVP schemes, the precise degree to which one must lack control remained an open question. Five years after *Hendricks*, Michael Crane seized on this ambiguity, arguing his commitment under the same Kansas law was unconstitutional.[42] Crane argued that *Hendricks* had required states to prove a total lack of control in order to justify civil confinement under SVP statutes, and Kansas had failed to do so in his case.[43] Thus, the Court

37. *Id.* at 371.
38. *Id.* at 358.
39. *Id.* at 359–60.
40. *Id.* at 360.
41. *Id.* at 373.
42. Kansas v. Crane, 534 U.S. 407, 411 (2002).
43. *Id.* at 413.

faced the question of how much control, or lack thereof, due process requires for commitment.

The Court rejected Crane's argument, but failed to provide a precise control standard. Instead, the Court held that due process only requires "proof of serious difficulty in controlling behavior," such as to distinguish the "dangerous sex offender" from "the dangerous but typical recidivist."[44] This serious-difficulty standard was deliberately vague. The Court noted that the standard does not carry "a particularly narrow or technical meaning" in order to provide the states with "considerable leeway" in drafting commitment statutes.[45]

This holding reiterated the distinguishing task identified in *Hendricks* as necessary for SVP laws to comport with due process. *Hendricks* found SVP laws constitutional when they require a volitional impairment that narrows the class of those eligible for confinement.[46] When asked to clarify that standard, the *Crane* Court responded by saying the impairment must sufficiently distinguish the sex offender from the typical recidivist;[47] in other words, the impairment must narrow the class of eligible individuals.

This circular non-answer to the question presented by *Hendricks* did not go uncontested, with Justice Antonin Scalia taking great exception to the imprecision of the Court's new control test. Scalia argued that this standard "gives trial courts . . . *not a clue* as to how they are supposed to charge the jury."[48] To Justice Scalia, a trial court could not possibly articulate the extent to which one must lack control in order to qualify for civil commitment.[49]

The majority, however, had an answer for the vagueness spotlighted by Justice Scalia: psychiatry. The majority thought it best to avoid precision, partly because "the science of psychiatry, which informs but does not control ultimate legal determinations, is an ever-advancing science, whose distinctions do not seek precisely to mirror those of law."[50] Similarly, the majority noted that any evidence of serious difficulty in control needed to be viewed "in light

44. *Id.*
45. *Id.*
46. Kansas v. Hendricks, 521 U.S. 346, 359–60 (1997).
47. *Crane*, 534 U.S. at 413.
48. *Id.* at 424 (emphasis in original) (Scalia, J., Dissenting).
49. *Id.*
50. *Id.* at 413.

of . . . the nature of the psychiatric diagnosis, and the severity of the mental abnormality itself."[51]

In sum, *Hendricks* sets up the finding of mental abnormality and lack of control as constitutionally necessary to commit sex offenders. *Crane* clarifies the control standard, and doubles down on the importance of psychiatry in accomplishing this distinction. As one scholar articulated it, "the *Hendricks-Crane* rationale assumes that . . . mental health professionals would reliably identify those whose medical conditions put them at a higher risk of committing sexual violence," in order to ensure that "SVP commitment laws would not sweep too broadly."[52] Article 10 itself, and *Donald DD.*, developed around *Hendricks* and *Crane* and advanced the central role of psychiatric professionals in SVP law.

III. THE ROLE OF PSYCHIATRIC DIAGNOSES IN NEW YORK'S ARTICLE 10 SVP LAW AND THE LEGAL EFFECT OF *DONALD DD.* ON THOSE DIAGNOSES

In 2007, New York enacted Article 10 in order to "expand civil commitment of one type of criminal — sex offenders — to persons who had previously not qualified as in need of commitment under the existing laws."[53] The statute defines mental abnormality as:

> a congenital or acquired condition, disease or disorder that affects the emotional, cognitive, or volitional capacity of a person in a manner that predisposes him or her to the commission of conduct constituting a sex offense, and that results in that person having serious difficulty in controlling such conduct.[54]

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51. *Id.*

52. *See* Smith, *supra* note 29, at 659–60.

53. State v. Floyd Y., 87 N.E.3d 143, 150 (N.Y. 2017) (Wilson, J., dissenting); *see also* Governor's Program Bill Mem., Bill Jacket, L. 2007, Ch. 7, 9–10 ("[M]any mentally abnormal sexual offenders may not have the kind of 'mental illness' that is a prerequisite for commitment."). This expansion references commitment laws that predated Article 10, and that the State had unsuccessfully attempted to use to commit sex offenders. *See* State *ex rel.* Harkavy v. Consilvio, 859 N.E.2d 508 (N.Y. 2006). For a more detailed description of the build-up to Article 10 in light of failed attempts to use other commitment laws, *see* Walsh, *supra* note 32, at 887–89.

54. *See* N.Y. MENTAL HYG. LAW § 10.03(i) (McKinney 2011).

Article 10 thus mirrors the Kansas law[55] approved in *Hendricks* and *Crane*, in its definition of mental abnormality, but goes further by incorporating *Crane*'s control standard directly into the statute.

This connection to *Hendricks* and *Crane* extends beyond the wording of the statute. As this Part discusses, *Hendricks* and *Crane* have led to the development of New York's own unique standards for psychiatric testimony in Article 10 cases. In turn, these standards have amplified the importance of psychiatric evidence in New York's SVP system. This Part also describes how these psychiatric diagnoses enter the Article 10 inquiry as a practical and procedural matter. Understanding this procedure is necessary for making sense of the appellate case law and of the source material used for the empirical analysis discussed later in this Note.[56]

Therefore, Part III.A begins with a discussion of Article 10's procedure. Part III.B then outlines the cases which have amplified the role of diagnoses in the Article 10 inquiry, with particular focus on *State v. Donald DD.* This focus on *Donald DD.* continues into Part III.C, which discusses criticisms of the decision. Because these criticisms appear rooted in fears that *Donald DD.* will encourage release, this subpart sets the stage for the discussion of whether *Donald DD.* has in fact led to the release of more sex offenders.

A. STAGES OF AN ARTICLE 10 PROCEEDING AND THE ROLE OF PSYCHIATRIC DIAGNOSES

An Article 10 proceeding involves four main stages: referral, the probable cause hearing, the mental abnormality trial, and annual review hearings.[57] The first step, referral, involves the State's deciding who within the prison population might qualify for civil management under Article 10. To accomplish this task, the Office of Mental Health deploys a "Risk Assessment and Record Review" (RARR) team to evaluate convicted sex offenders using Article 10's criteria.[58] Two teams evaluate the history of an offender. The first

55. *See supra* note 35.

56. *See infra* Part IV.

57. Discussion of the probable cause and mental abnormality trial stages appears *supra* Part I.

58. N.Y. STATE OFFICE OF MENTAL HEALTH, 2015 ANNUAL REPORT ON THE IMPLEMENTATION OF MENTAL HYGIENE LAW ARTICLE 10, at 4 (2016) [hereinafter OMH 2015].

team decides whether to refer the case to the second team, and the second team decides whether to refer the case to the Attorney General to seek civil management.[59] As part of the second team's determination, a psychiatrist provides initial diagnoses in order to see if the offender has a mental abnormality satisfying Article 10's criteria.[60] This represents the first point at which a psychiatric diagnosis enters the Article 10 process.

If the Attorney General moves forward with the case, a probable cause hearing is held.[61] Here, the court, without a jury, determines whether there is "probable cause to believe" the respondent is a sex offender with a mental abnormality.[62] At this hearing, the psychiatric examiner providing the initial diagnosis described above typically testifies.[63] The respondent also has an opportunity to present his own psychiatric examiner.[64] If the court finds probable cause, the case moves on to the mental abnormality trial,[65] which must occur within sixty days of that finding.[66] At trial, the State must prove, by clear and convincing evidence, that the respondent suffers from a mental abnormality.[67] As demonstrated by Jerome A.'s case, the State may supplement the evidence it used at the probable cause stage with additional psychiatric evidence.[68] The respondent has a right to have a jury evaluate the State's evidence, but may waive that right in favor of a bench trial.[69] If the court or jury finds a mental abnormality, the court then holds a second hearing to determine the respondent's dangerousness.[70] At this hearing, the court must determine whether the respondent is

59. *Id.*
60. *Id.*
61. *Id.* at 6–7; *see also* N.Y. MENTAL HYG. LAW §§ 10.06(g), (h) (McKinney 2011).
62. OMH 2015, *supra* note 58, at 6–7. *See also* MENTAL HYG. LAW § 10.06(g).
63. OMH 2015, *supra* note 58, at 6–7. In Jerome A.'s case, Dr. Charder provided this testimony. *See supra* Part I.
64. OMH 2015, *supra* note 58, at 6–7.
65. *Id.* at 7.
66. *See* MENTAL HYG. LAW § 10.07(a).
67. *See id.* § 10.07(d).
68. *Compare* State v. Jerome A., No. 30261-2014, 2015 N.Y. Misc. LEXIS 3243, at *3 (Sup. Ct. Sept. 8, 2015) (discussing the probable cause stage at which the State proffered evidence only of ASPD with psychopathy) *with* State v. Jerome A., No. 30261/2014, 2017 N.Y. Misc. LEXIS 4880, at *2–3 (Sup. Ct. Dec. 21, 2017) (discussing the mental abnormality trial stage at which the State proffered evidence of ASPD with narcissistic features, USPD, and substance abuse disorders).
69. *See* N.Y. MENTAL HYG. LAW § 10.07(d) (McKinney 2011).
70. *See id.* § 10.07(f).

sufficiently dangerous to require confinement, or only dangerous enough to require outpatient supervision and treatment.[71]

Diagnoses become relevant again during annual review hearings, prescribed by section 10.09.[72] Civilly committed respondents receive a yearly state-conducted psychiatric examination, but are also entitled to an independent examination.[73] Following these examinations, the respondent may petition for discharge, asking the court to find that the respondent no longer qualifies as a "dangerous sex offender requiring confinement."[74]

The court, which originally committed the respondent, then conducts an evidentiary hearing on the question of whether the respondent remains a "dangerous sex offender requiring confinement."[75] Qualifying as a "dangerous sex offender requiring confinement" requires the presence of a mental abnormality, and a high degree of dangerousness.[76] Thus, the reviewing court must again confront the mental abnormality question for each respondent every time the respondent desires an annual review hearing. As a result, and given the requirement for annual examinations, annual review hearings confront diagnoses, and sometimes those diagnoses differ from those assigned at the original mental abnormality trial.[77]

The realities of the Article 10 process reveal the centrality of diagnoses. Indeed, diagnoses play a major role in driving cases forward. Without a diagnosis to get through the probable cause stage, the case will end. Even if those diagnoses appear relatively weak, the State has a chance to supplement them at the mental

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71. *See id.* This outpatient treatment is called "strict and intensive supervision and treatment," abbreviated as SIST. *See supra* note 9.

72. MENTAL HYG. LAW § 10.09.

73. *See id.* § 10.09(b).

74. *Id.* § 10.09(d). The respondent may also waive his right to petition as a result of these examinations. However, if the court finds that the examinations create a "substantial issue as to whether the respondent remains a dangerous sex offender," the court must hold a hearing despite the respondent's waiver. *See id.*

75. *See id.*

76. *See id.* § 10.03(e) ("'Dangerous sex offender requiring confinement' means a person who is a detained sex offender suffering from a mental abnormality involving such a strong predisposition to commit sex offenses, and such an inability to control behavior, that the person is likely to be a danger to others and to commit sex offenses if not confined to a secure treatment facility.").

77. *Compare* State v. Charada T., No. 30111-2017, 2018 N.Y. Misc. LEXIS 942, *4 (Sup. Ct. Mar. 23, 2018) (describing an annual review hearing for Charada T. in which he was diagnosed with ASPD with psychopathy) *with* State v. Charada T., 14 N.E.3d 362, 364 (N.Y. 2014) (discussing Charada T.'s mental abnormality trial at which he was diagnosed with paraphilia NOS, personality disorder with antisocial traits, and alcohol abuse).

abnormality stage. Regardless of this ability to supplement, the strength of these diagnoses may not matter to the factfinder, as there is some reason to believe factfinders are reluctant to release sex offenders. For example, one commentator, Professor Deirdre Smith, reviewed judicial opinions for instances of judges voicing such hesitance.[78] She reached a common-sense conclusion: "it is difficult to imagine how a jury of laypersons, after hearing . . . a child rapist has a 33% chance of reoffending . . . would not commit that person."[79] Additionally, a 2006 study found participants more likely to find a volitional impairment when told the determination concerned civil commitment of sex offenders than when told it concerned an insanity defense.[80] That same study found this effect particularly strong among judges.[81] Because the fact-finding side of Article 10 seems unlikely to reject diagnoses, legal constraints on what diagnoses count, and do not count, become especially important. The following subpart discusses such constraints.

B. *DONALD DD.* AND OTHER CASES SETTING THE REQUIREMENTS FOR DIAGNOSES IN ARTICLE 10 PROCEEDINGS

Although *Donald DD.* represents the most significant development in Article 10 case law, a review of both prior and subsequent case law is necessary to fully understand the impact of *Donald DD.* Ultimately, it appears that ASPD combined with any other condition, including those not present in the Diagnostic and Statistical Manual of Mental Disorders (DSM),[82] is legally sufficient to impose civil management.

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78. *See* Smith, *supra* note 29, at 713 (citing United States v. Springer, 715 F.3d 535, 548, 551 (4th Cir. 2013) (Wilkinson J., dissenting) ("[T]hough we may never know the consequences of a poor predictive judgment on our part, I fear that some young child somewhere will experience them.")).

79. *See* Smith, *supra* note 29, at 713. Here, Smith is referring specifically to risk assessments in commitment proceedings. Smith looked at SVP legislation outside of New York, which may not contain New York's bifurcated structure in which a mental abnormality is found and then risk assessment occurs. Since the effect of finding no mental abnormality also results in letting a sex offender go free to potentially assault another child, it follows that jurors would be reluctant not to find a mental abnormality.

80. Cynthia Calkins Mercado et al., *Decision-Making About Volitional Impairment in Sexually Violent Predators*, 30 LAW & HUM. BEHAV. 587, 594 (2006).

81. *Id.* at 595.

82. For an overview of the DSM, *see* AM. PSYCH. ASS'N, *DSM-5 Frequently Asked Questions*, https://www.psychiatry.org/psychiatrists/practice/dsm/feedback-and-questions/frequently-asked-questions [https://perma.cc/6QSD-NLPQ] (last visited Jan. 25, 2020) ("The *Diagnostic and Statistical Manual of Mental Disorders (DSM)* is the handbook used by

The path to this rule began with *State v. Shannon S.*[83] Shannon S. initiated his Article 10 process like any other New York sex offender: through an interview with an OMH psychologist.[84] That doctor diagnosed Shannon S. with paraphilia not otherwise specified (paraphilia NOS), ASPD, and substance abuse disorder.[85] Based on that information, the doctor opined that Shannon S. suffered from a mental abnormality, and the case proceeded to trial.[86]

At a bench trial, the State presented the first doctor's opinion, as well as that of a second doctor. The second doctor also concluded that Shannon S. suffered from paraphilia NOS, but went further, stating that the kind of paraphilia presented by Shannon S. was "hebephilia," an attraction to pubescent girls.[87] Hebephilia, unlike paraphilia NOS, did not appear in the DSM, which the court has recognized as "an authoritative text widely used in the mental health profession."[88] *Shannon S.* also involved the testimony of a third doctor, who argued for the defense. This doctor took issue with the applicability of the hebephilia diagnosis to Shannon S., as well as with the use of paraphilia NOS as a stand-in for hebephilia.[89]

The lower court found that Shannon S. suffered from a mental abnormality, and the Appellate Division affirmed.[90] Then, while before the Court of Appeals, Shannon S. contended that a diagnosis not listed in the DSM, such as hebephilia, is too unreliable to serve as a viable "predicate medical condition for a finding of a mental abnormality."[91] The majority, in rejecting Shannon S.'s contention, relied partially on *Hendricks* and *Crane*. The court cited language from *Hendricks* explaining the leeway owed to states regarding SVP laws, and language from *Crane* recognizing the imperfect fit between psychiatry and law.[92] Because Article 10 contained no express DSM requirement, the majority found no constitutional

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health care professionals in the United States and much of the world as the authoritative guide to the diagnosis of mental disorders.").

83. 980 N.E.2d 510 (N.Y. 2012).

84. *See id.* at 511.

85. *See id.*

86. *See id.*

87. *Shannon S.*, 980 N.E.2d at 512. It is unclear if the second doctor concurred with the first doctor's other diagnoses.

88. *Id.* For more detailed discussion of the DSM and its diagnoses, *see infra* Part IV.B.

89. *Shannon S.*, 980 N.E.2d at 512–13.

90. *Id.* at 513.

91. *Id.*

92. *Id.*

grounding for a DSM requirement.[93] Ultimately, the court found that, in any event, the State had proven paraphilia NOS by clear and convincing evidence, and upheld the Appellate Division's ruling.[94]

The dissent, although not focusing expressly on non-DSM diagnoses, took a different approach, relying not only on the distinguishing task developed in *Hendricks* and ratified by *Crane*, but also on Justice Kennedy's separate concurrence on the imprecision of mental abnormality.[95] In light of this distinction, the dissent found the three diagnoses legally insufficient. The dissent believed that paraphilia NOS was not sufficiently distinctive under *Hendricks* and *Crane* because that diagnosis could apply to any recidivist sex offender.[96] With respect to hebephilia, the dissenting judge similarly found the diagnosis inadequate because it was not sufficiently severe or abnormal.[97] Finally, the dissent highlighted ASPD as unable to accomplish the necessary distinction,[98] an argument that presaged the *Donald DD.* opinion.

Donald DD. differed from Jerome A. and Shannon S. in that his first doctor concluded that Donald DD. did not suffer from a mental abnormality, despite having diagnosed him with ASPD.[99] He was subsequently released on parole, which he violated by committing further sex offenses.[100] With Donald DD. back in prison, the State went ahead with an Article 10 action against Donald DD., and brought two more doctors in for the mental abnormality trial.[101] Both agreed with the first doctor's diagnosis of ASPD.[102] The jury ultimately found that Donald DD. suffered from a mental abnormality, a verdict Donald DD. attempted to set aside.[103] The court upheld the jury verdict, Donald DD. appealed, and the Appellate Division upheld the lower court.[104]

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93. *Id.* at 513.
94. *Shannon S.*, 980 N.E.2d at 513–14.
95. *Id.* at 515–16 (Smith, J., dissenting). *See also supra* Part II.B.
96. *Id.* at 516–17.
97. *See id.* The judge added that these diagnoses "amount to junk science devised for the purpose of locking up dangerous criminals." *Id.* at 517.
98. *See id.*
99. State v. Donald DD., 21 N.E.3d 239, 244–45 (N.Y. 2014).
100. *Id.* at 244.
101. *Id.* at 245–46.
102. *Id.* at 246.
103. *Id.*
104. *Donald DD.*, 21 N.E.3d 239 at 246.

The New York Court of Appeals then reversed. Following *Hendricks*' requirement that SVP statutes distinguish the respondent from the typical recidivist, the State's highest court held that a diagnosis of ASPD, on its own, does not accomplish this task, and is therefore insufficient for a finding of mental abnormality.[105] The court reasoned that because so many inmates meet ASPD's diagnostic criteria, and because ASPD amounts to nothing more than a propensity to commit crimes, a diagnosis of ASPD by itself did not accomplish the necessary distinguishing task.[106]

As one New York court noted, "case law since *Donald DD.* . . . has significantly limited [*Donald DD.*'s] scope."[107] Most representative of this consequence was when the New York Court of Appeals substantially narrowed *Donald DD.*'s holding in *Matter of State of New York v. Dennis K.*,[108] in which the court held that (1) *Donald DD.* created no requirement that the State produce evidence of sexual disorders, and (2) that *Donald DD.* only applied to a sole diagnosis of ASPD; i.e., it did not extend to personality disorders similar to ASPD.[109]

Dennis K. addressed three separate respondents, two of whom had been diagnosed with various personality disorders, but not with sexual disorders.[110] *Donald DD.*'s criticism of ASPD alone, as a predicate diagnosis, included language that ASPD "proves no sexual abnormality[.]"[111] Armed with this language, respondents argued that *Donald DD.* required some diagnosis of a sexual disorder in every case.[112] In other words, respondents argued that any combination of non-sexual personality disorders would fail as a matter of law under *Donald DD.* The court in *Dennis K.* rejected this claim, finding that *Donald DD.* did not require evidence of a sexual disorder.[113]

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105. *Id.* at 250.

106. *Id.*

107. State v. Charada T., No. 30111-2017, 2018 N.Y. Misc. LEXIS 942, at *33 (Sup. Ct. Mar. 23, 2018).

108. 59 N.E.3d 500 (N.Y. 2016).

109. *Id.* at 516–17, 521–22.

110. *Id.* at 513, 519 (2016).

111. *Id.* at 517 (quoting State v. Donald DD., 21 N.E.3d 239, 250 (N.Y. 2014)) (internal quotation marks omitted).

112. *See id.*

113. *Dennis K.*, 59 N.E.3d 500 at 517 ("*Donald DD.* did not engraft upon the 'condition, disease or disorder' prong [of Article 10] a requirement that the 'condition, disease or disorder' must constitute a 'sexual disorder.'").

Respondents also argued that their non-ASPD diagnoses — i.e., borderline personality disorder and psychopathy — were so similar in nature to ASPD that even the combination of the three diagnoses could not satisfy *Donald DD.*[114] In effect, respondents argued that even if *Donald DD.* allowed the State to carry its burden through non-sexual personality disorders, the State could not do so through personality disorders so similar in nature to ASPD. The *Dennis K.* court refused to expand *Donald DD.*'s holding beyond cases involving a singular ASPD diagnosis,[115] thereby demonstrating an unwillingness to extend the case's reasoning to other personality disorders.

Lower appellate courts in New York have also followed the Court of Appeals' unwillingness to extend *Donald DD.* As noted earlier, the Appellate Division, First Department, found a diagnosis of "ASPD with psychopathy" sufficient to overcome *Donald DD.*[116] That holding illustrates the general reluctance to extend *Donald DD.* to other similar personality disorders, and demonstrates the absence of a sexual-disorder requirement. The Appellate Division for the Fourth Department continued this trend by reversing a trial court's decision to discharge a respondent diagnosed with "ASPD with psychopathic traits."[117] The trial court had relied on *Donald DD.*, a reliance the Appellate Division found to constitute reversible error.[118] The Third Department continued this trend by refusing to apply *Donald DD.* where ASPD was paired only with a diagnosis not included in the DSM-5.[119]

Recent cases demonstrate that courts have not yet reached a final consensus on *Donald DD.*'s meaning. For example, one trial court believed that a diagnosis of ASPD with any other condition would satisfy *Donald DD.*[120] This conclusion follows logically from the Court of Appeals' decision in *Dennis K.* and subsequent appellate authority. Another trial court, however, has held that the presence of any other condition, without some formal diagnosis like

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114. *Id.* at 521.

115. *Id.* at 517, 521–23.

116. State v. Jerome A., 27 N.Y.S.3d 150, 151 (App. Div. 2016).

117. *See* Suggs v. New York Office of Mental Health, 39 N.Y.S.3d 553, 554 (App. Div. 2016).

118. *Id.*

119. Christopher PP. v. State, 58 N.Y.S.3d 180, 183 (App. Div. 2017) (upholding a mental abnormality finding where respondent was diagnosed with ASPD and sexual preoccupation, which does not appear in the DSM).

120. State v. Charada T., No. 30111-2017, 2018 N.Y. Misc. LEXIS 942, at *38 (Sup. Ct. Mar. 23, 2018).

ASPD, is insufficient to overcome *Donald DD.*[121] Ultimately, courts continue to search for the meaning of *Donald DD.*, which remains unsettled. Still, subsequent cases have not strictly applied *Donald DD.*, and it is therefore safe to conclude that a diagnosis of ASPD and some other disorder, if sufficiently proven, would likely satisfy *Donald DD.*

C. CRITICISM OF *DONALD DD.*

Despite the narrowing of *Donald DD.*'s applicability, the case has invited substantial criticism. Most of the critical responses challenge *Donald DD.*'s legal reasoning with respect to substantive due process and Article 10. Importantly, some of these criticisms stem from a concern about the case's potential practical outcome: more dangerous sex criminals free to re-offend. While this Note does not defend *Donald DD.*'s legality, it questions whether, practically speaking, these criticisms are justified, or whether *Donald DD.* represents a relatively inconsequential change in the law.

The first criticism of *Donald DD.* emerged in the case itself in Judge Victoria Graffeo's dissenting opinion.[122] Judge Graffeo identified the "fundamental flaw" in the majority's holding as conflating Article 10's overall mental abnormality analysis with the single "condition, disease or disorder" sub-criterion.[123] Judge Graffeo pointed out that this criterion represents just "one element of a mental abnormality finding," while the full finding also requires a predisposition to commit sex offenses and serious difficulty controlling that conduct.[124] To Judge Graffeo, the crux of Article 10 is whether diagnoses, including ASPD, predispose respondents to sex offenses and cause serious difficulty controlling that conduct.[125] Judge Graffeo concluded that respondents meeting all of these criteria thereby sufficiently distinguish themselves from the typical

121. *See* State v. Wilson, No. 216/16, 2019 NYLJ LEXIS 257, at *8–*9 (Sup. Ct. Jan. 28, 2019) (holding that even though *Shannon S.* says no DSM diagnosis is required, *Donald DD.*'s emphasis on diagnoses requires at least one valid diagnosis).

122. State v. Donald DD., 21 N.E.3d 239, 251 (N.Y. 2014).

123. *Id.* at 253; *see also* N.Y. MENTAL HYG. LAW § 10.03(i) (McKinney 2011) ("'Mental abnormality' means a . . . "condition, disease or disorder . . . that predisposes [respondent] to the commission of conduct constituting a sex offense and that results in . . . serious difficulty controlling such conduct.").

124. *Donald DD.*, 21 N.E.3d at 254–55; *see also*, MENTAL HYG. LAW § 10.03(i).

125. *Id.*

recidivist, and satisfy due process.[126] Other courts, both within and outside of New York, have echoed Judge Graffeo's analysis.[127]

Of note, Judge Graffeo appeared motivated by the notion that *Donald DD.* would lead to dangerous individuals' evading treatment and re-offending in the community.[128] While little scholarship addresses *Donald DD.*, one author, Kaitlyn Walsh, attacked the decision, arguing that courts should assess civil commitment eligibility through an individualized inquiry rather than through a bright-line rule.[129] Like Judge Graffeo, Walsh seems motivated by the fear that *Donald DD.* allows dangerous sex offenders to continue to pose a threat to society.[130]

The foregoing discussion emphasizes the centrality of diagnoses in Article 10 proceedings. As a due process matter, diagnoses play a crucial role in distinguishing the dangerous sex offender from the typical recidivist. This due process feature supports the desirability of cases like *Donald DD.*, which police diagnostic evidence. On the other hand, diagnoses play a crucial evidentiary role, meaning diagnostic restraints will result in the release of potentially dangerous sex offenders.

These dueling concerns raise two questions: (1) whether a diagnostic constraint of the type in *Donald DD.* substantially affects the State's ability to civilly manage offenders, and (2) whether the State assigns these crucial diagnoses in a reliable way. These questions relate to one another because, as the *Jerome A.* case suggests, the State may have diminished *Donald DD.*'s effect through diagnostic adjustments. This Note attempts to provide some preliminary data on these subjects.

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126. *Id.* at 256.

127. *See* State v. Jerome A., No. 30261-2014, 2015 N.Y. Misc. LEXIS 3243, at *19 (Sup. Ct. Sept. 8, 2015) (arguing that *Donald DD.* misinterprets Article 10 to require that every "condition, disease or disorder . . . inherently include[s] the additional predisposition and impulse control elements"); *In re* Detention of Black, No. 71292-6-I, 2017 Wash. App. LEXIS 722, at *7 (Wash. Ct. App. 2017) (refusing to apply *Donald DD.* in Washington state); Commonwealth v. George, 76 N.E.3d 217, 223 n.5 (Mass. 2017) ("[W]e are not persuaded by [*Donald DD.*'s] analysis, which, as the dissent in that case points out, concludes that because ASPD does not, in every case, predispose the individual to commit sex crimes, the diagnosis can never satisfy the definitional requirements of the statute.").

128. State v. Donald DD., 21 N.E.3d 239, 255 (N.Y. 2014) (Graffeo, J., dissenting) ("This outcome is unfortunate since the elimination of treatment after release into the community exposes these offenders to a greater risk of re-offending and is detrimental to the protection of the public.").

129. *See* Walsh, *supra* note 32, at 909.

130. *Id.* at 917 (arguing that an individualized inquiry will allow courts "to thoroughly evaluate which sex offenders require civil commitment, without barring an entire class of offenders that have the same capability to pose a danger to society").

IV. ASSESSING THE EFFECTS OF *DONALD DD.* ON ARTICLE 10 PROCEEDINGS AND DIAGNOSES

As discussed above, psychiatric diagnoses have inspired controversy within the Article 10 sphere, as a matter of both public policy and constitutional law.[131] Constitutionally speaking, New York courts have determined that ASPD alone can never serve as a predicate diagnosis for civil management.[132] Some have questioned whether this decision reflects sound policy in light of its potential to bring sex offenders back into society.[133] Thus, it is worth questioning whether there is any validity to this fear. As discussed below, this Note finds little evidence that *Donald DD.* leads to more releases. If, however, this lack of releases stemmed from questionable diagnoses, New York's civil management scheme would face a substantial constitutional problem. This Part attempts to investigate these issues empirically.

New York reports some data on its civil management scheme, including trial success, number of cases reviewed, number of those cases referred for trial, and more. The State does not, however, report the diagnoses its experts assign to Article 10 respondents. Given the importance of psychiatric diagnoses discussed above, and the fact that the constitutionality of commitment depends in part on the accuracy of those diagnoses, a detailed report of the State's diagnostic practices would prove useful in assessing the quality of the commitment regime in New York.

Therefore, Part IV.A investigates data from three stages of the Article 10 process — i.e., the referral stage, the probable cause stage, and the mental abnormality stage — to determine whether *Donald DD.* has affected the State's ability to manage its sex offenders. Part IV.B then analyzes changes in diagnoses used since the Article 10's inception in 2007 by surveying the available caselaw containing the diagnoses of Article 10 respondents. The incidence of various diagnoses should remain constant, with the exception of ASPD by itself. The remaining diagnoses should

131. *See supra* Parts II and III.
132. *See Donald DD.*, 21 N.E.3d at 241.
133. *See supra* Part III.C.

remain largely similar in number to what they were pre-*Donald DD.*[134]

A. OUTCOMES OF ARTICLE 10 PROCEEDINGS

Part IV.A.1 analyzes the referral stage of Article 10's procedure, surveying New York's data on the percentage of those reviewed by the Office of Mental Health (OMH) are ultimately referred to the Attorney General. Because the last step in referral is psychiatric evaluation, and referral only occurs if the subject seems to meet the criteria for mental abnormality, one would expect a decline in those referred following the *Donald DD.* decision in 2014. Next, Part IV.A.2.a reviews the State's success at probable cause hearings following *Donald DD.* Because a finding of probable cause requires diagnoses satisfying *Donald DD.*, effects from the case may appear in changes to probable cause success rates. IV.A.2.b then examines the State's success in prosecuting mental abnormality hearings. If *Donald DD.* actually holds any weight, one would expect either similar success rates at fewer trials, or lower success rates at a similar number of trials. Taken together, this information should help clarify whether the case has had any effect on the State's ability to civilly manage sex offenders.

1. *Effect of* Donald DD. *at the Referral Stage*

The Office of Mental Health records how many inmates reviewed for civil management are ultimately referred to the Attorney General.[135] While this data will not contain the diagnoses involved in those referrals, it will reveal whether *Donald DD.* has had any effect on who could be referred to the Attorney General. Again, assuming the incidence of ASPD in the referral population remained largely the same, *Donald DD.* should have lowered the number of individuals ultimately referred for civil management.

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134. This assumes that the population of convicted sex offenders is not significantly different in the years after 2014 than in the years before. There will naturally be some variability here, but not enough to defeat the purpose of the study.

135. *See, e.g.*, OMH 2015, *supra* note 58, at 4. Because OMH reports this data yearly, it was possible to chart the rate of recommendations to referrals over the course of Article 10's existence. Further, given that *Donald DD.* was decided in October of 2014, it was possible to see whether the referral rates changed in the years following.

The data bear out this proposition.[136] While in 2007, the year of Article 10's inception, fourteen percent of those reviewed were referred for civil management, that number dropped to 2.70% by 2017.[137] That change, however, does not demonstrate the effect of *Donald DD.* alone, as the referral rate declined steadily from 2007 to 2010, and never approached anywhere near fourteen percent after 2008.[138] The most relevant area for analysis is how the rates changed immediately after *Donald DD.* — i.e., the rates after October 28, 2014. The 2014 data, a vast majority of which came from before *Donald DD.*, had a referral rate of five percent.[139] The 2015 data, all of which must have been taken after *Donald DD.*, dropped to a referral rate of 2.7%.[140] This change illustrates a potentially significant effect of *Donald DD.* on referral practices, suggesting that the case has impaired the ability of the State to push through commitments. The referral rate increases slightly to 3.60% in 2016,[141] but returns again to 2.70% in 2017.[142] Thus, the

136. For a description of how these data were collected, *see supra* note 135 and accompanying text.

137. N.Y. STATE OFFICE OF MENTAL HEALTH, REPORT TO THE GOVERNOR AND THE LEGISLATURE PURSUANT TO ARTICLE 10 OF NEW YORK STATE MENTAL HYGIENE LAW, at 6 (2008) [hereinafter OMH 2007]; N.Y. STATE OFFICE OF MENTAL HEALTH, 2017 ANNUAL REPORT ON THE IMPLEMENTATION OF MENTAL HYGIENE LAW ARTICLE 10, at 4 (2018) [hereinafter OMH 2017].

138. In 2008, 9.3% of those reviewed were referred to the attorney general for civil management. *See* N.Y. STATE OFFICE OF MENTAL HEALTH, 2008 ANNUAL REPORT ON THE IMPLEMENTATION OF MENTAL HYGIENE LAW ARTICLE 10, at 8 (2009) [hereinafter OMH 2008]. In 2009, that number fell sharply to 3.7%. *See* N.Y. STATE OFFICE OF MENTAL HEALTH, 2009 ANNUAL REPORT ON THE IMPLEMENTATION OF MENTAL HYGIENE LAW ARTICLE 10, at 8 (2010) [hereinafter OMH 2009]. This number rose slightly to 4.3% in 2010, and rose again to 6.2% in 2011. *See* N.Y. STATE OFFICE OF MENTAL HEALTH, 2010 ANNUAL REPORT ON THE IMPLEMENTATION OF MENTAL HYGIENE LAW ARTICLE 10, at 2 (2011) [hereinafter OMH 2010]; N.Y. STATE OFFICE OF MENTAL HEALTH, 2011 ANNUAL REPORT ON THE IMPLEMENTATION OF MENTAL HYGIENE LAW ARTICLE 10, at 4 (2012) [hereinafter OMH 2011]. The referral percentage dropped again in 2012 to 3.2%, but rose again to 6.9% in 2013. *See* N.Y. STATE OFFICE OF MENTAL HEALTH, 2012 ANNUAL REPORT ON THE IMPLEMENTATION OF MENTAL HYGIENE LAW ARTICLE 10, at 4 (2013) [hereinafter OMH 2012]; N.Y. STATE OFFICE OF MENTAL HEALTH, 2013 ANNUAL REPORT ON THE IMPLEMENTATION OF MENTAL HYGIENE LAW ARTICLE 10, at 4 (2014) [hereinafter OMH 2013]. None of the remaining years had referral rates above five percent. *See infra* notes 139–142 and accompanying text.

139. N.Y. STATE OFFICE OF MENTAL HEALTH., 2014 ANNUAL REPORT ON THE IMPLEMENTATION OF MENTAL HYGIENE LAW ARTICLE 10, at 5 (2015) [hereinafter OMH 2014].

140. OMH 2015, *supra* note 58, at 4.

141. N.Y. STATE OFFICE OF MENTAL HEALTH., 2016 ANNUAL REPORT ON THE IMPLEMENTATION OF MENTAL HYGIENE LAW ARTICLE 10, at 2 (2017) [hereinafter OMH 2016].

142. OMH 2017, *supra* note 137, at 3.

immediate effect of *Donald DD.* seems to have been a decrease in sex offenders referred for civil management.

This immediate effect becomes less significant in the context of prior years. Although *Donald DD.* cut the previous year's referral rate roughly in half,[143] such a change is not unprecedented; a similar drop occurred between 2011 and 2012,[144] and a larger one occurred between 2008 and 2009.[145] Likewise, although the referral rates of 2.70% in 2015 and 2017 are the lowest ever, the referral rate of 3.60% in 2016 lacks that historical significance, given the referral rates of 3.7% and 3.2% in 2009 and 2012, respectively.[146] Thus, while there is some indication that *Donald DD.* led to a drop in referral rates, that conclusion remains uncertain given similar occurrences in years prior to *Donald DD.* Continuing to monitor referral rates in the coming years would help to resolve whether *Donald DD.* itself actually changed referral rates.

2. *Effect of* Donald DD. *at the Probable Cause and Mental Abnormality Stages*

After referrals, the next places to look for an effect from *Donald DD.* are (1) probable cause hearings and (2) mental abnormality trials.[147] Like the OMH, the New York State Office of the Attorney General (OAG) has reported annually on the implementation of Article 10.[148] With respect to probable cause hearings and mental abnormality trials, each OAG annual report details how many

143. *See supra* notes 139–140 and accompanying text (describing an immediate decrease of 2.3% from 5.0% in 2014 to 2.7% in 2015, a 46.0% decrease).

144. *See supra* note 138 (discussing how the referral rate decreased from 6.2% in 2011 to 3.2% in 2012).

145. *See id.* (discussing how the referral rate decreased from 9.30% to 3.70%). Also relevant is the drop from a referral rate of 14.0% in 2007 to 9.30% in 2008. *See id.*; OMH 2007, *supra* note 137, at 6.

146. *See* OMH 2009, *supra* note 138, at 8; OMH 2012, *supra* note 138, at 4.

147. Although this Note uses annual review hearings for diagnostic data, *see infra* note 168 and accompanying text, this Note does not discuss state reports on annual review hearings. The reason is twofold. First, a respondent can be released from SIST or confinement due to a finding of diminished dangerousness alone. *See* N.Y. MENTAL HYG. L. § 10.09(h) (McKinney 2011) (highlighting the distinction between mental abnormality and dangerousness by stating that, on annual review, a court may release a confined individual to SIST "unless it finds that the respondent no longer suffers from a mental abnormality," in which case it would have to release the respondent with no conditions). Second, some state reports do not disclose how many annual reviews have resulted in release. *See, e.g.*, N.Y. STATE OFFICE OF THE ATTORNEY GENERAL SEX OFFENDER MANAGEMENT BUREAU, A REPORT ON THE SEX OFFENDER MANAGEMENT TREATMENT ACT 17–18 (2018), https://ag.ny.gov/sexual-offender/annual-reports [https://perma.cc/AEG8-NZWR] [hereinafter OAG 2018].

148. *See, e.g.*, OAG 2018, *supra* note 147, at 1.

have occurred since Article 10's inception, and how many have resulted in findings adverse to the respondent.[149] By looking at how these totals change over time, it is possible to determine whether *Donald DD.* has led to a decrease in probable cause or mental abnormality findings.

a. *Probable Cause Stage*

In assessing probable cause findings, this Note did not conduct a detailed, year-by-year analysis for three reasons. First, as discussed regarding the mental abnormality data below, the state data can be inconsistent from year to year. This problem developed immediately in the probable cause analysis.[150] Second, taking the OAG 2018 report as true, only eight cases since 2007 have resulted in a finding of no probable cause.[151] Third, as the *Jerome A.* case illustrates, probable cause carries a low burden of proof, and, diagnostically, anything more than ASPD alone would satisfy that burden.[152]

Because the year-to-year data are inconsistent and only eight cases found no probable cause, it is unlikely that meaningful conclusions can be drawn from a year-to-year analysis, unless every no probable cause finding occurred after *Donald DD.* To address this possibility, this Note simply calculated how many no probable cause findings occurred before *Donald DD.*, and how many occurred after. Of the eight no probable cause findings, either four or five occurred before *Donald DD.*,[153] meaning either three or four

149. *See id.* at 15, 16.

150. In its 2018 report, the OAG stated that 785 probable cause hearings had taken place since 2007, and 777 of those had found probable cause. *Id.* at 15. In its 2017 report, the OAG reported 758 hearings and 747 probable cause findings. *See, e.g.*, N.Y. STATE OFFICE OF THE ATTORNEY GENERAL SEX OFFENDER MANAGEMENT BUREAU, A REPORT ON THE SEX OFFENDER MANAGEMENT TREATMENT ACT 15 (2017), https://ag.ny.gov/sexual-offender/annual-reports [https://perma.cc/AEG8-NZWR] [hereinafter OAG 2017]. This would mean that only twenty-seven hearings took place in 2018, but thirty found probable cause, an impossibility.

151. *See* OAG 2018, *supra* note 147, at 15 (reporting that probable cause was found "777 times out of the 785 hearings held to date").

152. *See supra* Part I.

153. Because the annual reports cover a time period of April 1st of the prior year to March 31st of the report year, the 2015 report contains events from before and after *Donald DD.* *See* N.Y. STATE OFFICE OF THE ATTORNEY GENERAL SEX OFFENDER MANAGEMENT BUREAU, A REPORT ON THE SEX OFFENDER MANAGEMENT TREATMENT ACT 15 (2015), https://ag.ny.gov/sexual-offender/annual-reports [https://perma.cc/AEG8-NZWR] [hereinafter OAG 2015]. That report states that five no probable cause hearings had occurred up to that point. *Id.* at 17. As of April 1, 2014, courts had found no probable cause four times.

occurred after *Donald DD.* Thus, there were either the same or slightly fewer no probable cause findings after *Donald DD.*, suggesting no effect on probable cause hearings.

b. *Mental Abnormality Stage*

This Note conducted a year-to-year analysis of mental abnormality verdicts, and used the same OAG reports as described above.[154] Because each annual report states the total number of mental abnormality trials, and the number of those finding a mental abnormality, this Note proceeded by subtracting the totals of one year from the subsequent year's totals in order to determine how many trials occurred during the subsequent year.[155] This Note

See OAG 2018, *supra* note 147, at 15. Taken together, these reports mean that one no probable cause finding occurred between April 1, 2014, and March 31, 2015, meaning it could have happened either before or after *Donald DD.* *See* State v. Donald DD., 21 N.E.3d 239 (N.Y. Oct. 28, 2014).

154. This Note used every OAG annual report since Article 10's inception in order to compile this data. *See* N.Y. STATE OFFICE OF THE ATTORNEY GENERAL, THE SEX OFFENDER MANAGEMENT AND TREATMENT ACT: THE FIRST YEAR 9–10 (2008), https://ag.ny.gov/sexual-offender/annual-reports [https://perma.cc/AEG8-NZWR] [hereinafter OAG 2008]; N.Y. STATE OFFICE OF THE ATTORNEY GENERAL SEX OFFENDER MANAGEMENT UNIT, A REPORT ON THE 2007 LAW THAT ESTABLISHED CIVIL MANAGEMENT FOR SEX OFFENDERS IN NEW YORK STATE 16 (2009), https://ag.ny.gov/sexual-offender/annual-reports [https://perma.cc/AEG8-NZWR] [hereinafter OAG 2009]; N.Y. STATE OFFICE OF THE ATTORNEY GENERAL SEX OFFENDER MANAGEMENT BUREAU, A REPORT ON THE 2007 LAW THAT ESTABLISHED CIVIL MANAGEMENT FOR SEX OFFENDERS IN NEW YORK STATE 14 (2010), https://ag.ny.gov/sexual-offender/annual-reports [https://perma.cc/AEG8-NZWR] [hereinafter OAG 2010]; N.Y. STATE OFFICE OF THE ATTORNEY GENERAL SEX OFFENDER MANAGEMENT BUREAU, A REPORT ON THE 2007 LAW THAT ESTABLISHED CIVIL MANAGEMENT FOR SEX OFFENDERS IN NEW YORK STATE 20 (2011), https://ag.ny.gov/sexual-offender/annual-reports [https://perma.cc/AEG8-NZWR] [hereinafter OAG 2011]; N.Y. STATE OFFICE OF THE ATTORNEY GENERAL SEX OFFENDER MANAGEMENT BUREAU, A REPORT ON THE 2007 LAW THAT ESTABLISHED CIVIL MANAGEMENT FOR SEX OFFENDERS IN NEW YORK STATE 19 (2012), https://ag.ny.gov/sexual-offender/annual-reports [https://perma.cc/AEG8-NZWR] [hereinafter OAG 2012]; N.Y. STATE OFFICE OF THE ATTORNEY GENERAL SEX OFFENDER MANAGEMENT BUREAU, A REPORT ON THE SEX OFFENDER MANAGEMENT TREATMENT ACT 20 (2013), https://ag.ny.gov/sexual-offender/annual-reports [https://perma.cc/AEG8-NZWR] [hereinafter OAG 2013]; N.Y. STATE OFFICE OF THE ATTORNEY GENERAL SEX OFFENDER MANAGEMENT BUREAU, A REPORT ON THE SEX OFFENDER MANAGEMENT TREATMENT ACT 20 (2014), https://ag.ny.gov/sexual-offender/annual-reports [https://perma.cc/AEG8-NZWR] [hereinafter OAG 2014]; OAG 2015, *supra* note 153, at 19; N.Y. STATE OFFICE OF THE ATTORNEY GENERAL SEX OFFENDER MANAGEMENT BUREAU, A REPORT ON THE SEX OFFENDER MANAGEMENT TREATMENT ACT 18–19 (2016), https://ag.ny.gov/sexual-offender/annual-reports [https://perma.cc/AEG8-NZWR] [hereinafter OAG 2016]; OAG 2017, *supra* note 150, at 16; OAG 2018, *supra* note 147, at 16. For a description of how this Note compiled data from these reports, see *infra* notes 155–156 and accompanying text. A full summary of the data contained in these reports is on file with COLUM. J.L. & SOC. PROBS.

155. For example, the 2018 report showed 426 total mental abnormality trials since 2007 as well as 353 mental abnormality findings. *See* OAG 2018, *supra* note 147, at 16. The

simply reported the data contained in the reports, despite some impossibilities.[156]

Figure A below illustrates the findings from this analysis, in which "mental abnormality rate" refers to the percentage of trials that resulted in a mental abnormality finding. If *Donald DD.* had an effect, it would appear starting in the 2014–2015 row. Interestingly, this row reports the lowest mental abnormality rate of any year, indicating that *Donald DD.* may have had an immediate impact on mental abnormality trials. However, the previous year, 2013–2014, also presents an unusually low mental abnormality rate. Note that the mental abnormality rate rebounds immediately following that off year and then hovers around ninety percent. Finally, the average mental abnormality rate pre-*Donald DD.* is roughly eighty-two percent, and the average mental abnormality rate after that is eighty-four percent. These changes seem to suggest an initial shock from *Donald DD.*, followed by an adjustment by the State to the new circumstances.

2017 report listed 402 trials of which 331 found mental abnormalities. *See* OAG 2017, *supra* note 150, at 16. Subtracting these numbers results in a showing that twenty-four trials occurred in 2018, twenty-two of which found a mental abnormality.

156. In two instances, the OAG reported a decrease in mental abnormality findings between years. Such a decrease is impossible because the prior year states the total number of no mental abnormality verdicts to that point, and the reports do not account for reversals on appeal. Thus, mental abnormality counts should only go up. This Note simply reported those impossible changes, which resulted in certain years' reports revealing more mental abnormality findings than mental abnormality trials. Additionally, although by 2018 the OAG only reported trials that resulted in verdicts, *see* OAG 2018, *supra* note 147, at 16, earlier reports included all trials that went to a verdict, even if those verdicts remained pending at the time of the report. *See, e.g.*, OAG 2011, *supra* note 154, at 20 (reporting five cases remained pending at the time of publication). To address this problem, pending cases were subtracted from the calculated trial number of the year that reported them and then added to the next year's trial number. This method resulted in a total number of trials, mental abnormalities, and no mental abnormalities that matched the reports, meaning the only errors reported here are the negative no mental abnormality findings.

FIGURE A

	Cases Reaching Verdict	Mental Abnormality Found	No Mental Abnormality Found	Percent Mental Abnormality Success Rate
2007–2008	15	11	4	73.33
2008–2009	41	35	6	85.36
2009–2010	28	23	5	82.14
2010–2011	82	72	10	87.8
2011–2012	61	47	14	77.04
2012–2013	22	25	-3[157]	113[158]
2013–2014	56	38	18	67.85
2014–2015	33	18	15	54.54
2015–2016	40	41	-1[159]	102[160]
2016–2017	24	21	3	87.5
2017–2018	24	22	2	91.66

Both the data here and the OMH data described above supply a potential source of this adjustment: the State has started to pursue fewer cases, and has thereby been able to regain their prior success. This is certainly possible, especially with some impressive total trial numbers like 82, 61, and 56 prior to *Donald DD.*, compared to more recent trial numbers that have leveled out at twenty-four. That said, setting aside Article 10's first year, low

157. See *supra* note 156 for an explanation of why this number is negative.
158. *See id.*
159. *See id.*
160. *See id.*

trial numbers also occurred in 2012–2013 (twenty-two), and 2009–2010 (twenty-eight). More data after 2018 would help settle this issue.

An important limitation to the OAG's mental abnormality data merits attention: the OAG only reported cases reaching a verdict. A major concern about *Donald DD.* is that it will lead to the release of dangerous individuals, and the case could have led to releases on appeal from prior verdicts, as well as dismissals, grants of summary judgment, and the like. To that end, this Note discusses cases in which *Donald DD.* itself led to releases, rather than other procedural or substantive factors at play.[161]

In five reported cases immediately following *Donald DD.*, courts issued release orders on the grounds that *Donald DD.* had rendered the State's evidence insufficient.[162] These cases do not fully represent *Donald DD.*'s immediate impact, as a contemporaneous report found that *Donald DD.* had led to the release of thirteen sex offenders.[163] Since then, courts relied on *Donald DD.* to release at least six Article 10 respondents.[164] Thus, *Donald DD.* has directly led to the release of at least nineteen sex offenders. While this additional data lacks context, some would surely conclude that nineteen sex offenders released is nineteen too many.

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161. For cases in which such factors led to release, *see, e.g.*, State v. David S., 24 N.YS.3d 284, 286–87 (App. Div. 2016) (reversing mental abnormality finding where trial court erred in permitting hearsay testimony); State v. Adrien S., 980 N.Y.S.2d 558, 560–61 (App. Div. 2016) (reversing mental abnormality finding due to erroneous jury instructions); State v. Humberto G., 885 N.Y.S.2d 312, 313–14 (App. Div. 2009) (affirming dismissal for lack of agency jurisdiction to refer respondent for civil management); State v. Randy M., 870 N.Y.S.2d 490, 492–93 (App. Div. 2008) (also dismissing for lack of agency jurisdiction); State v. Kalchthaler, 919 N.Y.S.2d 442, 442 (App. Div. 2011) (reversing mental abnormality finding for defective voir dire).

162. *See* State v. Gen C., 9 N.Y.S.3d 48, 48–49 (App. Div. 2015); Groves v. State, 1 N.Y.S. 588, 589 (App. Div. 2015); State v. Frank P., 2 N.Y.S.3d 483, 485 (App. Div. 2015); State v. Maurice G., 4 N.Y.S.3d 860, 861–62 (App. Div. 2015); State v. Odell A., 18 N.Y.S.3d 350, 350 (App. Div. 2015).

163. Associated Press, *NY Frees "Antisocial Personality Disorder" Sex Offenders*, ONEIDA DAILY DISPATCH (June 1, 2015), https://www.oneidadispatch.com/article/od/20150601/news/150609993/ [https://perma.cc/ZYV9-FV8D].

164. *See* State v. Kenneth W., 16 N.Y.S.3d 733, 733 (App. Div. 2015); State v. Kevin F., 31 N.Y.S.3d 756, 763–66 (Sup. Ct. 2016); State v. Ralph P., 39 N.Y.S.3d 697, 699–700 (Sup. Ct. 2016); Glenn T. v. State, No. CA2015-001819, 2016 N.Y. Misc. LEXIS 5273, at *4 (Sup. Ct. Dec. 20, 2016) (citing an unreported decision that relied on *Donald DD.* to release a respondent); State v. Charada T., No. 30111-2017, 2018 N.Y. Misc. LEXIS 942 (Sup. Ct. Mar. 23, 2018); State v. Wilson, 2019 NYLJ LEXIS 257, at *10 (N.Y. Sup. Ct. Jan. 28, 2019).

B. *DONALD DD.*'S EFFECT ON THE TYPES, FREQUENCY, AND NUMBER OF DIAGNOSES ASSIGNED TO ARTICLE 10 RESPONDENTS

So far, *Donald DD.*'s precise effect remains unclear. The case has certainly led to the release of some sex offenders; however, it seems at least possible that the State has adjusted to the case. While some might reasonably consider the additional release of sex offenders objectionable in itself, the due process reasoning that motivated *Donald DD.* forecloses the possibility of keeping all sex offenders indefinitely confined. Furthermore, as discussed previously, the due process concern pervading all SVP law proceedings hinges on the validity and reliability of the diagnoses underpinning civil confinement. This Note now turns to those diagnoses.

1. *Methodology*

This Note reviewed every case available on Lexis and WestLaw citing Article 10 through March, 2019.[165] Cases included probable cause hearings,[166] mental abnormality trials and appeals,[167] annual review hearings and appeals,[168] habeas and civil rights cases,[169] and plea deals and sex offender registration cases.[170] Some cases occurring outside the Article 10 procedures listed diagnoses given during such procedures,[171] but this Note disregarded cases unrelated to any Article 10 petition,[172] leaving 398 cases from which to pull diagnoses.

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165. All data is on file with COLUM. J.L. & SOC. PROBS.

166. *See, e.g.*, People v. Brooks, 859 N.Y.S.2d 897 (Sup. Ct. 2008).

167. *See, e.g.*, State v. Sanchez, 880 N.Y.S.2d 227, 227 (Sup. Ct. Feb. 18, 2009).

168. *See, e.g.*, Luis S. v. State, 88 N.Y.S.3d 748, 750 (App. Div. 2018).

169. *See, e.g.*, Brooks v. Sawyer, No. 9:11-CV-0248 (NAM), 2012 U.S. Dist. LEXIS 190878, at *6 (N.D.N.Y. May 29, 2012); Rosado v. Schneiderman, No. 9:13-CV-1133 (GLS/ATB), 2014 U.S. Dist. LEXIS 83726, at *1 (N.D.N.Y. Apr. 29, 2014).

170. *See, e.g.*, People v. Okamura, 924 N.Y.S.2d 286, 286 (App. Div. 2011); People v. Francis, 25 N.Y.S.3d 221, 222 (App. Div. 2016).

171. *See, e.g.*, *Brooks*, 2012 U.S. Dist. LEXIS 190878, at *5; *Rosado*, 2014 U.S. Dist. LEXIS 83726, at *14 (N.D.N.Y. Apr. 29, 2014).

172. One recurring category of such cases involved sex offenders challenging their registration, the level at which they registered, or the requirements of that registration. *See, e.g.*, People v. Blair, 873 N.Y.S.2d 890, 891 (Albany City Ct. Feb. 18, 2009) (challenging conviction for residing within one-thousand feet of a school zone); *Francis*, 25 N.Y.S.3d at 222 (contesting status as a level three sex offender). Another such category involved offenders challenging plea deals as unknowing because such deals could lead to civil management. *See, e.g.*, *Okamura*, 924 N.Y.S.2d at 286; People v. Mosqueda, 73 N.Y.S.3d 907, 907 (App. Div. 2018). While the full menu of irrelevant cases goes beyond these categories, all were similar in their limited relationship to Article 10.

The cases were then assigned dates. If the court's opinion provided the year in which the respondent received his diagnoses, the case was assigned to that year. If the opinion did not provide that information, the year of the proceeding at which the state presented the diagnoses was used. Diagnoses occurring in 2014 were split into "pre" and "post" categories, depending on whether they occurred before or after October 28, the date on which the Court of Appeals decided *Donald DD*. This method resulted in clear boundaries, with 248 cases surveyed from 2007 to 2014 (pre-*Donald DD.*), and 150 surveyed from 2014 (post-*Donald DD.*) to 2019. Of those, there were 112 pre-*Donald DD.* cases that reported diagnoses, and seventy-eight cases that reported diagnoses post-*Donald DD*.

All diagnoses mentioned in these cases were then counted. This Note tallied two types of diagnoses: singular diagnoses from the DSM, and the combination of those diagnoses in a given respondent. For example, if a doctor in 2015 diagnosed a respondent with ASPD, pedophilic disorder, and substance abuse disorder,[173] they would fall into the 2015 counts for ASPD, pedophilic disorder, and substance abuse disorder, respectively. The overall diagnosis would be added to the count for the combination of ASPD, pedophilic disorder, and substance abuse disorder. As a result, this Note could report how many times ASPD was assigned in 2015, and how many times the combination of ASPD, pedophilic disorder, and substance abuse disorder was assigned in 2015.

The above example also illustrates how this Note addressed multiple state doctors. If a second doctor only diagnosed ASPD and pedophilic disorder, that would count with other combined diagnoses of ASPD and pedophilic disorder, and as individual diagnoses of (1) ASPD and (2) pedophilic disorder. Overall, that case would result in two tallies for ASPD, two tallies for pedophilic disorder, one tally for substance abuse, and one tally for each combined diagnosis.

Finally, some respondents appeared more than once. For reasons detailed previously, new diagnoses can be assigned between a probable cause hearing and a mental abnormality trial, or between a mental abnormality trial and an annual review. Such diagnoses counted as newly given in their respective years.

173. *See* State v. Jamie S., No. 250470, 2016 N.Y. Misc. LEXIS 2738, at *5–*6 (Sup. Ct. Jul. 18, 2016) (providing those diagnoses).

However, if multiple appeals by a single respondent simply discussed the diagnoses of the same hearing, the duplicates were discarded.[174] Ultimately, in order to assess *Donald DD.*'s effect, this Note computed the total individualized and combined diagnoses before *Donald DD.*, and again after *Donald DD.*

Before turning to the results, it is important to note the limitations of this analysis. First, most diagnoses came from appellate decisions, which could signify that they are more controversial. Second, the same respondents appear repeatedly, albeit at different procedural stages, which makes their subsequent diagnoses less novel. Finally, many cases surveyed did not report diagnoses at all, which makes the sample size for diagnoses even smaller. While these limitations may prevent drawing any strong conclusions from the results, it remains useful to report these diagnoses given their due-process significance.

2. *Personality Disorder Diagnoses*

Personality disorders represent the first common type of disorders this Note found ascribed to Article 10 respondents.[175] The personality disorders encountered by this Note included ASPD, narcissistic personality disorder, borderline personality disorder, avoidant personality disorder, and certain unspecified or not otherwise specified personality disorders. Because *Donald DD.* focused on ASPD, and because ASPD appears far more frequently than any other personality disorder in Article 10 cases,[176] this Note evaluates the case's effect on ASPD diagnoses.

Prior to *Donald DD.*, the State assigned ASPD seventy-four times. That number increases to eighty-one if "ASPD with

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174. *See, e.g.*, State v. Donald DD., 967 N.Y.S.2d 186, 188 (App. Div. 2014) (discussing Donald DD.'s diagnosis at the mental abnormality stage).

175. The DSM-5 defines a personality disorder as "an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment." *See* AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 645 (5th ed. 2000) [hereinafter DSM-5]. All personality disorders share the same general criteria, as defined by the DSM's "general personality disorder" criteria. *Id.* at 646–47.

176. This is true both before and after *Donald DD.* Prior to *Donald DD.*, borderline personality disorder was the second most commonly diagnosed personality disorder after ASPD, and was diagnosed sixty-seven fewer times. After *Donald DD.* — with the exception of psychopathy, as discussed later — narcissistic personality disorder was the second most diagnosed personality disorder, and was diagnosed fifty-nine fewer times.

psychopathy," and "ASPD with narcissistic features" are counted.[177] No diagnosis appeared more frequently than ASPD. After *Donald DD.*, experts assigned ASPD forty-nine times, which would increase to sixty-two if combined with "ASPD with psychopathy" diagnoses and "ASPD with narcissistic features" diagnoses.[178] ASPD remained the most frequently assigned diagnosis, and, experts assigned ASPD at roughly the same frequency: sixty-two percent after *Donald DD.*, and sixty-six percent before.[179] Not surprisingly, no sole diagnoses of ASPD appeared after *Donald DD.*, compared to fifteen before *Donald DD.* Thus, *Donald DD.* has not led to a decrease in ASPD diagnoses in Article 10 cases, it has only affected whether other diagnoses appear alongside ASPD.

Psychopathy frequently accompanied ASPD, especially after *Donald DD.*, and therefore warrants further attention. To understand why, one must understand the relationship between ASPD and psychopathy. Both editions of the DSM identify "[t]he essential feature of Antisocial Personality Disorder [as] a pervasive pattern of disregard for, and violation of, the rights of others that begins in childhood or early adolescence and continues into adulthood."[180] Both versions note that "this pattern has also been referred to as psychopathy."[181] Thus, the DSM itself links the two diagnoses.

Diagnosing ASPD, however, requires satisfying more specific criteria than just a pervasive disregard for the rights of others. According to the DSM-5, a patient must always meet three criteria: (1) he must be at least eighteen-years-old; (2) there must be evidence that he possessed a conduct disorder[182] prior to age fifteen; and (3) his antisocial behavior must not only appear as a result of

177. The former appears six times, and the latter once.

178. The former appeared eleven times, and the latter twice.

179. The difference is somewhat more pronounced if accounting for variations on ASPD, such as "ASPD with narcissistic features." The percentages change to seventy-nine percent post-*Donald DD.*, and seventy-two percent pre-*Donald DD.*

180. AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 701 (4th ed. text rev. 2000) [hereinafter DSM-IV-TR]; DSM-5, *supra* note 175, at 659.

181. *Id.*

182. A conduct disorder is a separate diagnosis. For the criteria, *see* DSM-5, *supra* note 175, at 469–70 ("A repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated, as manifested by at least three of . . . 15 criteria . . . , [categorized as] Aggression to People and Animals . . . Destruction of Property . . . Deceitfulness or Theft . . . Serious Violations of Rules."). The criteria in the DSM-IV-TR are identical. *See* DSM-IV-TR, *supra* note 180, at 99.

bipolar disorder[183] or schizophrenia.[184] In addition, the patient must meet at least three of seven sub-criteria,[185] which demonstrate the aforementioned pervasive disregard for others.[186] The *Donald DD.* opinion embodies the main criticisms of ASPD.

Unlike ASPD, psychopathy does not appear as a diagnosis in either edition of the DSM. Although psychopathy does not appear in the DSM, clinicians typically use Hare's Psychopathy Checklist-Revised (PCL-R) to determine whether a sex offender qualifies as a psychopath.[187] Psychologist Dr. Robert Hare, the checklist's inventor, described the central traits of psychopathy as "egocentricity, deceit, shallow affect, manipulativeness, selfishness, and lack of empathy, guilt or remorse."[188]

Importantly, Hare suspects that clinicians often fail to distinguish psychopathy from ASPD.[189] Because the PCL-R incorporates many antisocial features characteristic of ASPD, Hare notes that most psychopaths meet the criteria for ASPD; however, "most individuals with ASPD are not psychopaths."[190] Hare also attributes the clinical confusion to the DSM-IV's description of ASPD's "associated features."[191] These associated features highlight features of psychopathy, such as "[l]ack of empathy, inflated and arrogant self-appraisal, and glib, superficial charm."[192] These associated

183. The DSM-IV-TR replaces "bipolar disorder" with "Manic Episode," but is otherwise identical. *See* DSM-IV-TR, *supra* note 180, at 706.

184. DSM-5, *supra* note 175, at 659.

185. These sub-criteria are: "[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 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." *See* DSM-5, *supra* note 175, at 659. The criteria in the DSM-IV-TR are identical. *See* DSM-IV-TR, *supra* note 180, at 706.

186. DSM-5, *supra* note 175, at 659; DSM-IV-TR, *supra* note 180, at 706.

187. *See* Daniel C. Murrie et al., *Does Interrater (Dis)agreement on Psychopathy Checklist Scores in Sexually Violent Predator Trials Suggest Partisan Allegiance in Forensic Evaluations?*, 32 LAW & HUM. BEHAV. 352, 352 (2008).

188. Robert D. Hare, *Psychopathy and Antisocial Personality Disorder: A Case of Diagnostic Confusion*, PSYCHIATRIC TIMES 1 (Feb. 1, 1996), https://www.psychiatrictimes.com/antisocial-personality-disorder/psychopathy-and-antisocial-personality-disorder-case-diagnostic-confusion [https://perma.cc/UVF3-X6PM].

189. *Id.* at 2.

190. *Id.* at 1.

191. *Id.*

192. *Id.*

features also appear in both the DSM-IV-TR and the DSM-5.[193] Additionally, although PCL-R scores are considered reliable in clinical settings,[194] researchers have questioned their reliability in adversarial proceedings. One study found that prosecution experts score subjects significantly higher than do defense experts,[195] and a subsequent study found that independent raters tend to agree with neither the prosecution nor the defense.[196]

Given psychopathy's similarities to ASPD, the ease with which even trained clinicians can conflate the two, and the fact that a single diagnosis of "ASPD with psychopathy" satisfies *Donald DD.*, adding psychopathy to ASPD seems like a trivially easy way to bolster state evidence after *Donald DD*. Despite the minimal change in ASPD diagnoses, a substantial change occurred in psychopathy diagnoses. Looking only at "psychopathy," and not "ASPD with psychopathy" or "psychopathic traits," the diagnosis appeared nearly three times more often after *Donald DD*. Percentage wise, psychopathy increased in frequency from five percent pre-*Donald DD.* to twenty percent post-*Donald DD.*

Accounting for "ASPD with psychopathy" and "psychopathic traits" yields similar results: twenty-nine of these diagnoses appeared after *Donald DD.* as compared to thirteen before, with respective frequencies of thirty-seven percent and twelve percent. Notably, this increase occurred despite the fact that the post-*Donald DD.* numbers account for roughly four years, whereas the pre-*Donald DD.* numbers account for over seven years. Thus, the increased use of psychopathy presents some cause for concern.

Of course, alternative explanations exist. After *Donald DD.*, experts never assigned psychopathy without an accompanying diagnosis of ASPD. Arguably, this fact could bolster the theory outlined above. However, as Hare notes, most psychopaths have ASPD, so this trend means little on its own.[197] Similarly, psychopathy is a more severe disorder than ASPD, meaning *Donald DD.* may simply have had the effect of leading the State to select a more severely disordered population for civil management. Still, on the assumption that eligible sex offenders would represent similar

193. DSM-IV-TR, *supra* note 180, at 703; DSM-5, *supra* note 175, at 660.
194. *See* Murrie et al., *supra* note 187, at 352.
195. *Id.* at 359.
196. *See* Rufino et al., *When Experts Disagreed, Who was Correct? A Comparison of PCL-R Scores from Independent Raters and Opposing Forensic Experts*, 36 LAW & HUM. BEHAV. 527, 535 (2012).
197. *Id.*

pathologies over the last twelve years, it seems odd that experts would assign psychopathy with such increased frequency after *Donald DD.*

3. *Paraphilic Disorder Diagnoses*

Paraphilic disorders represent another category of diagnoses that have appeared frequently in Article 10 cases. Paraphilic disorders, or "paraphilias," as the DSM-IV-TR calls them,[198] refer to "any intense and persistent sexual interest other than sexual interest in genital stimulation or preparatory fondling with phenotypically normal, physically mature, consenting human partners . . . that is currently causing distress or impairment . . . or . . . whose satisfaction has entailed personal harm, or risk of harm, to others."[199] Each version of the DSM lists eight specific paraphilic disorders,[200] and each DSM has essentially the same criteria for these disorders.[201]

Because these specified disorders are relatively straightforward and do not appear frequently at Article 10 trials (apart from a few exceptions),[202] this subpart instead focuses on paraphilia not otherwise specified (PNOS), other specified paraphilic disorder (OSPD), and unspecified paraphilic disorder (USPD), which appear frequently, and require further explanation.

The DSM-IV-TR explains that, for every diagnostic class in the manual, there is "at least one Not Otherwise Specified (NOS) category."[203] The manual lists four situations in which to use them:

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198. DSM-IV-TR, *supra* note 180, at 566.

199. DSM-5, *supra* note 175, at 685–86.

200. *Id.* at 685 ("Paraphilic disorders included in this manual are [1] voyeuristic disorder (spying on others in private activities), [2] exhibitionistic disorder (exposing the genitals), [3] frotteuristic disorder (touching/rubbing against a nonconsenting individual), [4] sexual masochism disorder (undergoing humiliation, bondage, or suffering), [5] sexual sadism disorder (inflicting humiliation, bondage, or suffering), [6] pedophilic disorder (sexual focus on children), [7] fetishistic disorder (using nonliving objects or having a highly specific focus on nongenital body parts), and [8] transvestic disorder (engaging in sexually arousing cross-dressing)."). *See also* DSM-IV-TR, *supra* note 180, at 566–67 (same list).

201. *Compare, e.g.*, DSM-IV-TR, *supra* note 180, at 572 (describing criteria for pedophilia) *with* DSM-5, *supra* note 175, at 697–98 (describing same criteria for pedophilic disorder).

202. Pedophilia, exhibitionism, and sexual sadism come up frequently in Article 10 trials. Before *Donald DD.*, pedophilia was diagnosed thirty-eight times, exhibitionism eight times, and sexual sadism six times. After *Donald DD.*, pedophilic disorder was diagnosed twenty-five times, sexual sadism ten times, and exhibitionism three times.

203. DSM-IV-TR, *supra* note 180, at 4. As this statement clarifies, the NOS specifier can apply to any diagnostic category. This Note discusses the NOS specifier, and its DSM-

(1) the patient seems to qualify for the general guidelines of a given disorder, like a personality disorder, but does not meet the criteria for any specific disorder, such as ASPD, in that category; (2) the patient seems to qualify for a diagnosis not listed in the manual but that still causes "clinically significant distress or impairment;"[204] (3) "there is uncertainty about etiology;"[205] or (4) the clinician could not collect sufficient data to provide a more precise diagnosis.[206]

The DSM-5 split the NOS designation into "other specified" and "unspecified" disorders.[207] Clinicians use the "other specified" designation when they want to identify the exact reason for not choosing a specific DSM diagnosis.[208] If the clinician cannot further specify due to lack of evidence, or simply chooses not to, then the clinician would use the "unspecified designation."[209] With respect to paraphilias, the DSM-5 suggests using the designation "other specified paraphilic disorder" (OSPD) for deviant sexual interests outside of the eight that the manual specifies.[210] By this reasoning, the relationship between the NOS designation and its DSM-5 analogues means these two diagnoses, OSPD (zoophilia) and PNOS (zoophilia), are identical.[211] The same holds true for a diagnosis of PNOS, with no further specifier, and USPD.

Four diagnoses under these designations warrant particular attention for their commonality in the Article 10 sphere: PNOS (hebephilia), OSPD (hebephilia), PNOS (non-consent), and OSPD (non-consent). As discussed above, because PNOS and OSPD have

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5 analogues, in the context of paraphilic disorders because that is where they appear most commonly in the Article 10 context. Still, these specifiers sometimes appear with respect to other disorders in Article 10 trials. *See, e.g.*, Matter of Gooding v. State, 41 N.Y.S.3d 842, 843 (App. Div. 2016) (noting respondent was diagnosed with "personality disorder NOS").

204. DSM IV-TR, *supra* note 180, at 4.

205. *Id.*

206. *Id.*

207. DSM-5, *supra* note 175, at 15.

208. *See id.* ("For example, for an individual with clinically significant depressive symptoms lasting four weeks but whose symptomatology falls short of the diagnostic threshold for a major depressive episode, the clinician would record 'other specified depressive disorder, depressive episode with insufficient symptoms.'").

209. *Id.* at 15–16.

210. *Id.* at 705 ("Examples of presentations that can be specified using the 'other specified' designation include, but are not limited to, recurrent and intense sexual arousal involving telephone scatologia (obscene phone calls), necrophilia (corpses), zoophilia (animals)" and so on).

211. This fact is recognized in the courtroom as well. *See, e.g.*, Matter of Miguel II v. State, 87 N.YS.3d 376, 378 (App. Div. 2018) (noting that PNOS (non-consent) is the previous name for OSPD (non-consent)).

the same meaning, only two terms require further elucidation: non-consent and hebephilia. Hebephilia, which does not appear in the DSM-5 or DSM-IV-TR, describes a paraphilic disorder involving sexual attraction to pubescent children.[212] Likewise, non-consent does not appear in either DSM,[213] and refers to a paraphilic disorder involving a sexual attraction to non-consenting victims.[214]

Before *Donald DD.*, these non-specified paraphilic disorders appeared the fourth most frequently, following ASPD, substance abuse disorders, and pedophilia. PNOS and OSPD[215] were diagnosed a total of twenty-four times. This number would rise to thirty-four if it included PNOS (non-consent)/OSPD (non-consent) diagnoses and PNOS (hebephilia)/OSPD (hebephilia) diagnoses.[216] After *Donald DD.*, total diagnoses of both OSPD (non-consent) and OSPD (hebephilia) doubled in number, despite the smaller number of cases.[217] These numbers alone do not tell the whole story, as cases pre-*Donald DD.* often failed to report specifiers, resulting in twenty-four PNOS/OSPD with no specifiers. Adding the totals of non-specified disorders[218] to control for this difference revealed total PNOS, OSPD, and USPD diagnoses of thirty-six after *Donald DD.*, and thirty-four before *Donald DD.* Dividing by cases reporting diagnoses, this type of disorder appeared thirty percent of the time pre-*Donald DD.*, and forty-six of the time post-*Donald DD.*, a sizeable increase.

The frequency of these diagnoses throughout Article 10's life is cause for concern irrespective of any change in frequency following *Donald DD.* Other specified and unspecified paraphilic disorders are criticized for the absence of any demonstrated reliability or

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212. *See* State v. David D., 37 N.Y.S.3d 685, 688–89 (Sup. Ct. 2016).

213. Non-consent does not appear as a discrete diagnosis like pedophilic disorder or exhibitionistic disorder. The DSM-5 does, however, frequently refer to non-consenting victims in its explanation of paraphilias generally and of certain disorders. *See* DSM-5, *supra* note 175, at 685–86 (describing all paraphilic disorders as potentially involving harm or risk of harm to another, which would always occur if the victim did not, or could not, consent); *see, e.g.*, *id.* at 686 (describing a criterion for voyeuristic disorder as "the individual has acted on [voyeuristic] urges with a nonconsenting person). In other words, what does not appear is a disorder involving the arousal to non-consent *itself*.

214. *See* State v. Jason C., 26 N.Y.S.3d 423, 428–29 (Sup. Ct. 2016).

215. Although OSPD is supposed to have a specifier, cases often did not report one. Rather than guessing what the specifier might be, such diagnoses were counted among PNOS diagnoses lacking a specifier.

216. The non-consent specifier appeared seven times, and the hebephilia specifier appeared three times.

217. OSPD non-consent was diagnosed fifteen times, and hebephilia seven times.

218. OSPD, PNOS, and USPD.

validity.[219] PNOS (non-consent) specifically presents similar reliability problems. It is criticized for its misapplication by clinicians in the SVP setting, who assign it based on rape alone, which is a factor that will be present in every SVP evaluation.[220] Given the essential constitutional role of diagnoses in the SVP context, the fact that these shaky diagnoses appear so often in New York is concerning. The increase in these diagnoses following *Donald DD.* compounds this worry. As noted above, these paraphilic disorders are relatively easy to assign based only on the sexual assaults committed by the Article 10 respondent. Like psychopathy, then, these diagnoses could easily be used to shore up ASPD diagnoses.

Fortunately, New York courts have begun to recognize at least the reliability issues at play, and have started precluding testimony on certain PNOS, OSPD, and USPD diagnoses.[221] This development has not yet eliminated the potential for shoring up ASPD diagnoses, as the non-specified paraphilic disorders are not categorically precluded — indeed, as Jerome A.'s case demonstrates, the First Department has refused to follow the trend of precluding these unreliable paraphilic disorders.[222] If the courts reach a uniform approach to these disorders, it may be worth charting how this legal response has affected the incidence of these diagnoses.

4. *Effect on the Number of Diagnoses Assigned to Individual Respondents*

The final potential effect of *Donald DD.* might be seen in the number of diagnoses assigned in a given case. As noted above, adding diagnoses to ASPD shores up a given case by distancing it from *Donald DD.* With more diagnoses assigned, it becomes harder to show a respondent only presents with ASPD and should

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219. *See* Smith, *supra* note 29, at 671; Holly A. Miller et al., *Sexual Violent Predator Evaluations: Empirical Evidence Strategies for Professionals, and Research Directions*, 29 LAW AND HUM. BEHAV. 29, 37 (2005).

220. Allen Frances & Michael B. First, *Paraphilia NOS, Nonconsent: Not Ready for the Courtroom*, 39 J. AM. ACAD. PSYCHIATRY L. 555, 559–60 (2011).

221. *See* State v. Gary K., No. 30140/16, 2016 N.Y. Misc. LEXIS 3688, at *40 (Sup. Ct. Oct. 21 2016) (discussing the recent trend of precluding PNOS diagnoses through *Frye* hearings); *see also* State v. Hilton C., 35 N.Y.S.3d 389, 391 (App. Div. 2016) (precluding USPD); State v. Mercado, 19 N.Y.S.3d 658, 663 (Sup. Ct. 2015) (precluding OSPD hebephilia); State v. Jason C., 26 N.Y.S.3d 423, 424 (Sup. Ct. 2016) (precluding OSPD non-consent).

222. *See* State v. Jerome A., 98 N.Y.S.3d 191, 191–92 (App. Div. 2019).

therefore go free. The data indicate possible adjustments to this effect.

Before *Donald DD.*, forty-one cases went forward with just one assigned diagnosis; this only occurred in nine cases afterward. Of course, after *Donald DD.*, no cases could go forward with just ASPD, and ASPD alone represented fifteen of those forty-one diagnoses. Subtracting ASPD from the pre-*Donald DD.* total translates to seventy-seven percent of cases involving multiple diagnoses prior to *Donald DD.*, versus eighty-nine percent of cases involving multiple diagnoses after *Donald DD.*[223] Thus, there is at least some evidence of a tendency to add diagnoses where possible.

Like psychopathy and non-specified paraphilic disorders, substance abuse disorders provide another route to adding diagnoses.[224] Prior to *Donald DD.*, substance abuse disorders appeared in twenty-five percent of cases, and in thirty-eight percent of cases after *Donald DD.* Continuing with the assumption that the population of convicted sex offenders did not dramatically change in 2014, it seems particularly odd that the number of substance abusing sex offenders would increase by thirteen percent. The increased frequency of substance abuse disorders is notable because substance abuse disorders are never diagnosed by themselves; indeed, it would likely be impossible to prove a mental abnormality premised only on a substance abuse disorder.[225] In this way, any increase in substance abuse disorders suggests individual cases with more diagnoses than before.

Trends in pedophilia also indicate changes in diagnoses per case. After *Donald DD.*, the State assigned five times fewer sole diagnoses of pedophilic disorder than before *Donald DD.* (twenty *after Donald DD.* versus four before *Donald DD.*). This trend cannot reflect a direct response to *Donald DD.*, as the case had no bearing on sole diagnoses of pedophilia. Total assignments of pedophilic disorder also decreased, but this effect is diminished when accounting for the number of cases surveyed: out of cases reporting diagnoses, pedophilia appeared roughly a third of the time pre-

223. Without correcting for sole ASPD diagnoses, the pre-*Donald.* percentage is sixty-three percent.

224. The counting methodology used here did not distinguish between substance abuse disorders. Thus, a respondent with a cannabis use disorder and a respondent with an alcohol use disorder would both be categorized generally as substance abuse disorders. If a single person presented with multiple substance abuse disorders, those were counted twice.

225. If ASPD alone does not necessarily predispose one to sex crimes, it is difficult to see how a substance abuse disorder alone would predispose one to sex crimes.

Donald DD., and roughly thirty percent of the time post-*Donald DD*. Thus, pedophilia diagnoses could show a general trend toward diagnosing more than one disorder, given that it was assigned at roughly the same frequency, but rarely appeared alone after *Donald DD*.

V. CONCLUSION

This Note has attempted to provide a preliminary analysis of how *Donald DD.* has changed the Article 10 landscape, with a special focus on how the case has affected diagnostic practices. This Note concludes that *Donald DD.* has not had a pronounced effect on State success rates in Article 10 proceedings; however, this may result from the decrease in cases making it to trial as a result of insufficient predicate diagnoses. This Note also finds that there is a high incidence of questionable diagnoses used in civil management, and that the State may have changed its diagnostic practices to fit the requirements of *Donald DD.* All of these conclusions, however, are constrained by the limited data available, meaning they should be taken as tentative.

Even given the tentative nature of these conclusions, the constitutional significance of psychiatric diagnoses in the SVP context supports further, more rigorous investigation into their validity. Suspect diagnoses, whether because of deficiencies inherent to the diagnosis itself or its questionable application to a given case, present a substantial constitutional problem as determined by *Hendricks* and *Crane*. While one might argue that litigation can resolve such deficiencies — in other words, that suspect diagnoses can be ferreted out at trial leaving only valid ones behind — the potential for harm continues to exist. Indeed, as discussed with regard to Jerome A.'s case, respondents can remain confined well beyond their prison sentence without an ultimate determination as to the validity of their diagnoses. Moreover, given factfinders' preference of not releasing SVP respondents, it seems unlikely that factfinders will scrupulously evaluate proffered diagnoses.

Thus, while this Note's limited analysis forecloses definitive conclusions, the findings here present cause for concern. Going forward, studies in New York and other jurisdictions assessing data beyond the cases and reports discussed here would be useful in determining the fairness of diagnostic practices in the SVP sphere generally. In New York, such further information would

allow one to better determine whether *Donald DD.* has altered diagnostic practices themselves. States without an analogous decision could represent useful controls here, providing an idea of how diagnoses have generally changed over the years. Finally, given the concerns presented here that unreliable diagnoses lead to civil confinement, it is likely that similar diagnoses are being used elsewhere, which would call into question SVP laws' legitimacy on a broader scale. Therefore, even though it may be acknowledged that SVP laws serve an important purpose, the laws should do so constitutionally with valid diagnoses.