No. 00-957

In the Supreme Court of the United States

STATE OF KANSAS

Petitioner,

v.

MICHAEL T. CRANE,

Respondent.

On Writ of Certiorari to the Supreme Court of Kansas

BRIEF FOR THE ASSOCIATION FOR THE TREATMENT OF SEXUAL ABUSERS AS *AMICUS CURIAE* IN SUPPORT OF PETITIONER

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BRIEF FOR THE ASSOCIATION FOR THE TREATMENT OF SEXUAL ABUSERS AS *AMICUS CURIAE* IN SUPPORT OF PETITIONER

INTEREST OF THE *AMICUS CURIAE*

The Association for the Treatment of Sexual Abusers ("ATSA") is a non-profit international organization consisting of more than 2000 professionals who specialize in the research, treatment, assessment, and supervision of sexual abusers. ATSA's membership is drawn from all fifty states and nine foreign countries. The membership includes the most prominent clinicians and researchers in the field. Clinical membership requires an advanced degree in a recognized mental health profession in addition to 2000 hours of experience in evaluating and treating sex offenders. The ATSA Code of Ethics and Standards of Practice is an internationally recognized guide for the evaluation and treatment of sex offenders, and has been referred to by courts as the applicable professional standard. See, *e.g.*, *Turay* v. *Seling*, 108 F. Supp.2d 1148 (W.D. Wash. 2000). ATSA offers a uniquely informed perspective on the current research on and the diagnosis and treatment of sexually violent predators. ATSA's interest in this case is to ensure that the legal standard for the civil commitment of sexual predators is medically and scientifically sound, and that it can be sensibly applied by experts in the field, including ATSA members. ATSA has previously appeared as *amicus curiae* in *Kansas* v. *Hendricks*, 521 U.S. 346 (1997).[1]

INTRODUCTION AND SUMMARY OF ARGUMENT

ATSA does not take a position on the public policy issue of the use of civil commitment for sexual predators. ATSA is

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[1] Pursuant to Sup. Ct. R. 37.6, *amicus* states that no counsel for a party authored this brief in whole or in part, and no person or entity other than *amicus*, its members, or its counsel made any monetary contribution to the preparation or submission of this brief. Letters from the parties consenting to the filing of briefs from *amici* have been filed with the Court.

concerned, however, that the Kansas Supreme Court's reasoning in its opinion in this case, if adopted by this Court, would result in a scientifically suspect approach that would be unworkable as a practical matter.

Specifically, the Kansas court's "cannot control" substantive due process standard is untenable. Its first incarnation, the "irresistible impulse" insanity test, has been largely rejected by both the medical and legal professions. Moreover, experts in the field would be unable, as a practical matter, to implement the "cannot control" standard.

ATSA also would like to emphasize that numerous treatments are available for sexual predators. Since *Hendricks*, there have been significant advances in the field, although there remains no "cure" for most patients. Civil commitment, if properly implemented with appropriate treatment provided by trained professionals, can play an important role as one part of a comprehensive response to this difficult medical and public policy issue.

ARGUMENT

I. THE "CANNOT CONTROL" STANDARD IS MEANINGLESS AND UNWORKABLE.

The Kansas Supreme Court, purporting to interpret this Court's decision in *Kansas* v. *Hendricks*, 521 U.S. 346 (1997), held that a state violates federal due process when it commits an individual found beyond a reasonable doubt to be likely to engage in dangerous sexual predation, in the absence of a showing that the individual also "cannot control" his dangerous conduct. *In re the Care and Treatment of Crane*, 7 P.3d 285, 290 (Kan. 2000), cert. granted, 121 S. Ct. 1483 (Apr. 2, 2001). The "cannot control" standard should be rejected, because it is not based on sound medicine or science and is unworkable.

A. The "Cannot Control" Requirement Is Not Based On Sound Medicine Or Science.

It is extremely unlikely that even the most delusional and psychotic people suffer from a complete lack of control. See Christopher Slobogin, *An End To Insanity: Recasting The Role of Mental Disability In Criminal Cases*, 86 VA. L. REV. 1199, 1238 (2000) ("as Morse and others have shown, even the most severely crazy people usually intend their acts and therefore have some control of them"). Virtually no act is involuntary in a literal sense. See, *e.g.*, Stephen J. Morse, *Culpability and Control*, 142 U. PA. L. REV. 1587, 1591 (1994) ("the meaning[] of 'cannot help myself' and 'involuntariness' are not literal"). Thus, current scientific and medical knowledge provides no basis for a "cannot control" standard.[2]

People with mental disorders who commit sexual crimes *intend* to carry out their criminal acts. See Slobogin, *supra*, 86 VA. L. REV. at 1238. Thus, "in virtually all cases where volitional impairment is claimed, the defective will theories fail, and, therefore, a defendant's will may be considered perfectly operative." Carlos M. Pelayo, Comment, *"Give Me a Break! I Could Not Help Myself!"?: Rejecting Volitional Impairment as a Basis for Departure under Federal Sentencing Guidelines Section 5K2.13*, 147 U. PA. L. REV. 729, 750 (1999).

Under the Kansas court's "cannot control" standard a pedophile, for example, could be civilly committed only if professionals predicted, among other things, that he would sexually assault a child even if that child was standing next to a policeman. Anything less would indicate that the pedophile

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[2] In determining the appropriate standard for civil commitment, this Court has considered not only scientific knowledge but also reasonable legislative policy judgments. See *Jones* v. *United States*, 463 U.S. 354, 365 n.13 (1983); *Leland* v. *Oregon*, 343 U.S. 790, 801 (1952). This brief focuses on the medical and scientific aspects of the "cannot control" standard to provide additional context to the issues the Court must decide.

has sufficient control to avoid his paraphilic behavior. ATSA is unaware of any offender who suffers from a paraphilia who does not possess at least that degree of self control.

In fact, the Kansas court's "cannot control" substantive due process requirement for civil commitment harkens back to the widely criticized "irresistible impulse" test for mental illness.[3] Both the legal and medical professions have rejected that standard, essentially because both recognize that it is scientifically suspect and unworkable as a practical matter. See, *e.g.*, *Wade* v. *United States*, 426 F.2d 64, 67 (9th Cir. 1970) (irresistible impulse test has "induced widespread criticism * * * by prestigious bar and medical groups, medicolegal scholars, and state courts") (citations omitted); *United States* v. *Freeman*, 357 F.2d 606, 620-621 (2d Cir. 1966) ("the irresistible impulse test [is] inherently inadequate and unsatisfactory. Psychiatrists have long questioned whether 'irresistible impulses' actually exist * * * and [the test] carries the misleading implication that a crime impulsively committed must have been perpetrated in a sudden and explosive fit"); see also Stephen J. Morse, *Crazy Reasons*, 10 J. CONTEMP. LEGAL ISSUES 189, 224 (1999) (American Psychiatric Association and American Bar Association recommended abolishing irresistible impulse test). The "cannot control" standard suffers from the same infirmities.

In 1982, the American Psychiatric Association ("APA") acknowledged a lack of consensus among psychiatrists regarding the role of volition in human conduct and warned against its use in legal proceedings:

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[3] The standard is popularly characterized as the "policeman at the elbow" test because offenders would be found insane only if they would have committed their offenses in the presence of an officer. See, *e.g.*, *United States* v. *Kunak*, 17 C.M.R. 346, 357-358 (1954).

> The line between an irresistible impulse and an impulse not resisted is probably no sharper than that between twilight and dusk * * *. The concept of volition is the subject of some disagreement among psychiatrists. Many psychiatrists therefore believe that psychiatric testimony (particularly that of a conclusory nature) about volition is more likely to produce confusion for jurors than is psychiatric testimony relevant to a defendant's appreciation or understanding.

American Psychiatric Association, Statement on the Insanity Defense 11 (1982) *reprinted in* PSYCHOLOGICAL EVALUATIONS FOR THE COURTS 200 (2d ed. 1997) (hereinafter "APA Statement").

Two years later, the American Medical Association ("AMA") went one step further, explaining that the medical profession could not determine whether people lack complete volitional control over their actions, and advised the legal community against adopting the "irresistible impulse" test as the standard for legal insanity. According to the AMA, that insanity defense impermissibly confuses medical and legal concepts in its insistence that a defendant's mental condition deprives him of self-control:

> A defense premised on psychiatric models represents a singularly unsatisfactory, and inherently contradictory approach to the issue of accountability * * *. The essential goal of an exculpatory test for insanity is to identify the point at which a defendant's mental condition has become so impaired that society may confidently conclude that he has lost his free will * * *. *Because free will is an article of faith, rather than a concept that can be explained in medical terms, it is impossible for psychiatrists to determine whether a mental impairment has affected the defendant's capacity for voluntary choice, or caused him to commit the particular act in question*. Accordingly, since

> models of mental illness are indeterminant in this respect, they can provide no reliable measure of responsibility.

AMA Board of Trustees, *Insanity Defense in Criminal Trials and Limitations of Psychiatric Testimony*, 251 J.A.M.A. 2967, 2978 (1984) (emphasis added).[4]

Consequently, "it simply is not yet the time to write into the Constitution formulas cast in terms [such as "cannot control"] whose meaning, let alone relevance, is not yet clear either to doctors or to lawyers." *Foucha* v. *Louisiana*, 504 U.S. 71, 96 (1992) (Kennedy, J., dissenting) (citation and internal quotations omitted).

B. The "Cannot Control" Standard Is Unworkable.

This Court should reject the "cannot control" standard for another reason: It is unworkable as a practical matter. As the psychiatric profession explained almost twenty years ago, it is simply impossible to tell the difference between an impulse that is "irresistible" and one that simply is not resisted enough. See APA Statement; see also Morse, *Culpability and Control*, *supra*, at 1657 ("famously, we cannot distinguish between irresistible impulses and those impulses simply not resisted").

Psychologists can use self reporting to gauge a patient's sexual urges. Those self reports are reasonably reliable when used to determine appropriate treatments. In addition, professionals can use personality testing to measure, to some degree, the extent to which a patient can control his impulses.[5]

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[4] Congress agreed in 1984, when it enacted the Insanity Defense Reform Act, 18 U.S.C. § 17(a) (1994), codifying the traditional "defect-of-cognition" test as the exclusive one for federal insanity defenses. See generally Pelayo, *supra*, at 733-735.

[5] Although there have been attempts, such as by penile plethysmography, to measure an individual's sexual arousal in response to visual and auditory stimuli, the reliability and validity of these procedures have "not been well

A professional, however, cannot use either of those tests to form a conclusion whether a patient "cannot control" his future behavior.

Professionals also are able to diagnose mental disorders accurately. A diagnosis in itself, however, "does not demonstrate that a particular individual is (or was) unable to control his or her behavior at a particular time."AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (TEXT REVISION) xxxiii (4th ed. 2000). And "the fact that an individual's presentation meets the criteria for a DSM-IV diagnosis does not carry any necessary implication regarding the individual's degree of control over the behaviors that may be associated with the disorder." *Ibid.*

Thus, based on currently available diagnostic techniques, it is difficult to determine whether certain abnormal impulses are any more "irresistible" than normal ones. See also Pelayo, *supra*, at 750–751. If the law is indeed concerned with whether a defendant could control his actions, the law must look beyond current knowledge for assistance in that determination; any such inquiry would have to focus on the defendant's desires, thoughts, and feelings, which are, needless to say, inaccessible by any currently known measuring techniques.

II. TREATMENTS EXIST FOR SEX OFFENDERS.

Although ATSA does not take a position either in favor of or opposed to the use of civil commitment for sexual predators, the organization has established recommendations regarding how states that do choose to enact such laws should implement them. See Association for the Treatment of Sexual Abusers,

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established, and clinical experience suggests that subjects can simulate response by manipulating mental images." AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (TEXT REVISION) 567 (4th ed. 2000).

Civil Commitment of Sexually Violent Offenders (Mar. 20, 2001), *at* http://www.atsa.com/ppcivilcommit.html. If those recommendations are followed, civil commitment facilities can play an important part in a comprehensive response to sexual predation. Moreover, such facilities may provide treatment for offenders who otherwise would receive none.

Although currently there is no "cure" for sexual predation, treatment programs, many of which have been developed over the last decade by professionals associated with ATSA, can significantly reduce recidivism. See R. Karl Hanson, *et al.*, *First Report of the Collaborative Outcome Data Project On The Effectiveness Of Treatment For Sex Offenders*, 14(2) SEXUAL ABUSE: J. OF RES. & TREATMENT (forthcoming 2002).[6] Although treatment is still a developing field, recent research suggests that it might be effective for high-risk offenders.[7]

Sexual predators are far from a homogenous group of deviants. Each offender has a unique psychic make-up, which includes various "dynamics of physical arousal and distorted emotional needs." B.K. Schwartz, *Effective Treatment for Sex Offenders*, 22 PSYCHIATRIC ANNALS 315, 318 (1992). To

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[6] J.K. Marques, *et al.*, *Effects of Cognitive-Behavioral Treatment on Sex Offender Recidivism*, 21 CRIM. JUST. & BEHAVIOR 28, 28-52 (1994); W.L. Marshall & W.D. Pithers, *A Reconsideration of Treatment Outcome with Sex Offenders*, 21 CRIM. JUST. & BEHAVIOR 10, 10-27 (1994); J.V. Becker & J.A. Hunter, Jr., *Evaluation of Treatment Outcome for Adult Perpetrators of Child Sexual Abuse*, 19 CRIM. JUST. & BEHAVIOR 74 (1992); W.L. Marshall & H.E. Barbaree, "Outcome of Comprehensive Cognitive-Behavioral Treatment Programs," *in* HANDBOOK OF SEXUAL ASSAULT, ch. 21 (W.L. Marshall, *et al.* eds., 1990); W.D. Pithers, "Relapse Prevention with Sexual Aggressors," *in* HANDBOOK OF SEXUAL ASSAULT, ch. 20 (W.L. Marshall *et al.* eds., 1990) and other authorities cited in these sources. G. Hall, *Sex Offender Recidivism Revisited: A Meta-analysis of Recent Treatment Studie*s, 63 J. CONSULTING & CLINICAL PSYCHOL. 802-809 (1995).

[7] A. Gordon & T. Nicholaichuk, *Applying the Risk Principle to Sex Offender Treatment*, 8(2) FORUM ON CORRECTIONS RES. 36-38 (1996).

address the range of their emotional deficiencies, psychologists have developed specialized therapeutic interventions specifically tailored to meet the requirements of the individual offenders.

Modern treatment can include psychotherapy or drug therapy, *i.e.*, pharmacotherapy. The psychotherapy component of treatment for sexual deviance can be conducted in several ways, including group therapy, role-playing/role-reversal therapy, covert sensitization (acquiring reactions of repulsion to deviant fantasies and impulses), and cognitive restructuring (confronting denial). See Priest, *et al.*, *Counseling Adult Sex Offenders: Unique Challenges and Treatment Paradigms*, 71 J. OF COUNSELING & DEVEL. 27, 30-31 (1992). The core approach used in many programs is cognitive-behavioral, the goal of which is to enable offenders to understand their behavior, take responsibility for it, motivate them to want to change their conduct, and learn the skills necessary to accomplish that. See Association for the Treatment of Sexual Abusers, *Reducing Sexual Abuse Through Treatment and Intervention with Abusers* (Nov. 6, 1996), *at* http://www.atsa.com/pptreatment.html. Other accepted methods for treating sex offenders include: addressing directly the predator's deviant sexual fantasies, exploring the offender's own possible sexual abuse and recognizing and treating victimization,[8] addressing cognitive distortion, helping the offender develop a plan to interrupt unhealthy patterns and habits that may lead to sexual deviance, and overcoming denial of sexual problems. Schwartz, *supra*, at 317. As of 1992, there

[8] "A theme common to many dangerous sex offenders is a history of abuse and neglect during their formative years, including sexploitation." L.A. French & J.J. Vollman, Jr., *Treating the Dangerous Sex Offenders: A Clinical/Legal Dilemma*, 31 INT'L J. OF OFFENDER THERAPY & COMPARATIVE CRIMINOLOGY 62 (1987). Psychotherapy addresses underlying issues like past child abuse in the offender's youth in order to enable him to break his current cycle of abuse.

were more than 1200 programs in the United States for treating sexual predators. *Id.* at 318.

There also have been significant advances in the use of drugs for treatment of sexual deviance. Anti-androgen therapy, as part of a comprehensive treatment plan, has been shown to have some success in treating offenders. See Association for the Treatment of Sexual Abusers, *Anti-Androgen Therapy and Surgical Castration* (Feb. 7, 1997) *at* http://www.atsa.com/ppantiandro.html. Cyproterone acetate, for example, has proven effective in controlling deviant sexual fantasies. V.L. Quinsey & C.M. Earl, "The Modifiable Sexual Preference" *in* HANDBOOK OF SEXUAL ASSAULT 279-295 (W.L. Marshall, *et al*. eds., 1990). Psychotropic drugs have been found to be somewhat effective for offenders whose sexual deviance is related to an obsessive-compulsive disorder. E. Coleman, *et al.*, *An Exploratory Study of the Role of Psychotropic Medications in the Treatment of Sex Offenders*, 18 J. OF OFFENDER REHABILITATION 75 (1992).

As the above makes clear, modern psychology offers a host of beneficial treatments for sex offenders. See also W.L. Marshall, *et al.*, *Treatment Outcome with Sex Offenders*, 2 CLINICAL PSYCHOL. REV. 465 (1991) (discussing numerous modern treatment programs); P. Gendreau & R.R. Ross, *Revivification of Rehabilitation: Evidence From the 1980s*, 4 JUST. Q. 349, 381-384 (1987) (same); M.C. Henderson & S.C. Kalichman, *Sexually Deviant Behavior and Schizotypy: A Theoretical Perspective With Supportive Data*, 61 PSYCHIATRIC Q. 273, 273-282 (1990) (same). Even so, psychological knowledge of treatment of sexual deviance is still an evolving field, and all of the dynamics of sexual psychopathology still are not known.

For the foregoing reasons, the judgment of the Supreme Court of Kansas should be reversed.

Respectfully submitted.

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