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No. 94494-6

THE SUPREME COURT OF THE STATE OF WASHINGTON

IN RE DETENTION OF MARK BLACK

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

PETITIONER'S SUPPLEMENTAL BRIEF

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A. INTRODUCTION

To convince the jury Mark Black's behavior merited indefinite civil commitment under RCW 71.09, the State contended he had a mental abnormality called "paraphilia NOS [not otherwise specified], persistent sexual interest in pubescent aged females." The State's evaluator said he created this unique label for Mr. Black, resting on the same theory as "hebephilia." This theory has been rejected by psychiatrists and it is not accepted as a valid mental disorder.

After a *Frye* hearing, the trial court ruled hebephilia was too controversial and its scientific support too flimsy to satisfy the test for admissibility. But despite this explicit finding, the court admitted the same diagnosis under the label "paraphilia NOS." Did the court permit the jurors to rest their verdict on a novel diagnosis that lacks general acceptance in the scientific community?

B. STATEMENT OF THE CASE

1. Frye hearing

The trial court held a pretrial hearing to determine the admissibility of the diagnosis "paraphilia NOS, persistent sexual interest in pubescent aged females," which the State's evaluator conceded was "the equivalent" of hebephilia. CP 315. The only

testifying witness was Dr. Karen Franklin, a psychologist with “considerable expertise” in the debate about hebephilia. CP 1412 (Finding of Fact); 9/13/13RP 149.

Dr. Franklin explained hebephilia is called different names but it rests on an adult’s attraction to minors who are physically in puberty. 9/13/13RP 35, 69. As a mental disorder, it is “certainly a novel diagnosis” and remains “very, very obscure” in the mental health community. 9/13/13RP 3, 72. The “general consensus among researchers of sexuality” is that it is normal for an adult to find pubescent children sexually attractive and it is also “evolutionarily and biologically normal” because these children can procreate, yet it is “illegal and immoral” to act on the attraction. *Id.* at 97-98. Mental health practitioners dispute whether a mental disorder rests on this normal yet controversial attraction; and if a disorder exists, there is no agreed, reliable method of diagnosing it. *Id.* at 39, 42, 93, 98.

Dr. Franklin explained that when the American Psychiatric Association prepared the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) in 2013, the main proponent of the disorder, Dr. Ray Blanchard, chaired the “paraphilia” subgroup and petitioned to include hebephilia. *Id.* at 61. In response, there was “a lot

of opposition” nationally and internationally by a wide range of practitioners throughout the mental health community. *Id.* at 57. As a result, the DSM-5’s authors refused to include a paraphilia premised on attraction to youth in puberty and did not list this topic as something meriting further study. 9/13/13RP 61, 71.

Using paraphilia NOS as an alternative method of diagnosing an attraction to pubescent children is not generally accepted, Dr. Franklin explained. 9/13/13RP 88. There are no “empirical studies” or research marking the factors for when attraction to pubescent children is paraphilic or pathological. *Id.* at 90-92. It is not peer-reviewed, cross-validated, or “subject to any type of reliability testing.” *Id.* at 92-93.

The State did not present any witnesses at the *Frye* hearing, but offered written materials, including Dr. Dale Arnold’s deposition and his evaluations of Mr. Black. In his deposition, Dr. Arnold agreed there is “a lot of professional debate about” whether hebephilia is a mental disorder. CP 484. When asked if paraphilia NOS, attraction to pubescent-aged children is “also hebephilia,” he responded, “You can call it that . . . the research classification would be hebephilia.” CP 499; CP 827 (when asked if his paraphilia NOS diagnosis “has also been

called hebephilia,” Dr. Arnold said, “Yes.”). Dr. Arnold was not “aware of” any research using this paraphilia descriptor. CP 827, 839.

2. *Frye hearing ruling.*

The trial court credited Dr. Franklin’s expertise. CP 1412-13. It found hebephilia was controversial and lacked reliable methodology for diagnosis. *Id.* Based on hebephilia’s lack of general acceptance, the court ruled it was inadmissible. CP 1413.

However, the court simultaneously deemed Dr. Arnold’s diagnosis of “paraphilia NOS sexual attraction to pubescent aged females non-exclusive” as fully distinct from hebephilia. CP 1413. It found Dr. Arnold’s diagnosis was supported by the scientific community, based on reliable standards, and admissible at trial. *Id.* The court did not explain what those standards were. *Id.*

After its *Frye* ruling, the court ordered Mr. Black could not mention hebephilia at trial or cross-examine Dr. Arnold about the controversy surrounding it. CP 662, 2116-17.

3. *Court of Appeals opinion regarding hebephilia.*

The Court of Appeals initially reversed the trial on other grounds, discussing but declining to rule on the hebephilia issue. COA 71292-6-I, Slip op. at 19 (2015). But this Court reversed that decision, and on remand, the Court of Appeals sidestepped the issue, ruling that another mental abnormality and personality disorder were also presented even though the jury did not specify the basis of its verdict. COA 71292-6-I, Slip op. at 1, 9-10 (2017); CP 1411 (general verdict); CP 1385 (instruction verdict need not be unanimous).

The trial testimony is explained in Appellant's Opening Brief, at 4-9 and 38-44.

C. ARGUMENT

The State's reliance on a scientifically controversial diagnosis, and the court's nonsensical evidentiary rulings related to this diagnosis, undermine the fairness of Mr. Black's trial

1. A valid mental disorder is a mandatory and constitutionally required predicate for indefinite civil commitment.

It is unconstitutional to civilly commit someone who is not both currently mentally ill and dangerous. *Foucha v. Louisiana*, 504 U.S. 71, 75-76, 112 S. Ct. 1780, 118 L. Ed.2d 437 (1992); *In re Young*, 122 Wn.2d 1, 27, 36-37, 857 P.2d 989 (1993). Civil commitment is “a

massive curtailment of liberty” at which due process protections are at their highest. *In re Det. of Marcum*, 189 Wn.2d 1, 8, 403 P.3d 16 (2017); *Young*, 122 Wn.2d at 26.

When civil commitment is predicated on a person’s propensity to commit sex offenses, the person must have a mental illness that “the psychiatric profession itself classifies as a serious mental disorder.” *Kansas v. Hendricks*, 521 U.S. 346, 360, 117 S.Ct. 2072, 138 L.Ed.2d 501 (1997); *Kansas v. Crane*, 534 U.S. 407, 412, 122 S.Ct. 867, 151 L.Ed.3d 856 (2002) (affirming this “critical” feature of *Hendricks*).

Civil commitment would be unconstitutional if a person’s “mental abnormality is too imprecise a category to offer a solid basis for concluding that civil detention is justified.” *Hendricks*, 521 U.S. at 373 (Kennedy, J., concurring). A serious mental disorder is also essential to distinguish “individuals who are mentally disordered from those who are mere criminals.” *Mierhofer*, 182 Wn.2d at 656 (Wiggins, J., dissenting) (noting all nine United States Supreme Court justices agree on this point in *Hendricks*, 521 U.S. at 360, 373, 375). Civilly committing a person simply because he committed past crimes would be unconstitutional. *Crane*, 534 U.S. at 412; *Hendricks*, 521 U.S. at 372-73. Such a commitment scheme violates double jeopardy, because

the detention would further punish people who finished serving their sentences for their criminal convictions. *In re Pers. Restraint of Meirhofer*, 182 Wn.2d 632, 653, 343 P.3d 731 (2015) (Wiggins, J., dissenting). Dangerousness alone does not authorize civil commitment. *Foucha*, 504 U.S. at 78.

Furthermore, if a person “does not suffer from an actual mental disorder, then there is nothing to cure and commitment is pointless.” *Merhofer*, 182 Wn.2d at 645, quoting *In re Det. of New*, 992 N.E.2d 519, 531 (Ill. App. 2013), *affirmed*, 21 N.E.3d 406 (Ill. 2014); *see also Foucha*, 504 U.S. at 79 (if “Foucha is not suffering from a mental disease or illness he should not be held as a mentally ill person”).

2. *A diagnosis of a mental disorder is inadmissible if it is not generally accepted and based on reliable methodology.*

The trial court “must exclude expert testimony involving scientific evidence” that does not satisfy the requirements of *Frye v. United States*, 293 F. 1013, 1014 (D.C. 1923); *Lahey v. Puget Sound Energy, Inc.*, 176 Wn.2d 909, 918, 296 P.3d 860 (2013). *Frye* governs the admissibility of expert testimony in a civil commitment proceeding. *In re Det. of Ambers*, 160 Wn.2d 543, 553 n.5, 158 P.3d 1144 (2007) *see also In re Det. of New*, 21 N.E.3d 406, 412-13 (Ill. 2014)

(admissibility of hebephilia diagnosis “is the type of scientific evidence that the analytic framework established by *Frye* was designed to address”).

To be admissible under *Frye*, novel scientific evidence (1) must rest on a scientific theory or principle that “has gained general acceptance in the relevant scientific community of which it is part,” and (2) there must be “generally accepted methods of applying the theory or principle in a manner capable of producing reliable results.” *State v. Greene*, 139 Wn.2d 64, 70, 984 P.2d 1024 (1999), *reversed on other grounds*, 288 F.3d 1081 (9th Cir. 2002).

When “there is a significant dispute between qualified experts as to the validity of scientific evidence, it may not be admitted.” *Id.*, quoting *State v. Copeland*, 130 Wn.2d 244, 255, 922 P.3d 1304 (1996). Likewise, “*Frye* excludes testimony based on novel scientific methodology until a scientific consensus decides the methodology is reliable.” *Lahey*, 176 Wn.2d at 918. Both the theory underlying the evidence and the methodology used to implement the theory must be generally accepted in the scientific community for evidence to be admissible under *Frye*. *Id.*

“The relevant scientific community for assessing the general acceptance of a mental disorder is “the psychiatric and psychological communities.” *State v. Hilton C.*, 35 N.Y.S.3d 389, 391 (N.Y. App. Div. 2016) (ordering *Frye* hearing on diagnosis of “other unspecified paraphilic disorder”); *see also State v. Ralph P.*, 39 N.Y.S.3d 643, 682 (N.Y. Sup. Ct. 2016) (discussing relevant scientific community for *Frye* hearing on mental disorder underlying civil commitment); *New*, 21 N.E.3d at 414 (examining general acceptance of hebephilia in “psychological and psychiatric communities”).

i. The scientific community has not generally accepted the diagnosis of hebephilia.

Hebephilia was presented, debated, and purposefully excluded from the DSM-5. The DSM “reflects a consensus of current formulations of evolving knowledge in the mental health field.” *Greene*, 139 Wn.2d at 71 (internal quotation omitted); *see Hall v. Florida*, _ U.S. _, 134 S. Ct. 1986, 1990, 188 L.Ed.2d 1007 (2014) (relying on criteria “approved and used in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders, one of the basic texts used by psychiatrists and other experts”).

If a mental abnormality is not listed in the DSM, it is not automatically invalidated as a basis of civil commitment. *Young*, 122 Wn.2d at 28. But it remains “critical” that any mental abnormality is recognized by psychiatrists and psychologists to be “as real and meaningful” as those well-established diagnoses listed in the DSM. *Id.* Consequently, it must be generally accepted by the psychological community. *Id.*

The DSM-5’s authors excluded hebephilia after “vigorous criticism about its scientific validity and methodological flaws.” *New*, 21 N.E.3d at 414. Since its exclusion from the DSM-5, no new scientific agreement has emerged to legitimize and render reliable this diagnosis. *See Id.* While the field of psychiatry is “ever-advancing,” the recent debate and resulting exclusion of hebephilia from the DSM-5 reflects its lack of general acceptance. *Crane*, 534 U.S. at 413.

The lack of general acceptance is also evident in scholarly articles. Most scholarly articles expressing an opinion on hebephilia oppose it as a diagnosis. *Ralph P.*, 39 N.Y.S.3d at 662; *see, e.g.*, John Matthew Fabian, Diagnosing and Litigating Hebephilia in Sexually Violent Predator Civil Commitment Proceedings, 39 J. Am. Acad. Psychiatry & L. 496, 501 (2011) (“there appears to be no clear

professional consensus as to the clinical application of hebephilia”); Allen Frances & Michael B. First, Hebephilia Is Not a Mental Disorder in the DSM-IV-Tr and Should Not Become One in the DSM-5, 39 J. Am. Acad. Psychiatry & L. 78, 84-85 (2011) (hebephilia lacks “any solid scientific support. Hebephilia is not an accepted mental disorder that can be reliably diagnosed”).

In the Court of Appeals, the State raised the notion that general acceptance may rest on the “ICD-10,” the World Health Organization’s diagnostic tool called the International Statistical Classification of Diseases and Related Health Problems § F65.4 (10th rev. ed. 2015). COA Resp. Brief at 32-33. The ICD-10 is not an accepted resource in forensic psychology, and is instead a coding tool for billing insurance companies. 9/13/13RP 125, 130-31; *see also Ralph P.*, 39 N.Y.S.3d at 682-83 (“ICD-10 not used as an authoritative diagnostic source in the United States”).

In any event, no one diagnosed Mr. Black under the ICD-10. The ICD-10 merely lists a disorder of “paedophilia,” defined as a “sexual preference for children, boys or girls or both, usually of prepubertal or early pubertal age.” ICD-10, § F65.4; 9/13/13RP 131.

But related materials clarify this is pedophilia for “prepubescent” children. 2017-18 ICD-10-CM Diagnosis Code F65.4, available at: <http://www.icd10data.com/ICD10CM/Codes/F01-F99/F60-F69/F65-/F65.4> (last viewed Oct. 25, 2017); ICD-10 Classification of Mental and Behavioral Disorders, Diagnostic Criteria for Research, F-65.4 (1993), <http://www.who.int/classifications/icd/en/GRNBOOK.pdf> (similarly describing “paedophilia” as limited to “prepubescent child”).

In the trial court, the State cited some cases where an expert used hebephilia as the basis of commitment. CP 375-76. However, these cases did not involve a *Frye* challenge or pre-dated the DSM-5’s rejection of hebephilia.¹ Other courts have reached the opposite conclusion, after extensive review of the debate, and either rejected hebephilia after a *Frye* hearing or ordered a *Frye* hearing.²

¹ A Pennsylvania case cited by the State is misleading because that state’s “SVP” law is not a civil commitment scheme, but a registration requirement imposed at sentencing, and it does not require a person have a commonly accepted mental health diagnosis. *Comm. v. Williams*, 832 A.2d 962, 967 (Pa. 2003); *Comm. v. Hollingshead*, 111 A.3d 186, 190-91 (Pa. Super. Ct. 2015).

² For example, several New York courts have ruled hebephilia is inadmissible under *Frye*. *State v. Donald D.*, 37 N.Y.S.3d 685, 694 (N.Y. Sup. Ct. 2016); *State v. Ralph P.*, 39 N.Y.S.3d 643 (N.Y. Sup. Ct. 2016); *State v. Mercado*, 19 N.Y.S.3d 658, 669 (N.Y. Sup. Ct. 2015).

The trial court accurately found a “controversy” among psychologists over hebephilia as a mental disorder and hebephilia is “not favored in the relevant scientific community.” CP 1412. The State did not challenge this finding of fact, which “is therefore a verity on appeal.” *Cowiche Canyon Conservancy v. Bosley*, 118 Wn.2d 801, 808, 828 P.2d 549 (1992); RAP 10.3(g). Although the State’s appellate brief did not concede hebephilia lacks general acceptance, it made no argument in support of it and claimed Dr. Arnold’s diagnosis is valid because it is not hebephilia. Resp. Brief at 26; RAP 10.3(a)(4), (6); *State v. Cruz*, _ Wn.2d _, 2017 WL 4978629, *4 (Nov. 2, 2017) (failing to brief or assign error to issue precludes appellate review).

ii. Hebephilia lacks a reliable methodology for diagnosis.

To satisfy *Frye*, there must be “scientific consensus” that “the methodology is reliable” in addition to the underlying theory’s general acceptance. *Lakey*, 176 Wn.2d at 919.

The trial court’s findings underscore the lack of reliable methodology. CP 1413. The disorder has not been peer-reviewed. *Id.* There is no set of standards to diagnosis it. It has very low “inter-rater reliability” meaning different evaluators are unlikely to agree on its application. *Id.* One of the only studies attempting to assess a

preference for pubescent children has not been replicated and had “astronomically high” false positives. 9/13/13RP 70-71, 82, 92.

Even the definition of hebephilia is inconsistent within the mental health field, so its contours are a “moving target” for those studying it. 9/13/13RP 35. “There cannot be any reliability in studies or construct when everybody is using different terminology and different definitions.” *Id.* at 77. The basis step of ascertaining a child’s physical development at the time of a past incident is not a reliable indicator of physical development due to wide variations in when children change during puberty, further muddying the diagnostic reliability. *Id.* at 35.

The trial court correctly ruled hebephilia does not satisfy *Frye* due to the lack of reliable methodology. CP 1412-13.

3. *The trial court illogically and unreasonably confused the change in diagnostic label with a change in general acceptance among scientists.*

The court summarily concluded Dr. Arnold’s diagnosis of “Paraphilia NOS, persistent sexual interest in pubescent aged females, non-exclusive” was not hebephilia and was generally accepted. CP 1413. The court found this diagnosis was “based on a set of commonly accepted standards in the psychological community,” but did not

specify what those standards are or explain how it was distinguishing this disorder from hebephilia. *Id.*

The court's conclusion and reasoning are illogical and unsupported by the record. Dr. Arnold admitted he was not "aware of any" research on his paraphilia NOS specifier and "doubt[ed]" any existed. CP 839. He said he "uniquely described what I thought Mr. Black's paraphilia was," and concocted this label for this case. CP 839-40. He used it because the DSM-5 rejected hebephilia. CP 830. He relied on the same underlying research as was the predicate for hebephilia as proposed, and rejected, in the DSM-5. CP 841.

Using "paraphilia NOS" criteria to diagnose hebephilia is not generally accepted, as Dr. Franklin explained. 9/13/13RP 35, 88. Dr. Arnold's "intuitive" and idiosyncratic approach had not been subject to any reliability testing critical to a valid diagnosis. *Id.* at 90, 93.

After the DSM-5 considered and rejected proposals to include hebephilia as a paraphilia, even as an item to study for the future, it is illogical to simply apply a generic paraphilia framework and claim this analysis is generally accepted. 9/13/13RP 61, 71. The Illinois Supreme Court rejected this same argument in *New*. It noted that "part of the debate" underlying hebephilia is whether it "fits within the rubric of

paraphilia NOS or whether the paraphilia NOS diagnosis is being misused in this context.” 21 N.E.3d at 416. Because the scientific controversy includes this very debate – whether hebephilia may be treated as paraphilia NOS – it does not satisfy *Frye* for one expert to extend an existing framework to include hebephilia-type conduct. *Id.*

An expert’s scientific theory or method may not be based on his own practice under *Frye*. “It makes little sense to conclude that an expert could avoid the application of *Frye* simply by eschewing the use of any particular methodology or technique and purporting to rely only on their knowledge and experience.” *Lake Chelan Shores Homeowners v. St. Paul Fire & Marine Ins. Co.*, 176 Wn.App. 168, 181, 313 P.3d 408 (2013). Additionally, “the relevant inquiry is general acceptance by the scientists, not the courts.” *Id.* at 176.

Giving hebephilia different label does not change its lack of general acceptance. Psychiatrists and psychologists use different labels for hebephilia, but usually concede they are talking about the same “construct” and “underlying concept,” as Dr. Arnold admitted multiple times in his deposition. CP 827, 829, 831, 832, 841.

For example, in *Meirhofer*, this Court discussed “paraphilia, NOS hebephilia,” but called it a “hebephilia diagnosis.” 182 Wn.2d at

640. In *New*, the Illinois Supreme Court ordered a *Frye* hearing for “paraphilia NOS, sexual attraction to early adolescent males, otherwise known as hebephilia,” acknowledging these labels mean the same thing. 21 N.E.3d at 409-10, 413; *see also People v. Wright*, 4 Cal. App. 5th 537, 541, 546 (Cal. Ct. App. 2016) (assessing diagnosis of “paraphilia not otherwise specified, hebephilia” as hebephilia).

The principal proponents for adding hebephilia to the DSM-5 admit the term hebephilia “has not come into widespread use, even among professionals who work with sex offenders.” *New*, 21 N.E.3d at 413 (quoting Ray Blanchard *et al.*, *Pedophilia, Hebephilia, and the DSM–V*, 38 Archives of Sexual Behav. 336 (2009)).

Dr. Arnold consistently described his diagnosis of paraphilia NOS as resting on the same research, construct, and theory as hebephilia. CP 425, 485, 499, 827, 830-31, 842. Construing hebephilia as an unspecified type of paraphilia does not erase the underlying controversy or provide general acceptance under *Frye*.

The State failed to prove Dr. Arnold’s uniquely constructed diagnosis was generally accepted in the scientific community as a valid and reliably diagnosable mental disorder.

4. *The court's admission of an unreliable diagnosis was coupled with unreasonable restrictions on Mr. Black's ability to challenge this diagnosis.*

After the court's illogical *Frye* ruling, it granted the State's motion to prohibit Mr. Black from "mentioning" hebephilia, including barring him from "cross-examining Dr. Arnold regarding Hebephilia or suggesting that Dr. Arnold was trying to 'back door' in such a diagnosis through his diagnosis of paraphilia NOS." CP 662.

During trial, when Mr. Black asked Dr. Arnold if there was "professional debate" regarding his diagnosis, the State objected as a violation of the "pretrial order," thus reminding the court to enforce its ruling that Mr. Black could not mention or cross-examine Dr. Arnold on the controversial roots of his diagnosis related to hebephilia. 6RP 520-21; CP 662. Although Mr. Black asked an oblique question about a "debate," but could not press Dr. Arnold on his admissions that his diagnosis was the same as hebephilia, or that hebephilia was excluded from the DSM-5, to counter his testimony.

The State complained when defense expert Dr. Joseph Plaud mentioned a "debate" about the existence of mental disorder premised on sexual attraction to pubescent girls. 10RP 1135-36. In response, Mr. Black assured the court that Dr. Plaud was told to obey the order

barring him from mentioning hebephilia, even when explaining his disagreement with the State's diagnosis. 10RP 1136-37.

Prohibiting Mr. Black from discussing the scientific community's dispute over the existence of hebephilia as a valid mental disorder undermined his right to defend against the commitment petition. He could not attack Dr. Arnold's diagnosis as being drawn from hebephilia, tell the jurors that the scientific community did not generally accept hebephilia, or elicit testimony from his own expert about dubious scientific standing.

Erroneously admitted evidence requires a new trial "where there is a risk of prejudice and 'no way to know what value the jury placed upon the improperly admitted evidence.'" *Salas v. Hi-Tech Erectors*, 168 Wn.2d 664, 673, 230 P.3d 583, 587 (2010). Here, not only was novel, unreliable evidence presented to the jury, the court further constrained Mr. Black from challenging the State's principal witness based on the unreliable science surrounding hebephilia when the evaluator admitted the same science underlie both labels. The court's rulings materially affected the outcome of the case and denied Mr. Black the ability to meaningfully challenge a key aspect of the State's

case. See *In re Det. of Post*, 170 Wn.2d 302, 314, 241 P.3d 1234 (2010).

6. *The jury's general verdict rested on an unreliable diagnosis that Mr. Black was unable to effectively contest, denying him a fair trial by unanimous jury.*

In a civil commitment trial under chapter 71.09 RCW, the jury must “unanimously agree[] on the basis for confinement.” *In re Det. of Halgren*, 156 Wn.2d 795, 809, 132 P.2d 714 (2006). The mental abnormality or personality disorder alleged for commitment are “distinct means of establishing the mental illness element” required for commitment as part of the right to a unanimous jury verdict. *Id.* at 811.

When one alternative means lacks sufficient evidentiary support, a general verdict must be reversed. *State v. Woodlyn*, 188 Wn.2d 157, 165-66, 392 P.3d 1062 (2017). The reviewing court does not speculate about what means the jury relied upon. *Id.* *Woodlyn* relied on the same due process requirement of jury unanimity and case law discussed in *Halgren* to explain the necessity of clear, unanimous jury findings when a flawed alternative means is presented to the jury. *Id.* at 162, 164-65; *Halgren*. 156 Wn.2d at 808-11.

Dr. Arnold's diagnosis of paraphilia NOS, attraction to pubescent aged females, was the focal point of the evidence and

argument. *See* 5RP 379-81, 429-35, 441-42; 12RP 1539-40, 1543-44. It was how the State started its closing argument in chief and in rebuttal. 12 RP 1539, 1601. The State argued that if jurors did not believe Mr. Black's behavior toward "12, 13, and 14" year old girls was a mental disorder, they "might as well just pack it in and go home," highlighting its focus on this diagnosis and its likely impact on the jury. 12RP 1544.

Although Dr. Arnold also diagnosed Mr. Black with sexual sadism based on instances of "rough sex" with adult women and a "personality disorder not otherwise specified (antisocial and narcissistic traits)," these diagnoses were ancillary and unlikely to have been unanimously supported as predicates for commitment. *See* Opening Brief, at 38-44 (discussing flaws in diagnoses). The court instructed the jury its verdict did not need to be unanimous and the verdict form was silent about its basis. CP 1385; 1411.

This Court "is compelled to reverse a general verdict" unless the jury expressly rests its verdict on an alternative means supported by sufficient evidence. *Woodlyn*, 188 Wn.2d at 166. The jury's verdict likely rested on a controversial diagnosis that lacks general acceptance in the scientific community. It should not have been presented as a basis for civil commitment, and if admissible, the court unfairly limited Mr.

Black's ability to effectively challenge it. The jury did not declare its verdict rested on valid mental abnormality or personality disorder and was encouraged to issue a verdict without unanimity. Under these circumstances, a new trial is required. *See Woodlyn*, 188 Wn.2d at 165.

D. CONCLUSION.

Mr. Black respectfully requests this Court reverse the commitment order and remand the case for further proceedings.

DATED this 6th day of November 2017.

Respectfully submitted,

A handwritten signature in black ink, appearing to read 'Nancy P. Collins', written in a cursive style.

NANCY P. COLLINS (28806)
Washington Appellate Project (91052)
Attorneys for Petitioner

IN THE SUPREME COURT OF THE STATE OF WASHINGTON

IN RE THE DETENTION OF)
)
)
 MARK BLACK,) NO. 94494-6
)
)
)
 PETITIONER.)
)

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