Mental Illness, Disabilities & Criminal Law: Myths, Sanism, Ethical Considerations & Characterizations

A Guide to the Effective Representation of Clients With A Mental or Physical Disability

Speakers:

Gene Hughes, ***Director of Advocacy, Utica, Resource Center for Independent Living***
Danny McLain, ***Accessibility Consultant, RCIL***
Frank J. Nebush, Jr., ***Oneida County Public Defender, Criminal Division***
Dr. Norman J. Lesswing, ***Forensic Psychologist, Syracuse, NY***

Saturday, September 15, 2018
Mohawk Valley Community College
IT Room 225
9:00 a.m. – 12:00 p.m.

This program is being presented in coordination with the:

Criminal Division, Oneida County Public Defender's Office
New York State Defenders Association, Inc.
New York Office of Indigent Legal Services
Oneida County Supplemental Assigned Counsel Program

CLE Credits
1 Diversity & Inclusion and Elimination of Bias in the Legal Profession
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8:30 a.m. - 9:00 a.m.	**REGISTRATION**
9:00 a.m. – 9:55 a.m.	***Dealing with the Stereotypes, Myths and Superstitions of Mental Illness and Physical Disabilities*** **Gene Hughes, Director of Advocacy, Utica, RCIL** **Danny McLain, Accessibility Consultant, RCIL**
10:00 a.m. – 10:55 a.m.	***The Criminal Defense Attorney's Ethical Obligations in the Representation of a Mentally Ill Client*** **Frank J. Nebush, Jr., Oneida County Public Defender, Criminal Division**
11:00 a.m. – 12:00 p.m.	***Forensic Psychological & Psychiatric Evaluations in Criminal Defense: A Brief Review and Examination of the Practical Aspects*** **Dr. Norman J. Lesswing, Ph.D., Forensic Psychologist**

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The Oneida County Public Defender, Criminal Division is fortunate to work with the Oneida County Bar Association, the sponsor of the Criminal Track Programs, the annual Criminal Law Academy and the Assigned Counsel Schools. The Academy will be held on December 1st this year. We are grateful to the CLE Committee for granting us the latitude to develop meaningful and significant programs for the criminal defense bar. We are especially appreciative for the help given to us by the Bar Association's Executive Director, Diane Davis. Without her able assistance, the Assigned Counsel Schools, the Criminal Law Academy and the Criminal Track Programs would not be possible.

The Oneida County Bar Association offers a wide range of CLE programs on other topics throughout the year. A full calendar of programs is available at their website *www.oneidacountybar.org*. Oneida County Bar members are eligible to purchase a Sempass which entitles the holder to attend any or all of the programs offered by the Association.

The Oneida County Public Defender, Criminal Division makes several of the materials from the Assigned Counsel School, our Criminal Track Programs and the Criminal Law Academy available at our website: *http://www.ocgov.net/oneida/pdcriminal/training*.

We would like to acknowledge the assistance of the New York State Defenders Association, Inc. and Managing Attorney Charles O'Brien whose advice has proved invaluable in developing our programs throughout the years. Unfortunately, Charlie has been on sick leave for a few months but is expected to be back at NYSDA shortly. We wish him a speedy recovery.

NYSDA is also a valuable resource for criminal law practitioners through their website http://www.nysda.org/. Their two-day training conference in Saratoga in July is unsurpassed in the depth and experience of the faculty and the relevant topics presented every year. We encourage you to visit their website and become a member.

We would be remiss if we failed to mention the New York State Association of Criminal Defense Lawyers (NYSACDL). Many of their members have been featured faculty at both the Academy and the Criminal Track Programs and they sponsor many CLE training programs across the state each year. Their listserv provides critical assistance to criminal defense practitioners. You can check out their website at http://www.nysacdl.org/.

Last but not least, we gratefully recognize the support and encouragement of the staff of the New York State Office of Indigent Services. Director Bill Leahy and his staff, especially Matt Alpern, Director of Quality Enhancement for Criminal Defense Trials; Joanne Macri, Director of Regional Initiatives and Patricia Warth, Chief Hurrell-Harring Implementation Attorney have always been willing to go out of their way to help us improve our programs.

On behalf of our sponsor and our cooperating agencies, we welcome you and hope you find this program informative and valuable to your practice. As always, we welcome your comments and suggestions for future programs.

NOTE: Members of Assigned Counsel Panels and Assistant Public Defenders are encouraged to contact our Regional Immigration Assistance Center, Region #2 whenever they have a case involving a non-citizen. The Region #2 Center is located in the Oneida County Courthouse in Rome and covers sixteen counties in central and northern New York. You're welcome to contact our Director of Immigration Sharon Ames or the Criminal Law Director Tina Hartwell at 315-356-5794.

Dealing With The Stereotypes Myths and Superstitions of Mental Illness and Physical Disabilities

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Medicine and Society

Sanism and the Law

Michael L. Perlin, JD

"Sanism," an irrational prejudice against people with mental illness, is of the same quality and character as other irrational prejudices such as racism, sexism, homophobia, and ethnic bigotry that cause (and are reflected in) prevailing social attitudes [1, 2]. It infects both our jurisprudence and our lawyering practices. Sanism is largely invisible and largely socially acceptable. It is based predominantly upon stereotype, myth, superstition, and deindividualization and is sustained and perpetuated by our use of alleged "ordinary common sense" (OCS) and heuristic reasoning in irrational responses to events in both everyday life and the legal process [3, 4].

I have written extensively about the roots of the assumptions that are made by the legal system about persons with mental disabilities. These mistaken assumptions include: that people with mental illness are erratic, deviant, sexually uncontrollable, emotionally unstable, superstitious, lazy, and ignorant; that they demonstrate a primitive morality; they are invariably more dangerous than persons without mental illness, and such dangerousness is easily and accurately identified by experts; that for a person in treatment for mental illness to decline to take prescribed antipsychotic medication is an excellent predictor of (1) future dangerousness and (2) need for involuntary institutionalization; that people with mental illness should be segregated in large, distant institutions because their presence threatens the economic and social stability of residential communities; that they give in too easily to their basest instincts and do not exercise appropriate self-restraint [5].

These assumptions—which reflect societal fears and apprehensions about mental disability, persons with mental disabilities, and the possibility that any individual may become mentally disabled—ignore the most important question of all—why do we feel the way we do about people with mental disabilities [6, 7]? One explanation may lay in history. Thousands of years ago, it was commonly believed that sickness was "a punishment sent by God" [8]. Historian Judith Neaman has concluded that "demonic possession remains the simplest, the most dramatic, and secretly, the most attractive of all explanations of insanity in the Middle Ages" [9, 10]. Society saw madness as a condition "in which a person was 'possessed, controlled, or affected by some supernatural power or being,' and this connection has remained 'extremely resilient in western culture'" [11].

Any attempt to place mental disability jurisprudence in context results in confrontation with a discordant reality: social science data that refutes these assumptions is rarely a coherent influence on mental disability law doctrine [12-14]. Rather, the legal system selectively—teleologically—accepts or rejects social science data depending on whether or not the use of that data meets the *a priori* needs of the legal system [15, 16]. In other words, social science data is privileged when it supports the conclusion the fact finder wishes to reach, but it is subordinated when it questions that conclusion [17].

By way of example, as Susan Stefan has perceptively noted, courts routinely find mentally disabled women to lack sufficient competence to engage knowingly and voluntarily in sexual intercourse but just as routinely find them competent to consent to give their children up for adoption. In one startling case, a court made both of these findings simultaneously about the same woman [18].

Thus, it is no surprise that courts selectively accept stereotypes to exert social control—engaging in gross stereotyping about the impact of mental illness on behavior when sentencing persons

convicted of crime or deciding on involuntary civil commitment and rejecting the stereotypes when acknowledging them might lead to a socially undesirable result, such as an insanity acquittal [19].

This stereotyping of the effects of mental illness also flows from the meretricious impact of a false "ordinary common sense" ("OCS") and the pernicious impact of heuristic thinking on judicial decision making. OCS is self-referential and non-reflective ("I see it that way, therefore everyone sees it that way; I see it that way, therefore that's the way it is"). Not surprisingly, many of the greatest areas of OCS-caused dissonance emerge in cases involving family relationships ("If Joe was that bad...why didn't the defendant divorce him? Why didn't she just leave him?"), sexual assault ("Look at the way she was dressed; she was asking for it"), and mental illness ("If he had just tried harder, he really could have gotten better"). Areas such as these are treasure troves of self-righteousness, narrow thinking, and "atrophied moral development" [20].

Heuristics are "simplifying cognitive devices that frequently lead to...systematically erroneous decisions through ignoring or misusing rationally useful information" [21-23]. The vividness heuristic, for example, is a cognitive simplifying device through which a "single vivid, memorable case overwhelms mountains of abstract, colorless data upon which rational choices should be made" [24]. So, because most high-profile cases involving the insanity defense are the focus of exaggerated media attention, the illusion is created that they are reflective of the entire universe of insanity cases, or even the entire universe of all cases [25].

The law's use and misuse of social science and OCS nurture sanism. Decision making in mental disability law cases is inspired by (and reflects) the same kinds of irrational, unconscious, bias-driven stereotypes and prejudices that are exhibited in racist, sexist, homophobic, and religiously and ethnically bigoted decision making. Sanist decision making infects all branches of mental disability law and distorts mental disability jurisprudence by, for instance, relying vividly on the heuristic of the statistically exceptional but graphically compelling case of the person with a major mental disorder who is randomly violent [26].

Paradoxically, while sanist decisions are frequently justified as being therapeutically based, sanism customarily results in antitherapeutic outcomes [27-29]. This happens in a wide array of decisions, ranging from those that commit insanity acquittees charged with misdemeanors to maximum-security facilities for many years longer than the maximum sentence they would have received if found guilty [30] to those that ignore a Supreme Court decision limiting the indefinite commitment of persons found permanently incompetent to stand trial [31] to those that mandate medication over objection even where there is a strong likelihood that neurological side effects may result [32].

Judges are not immune to sanism. "Embedded in the cultural presuppositions that engulf us all," judges also take deeper refuge in heuristic thinking and flawed, non-reflective "ordinary common sense" [33]. They reflect and project the conventional morality of the community, and judicial decisions in all areas of civil and criminal mental disability law continue to reflect and perpetuate sanist stereotypes [34]. Thus, a trial judge responding to a National Center for State Courts' survey indicated that, in his mind, defendants who were incompetent to stand trial *could have* communicated with and understood their attorneys "if they [had] only wanted" [35]. Judges are not the only sanist actors. Lawyers, legislators, jurors, and witnesses (both lay and expert) all exhibit sanist traits and characteristics [36].

Sanist attitudes also lead to pretextual decisions. "Pretextuality" refers to the fact that courts regularly accept (either implicitly or explicitly) testimonial dishonesty, countenance liberty deprivations in disingenuous ways that bear little or no relationship to case law or to statutes, and engage in dishonest (and frequently meretricious) decision making, specifically when witnesses, especially expert witnesses, show a "high propensity to purposely distort their testimony in order to achieve desired ends" [37]. The failure of more than half the states to implement the Supreme Court's 1972 decision in *Jackson v. Indiana* [38] (limiting the length of time one can be kept in a maximum security forensic psychiatric facility solely because of incompetence to stand trial) is a textbook example of pretextuality [39]. As I have written elsewhere, "the political decision making in insanity acquittal cases—best exemplified by a National Institute of Mental Health Report conceding that individual release decisions are made in accordance with political dictates in 'controversial cases'—demonstrates that pretextuality drives this area of jurisprudence" [39]. Pretextuality is poisonous; it infects all participants in the judicial system, breeds cynicism and disrespect for the law, demeans participants, and reinforces shoddy lawyering, blasé judging, and, at times, perjurious or corrupt testifying.

Pretextual devices such as condoning perjured testimony, distorting appellate readings of trial testimony, subordinating statistically significant social science data, and enacting purportedly prophylactic civil rights laws that have little or no "real-world" impact dominate the mental disability law landscape [40]. A few examples are illustrative. Although the District of Columbia Code contains

a provision that patients can seek either periodic review of their commitment or an independent psychiatric evaluation, in the first 22 years following the law's passage not a single patient exercised this right to statutory review [41]. While former attorney general William French Smith told Congress that the insanity defense "allows *so many persons* to commit crimes of violence," one of his top aides candidly told a federal judicial conference that the number of insanity defense cases was, statistically, "probably insignificant" [42]. When a state enacts a new statutory scheme to "treat" sex offenders, but fails to hire any professionals experienced in the provision of such treatment, that new statute is pretextual [43, 44].

In other circumstances, courts simply "rewrite" factual records to avoid having to deal with social science data that controverts their view of how the world "ought to be" [45]. The classic example is Chief Justice Burger's opinion for the court in *Parham v. J.R.* (1979) [46], approving more relaxed involuntary civil commitment procedures for juveniles than for adults. Gail Perry and Gary Melton accurately characterized the *Parham* case in this way:

> *The Parham case is an example of the Supreme Court's taking advantage of the free rein on social facts to promulgate a dozen or so of its own by employing one tentacle of the judicial notice doctrine. The Court's opinion is filled with social facts of questionable veracity, accompanied by the authority to propel these facts into subsequent case law and, therefore, a spiral of less than rational legal policy making [47].*

Even when courts do acknowledge the existence and possible validity of studies that take a position contrary to their decisions, this acknowledgement is frequently little more than mere "lip service." Involuntary civil commitment and periodic review hearings, for example, rarely make vigorous and authentic inquiries into the restrictivity of confinement and the availability of community treatment, both of which they are mandated to do by an array of court decisions [48], and refusal-of-treatment hearings rarely take seriously the autonomy-privileging language of cases such as *Rivers v. Katz* [49, 50].

Until system "players" confront the ways that sanist biases inspire the selective incorporation or misuse of social science data and such pretextual decision making, mental disability jurisprudence will remain incoherent. Behaviorists, medical researchers, social scientists, and legal scholars must begin to develop research agendas to (1) determine and assess the ultimate impact of sanism, (2) better understand how social science data is manipulated to serve sanist ends, and (3) formulate normative and instrumental strategies that can be used to rebut sanist pretextuality in the legal system. Practicing lawyers need to articulate the existence and dominance of sanism and of pretextual legal behavior in their briefs and oral arguments so as to sensitize judges to the underlying issues.

A rare example of judicial understanding of the ravages of sanism and pretextual thinking is *In re the mental health* of K.G.F. [51], a decision by the Montana Supreme Court that focused specifically on sanism as a factor in assessing effectiveness of counsel in involuntary civil commitment hearings. Underscored the court:

> *The use of such stereotypical labels [to describe people with mental illness, e.g., "idiots" and "lunatics"]—which, as numerous commentators point out, helps create and reinforce an inferior second-class of citizens—is emblematic of the benign prejudice individuals with mental illnesses face, and which are, we conclude, repugnant to our state constitution. See generally Michael L. Perlin, On "Sanism," 46 Smu L. Rev. 373, 374 (1992) (identifying prejudice toward the*

mentally ill among "well-meaning citizens" as the same "quality and character of other prevailing prejudices such as racism, sexism, heterosexism and ethnic bigotry," which in turn is reflected in our legal system) [and Bruce Winick's 1999 article "Therapeutic Jurisprudence and the Civil Commitment Hearing" in the Journal of Contemporary Legal Issues] (stating that because people with a mental illness "already have been marginalized and stigmatized by a variety of social mechanisms, self-respect and their sense of their value as members of society are of special importance to them" throughout legal proceedings) [52].

"Sanism" is well known in the legal community. A recent search of the WESTLAW database reveals that it has been referred to in 272 law review articles between 1992 and 2013. It is, sadly, much less well-known in the medical community. It is vital that physicians begin to confront its scope and its significance.

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Michael L. Perlin, JD, is a professor of law, director of the International Mental Disability Law Reform Project, and director of the Online Mental Disability Law Program at New York Law School.

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Registries, Violence, and Threats of Harm, October 2013

Top 11 Myths about mental illness

Source: Canadian Living and Pathstone Mental Health

Myth #1: Mental health problems do not affect children or youth. Any problems they have are just part of growing up.

Reality: One in five children and youth struggle with their mental health. 70% of adult mental illness begins during childhood or adolescence, including: depression, eating disorders, obsessive compulsive disorder and anxiety disorders. However, 79% of youth who receive help improve significantly with treatment, which lasts less than 12 sessions for 66% of them.

Myth #2: It is the parents' fault if children suffer from mental health problems.

Reality: Mental health disorders in children are caused by biology, environment, or a combination of both. They can be caused by genetics or biological factors such as a chemical imbalance or prenatal exposure to alcohol or drugs. They can also be the result of abusive or neglectful treatment or stressful events.

Myth #3: People with a mental illness are 'psycho', mad and dangerous, and should be locked away.

Reality: Most people who have a mental illness struggle with depression and anxiety. They have normal lives, but their feelings and behaviours negatively affect their day-to-day activities. Conduct disorders or acting out behaviours are consistently the primary reason for referral to a children's mental health agency.

Myth # 4: All people with Schizophrenia are violent.

Reality: Very little violence in society is caused by people who are mentally ill (violence and mental illness). Unfortunately, Hollywood often portrays mentally ill people as dangerous. People with a major mental illness are more likely to be victims of violence than perpetrators.

Myth #5: Depression is a character flaw and people should just 'snap out of it'.

Reality: Research shows that depression has nothing to do with being lazy or weak. It

results from changes in brain chemistry or brain function. Therapy and/or medication help people to recover.

Myth #6: Addiction is a lifestyle choice and shows a lack of willpower.

Reality: Addictions involve complex factors including genetics the environment, and sometimes other underlying psychiatric conditions such as depression. When people who become addicted have these underlying vulnerabilities it's harder for them to simply kick the habit.

Myth #7: Electroconvulsive therapy (ECT), also known as shock therapy, is painful and barbaric.

Reality: ECT is one of the most effective treatments for people whose depression is so severe that antidepressant medications just don't do the job and who are debilitated by the depression.

Myth #8: People with a mental illness lack intelligence.

Reality: Intelligence has nothing to do with mental illnesses or brain disorders. On one hand, many people with mental disorders are brilliant, creative, productive people. On the other hand, some people with mental disorders are not brilliant or creative. Certain mental illnesses may make it difficult for people to remember facts or get along with other people, making it seem like they are cognitively challenged. Overall, the level of intelligence among people with mental illness likely parallels the patterns seen in any healthy population.

Myth #9: People with a mental illness shouldn't work because they'll just drag down the rest of the staff.

Reality: People with mental illness can and do function well in the workplace. They are unlikely to miss any more workdays because of their condition than people with a chronic physical condition such as diabetes or heart disease. The real problem is the prejudice against hiring people with mental illness (how will disclosing my mental illness affect work/school). The resulting unemployment leaves them isolated, a situation that can add to their stress, and make it more difficult to recover from the illness.

Myth #10: Mental illness is a single, rare disorder.

Reality: Anxiety disorders, mood disorders, personality disorders, addiction disorders and impulse control disorders are all different categories of very different mental illnesses- each with its own features and underlying causes (common mental illnesses). Each mental illness is a variation on the theme of brain chemistry gone awry, affecting things like mood and perception and each has its own specific causes, features and approaches to treatment.

Myth #11: People with a mental illness never get better.

Reality: TREATMENT WORKS! Treatments for mental illnesses are more numerous and more sophisticated than ever and researchers continue to discover new treatments. Because of these advances, many people can and do recover from mental illness.

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The Criminal Defense Attorney's Ethical Obligations in the Representation of Mentally-Ill Client

Frank J. Nebush, Jr., Esq.
Oneida County Public Defender
Criminal Division

An Overview of a Lawyers Ethical Obligations In a Criminal Proceeding When an Attorney Believes the Client May be Mentally-Ill

Ethical Concerns: You have an ethical obligation to zealously represent your client and act in his or her best interest. This can be especially difficult when a client is obviously suffering from a mental illness or is clearly incompetent. The law allows clients to control their own destinies and the attorney has to respect those choices even when the client is not fully capable of making the best decisions.

More than any other type of case, a criminal defense attorney has to make every effort to develop the client's personal and social history as well as his medical and mental health history to gauge the extent of the mental disability. The pitfalls of representing this type of client is outlined in the attached article by John Fabian, *"Practice Points: How to Deal with Difficult Clients from a Mental Health Perspective"* where he deals with tensions and conflicts in the attorney-client relationship developing from the client's mental impairment. An awareness of your ethical obligations is essential to taking actions in the best interests of the client and avoid making decisions for the client that are his right to make.

Competency v. Affirmative Defenses: The two are distinguishable and are not to be confused with each other although they are often intertwined. **Competency or fitness to proceed under CPL Article 730 does NOT deal with the client's mental state at the time the crime was committed,** it only deals with his **PRESENT** mental capacity and can brought before the court at any time, i.e. – arraignment, pretrial, plea or sentencing. (*See Matter of Westchester Rockland Newspapers, Inc. v. Leggett, 1979, 48 N.Y.2d 430).*

Affirmative defenses based on mental disease or defect relate to the client's mental state **at the time the crime was actually committed.**

Simply put, competency deals with the mental state of the client **at the present time:**

i. **Does he understand the proceedings against him?;**
ii. **Is he able to assist in his defense?**

This two-pronged test comes from *Dusky v. United States, 1960, 80 S.Ct. 788, 362 U.S. 402, 4 L.Ed.2d 824* which clearly set forth the standard from which our Criminal Procedure Law emanated when, in setting forth the definition of an "incapacitated person" it declared that in making such a determination

> **"**it is not enough that the defendant is oriented to time and place and has some recollection of events, but that the test must be **whether he has sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding – AND whether he has a rational as well as factual understanding of the proceedings against him."** (emphasis added).

NOTE: The statute does not say charges it says "proceedings". Attorneys and judges often state "charges" while the statute contemplates that the defendant understand the legal proceedings against him which encompasses the charges but has a wider meaning, i.e. the judges and prosecutors role, the defense attorney is there to help him, a jury hears the evidence in the case, etc.

Why is this important? Usually the client understands the charge, that doesn't always mean he understands the court proceedings. If a client is found to be an incapacitated person, the mental

institution will work with him or her on definitions of court, judge, prosecutor, and attorney. Upon the return of the client to court after being found competent, you will see in his medical records references to the staff of the institution instructing the client on all of these areas. Often, clients will understand that they are charged with a crime and what the crime is and therefore it **seems** that the first part of the prong is satisfied. It is necessary for you on your **initial interview** to determine if in fact the client does understand the charge, but you must go further and discuss with the client, if you can, whether he actually does understand what a court is and what the roles of the judge, jury, prosecutor and defense attorney are. **Take notes** because the result of this line of questioning can be surprising. On more than one occasion clients will state they were in jail because "they killed" somebody and it is the job of the judge, jury, prosecutor and the defense attorney to send them to prison or he may make other statements to you that indicate his understanding of the proceedings is not rational.

Is he able to assist in his own defense?

This is the most often used grounds for asserting incompetency. As defense counsel, you want to **BUILD** your case and the client's revelations can do that especially if his version of events is filled with obvious delusions and hallucinations. So how do you determine whether or not your client can assist in his own defense?

Ask the client to tell you what happened and **do not engage in direct examination**, let him talk **Take good notes** on the conversation. Especially with paranoid schizophrenics, some of the events they tell you may seem plausible, i.e. family gatherings, arguments or confrontations. They will repeat in great detail the same occurrence to you every time you interview them, but when you interview family members the incidents never happened. When the client recounts obviously bizarre and fanciful events, **write it down.**

Ethical Concerns in Dealing With a Client You Believe May Not Be Competent

If you were representing a client who had been assaulted, the first thing you would do is have a picture taken of the client's injuries - a picture taken not when you got around to it or two weeks or a month after, but a picture taken **as soon as possible.** Then you would want him to see a doctor **as soon as possible** so the injuries are medically documented.

An attorney must treat a mental ill client with the same urgency. AS SOON AFTER THE COMMISSION OF THE CRIME AS POSSIBLE the attorney needs to interview the client.

Document the client's demeanor, manner of speech, ability to communicate and physical appearance. You need to see the client "in the raw." In essence, you are taking a picture of the client's mental and physical state. This will not only assist you in making a decision on requesting a CPL §730 evaluation, but it also assists you in building an affirmative defense of mental disease or defect. The client may be **decompensating.** Particularly after the crime, especially in homicides or violent crimes, stress and fatigue can cause the mental process of clients suffering from a mental illness to disintegrate. Basically they come apart emotionally and mentally. Their stress overcomes their ability to cope. The attorney needs to attempt to communicate with the client and **record** his observations so they can be communicated to the court.

Look for:

Blunted affect or flat affect. A severe reduction in emotional expressiveness. There are no signs of joy, pleasure, sadness or emotion of any kind. The client may speak in a droning monotone showing no vocal or facial emotion when describing his actions. The client will not react with you, look at you or address you directly. This is characteristic of clients suffering from schizophrenia and post- traumatic stress syndrome.

Lack of concentration. The client will bounce from subject to subject or not answer your questions, or take a long time answering you.

"Thought Blocking." Regular interruptions in the stream of thought. This is more than simply losing one's place, it is a complete halt to the process of thought. Outward signs are abrupt, repeated interruptions in the flow of conversation or actions.

Staring. The client will look about and stare expressionless. Combat veterans suffering from PTS will have the "thousand yard stare." Schizophrenics act the same way.

Disorganized speech. The client will wander from topic to topic randomly with no thread linking his thoughts, or stop in the middle of a sentence and go on to some unrelated subject.

Persecutory delusions. Commonly, the client believes that he is being
"tormented, followed, tricked, spied on or ridiculed."
(DSM 5, p. 87, 90-91)

Referential delusions. Also quite common, the client will express a belief that "comments, passages in books, newspapers, song lyrics" are directed at him. (DSM 5, p. 87)

Bizarre delusions. It is common for schizophrenics to relate to you their delusions. These common delusions were taken from the DSM- 5:

> **"**A stranger removed his internal organs and replaced them with someone else's organs"
>
> "His thoughts are being taken away by some outside force." "Alien thoughts have been put into his mind."
>
> "His body or actions are being acted on or manipulated by some outside force."

Auditory or visual hallucinations. Be sure to ask if the client hears voices or sees things. Usually a client will offer that information. Ask him who is talking to him and what he is saying or what he is seeing.. Audio hallucinations are much more common than visual.

Hyper-religiousity. The client has grandiose delusions about God and religion. The following are some observations made by friends or relatives of schizophrenics:

> "He thought he was Jesus' son. He did not talk about it much, but spent a lot of time reading the bible and looking off into space."
>
> "He says that he felt that the things in his life that have happened to him were like being crucified. That he was suffering like Jesus did, and that it was because he was Jesus' son."

"He thinks he is Satan, and if he goes to church or reads the Bible, he thinks he is Satan or one of the characters from the Bible. He is petrified of going to hell and thinks people are talking about us on TV NEWS, or radio."

"He thinks he is the latest prophet and has a mission to change the world. He also talks about Hitler and how he killed his retinue in order to gain the power he wanted. My boyfriend wants this kind of power."

The attorney also needs to obtain from the client the names, addresses and telephone numbers of the client's family, friends, associates, doctors and anyone that has had recent contact with him or he has communicated with so you can investigate his personal, social, medical and psychiatric history. These people have to be interviewed so you can make a more informed decision on whether to request a CPL §730 evaluation and at the same time start exploring whether you have sufficient evidence to validate the affirmative defense of mental disease or defect.

Bring copies of releases with you for the client to sign:

Medical releases (HIPPA)
School records
College records
Social Service records

<u>ARRAIGNMENT AND THE PRELIMINARY HEARING</u>. After arraignment and prior to the preliminary hearing on the felony, if a felony is charged, a decision must be made whether you will be holding the hearing or requesting a competency evaluation under CPL §730

Although the preliminary hearing may provide valuable information, it is critical to establish the client's mental state as soon after the crime as possible. If after interviewing the client, an attorney believes the client is an "incapacitated person" and not competent, you want that documented by psychiatric professionals and CPL §730 evaluation will do that.

<u>PRACTICE TIP</u>: If you have an indication that a client is not competent prior to arraignment in the local criminal court (the judge, district attorney, sheriff's deputies, court personnel, family members often will tell you that the client is displaying symptoms of mental dysfunction), **at the arraignment** request that the court provide you with the longest period of time possible to prepare for the preliminary hearing, even if you have to waive the time periods in CPL §180.80. This provides you with time to interview the client and more importantly, talk to family, friends, relatives and any other people associated with your client. You need to obtain his personal and mental health history along with specific details of any incidents your client was involved in indicative of a mental health problem. The history and actions need to be setforth before the court to justify your request for a CPL §730 evaluation**.**

<u>Do not take for granted that the Court will automatically order the evaluation or the District Attorney will consent to it.</u> Set forth for the Court specific details of your client's actions that you believe will convince the court that your client is an incapacitated person and not able to either understand the proceedings against him or be able to assist in his defense, or both. **If you decide to have the preliminary hearing and thereafter request a CPL §730 evaluation the court will likely inform you that your client has been held for the action of the grand jury and therefore the court is divested of jurisdiction and does not have the power to order a CPL §730 order.** ***(See CPL Article 180)***

Ethically, the decision to request a competency evaluation under CPL §730 is a decision the **attorney** has to make, but should not be made without thoroughly interviewing the client when there are indications either from the client or someone else that the client may be incompetent. By not requesting a competency evaluation when one may be strongly indicated is doing your client a disservice, **even when your client objects.** The best evidence of a mental disability will come from the psychiatric evaluators. Conversely, if the attorney is clearly able to communicate with the client, the client is cooperative, indicates an understanding of the proceedings after an in-depth review by the attorney, and seems to be able to assist in his defense, a CPL §730 evaluation is not required and will be of little value in building an affirmative defense based on mental disease or defect.

Remember: In order to enter a plea of not responsible by reason of mental disease or defect, a client MUST be competent and defense counsel must state that on the record at the time of the plea. (CPL §220.15).

The CPL §730 Evaluation: Procedure

Once a local criminal court orders a CPL §730 evaluation on your client, the order will normally go to the county director of mental health. (See CPL §730.10 and §730.20).

The director has to appoint two (2) psychiatric examiners.

As defined by CPL §730.10, a psychiatric examiner may be "a qualified psychiatrist or a certified psychologist" Both are defined in CPL sections 730.10(5) and (6)

- **The psychiatric examiners may conduct their evaluations on an out-patient basis if the client is not incarcerated, otherwise it must be conducted where the client is being held in custody,**
- **The examiners have 30 days to complete their examination and prepare their reports but the court may extend that period for another 30 days. (CPL §730.20(4),**
- **If the psychiatric examiners do not agree, the director must appoint a third examiner,**
- **Statements made by the client to the examiners are inadmissible in evidence in any criminal action on any issue other than that of his mental condition *CPL §720.20(6),***
- **Under CPL §730.30, the client is entitled to a hearing if the psychiatric examiners find the client NOT to be incapacitated,**
- **If the client is found to be an "incapacitated person", the court must issue a TEMPORARY or a FINAL ORDER OF OBSERVATION.**

PRACTICE TIP: If you have information concerning your client's mental health history, defense counsel should call the county office of mental health and ascertain who the doctors conducting the examination will be. (In Oneida County, Linda Rood at the Oneida County Mental Health Department

is the person to contact at 768-3660, Ext. 3666, email lrood@ocgov.net. The doctors presently retained to conduct evaluations are Dr. Lawrence Farago (forensic psychiatrist), Dr. David Stang (psychologist) and the Clinton Therapy & Testing Center (Dr. Brad Bennett, Dr.
Kristina Berg, and Dr. Heather Lester – all psychologists).

The examiners normally have very scant information about your client. If you have information, particularly if you have been able to obtain a diagnosis, hospital admissions, or any records relating to the client's mental health, it is well worth the effort to contact county mental health and find out the names of the doctors retained to perform the evaluations. Call the doctors and provide any information you have to them.

Additionally, after the reports have been submitted, do not hesitate to attempt to contact them to review their findings.

TEMPORARY ORDER OF OBSERVATION

Where a felony has been charged, a Temporary Order of Observation will be issued committing the client to the New York State Office of Mental Health for a period **not to exceed 90 days unless the District Attorney consents to a Final Order.**

The District Attorney may present the case to the grand jury within 6 months of the expiration of the Temporary Order of Observation. An untimely indictment MUST be dismissed unless good cause is shown.

Under CPL §730.40, subdivision 3, once either the order for the evaluation or a temporary order of observation is issued by a local criminal court, the client is NOT entitled to be heard by the grand jury pursuant to CPL §190.50 unless an application is made to the superior court that impaneled the grand jury and the court finds the client NOT to be incapacitated.

- **When the grand jury files an indictment, CPL §730.40, subdivision 4 and subdivision 5 set up two scenarios that defense attorneys should be aware of and be prepared to deal with:**

  Scenario One Under Subd. 4
  If the indictment is filed after the local criminal court issued an order of examination, BUT has NOT issued a Temporary Order of Observation;

  1. the client MUST be brought before the superior court for arraignment on the indictment;

  2. all proceedings in the local criminal court terminate and the accusatory instrument dismissed;

  3. If the examination reports have been submitted to the local criminal court, the examination report MUST be forwarded to County Court.

  4. If the director has the reports than he MUST submit them to County Court.

Scenario Two Under Subd. 5

The indictment is filed after the issuance of a temporary order of observation by the local criminal court:

1. County Court or the superior court MUST direct the Sheriff to take the client into custody at the institution in which he is confined (usually Central NY Psychiatric Center, Marcy, New York or Mid-Hudson Forensic Psychiatric Center, New Hampton, NY) and bring him into County Court for arraignment on the indictment;

2. After arraignment, the temporary order of observation and any orders issued pursuant to the mental hygiene law are nullified.

• What Effect Do Those Subdivisions Have On The Client

Despite the language of CPL §730.40, subds. 4 & 5, they are only meant to clear away all of the orders and pending matters in the local criminal court allowing County Court or the superior court a clean slate and can proceed unfettered on the indictment. It does **NOT** mean that all the proceedings in the local criminal court were a waste of time.

The critical part is contained in subdivision 4 directing that:

• If the local criminal court has the examination reports, it MUST forward them to County Court or the superior court;

• If the director has not submitted the examination reports to the local criminal court, he MUST submit them to County Court or the superior court.

Since County Court has the examination reports, and assuming the reports indicate that the client is incapacitated, counsel simply moves after arraignment on the indictment, for the court to accept the reports. Under CPL §730.30, the District Attorney can either consent or request a hearing.

However**, should the District Attorney request a hearing in this situation, he must prove to the court by a preponderance of the evidence that the client is not an incapacitated person AND he will have to do this by calling the psychiatric examiners who will be his witnesses**. *[See People v. Santos, 43 A.D.2d 73, 75 (1973), People v. Christopher, 65 N.Y.2d 417 (1985), People v. Mendez, 1 NY3d 15 (2003), People v. Frazier, 58 AD3d 468(2009)]*. For an in-depth discussion of the right of a client to a competency hearing read Pate v. Robinson, 383 U.S. 375, 15 L.Ed.2d 815 (1966).

NOTE: Any attempt by the district attorney to impeach the examiners while they are on the stand usually meets with repeated sustained objections by the defense counsel because they are his witnesses. HOWEVER, the District Attorney or defense counsel has the right to introduce their own expert witnesses.

WARNING: It is not unusual for the district attorney to request a hearing in high profile cases even it is difficult for him to prevail or for a judge to order a hearing *sua sponte.* When a judge orders a hearing, it is usually when the psychiatric examiners make a competency finding and the court is not satisfied that the client is fit to proceed. This situation most often involves state prisoners charged with

committing a crime within a state correctional facility and have later been transferred to a state OMH psychiatric facility while the charge is pending.

• The Client is Found to be Incompetent: Temporary & Final Orders of Commitment

TEMPORARY ORDER OF COMMITMENT - FELONY

Once County Court has made a finding that your client is not fit to proceed, the court must issue a **Temporary Order of Commitment** for a period not to exceed one (1) year which can be renewed by an **Order of Retention** not to exceed one (1) year. Thereafter, as long as the client remains incapacitated, the court may issue retention orders every two (2) years until the total period of confinement **equals two-thirds of the authorized maximum term of imprisonment for the highest class felony contained in the indictment. (See CPL §730.50)**

If the client is still in the custody of OMH when that period is reached, the criminal action is terminated. OMH may then apply for civil commitment.

FINAL ORDER OF OBSERVATION

Under CPL §730.40, the Final Order of Observation applies to "an information, prosecutor's information, or misdemeanor complaint unless of course the District Attorney has consented to the order on a felony complaint. **The Final Order of Observation is a final determination of a criminal charge and bars any further prosecution of the charge.**

CPL §730.50 mandates that the court:

a) MUST issue a Final Order of Observation committing the client to the custody of the NYS Commissioner of Mental Health for period NOT TO EXCEED 90 DAYS.

b) The criminal proceedings must be dismissed.

Once the client is committed to the custody of OMH, the Commissioner may discharge him at any time prior to expiration of the court order and may treat or transfer him during the duration of the commitment as a patient not in confinement under a criminal court order.

Ethical Obligations of the Attorney When the Court Orders a CPL §730 Evaluation

After the court orders a psychiatric evaluation on your client, the District Attorney is going to be busy preparing his case for presentation to the grand jury. No matter how sure you may be that your client will be found an incapacitated person, **do not sit back** and wait for the report to be submitted to the court. Your ethical obligation to zealously represent your client has not been satisfied. You have been provided valuable time to investigate and prepare your case**. Even if your client is found to be incapacitated, that finding is not a final disposition and in most cases the client will be found competent and returned within a few months.**

On your list of things to do:

1. Send out the signed releases as soon as possible;

2. Find out where the client is being held. The county mental health office should know. Patients are assigned a counselor and they are good source of information about your client. Call the facility and find out the counselor's name and talk to her;

3. Retain a forensic mental health expert, either a psychologist or psychiatrist to consult with. Be sure to check out the expert's background. You need to know if the expert has testified in court before or has been used by other attorneys in a criminal case and of course, the hourly fee. Assigned counsel will have to make an *ex parte* application under County Law §722-c for approval of these services**;**

Practice Tip: In one case involving numerous family, friends and potential witnesses, we engaged a psychiatric nurse to help us interview the witnesses. Besides the cost savings, she was able to provide more in-depth and thorough interview reports because she keyed in on the psychiatric indicators much better than an attorney or investigator. Her reports enabled our forensic psychologist to use her reports to evaluate the client without spending the time actually doing the interviewing**.**

4. Interviewing family, friends, relatives and witnesses is a crucial element in establishing an affirmative defense of not responsible by reason of mental disease or defect. Whether or not there is a diagnosis of a specific mental illness, these interviews will establish indicators used to diagnosis a disorder or illness, and if there is a specific diagnosis, the interviews will substantiate the diagnosis.

5. Review all of the incoming records for other leads and get releases out for their records.

6. **Review the interrogation tapes.** The tapes are often the case maker because usually they totality of the questioning, carefully observing the client's reactions and behavior. Watch them again and take notes on the questions and the client's answers to questions. **The client's behavior is very important. Be sure to have copies of the interrogation tapes made and delivered to your expert witness as soon as you receive them.**

7. Read all of the records you have received from all sources. School and college records can provide great insight into the onset of a mental illness.

The Ethical Obligations When Preparing and Presenting The Affirmative Defense

Unlike the decisions that have to be made when an attorney suspects the client is an incapacitated person which allows the attorney wide latitude in decision making, the affirmative defense of not responsible by reason of mental disease or defect is in the hands of the client. *(See EC 7-1, EC 7-7, EC 7-11 and EC 7-12, also Jones v. Barnes, 463 U.S. 745, 77 L.Ed.2d 987. (1983), Florida v. Nixon, 543 U.S. 175, 160 L.Ed.2d 565 (2004) and Fabian's "Practice Points" in the materials.)*

EC 7-7 clearly states and case law reiterates that:

"A defense lawyer in a criminal case has the duty to advise the client fully on whether a particular plea to a charge appears to be desirable and as to the prospects of success on appeal,

BUT IT IS FOR THE CLIENT TO DECIDE WHAT PLEA SHOULD BE ENTERED AND WHETHER AN APPEAL SHOULD BE TAKEN."

Justice Ginsberg in *Nixon* confirms the obligation of the lawyer in criminal cases:

"An attorney undoubtedly has a duty to consult with the client regarding "important decisions," including questions of overarching defense strategy….That obligation, however, does not require counsel to obtain the defendant's consent to "every tactical decision…(an attorney has authority to manage most aspects of the defense without obtaining his client's approval)…But certain decisions regarding the exercise or waiver of basic trial rights are of such moment that they cannot be made for the defendant by a surrogate. **A defendant…has "the ultimate authority" to determine "whether to plead guilty, waive a jury, testify in his or her own behalf, or take an appeal."…Concerning these decisions, an attorney must both consult with the defendant and obtain consent to the recommended course of action."**

The attorney MUST explain the consequences of the disposition to the client and the client's family. Usually the family is in favor of the disposition. Clients can present a greater difficulty. The attorney's **ETHICAL OBLIGATION** is to insure that the client knows and understands what will happen to him if he decides to:

1) Proceed within the court system and take a plea or go to trial,

2) Enter a plea of not responsible by reason of mental disease or defect or go to trial and be found not responsible by reason of mental disease or defect.

Once the client has been found fit to proceed, he is usually on medication and is easier to communicate with than when he was initially interviewed. Although he receives regular medication and counseling, depending on the disorder or mental illness, the client still suffers from the disorder or illness. **A regular discussion with his mental health counselor is critical to determine the ability of the client to understand the proceedings**. A regular conversation between the client and the attorney should not be neglected. A client suffering from a severe mental illness like paranoid schizophrenia who has committed a violent offense, especially if the

act was against a family member, has great difficulty coping once they begin to grapple with the enormity of their action.

It is not unusual for the client to "compensate" and then "decompensate" during the course of his therapy as the counselors try to get him to "come to terms" with his actions. The attorney will have the same problem communicating with the client that the mental health professionals have and often, the attorney will question whether the client is able to assist in his defense. **Courtroom appearances invariably aggravate the stressors on the client.** They may act and communicate effectively in the holding area, but "flip out' or act bizarrely once they are physically in the courtroom. Only through continued interaction with him and his counselor can you gauge his ability to understand you. **Remember, a plea of not responsible by reason of mental disease or defect can only be entered if the client is COMPETENT.**

BE SURE THE CLIENT UNDERSTANDS HE WILL HAVE TO ADMIT THE ALLEGATIONS IN THE INDICTMENT

Whether the attorney seeks to negotiate a plea of not responsible or is going to trial using the affirmative defense, counsel **MUST** discuss with the client an **admission** to the allegations made against him and the client **MUST** be told that at some point, certainly at the plea or possibly at the trial, he will have to recite the events for which he was charged. ***Defense counsel has to know how much the client is willing or able to relate to the court.*** By the time the attorney has reached this
point, he should have some indication of how the client is dealing with this issue**.**

CPL §220.15(3)(e) requires the court during a plea of not responsible to inform the client that "the court will ask him questions about the offense or offenses charged in the indictment"

and

under subdivision 4, the court is obligated to determine "that there is a factual basis for the plea….The court may make such inquiry as it deems necessary or appropriate for the purpose of making the determinations required by this section."

If the case is going to trial and the client is going to testify, admissions are going to be necessary. In either event, the subject of the client's admissions has to be addressed with him.

NOTE: Take the time to review the requirements of CPL 220.15 carefully with the client, especially in regard to what the client will relate about the offense and **WRITE DOWN** his response. If the client is providing sufficient details and you are satisfied the court will accept the plea, arrange a plea date. **IF NOT**, (***and this is the usual scenario) meet with the judge and district attorney prior to setting a date certain for the plea. Tell them what your client is able to say regarding the offense to ascertain if your client's allocution is going to satisfy the court.***

Once the attorney has determined that the client understands the consequences of a plea of not responsible by reason of mental disease or defect, and the attorney and client have decided to pursue the defense, obtain a release from your client to share information with the District Attorney (a copy of a release is in the materials.)

NOTICE REQUIREMENT INVOLVING PSYCHIATRIC DEFENSES

When the attorney and the client have decided to pursue the defense of not responsible by reason of mental disease or defect, **CPL §250.10(3) requires that written notice be given to the District Attorney "before trial and not more than thirty (30) days after entry of the plea of not guilty to the indictment.**" A copy of the **Notice of Intent to Proffer Psychiatric Evidence** is in the materials. The time requirement is liberally construed however and allows filing in the interests of justice and for good cause shown "at any later time prior to the close of evidence."

The District Attorney will have the right to obtain their own expert to examine your client under CPL §250.10(3). The District Attorney may then move for an examination of the client. The District Attorney must provide a written copy of the evaluation report prepared by the
prosecution expert to defense counsel.

Practice Tip: **CPL §250.10(3) allows defense counsel and the district attorney to be present at the examination. In fact, the statute directs the district attorney to give defense counsel notice of the time and place of the evaluation. ATTEND THE EVALUATION AND TAKE GOOD NOTES ON THE QUESTIONS AND ANSWERS.**

Although **neither defense counsel nor district attorney may actively participate in the evaluation** and can only be observers, by attending defense counsel is able to gauge the effectiveness and demeanor of the district attorney's expert which is invaluable at the trial. If you have turned over documentation of your client's mental illness, you will also be able to learn whether the expert has taken the time to review those materials. **The expert for the defense DOES NOT have the right to be present at the evaluation *(See People v. Ceasar, 188 Misc. 2d 219.)***

Note: The Notice of Intent to Offer Psychiatric Evidence is also required when defense counsel raises the affirmative defense of Extreme Emotional Disturbance and the District Attorney is allowed to have the client evaluated by an expert EVEN WHERE THE SOLE TESTIMONY SUPPORTING THE DEFENSE WILL BE LAY TESTIMONY AND EVEN WHEN ONLY THE CLIENT WILL BE TESTIFYING FOR THE DEFENSE. (See *People v. Diaz, 15 NY3 40(2010*).

UNDERSTAND THE PROCEEDINGS INVOLVING THE PLEA

There are obligations that the defense attorney, the court and the district attorney **MUST** fulfill for the plea of not responsible by reason of mental disease or defect to be entered. The materials contain a detailed outline of the proceedings under CPL §220.15 for the entry of the plea and the proceedings under CPL §330.20 after the plea is entered. **Your ethical obligation is not complete unless you understand your role in these proceedings**. Informing the client and his family of the consequences of a plea is foremost on the list of obligations. The client may be institutionalized in a secure mental health facility for a long time.

Under CPL §220.15

1) **The client** must enter the plea with permission of the Court and the District Attorney to the **ENTIRE** indictment,

2) **The District Attorney must state for the record**

a.) that he is satisfied the affirmative defense would be proven by a preponderance of the evidence at trial;

b) detail the evidence against defendant; **and**

c) provide the reasons for recommending the plea;

3) **Defense counsel must state that**

a) his client understands the proceedings and is able to assist in his defense;

b) understands the consequences of the plea;

c) whether he has any other viable defenses; **and**

d) detail the psychiatric evidence in support of the plea;

4) **The Court must then address the defendant** to make a number of determinations as setforth in CPL §220.15, subds. 3, 4 and 5. These are all in the "NGRI Plea" notes in the materials.

Under CPL 220.15 (3) The Court **MUST** address the defendant in open Court and determine if he understands **EACH** of the following:

a) the nature of the charges to which the plea is offered,
b) the consequences of the plea,
c) that he has the right to plead NOT Guilty,
d) that he has the right
    a. to trial by jury,
    b. assistance of counsel,
    c. to confront and cross-examine the witnesses against him, and
    d. the right NOT to be compelled to incriminate himself.
e) If he pleads "Not Guilty By Reason of Mental Disease or Defect" there will be no trial and he waives his right to a trial,
f) If he pleads "Not Guilty by Reason of Mental Disease of Defect" the Court will ask him questions about the charges in the indictment and he waives the right not to be compelled to incriminate himself,
g) The acceptance of the plea of "Not Guilty by Reason of Mental Disease or Defect" it is the equivalent of a conviction after trial of "Not Guilty by Reason of Mental Disease or Defect."

Under CPL 220.15(4), the Court MUST further determine that there is:

a) A factual basis for the plea,
b) The pleas is voluntary and knowingly made and not the result of force, threats or promises,
c) The Court must inquire whether the defendant's willingness to plead results from prior discussions between the District Attorney and defense counsel, and
d) The Court must be satisfied that the defendant:
    a. Understands the proceedings against him,
    b. Has sufficient capacity to assist in his own defense,
    c. Understands the consequences of a plea of "Not Guilty by Reason of Mental Disease or Defect."

Under CPL 220.15(5), before the Court accepts a plea of "Not Guilty by Reason of Mental disease or defect must **FIND** and **STATE <u>EACH</u>** of the following **on the record IN DETAIL**:

a) That is satisfied that each element of the charge(s) in the indictment would be established beyond a reasonable doubt at trial,
b) That "Not Guilty by Reason of Mental Disease or Defect" would be proven by the defendant at trial by a preponderance of the evidence,
c) That the defendant has the capacity to understand the proceedings against him and assist in his own defense,
d) That defendant's plea is knowing and voluntary and there is a factual basis for his plea, and
e) Acceptance of a plea of "Not Guilty by Reason of Mental Disease or Defect" is required in the interest of justice.

CPL §220.15 (6) declares that after the plea of "Not Guilty by Reason of Mental Disease or Defect" has been accepted by the Court, the provisions of "**CPL §330.20 shall govern all subsequent proceedings."**

<u>Under CPL §330.20</u>

The procedure after the entry of the plea requires the court to enter an examination order to have the client evaluated by two (2) psychiatric evaluators to determine if the client is:

1) dangerously mentally ill
2) mentally-ill, but not dangerously mentally ill,
3) not mentally-ill

The evaluation must be done within **30 days**, but may be extended another 30 days. The Court will then conduct an **"Initial Hearing**" within ten (10) days of receiving the examination reports. **At the hearing, the District Attorney must establish to the "satisfaction of the court" that the client has a dangerous mental disorder or is mentally ill.**

<u>"Dangerous Mental Disorder" (Secure Facility)</u>

If the court finds the client to be dangerously mentally ill, the court must issue a commitment order and the client will be placed in a "secure facility" (i.e. – Rochester Psychiatric Center or Mid-Hudson Psychiatric Center) for six (6) months. Thirty days prior to the expiration of that order, the facility may apply for a "First Retention Order." The court may hold a hearing, but a hearing must be held if requested by the district attorney, defense counsel or the client. If the client is found to be dangerously mentally ill, the court issues a commitment order not to exceed one (1) year. After that, a "Second Retention Order" or "Subsequent Retention" orders may be requested for commitment not to exceed two (2) years.

Mentally-Ill, But Not Dangerous (Non-Secure Facility)

If the court finds the client to be not dangerously mentally ill, but mentally ill, the court issues an "Order of Conditions" and an order committing the client to the NYS Commissioner of Mental Health. The "Order of Conditions" issued by the court basically directs the client to comply with the treatment prescribed by OMH, "or any other condition the court determines to be reasonably necessary and appropriate." The court may also issue "special conditions" relating to the victim or victims. An order of conditions is good for five (5) years and may be extended another five years for good cause shown.

Not Mentally Ill (Discharge)

If the court finds the client not mentally ill, the court must discharge the client either unconditionally or subject to conditions.

How to Deal With Difficult Clients From a Mental Health Perspective

By John Matthew Fabian

Read more Practice Points columns.

A criminal defense lawyer has an ethical obligation to best serve the interests of his or her clients. When a client has a mental impairment, it is critical for counsel to understand the client and how the impairment affects the client's ability to functionally participate in the legal proceedings.

This article addresses difficult clients from a psychological and psychiatric perspective. The focus is on mental health issues that may lead to conflicts in the attorney-client relationship as well as suggestions to better serve clients. This information is relevant in various legal contexts, including competency to waive Miranda rights, competency to stand trial, and issues regarding not guilty by reason of insanity pleas. Understanding a client from a mental health perspective assists in improving an attorney's legal representation of the client.

Prevalence of Mental Disorders

Before discussing potential difficulties a defense attorney may encounter with mentally ill or personality disordered clients, it is helpful to understand the plethora of mentally ill defendants in the criminal justice system.

The U.S. Department of Justice Bureau of Justice Statistics[1] has published data relevant to mental illness within the criminal justice system (see Figure 1).

Once admitted to state prisons, over 70 percent of inmates receive mental health treatment and 50 percent receive psychiatric medication.[2] In addition, over 40 percent of jail inmates receive mental health treatment after admission to jail.[3] Criminal defense attorneys have some doubt about the mental capacity of their clients in about 8 to 15 percent of felony cases, although forensic mental health assessments are only sought in about half of these cases.[4] Attorneys doubt a client's competence more often in felony than misdemeanor cases.[5]

In addition, most defendants who are ultimately found incompetent to stand trial suffer from serious psychotic disorders such as schizophrenia or the developmental disorder mental retardation. Defendants with prior hospitalizations, older offenders, minority offenders, single offenders, those with speech disorganization, delusions, hallucinations, and poor interactional behavior with their attorneys are more likely to be adjudicated not competent to stand trial.

Interestingly, some research has indicated that defendants without diagnosed mental disorders also display relatively poor comprehension concerning their understanding of elements of interrogation warnings and competence to stand trial. Often, IQ scores are among the strongest predictors of a defendant's capacity to understand legal concepts.

When encountering a mentally ill client, there is a 50 percent chance he or she is non-compliant with medication.[6] Forty to 70 percent of these individuals go undiagnosed and untreated.[7] Therefore, the attorney might have to initiate a psychiatric assessment for the client while he or she is in jail. Finally, about 57 percent of all mentally ill individuals are unaware or moderately un-aware of their mental

condition.[8] Given this fact, many mentally ill defendants will refuse to agree to participate in or exercise legal rights relevant to examinations of their legal sanity.

Potential Difficulties

The criminal defense attorney has spent countless hours in law school, continuing education classes, courtrooms, and jails learning how to best represent clients. The criminal defense attorney often does not have extensive background and training, however, regarding how to deal with clients who have mental illnesses, psychiatric diagnoses, and other impairments. Such client difficulties are present when the following situations arise:

- Counsel has to repeatedly explain courtroom procedure to the defendant;
- Client has difficulty explaining the facts of the case;
- Client makes unrealistic requests for the attorney to file motions that lack merit (violating an attorney's ethical obligations to not file frivolous motions);
- Counsel communicates to the judge and the prosecutor that the defendant is limited in intellectual functioning and was not the primary offender;
- Defendant is angry, distrustful, and will not cooperate with attorney requests, i.e., writes letters to the prosecutor and judge, or writes motions in which he or she makes admissions;
- Defendant is passive and not involved in decision making;
- Defendant refuses to accept the lawyer's advice;
- Due to a fear of being labeled "crazy" or "mentally ill," the client is hesitant to undergo a pretrial psychological evaluation;
- Defendant refuses a plea bargain or the insanity defense, which the attorney believes is in the client's best interest; and
- Defendant exhibits radical beliefs, i.e., religious beliefs (not necessarily due to mental illness) that affect his or her legal decision making.

The difficulties in dealing with a client who has mental health issues may stem from various psychiatric or psychological elements. For example, the client might be distrustful, angry, and hostile due to life experiences, the current situation, and historical attitudes about attorneys. Feelings of anger, distrust, and hostility also might be the result of a personality disorder (often antisocial personality disorder and borderline personality disorder).

Moreover, difficulties can arise when the client is exhibiting psychiatric symptoms, i.e., delusions and disorganized thinking in which he or she is unaware and is unyielding in these beliefs despite evidence to the contrary. Also, a lawyer might face challenges when a client has a history of organic, neuropsychological, and neurological impairments, is learning disabled, or is still under the influence of substances and might be experiencing a substance-induced psychotic or mood disorder.

Is It an Attitude or an Illness?[9]

Even for the forensic mental health expert, sometimes it is challenging to initially distinguish whether a defendant's behaviors and attitudes are due to his or her life experiences, character, and personality versus genuine mental illness and psychiatric disorder. In competency to stand trial evaluations, for example, not infrequently a defendant will have both personality disorder and attitude issues in addition to psychiatric symptoms. The expert is challenged and will ultimately assess whether the individual is unwilling or incapable of functionally assisting in his defense. For the attorney, this confusion can be quite frustrating when attempting to represent a client.

The Need to Gather Data

An attorney should gather as much collateral information as possible to learn more about the client. When the client's competence or mental stability is in doubt, the attorney should attempt to gather information including social security disability records, past psychiatric records addressing inpatient treatment, and current jail medical and psychiatric records. Substance abuse assessment and treatment records are another source of information, as well as information from family members and academic records that highlight a history of learning disabilities. In addition, an attorney should consult with forensic mental health professionals to learn what assessment is required, what assessment instruments should be considered to determine competence to stand trial or waive Miranda rights, and what psychiatric medication issues are relevant.

The defense lawyer should attempt to discern the accuracy and completeness of the information conveyed by the client. If possible, it is helpful to verify details provided by the client with information supplied by a supportive family member or information gathered by the social work staff of the public defender's office. This connection with family will assist counsel in building rapport with the client.

Further, defense counsel should monitor the stability of the client's mental status as contacts with the client progress in jail. Importantly, the stressful jail setting may exacerbate existing symptoms or cause a predisposed mental health condition to surface. For example, incarceration may exacerbate an underlying long-term depression to the point that the client is suicidal and cannot focus on the case or participate in the defense. Critically, a defendant's competency to stand trial is not a fixed state. Rather, it may fluctuate as a function of the course of illness, a response to treatment attempts and effects of medications, and a reaction to his or her legal situation.

Legal Strategies With the Disturbed Client

When an attorney suspects that a client is mentally ill, dependent on substances, or low functioning, the attorney should consider these deficits relevant to the legal strategy from the pretrial to presentence phases. The attorney should consider the statements the client made to police and question whether the client was competent to make these statements. When doubting a client's competency to stand trial, function rather than diagnosis is the key issue. When an attorney suspects that a client is mentally ill and is either unable or unwilling to assist in his or her defense, a motion for a competency assessment should be made. Attorneys must document communication problems relevant to the progression of the psychiatric decompensation of clients and share this information with their experts. Additionally, they may wish to discuss with the experts the legal complexities and nuances of the case and their difficulties with their clients. This author recommends that the expert consider assessing the interaction between lawyer and client in order to examine the client's functional legal abilities relevant to him or her assisting in the defense.

The defense attorney who inherits a mentally ill client should also consider taking the following steps:

- Refer for a competency to stand trial evaluation whenever the attorney has a "good faith doubt" about the client's competence;
- Pursue a competency evaluation when the attorney perceives the client as being passive and uninvolved in the legal decision making process;
- Refer for competency evaluation when the client has a history of mental illness and wishes to represent himself or herself pro se;
- Pursue a competency evaluation with a delusional client who otherwise is competent to stand trial, but refuses a viable insanity defense based on his or her delusion;

- Consider a competency to stand trial evaluation when the defendant has a history of mental illness and there is a significant impairment in the interactional process between attorney and client;
- Pursue a competency evaluation when the defendant has a history of mental illness and currently refuses legal advice when it is clearly in his best interests;
- Work with an expert witness to persuade the client to consider pursuing mental illness defenses if the client is not aware of his or her mental illness; and
- Try to establish a record during the pretrial phase that the client is mentally ill; the condition (if established) might be used later as mitigation during the sentencing phase to establish a nexus with the offending behaviors.

Substituted Judgment for the Mentally Ill Client

Every lawyer is different and every client is unique. When representing a mentally ill client, should defense attorneys exercise their autonomy and substitute their judgment as a "de facto guardian?"[10] According to the ALI's Restatement (Third) of the Law Governing Lawyers, "A lawyer's failure to follow valid client instructions in a criminal case does not necessarily constitute ineffective assistance of counsel rendering a conviction invalid."[11] The ABA's Model Rules of Professional Conduct and Model Code of Professional Responsibility provide that in the representation of a client, a lawyer may, where permissible, exercise his or her professional judgment to waive or fail to assert a right or position of the client.[12]

There is a tendency for an ambiguous ethical norm related to an attorney's obligation to facilitate client participation and an attorney's paternalistic attitude relevant to decision making in cases involving defendants with mental health histories. Accordingly, it may be tempting for a defense lawyer to usurp a client's authority, especially if the client is difficult to work with, mentally ill, or lacks insight into his mental illness. Circumstances such as these can detrimentally affect both the attorney-client relationship and the effectiveness of mental illness defenses. The criminal defense attorney who does encounter mentally ill clients must be mindful, however, of the U.S. Supreme Court decisions in Jones v. Barnes[13] and Florida v. Nixon,[14] holding that a defendant must make various legal decisions on his or her own, including whether to plead guilty, waive a jury, testify, and appeal. A lawyer is ineffective if he supplants the client's right to decide in these areas.

For purposes of this article, there is no ethical quandary, however, concerning the duty of criminal defense attorneys to best serve the interests of their clients. Therefore, it is imperative for these professionals to attempt to understand not only the legal situations of their clients, but also their inherent mental deficiencies.

Notes

1. U.S. Department of Justice, Bureau of Justice Statistics, available at http://www.ojp.usdoj.gov/bjs/pub/press/mhppjipr.htm.
2. Paula M. Ditton, Mental Health and Treatment of Inmates and Probationers, U.S. Department of Justice, Office of Justice Programs (1999).
3. Id.
4. Norman Poythress et al., Attorney-Client Decision Making in Criminal Cases: Findings From Three Studies, 18 Law & Human Behav. 437 (1994); Steven K. Hoge et al., Attorney-Client Decision Making in Criminal Cases: Client Competence and Participation as Perceived by Their Attorneys, 10 Behav. Sci. & L. 385 (1992).
5. Id.
6. Xavier Amador, Recognizing and Explaining Mental Illness, Address at Making the Case for Life IX (September 2006), seminar sponsored by NACDL.
7. Id.

Dealing With Experts on Competence to Stand Trial: Suggestions and Approaches - Part One

By John T. Philipsborn

Since the publication in 1988 of Dr. Thomas Grisso's influential discussion of the competence to stand trial assessment process, there have been a number of developments aimed at improving the performance of defense counsel in that process.[1] The need for lawyers to be familiar with the definitions, assessment processes, and methods of adjudication of the accused's (in)competence to stand trial has been underscored by rulings from the U.S. Supreme Court on competence to stand trial definitions, the development of state-specific case law amplifying existing state statutory definitions of the competence assessment process, scholarly research on that process leading to several influential publications, and ongoing training for defense counsel.

The objective of this article is to review basic information that should be integrated into the evidence presented in a hearing or trial of a person's incompetence to stand trial. Part one will emphasize background information that counsel should be aware of and should collect to better understand who conducts competence assessments, and how to probe the qualifications and professional competence and methodology employed by experts. Part two will review how lawyers can "operationalize" the legal definitions of competence to stand trial and the professional standards applicable to the mental health assessment process in order to either effectively present evidence of incompetence or attack unreliable or invalid opinions of competence.

Participating in the Assessment Process

The basic premise is, admittedly, both simple and simplistic. When lawyers understand the education and training of mental health experts, the professional standards on which they rely, and the practice of competence assessment as defined in the literature, they can effectively present (or where necessary attack) competence assessment evidence. There is enough written about competence assessments to allow lawyers a measure of control over, and input into, the competence adjudication process. Conversely, problems arise where lawyers are unable to participate in the assessment and adjudication of competence because they have failed to educate themselves.

Frequently, defense counsel in jurisdictions in which there is a centralized mechanism for competence evaluations — such as a designated forensic assessment center, a state hospital, or a court forensic assessment unit — will lament that their opportunity for input into the assessment process is minimal and access to qualified independent experts is limited. These complaints are often valid, though part of the problem is that the defense bar in a number of geographical areas has not developed a proactive approach to the competence assessment process. It often comes as a surprise to some members of the defense bar that their colleagues will make a record of their communications with state hospital doctors while sending packets of information and referral questions to be addressed. They do this in part to demonstrate their interest in participating and the availability of information from defense counsel. Certain lawyers will make the effort to request to be present during "staffings" of particular clients. These lawyers will request the opportunity for input into the assessment process and an opportunity to present data. Where such legitimate requests are rebuffed, as noted below, the basis for foundational objections emerge, as do opportunities to attack the integrity and reliability of the process.

The approach encouraged here, besides advising defense counsel to be involved in the assessment process (whether as active participant or active observer is a strategic and tactical issue not addressed here), is for lawyers to carefully assess the principal foundational aspects of competence assessments so that valid and reliable work can be recognized, and "bad" science and unprofessional approaches can be unmasked and effectively challenged.

In order to deal effectively with the issue of (in)competence to stand trial, it is critical to understand: (1) how experts are trained; (2) how to assess the significance of their training and professional affiliations; (3) where to find the standards that apply to their work; and (4) how to prepare to present or challenge their opinions.

History of the Diagnostic And Forensic Assessment Process

One useful starting point to this discussion is the history of the endeavor. Competence to stand trial, according the U.S. Supreme Court's opinion in Cooper v. Oklahoma, is a concept that has been around our legal tradition for at least 300 years.[2] It was some time, however (and often not until the middle of 20th century in the United States), before legislatures enacted the "modern" competence tests in this country. Moreover, it was not until the latter part of the 20th century that the U.S. Supreme Court reiterated, in its current formulation, the basic elements of competence to stand trial.

The legal concepts have been around much longer than the sciences, diagnostic criteria, education curricula, and assessment methodologies in use by the psychologists and psychiatrists charged with evaluating the competence to stand trial of defendants in criminal cases. Thus, it is helpful to have some notion of how well established some of these important aspects of the foundation for competence opinions are. For example, the lawyer who goes into session without the vaguest idea of the development of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM) may be surprised by a cross-examination that points out that when the Manual was first published in 1952 it covered a limited number of diagnostic criteria. The DSM underwent significant changes in each edition, most dramatically between the second and third editions — and it can be described as a work in progress not particularly well suited for literal use in courtrooms.

Therefore, one could use the DSM as a sword or a shield in the examination of an expert to point out that as the DSM has "aged," it has changed. This demonstrates that mental illnesses and conditions are the subject of ongoing inquiry, and mental health experts continue to refine their approaches to them. Moreover, the DSM explains, when ". . . employed for forensic purposes, there are significant risks that diagnostic information will be misused or misunderstood. These dangers arise because of the imperfect fit between the questions of ultimate concern to the law and the information contained in a clinical diagnosis."[3] And since many mental health evaluators use the DSM as a diagnostic gold standard, both the history of its evolution and knowledge of its stated limitations are important.

It is also important to know that there has been an evolution in the level of development and professional regulation of the forensic mental health sciences up to the present time. Having in mind a few significant historical reference points, and discussing them to provide a context to the assessment in the case in question, will be helpful.

Here are a few of these reference points.

- 1952 Publication of DSM-I.
- 1965 Robey's Research and Basic Inventory on Competence to Stand Trial (one of the first instruments developed specifically for forensic mental health).
- 1967 Classification of psychiatric illnesses is addressed in the Comprehensive Textbook of Psychiatry.

- 1968 DSM-II published.
- 1968 The American Academy of Psychiatry and the Law founded.
- 1969 The American Board of Forensic Psychology founded.
- 1973 Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry published by the American Psychiatric Association.
- 1980 DSM-III published, involves a large expansion of diagnostic categories.
- 1986-1988 Thomas Grisso begins publishing on the evaluation of competency to stand trial, and urges regard for standards in the assessment and report writing.
- 1987 Melton et al., publish updated edition of Psychological Evaluation for the Courts, covering protocols and methods to be applied to a wide variety of examinations (updated and newly published in 2007 in its Third Edition).
- 1994 Publication of DSM-IV.
- 2000 Publication of DSM-IV-TR.
- 2011 Publication of DSM-V.

Concentrating on Education, Ongoing Training, and Experience

Every legal system in the United States has some basic statement of the requirements applicable to experts. Under the California Evidence Code, an expert is a person who has ". . . special knowledge, skill, experience, training, or education sufficient to qualify him [or her] as an expert on the subject to which his [or her] testimony relates."[4] The Federal Rules of Evidence set forth a similar threshold definition, providing that an expert is "a witness qualified . . . by knowledge, skill, experience, training, or education. . . ."[5]

Too many practitioners involved in the competence assessment process concede that a proffered expert possesses the basic qualifications to testify regarding the assessment of competence to stand trial — either in preparing to present, voir dire, or otherwise cross-examine that expert. Often they do so out of expediency, because the report is "favorable," or so "negative" that it seems impossible (or impractical) to fight. But even an experienced mental health expert may be an inadequate and unqualified expert on trial competence.

A few observations are in order regarding the training and credentials of psychologists. Psychologists often have (though not always) a Ph.D. obtained after completion of a course of graduate study of between five and seven years. A dissertation helps to define the expert's area of concentration as a doctoral student. Rarely will it have been on the subject of the assessment of competence to stand trial — or even on some related topic.

This observation leads to this point: other than obtaining some school-based training that provided a foundation for forensic work, little in the expert's academic education may have centered on material of direct use to forensic work, and especially to the assessment of competence to stand trial. The exception may be the graduate of some of the newer programs in forensic mental health.

But for the "mainstream" expert, the process of preparing for the hearing should include the careful review of the expert's course of study and consideration of its relevance to the establishment of expertise in competence assessments. With the exception of those who happened to have studied in areas that are obviously relevant, it is possible that either for the purposes of direct examination or cross-examination, the expert's academic training will prove to be of little use in establishing relevant expertise. It will often be nothing more than some continuing legal education time and "OJT," i.e., on-the-job training.

It was not until relatively recently that the American Board of Professional Psychology (ABPP) began awarding specialty certificates in several fields of psychology, including: clinical psychology; forensic psychology; clinical neuropsychology; counseling and school psychology. Those possessed of ABPP certificates demonstrate credentials including the appropriate doctorate; post-doctoral training in their area of specialty; at least five years of experience; recommendations and endorsements from people in the field; and suitable results on a field-specific examination.

Psychiatrists follow different courses of study than do psychologists. Many, though not all, study medicine and complete medical internships before going on to further study and residency programs in psychiatry as part of a course of medical studies. Not all psychiatrists, however, are licensed physicians. Training courses other than medical school education may provide a basis for practice as a psychiatrist, including (at least in some states) obtaining a final degree as a Doctor of Osteopathy.

Some physicians who completed residency programs in psychiatry may not have received prolonged exposure to areas of study such as psychopharmacology, neurochemistry, or the neurobiological bases of behavior (beyond basic courses). Thus, these experts may not have easily demonstrable academic training in the effects of certain classes of medications that may be of issue in a given case. Their initial training and continuing education may not have emphasized areas that are critical to a given competency inquiry. These are matters into which counsel should inquire.

Several specialty organizations certify physicians in specialty areas. For example, the American Board of Psychiatry and Neurology certifies physicians in psychiatry, neurology, and child neurology. The American Academy of Psychiatry and the Law emphasizes forensic practice and forensic credentials. It is one of the organizations that has coordinated with the American Medical Association and the American Psychiatric Association in the development of sub-specialty expertise, specialty certificates, standards for education, and requirements for continuing education.

Each of the pertinent organizations or boards explains its relationship (if any) to the predominant organizations. Some of these credentialing bodies publish materials that are useful either in establishing or attacking the approaches and methods used by a given examiner. For example, the American Board of Psychiatry and Neurology commissioned reports on Core Competencies for Psychiatric Practice, which are published by the American Psychiatric Press. The title speaks for itself.[6]

Psychiatrists who have completed their residency in psychiatry and have acquired the relevant experience may develop sub-specialty expertise and be awarded either specialty certificates or Board certifications (depending on the credential-awarding organization). Not all of those who conduct forensic examinations will possess board certification or specific training in forensic psychiatry. Establishing how a given expert has demonstrated his or her expertise in forensic examinations may prove to be a critical part of the competence adjudication proceeding.

There are various groups providing credentials to psychiatrists and psychologists. Some are highly legitimate and professionally prized, and others less so. The major organizations mentioned here, including the American Medical Association, American Psychiatric Association, and American Psychological Association, all have Web sites that explain the information set forth here (as does some of the pertinent literature).[7] The American Academy of Psychiatry and the Law sets forth standards specific to forensic psychiatry. Similarly, Division 41 of the American Psychological Association provides a wealth of information about forensic psychology, including the standards applicable to forensic assessments.

The reason for this tour of the sources of information (and credentialing bodies) is that lawyers are sometimes not fully aware of what training psychiatrists or psychologists may have had. Both the American Psychiatric Association and American Psychological Association (and their sub-specialty affiliates) regularly

publish practice-related standards and information about continuing education. They maintain and publish ethical codes and standards, including guidelines on the qualifications of test users.[8] The failure to pay attention to these sources of information will deprive a lawyer either of the ability to demonstrate a given expert's adherence to, or departure from, current standards of practice.

Academic programs in psychiatry and psychology changed over a period of time. The advent of programs that offer concentrated training in forensic psychiatry or forensic psychology has changed the educational "baggage" that experts possess, depending on when or where they were trained.

For example, many psychologists trained and licensed in clinical psychology, particularly more than 20 years ago, may have had no academic or supervised training at all in forensic psychology and no clinical experience that would have involved competence to stand trial assessments. Thus, their knowledge of the competence to stand trial assessment process may have been learned on the job and as a result of some continuing education. Indeed, it is surprising to note how many "experts" on competence assessments have little formal training of any kind specific to such endeavors. Similarly, psychiatrists may have had little or no forensic training. Furthermore, they may have had no exposure to the competence to stand trial assessment process until after they left their residency programs and were in practice — and they may not be able to establish any formal relevant training.

People v. Ary

The importance of inquiries into qualifications can be illustrated by a brief description of the evidentiary hearing held in People v. Ary, a case remanded by a California Court of Appeal to a trial court for a retrospective competence assessment.[9] James Ary was evaluated at the time of his initial trial proceedings (though not specifically for his competence to stand trial). Evidence of his possible incompetence, however, was argued as a critical issue on appeal. During the post-conviction retrospective competence assessment, at least eight mental health professionals, the majority of them psychologists, gave opinion testimony about Ary's competence to stand trial. Some of the experts were retained by the state, others by the defense. Two were considered "court experts," though they were nominated by the parties. Not all of the experts actually examined Ary, but several did. All of the experts professed to have some opinion about his competence.

The most recently educated psychologist had obtained doctoral training (and a doctorate in clinical psychology), and then had completed a post-doctoral program in forensic psychology that added 2,000 hours of specific training in forensic issues, including the assessment of competence to stand trial. The majority of the other experts had obtained their doctoral degrees at least 20 years before the commencement of the hearing (one had been a practicing psychologist for at least 40 years). None of these "older" experts had any training during the course of their education that touched either on forensic issues or on the assessment of competence to stand trial. Only three of the experts professed to have ever been asked about their training in, and knowledge of, the assessment of competence to stand trial in any detail during their careers prior to the hearing.

Only half of the experts purported to have recently read cases involving the definition of competence to stand trial, though most recognized that Dusky v. United States and Drope v. Missouri were case names related to the definition of competence to stand trial.[10] Only two of the eight could even state the formulation of the basic competence test by the U.S. Supreme Court. Three of the eight professed to be aware of the discussion of the attributes of competence as discussed in Godinez v. Moran — though all three had been asked to review the decision by counsel.[11]

Almost all of these experts were aware of and described Dr. Thomas Grisso as an acknowledged expert on the assessment of competence. Only three, however, professed any recent review of Grisso's Evaluating Competencies, Melton's Psychological Evaluations for the Courts, or Sadock and Sadock's Comprehensive

Textbook of Psychiatry — and each of these had been asked about these sources in advance of the hearing.

Prior to the hearing, two of the experts indicated awareness of the research on the CAST-MR (the Competency Assessment for Standing Trial of Defendants with Mental Retardation). Half of the experts had reviewed literature pertinent to the CAST-MR (which had been administered to the accused). Only two of the experts professed to be conversant on the limitations of competency assessment instruments, including the CAST-MR.[12]

All of the experts at issue had previously qualified as experts in criminal cases, some on many occasions. The experts quizzed on the reasons for the variation in their foundation noted the differences in the approaches of the lawyers they were working with to prepare their testimony.

Admittedly, evidence from one case is an insufficient basis from which to generalize. Anecdotal information from mental health experts and lawyers alike, however, suggests that both professions have highly varied knowledge of competence assessment tools and methodologies — to say nothing of the variations of knowledge about the combination of the definitions of (in)competence found in statutes and case law. There is some reason to be concerned that it is uninformed lawyering that is allowing uninformed experts to continue to operate without the need for current knowledge. Anecdotal information from lawyers handling criminal appeals indicates that it is relatively rare for there to be an extensive inquiry into the basic expertise of a psychiatrist or psychologist testifying on the question of competence to stand trial.[13]

Assuming that defense counsel prepares by reviewing relevant literature and case law, the defense can bear its burden of proof in part by defining the standard of practice that applies to an expert's assessment of competence to stand trial. The expert who can specifically link the elements of a given competence assessment to the U.S. Supreme Court's rulings on competence (as well as to any seminal state rulings) and to the state statutory scheme will establish a baseline of relevant knowledge.

Approaching the presentation of evidence of competence (at least from the defense's viewpoint) with these basics in mind has another advantage — it diminishes the possibility that counsel will rely on essentially uninformed experts to set the tone in the competence assessment adjudications. It is rarely helpful to endorse an expert's "I know it when I see it" approach. If an expert is unable during preparation sessions to make the basic connections between the legal definitions and the assessment process that he or she used, that expert is unlikely to make a good impression on cross-examination. Why do experts get away with displays of blissful ignorance of the legal definitions and contents of relevant professional literature? Part of the reason is that lawyers let them do so.

Prepare the Packet

There is a way to avoid the problem of the experienced expert whose foundation on competence issues seems weak. Counsel should prepare a relevant packet of information about the competence assessment process. The packet should include not only copies of the pertinent statutes and relevant case law, but also copies of the literature, including Grisso, Melton, and others whose information will be useful to establishing the adequacy of the work done by the defense expert and the standards that should be used in a competence assessment process. While this seems to be a basic insight into the obvious, few lawyers seem to do it. Unlike other areas of expertise that could involve extensive preparation, the task just outlined can be accomplished by accessing a few easily available legal standards and a few excerpts from widely available literature. Some lawyers will make it a point to make the packet part of the record so that the judge reviews it as well.

Using such a packet can also force opposing counsel to pay careful attention to phrasing questions in terms of the actual language of the cases and quoted literature. Also, it is a relatively easy way of showing a jury

(in those jurisdictions that allow the question of competence to be tried by a jury) that there is a body of written information that plays a part in defining terms and processes applicable to competence to stand trial.

In addition to the materials just described, this packet might include materials on standards of practice applicable to the relevant areas of mental health expertise — an area often overlooked.

Conclusion

We have now looked at the basic issues that must be reviewed in dealing with an expert on the assessment of competence to stand trial. The emphasis here has been on understanding what background that expert brings to the assessment, and what gaps in the expert's understanding of the issues may have to be addressed early in the interaction between counsel and expert. In part two of the article, we will focus more specifically on methodology and approach, and how to ensure that an expert is either properly supported or appropriately challenged in rendering a competence-related opinion.

Excerpts from this piece appeared in Matthew Bender's California Criminal Defense Practice Reporter in November 2006. They are reproduced by permission.

Notes

1. Thomas Grisso, Competency to Stand Trial Evaluations: A Manual for Practice (1988).
2. 517 U.S. 348, 356-357 n.9 (1996), noting that the concept was recognized in reported cases in the 17th century, and embodied in the Criminal Lunatics Act of 1800.
3. American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders, 4th ed., text revision (DSM-IV-TR) at xxxii-xxxiii (2000).
4. Cal. Evid. Code § 720(a).
5. Fed. R. Evid. 702.
6. Core Competencies for Psychiatric Practice: What Clinicians Need to Know (Stephen Scheiber et al. eds., 2003).
7. As with psychologists, a good primer on the credentials available to psychiatrists can be found in Virginia Sadock & Benjamin Sadock's Comprehensive Textbook of Psychiatry (8th ed.).
8. APA: Guidelines for Test User Qualifications, 56 Am. Psychol. 1099 (2001).
9. People v. Ary, 118 Cal.App.4th 1016 (2004).
10. Dusky v. United States, 362 U.S. 402 (1960); Drope v. Missouri, 420 U.S. 162 (1975).
11. Godinez v. Moran, 509 U.S. 389 (1993).
12. See Richard Rogers & Daniel Shuman, Fundamentals of Forensic Practice 175-176 (2005).
13. The anecdotes were not collected in a methodical way, but involved the writer's contacts with lawyers litigating competence to stand trial issues in several California state and federal cases.

Dealing With Experts on Competence to Stand Trial: Suggestions and Approaches Part Two

By John T. Philipsbrn

Standards Related to Experts and Opinions

In many court systems, the same experts are involved in competence assessments time and time again. A number of lawyers hold the view that judges and juries (where juries make competence determinations) generally disfavor contested competence adjudications, in part because they are viewed as an unnecessary challenge of a usually familiar expert's views by the defense. Thus, some lawyers counsel against contesting a client's incompetence even where it likely could be contested because the systemic "realities" are felt to work against the defense. A similar, though more strategic, issue raised by lawyers concerned with the competence adjudication process is that the state (or federal government) obtains insight into the client that would otherwise not have been provided had there been no competence inquiry.

It appears that some of these concerns are raised because lawyers feel they cannot control the competence assessment process well enough to ensure the correct outcome where the client is indeed incompetent.

Some of this lack of "control" is attributable to lawyers' lack of familiarity with the standards of practice and ethical rules pertinent to psychiatry and psychology. While there are indeed many variables in any given case that lawyers cannot control, they can point out where mental health professions do not adhere to their own rules in conducting an assessment, in arriving at a diagnosis or opinion, or in offering courtroom testimony. Armed with some sense of how to define proper from improper practice in the mental health professions, lawyers can more effectively address the process and outcome of a competence assessment.

The Ethical Principles of Psychologists and Code of Conduct, published by the American Psychological Association, covers a number of issues involved in the practice of psychology, including the assessment process, bases for assessments, test construction, and interpretation of test results. Ethical Principles defines a number of the limitations that psychologists should reflect in stating opinions depending on what data is available.

Similarly, for psychiatrists, the Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry is viewed as defining standards of practice applicable to the profession. It has been referred to not only in some of the leading publications, but also in rulings of the U.S. Supreme Court.[1]

A legitimate question can arise about how influential these organizational ethical principles are to an expert who professes not to belong to a given organization. Nevertheless, both in decisions of reviewing courts on constitutional law and criminal procedure issues, as well as in civil case decisions pertinent to practice and malpractice by psychologists and psychiatrists, courts have made reference to the predominant ethical codes and standards of practice of the dominant organizations. In specialty areas, several well known professional groups publish ethical guidelines or specialty guidelines. For example, the American Academy of Psychiatry and the Law publishes Ethical Guidelines for the Practice of Forensic Psychiatry. Likewise, guidelines

are also published by organizations such as the American Academy of Forensic Psychology as well as the American Board of Forensic Psychology.

As is pointed out in the Federal Judicial Center's Reference Manual on Scientific Evidence, the American Medical Association (AMA) issued a report and a set of recommendations to state licensing boards urging that erroneous testimony by physicians be included as a type of malpractice and be subject to discipline.[2] These recommendations clearly would affect psychiatrists. Indeed, the AMA and several states have discussed expert medical testimony as a form of medical practice. This is an important development, as it emphasizes the concern for adherence to standards.

The advantage of a lawyer's familiarity with ethical rules for psychology and psychiatry, as well as with the announced standards of practice for these professions, is that they form the basis not only of establishing for the trier of fact that there is a baseline, but also that departure from these standards must be viewed as evidence of questionable practices. For example, the evaluator of competence to stand trial who professes to function under pertinent rules should be the subject of a wide-ranging voir dire or cross-examination where he or she: (1) has not maintained his or her knowledge of the field, including knowledge of pertinent literature and case law, and (2) has failed to obtain continuing education on the assessment of competence to stand trial. Counsel who have previously asked limited questions on an expert's qualifications should prepare more detailed inquires and should obtain continuing education and professional certification records for the proposed expert. A surprising number of experts have simply not kept up.

A defense attorney should review foundational issues — even when making contact with a familiar expert. What literature on competence assessments does the expert use as standard references? Because a surprisingly high number of experts use a general understanding of the competence standards in the assessments, ask what statutory or case authority the expert keeps on hand. In some states, Florida and Nebraska for example, the "elements" of a competence inquiry as set forth in controlling law are more detailed than elsewhere. Moreover, other than Richard Rogers and Daniel Shuman, few publications address these differences.[3] How recently has the expert received training on competence to stand trial either as a subject or as an assessment process? It makes sense to ask these questions, and they provide the basis for counsel to provide a "packet" of information to the expert that includes pertinent literature, legal standards, and case-specific material. (See The Champion, January/February 2008 at 15.) This is true (tactical considerations aside) regardless of whether the expert is friendly or adverse.

In addition to the general standards of practice and generalized ethical standards pertinent to the mental health professions, there are a number of standards that govern in the arena of competence to stand trial assessments.

Standards Exist for Competence Assessments

Experienced lawyers will seek to have an expert define how he or she approaches the assessment of competence. Is it done the same way in every case? Is the design of the assessment case specific? How did the examiner decide how to structure the examination or assessment in this case? This is not a matter of guesswork; it is a subject addressed in the literature. According to

Melton et al., while the assessment of competence to stand trial is rooted in the U.S. Supreme Court's definitions, it is conducted in a specific context:

With respect to the first prong of the competency test, for instance, a level of capacity sufficient to understand simple charges . . . may be grossly insufficient when a more complicated offense is involved. . . .[4]

Melton et al. are not alone in this observation. A similar observation appears in the Comprehensive Textbook of Psychiatry:

The impairment must be considered in the context of the particular case or proceeding. For example, mental impairment that renders an individual incompetent to stand trial in a complicated tax fraud case may not render that individual incompetent for a misdemeanor trial.[5]

Because of the dearth of detailed analysis in the case law, it is hard to find language that specifically anoints this view of a competence assessment (though there is some in certain state court decisions). Since this is the literature often relied upon by the mental health professions, however, such language is important, if for no other reason than to establish what an expert knows or has not bothered to consider.

There is another critical issue that often arises in a competence assessment, particularly when it is conducted by a court-appointed expert who is paid a flat (usually low) rate and thus can devote only little time to it. The issue surfaces even when the assessment is undertaken in a state hospital setting where time should not be as precious. The issue is whether contact should be made with the attorney of record to obtain data pertinent to competence. The literature recommends contact between the evaluator and the attorney representing the accused — particularly on the question of ability to assist counsel. Melton et al. are quite clear:

The consultation process should not be conceptualized as unidirectional, however. The clinician also needs to obtain information from the attorney. . . . More important, only the attorney can provide the clinician with information about the length, substance, and nature of previous attorney-client contacts.[6]

Indeed, it is important to note that Melton et al. acknowledge the phrasing contained in Medina v. California that it is defense counsel who will " . . . often have the best informed view of the defendant's ability to participate in his defense. . . ."[7]

This same point was made by Dr. Thomas Grisso in his 1988 Competency to Stand Trial Evaluations, though at that point his view on the subject was narrower than as stated since. He noted that in attempting to obtain background information, " . . . the examiner should attempt to learn from the defendant's attorney those specific behaviors of the defendant that raised doubt concerning the defendant's competency."[8]

While other mental health professionals have published primers and practice guides related to the assessment of competence to stand trial, the above quoted sources are significant because of their influence. It is surprising, particularly when the problem revolves around the accused's ability to

assist counsel (or cooperate in the preparation of a defense), that lawyers do not focus on an expert's failure to contact them.

Many experienced lawyers will pro-actively contact competence examiners to try to spur communication, or at least to make a record that counsel tried to make the contact. Lawyers in those jurisdictions in which competence assessments are conducted in a hospital or locked ward setting, or where competence restoration "work" is done in such settings, should formulate a specific strategy on communication with the mental health experts. The actual practices of the legal profession in this area vary a great deal. Clearly, examiners in state or federal hospital settings have no better gauge than do their colleagues in the community on what issues are encountered by defense counsel in a specific attorney-client relationship unless they confer with counsel. They have little understanding of the demands of a specific case, or how the communication between the lawyer and client has occurred.

The lawyer who has created a trail of communication with the examining expert, or who has at least created a paper trail evidencing efforts at communication, is in a good position to raise omissions by mental health experts where counsel's attempted input was ignored.

Knowledge of Available Formats of Competency Evaluations

In establishing or testing expertise in this area, counsel should become familiar with the various approaches to competence evaluations. Richard Rogers and Daniel Shuman, two well known scholars in the field of forensic mental health, have noted that there are basically three approaches to the diagnostic process in forensic practice. The first is unstandardized, depending on a clinical interview, plus some record review and collateral interviews as well (i.e., interviews of people other than the defendants). An unstandardized approach emphasizes the "I know it when I see it" type of expertise. It is difficult to validate because it is dependent on one person's judgment. And it is not unusual for experts relying on an unstandardized approach not to write very detailed reports, making their opinions even more subject to individual judgment rather than verifiable work.

This unstandardized approach can be contrasted with the standardized diagnosis based on structured interviews empirically validated for use in competence assessments (and including collateral interviews and record review as well as examination of the accused). The notion is that these diagnoses are based in some verifiable methodology and in techniques that can be replicated by another examiner.

Third, according to the Rogers and Shuman view, there are extrapolated diagnoses. These are based on investigating the relationship between results on psychological tests designed and associated with broad diagnostic groups that are related to a clinical assessment process of the individual at issue.[9]

While other scholars have described the diagnostic process in other ways, the Rogers and Shuman description has a great advantage for lawyers. It is simple and easily establishes that a mental health evaluation is a process that can be subjected to some level of analysis. Lawyers often miss the point in this area. Lawyers often question how a mental health professional arrived

at a given opinion, but they do not know how to ask what process was involved. Did you do something that another expert can review and try to validate? Did you use techniques that have been subject to research and review? Did you write a report according to any published standards or approaches? (Grisso points out the importance of standardized report writing methods.)

Having a compact and easy way to describe the diagnostic process is important in a hearing or competence trial. Counsel has to find a way to differentiate between the methods used by examiners, and to introduce language into the court hearing or trial that differentiates between approaches used by experts. Basically put, lawyers have to be able to explain why the "drive by" evaluation – consisting of some time spent with the accused and some time spent reviewing records — does not produce an easily verifiable opinion. Developing the ability to explain to the trier of fact with explanations of how a diagnostic process can be verified (and where it cannot) is what results from understanding the various approaches to competence assessments.

Competence to stand trial assessments often involve the use of fairly well known instruments that may be described as structured interviews, inventories, or tests. Usually, such instruments — such as the Competence Assessment Instrument (CAI), the MacArthur assessment tools (including the MacCAT), and Rogers' Evaluating Competence to Stand Trial-Revised (ECST-R) — are an ingredient in a more methodical process than the "drive-by."

Expertise is established when the following items are included as part of the statement of an expert's background: (1) knowledge of the different categories and types of assessments; (2) knowledge of the different assessment tools; and (3) varied opportunities for acquisition of information on competence to stand trial. (Conversely, when this information is used on cross-examination, it opens up the expertise to question.) Not only does this information establish expertise, it also serves to establish the strengths and weaknesses of any given competence to stand trial assessment process. It serves to establish a description of the science of competence evaluations, as well as their weaknesses — especially in the assessment of the so called "aid and assist" counsel element of the legal test of competence. There are no particularly well established or validated approaches in that area — particularly if one understands the need for examiner contact with counsel to mean that this is an area in which examiners must at least try to acquire data from counsel.

Experts Offering 'Relevant' Evidence

Dr. Thomas Grisso has written that, historically, mental health examiners were viewed as failing to provide testimony that was relevant to the law's concerns, and also that many examiners seemed to be ignorant of the nature of the legal inquiry.[10] As he puts it:

Something more is needed, therefore, than a mere diagnosis of mental disorder, a reference to an individual's inadequate contact with reality, or a statement about general mental retardation. For clinical information to be relevant in addressing legal questions of competence, examiners must present the logic that links these observations to the specific abilities and capacities with which the law is concerned.[11]

Others have explained that " . . . forensic clinicians must consider individually the clinical issues associated with each Dusky prong."[12] Attention needs to be paid to the "clinical operationalization of the competency standard."[13]

These comments frame some interrelated points that will be lost on lawyers who approach competence to stand trial hearings as though the objective were simply to present some expert opinions on an individual's disorders and how they are manifested — with the legal issues left to be explained through counsel's arguments. Even relatively experienced judges often do not have in mind all of the essential formulations and phrases of the U.S. Supreme Court's competence definitions. They may reference a statute, ruling, or (where employed) jury instruction that is clearly out of step with the Supreme Court's requirements. This is true, for example, of the California statutory definition that was formulated in 1967. It is a significant oddity since the statutory definition has not been changed to incorporate the more recent rulings.

From a tactical standpoint, the failure to make use of an expert's understanding of the various competence to stand trial definitions, and to have the expert explain how each activity engaged in during the assessment (the interview, record review, testing, consultation with counsel, observation of the accused with counsel, etc.) relates to an understanding of this individual's competency to stand trial, represents a failure to explain basic linkages between definitions in an assessment process.
It is in part for this reason that counsel are urged to work carefully with experts to ensure that they are fully aware of the content of the case law. Counsel must make sure they have thought how their work as psychologists or psychiatrists in the particular case has addressed the salient questions set forth in the law.

Supporting the Basic Showing of Incompetence

It has been pointed out that the U.S. Supreme Court has never required proof of a specific disorder to establish incompetence or otherwise specified what evidence will establish incompetence. Some state statutes, however, create a linkage between proof of an underlying mental disorder or developmental disability and incompetence to stand trial. Whether this linkage would pass constitutional muster if properly challenged is beyond the scope of this piece. Suffice it to say that when contemplating the presentation of evidence of incompetence, lawyers often contemplate calling one or more mental health experts who are important to the process, in part because they provide the diagnostic information.

Some thorough examiners and lawyers will also call upon a variety of supporting witnesses to flesh out their understanding of the client's functioning, including family members; jail and prison visitors, inmates, staff, and mental health experts; witnesses (including experts) from prior hospitalizations; and prior diagnosticians.

It appears that in the cases in which counsel have been successful in establishing incompetence, the trier of fact was presented with ample, sometimes redundant, testimony from a wide variety of witnesses. Indeed, often the government will seek to rebut the defense evidence by calling the same types of witnesses the defense will call — notably jail, prison, or state hospital personnel who are often offered as sources of information about an individual's behavior when the light of

a mental health examination is not on them, and when (according to the arguments usually proffered) the accused's guard is down. Clearly, proactive counsel who undertake the burden of demonstrating the existence of incompetence should avail themselves of this wide range of evidence.

Exercise care in choosing lay witnesses on competence. Without doubt, some triers of fact will believe a credible lay witness over an expert. But some care should be taken to develop specific parts of the evidence of incompetence through the corroborating witnesses. Often, these witnesses are called to establish that the accused is demonstrating confusion, incoherence, or paranoia (to name a few) even when no lawyers, doctors, or other "officials" are looking.

Several reported cases discuss, in some detail, the witnesses called on the issue of competence or restoration to competence in a way that may assist counsel in formulating plans. One series of such cases centered on New York's Vincent Gigante. Over a period of time, Gigante was the subject of several different competence adjudications.[14] The Gigante saga is of importance because it involved well known psychologists and psychiatrists who lined up on the two sides of the issue, and because it chronicled the various lay witness opinions that were introduced.

After the tortured litigation of the competence issues, Gigante eventually made certain admissions on the record in his federal case to the effect that he had been faking certain aspects of his apparent incompetence. This admission led, among other things, to editorials and commentaries by well known mental health professionals questioning (once again) the usefulness of the injection of mental health opinion evidence in forensic settings.

Another discussion of the subject is found in United States v. Duhon, a federal district court case that offers a rich discussion of competence law and literature pertinent to competence inquiries, as well as a review of the testimony of various witnesses in a competence restoration proceeding.[15] Duhon also involved the use of an attorney-expert, i.e., a lawyer called to explain how defense of the case necessitated attorney-client communication.

The suggestion to use lawyer-experts in competence proceedings has been made over a period of time.[16] The attorney-expert contemplated is one who would explain, either specifically (in the appropriate case) or generally: the demands placed on a client in that type of case; the components of the effective representation of an individual given the charges; the existence of the various standards, including ABA Standards (or ABA Guidelines in death penalty cases) that require the lawyer to do specified things to assist the client; the various choices and decisions defined by the Fifth and Sixth Amendments that clients face; the nature of the discussions that take place between counsel and client in a given type of case; and the strategic decisions that would need to be discussed as well, according to the case law.[17]

Use of an attorney-expert provides an alternative for lawyers who are of the view that some evidence from counsel is needed but where counsel of record may not be an appropriate source of information.

Defining the Problem; Setting the Stage For a Solution

There is an overarching theme that defense counsel may need to address in a competence case. This involves describing how the competence issue impacts the integrity of the process, and what the prospects for restoration of competence may be. Indeed, many of the suggestions offered above might be viewed as secondary to the one discussed here, which is that counsel should have a basic, fact-driven, explanation of how a client's paranoia, psychosis, or other symptom has compromised the conduct of the criminal proceedings.

Focusing on this theme is particularly important when the issue of competence is left to a jury's determination, as well as where the case law requires proof of changed circumstances before a second or third competence to stand trial determination may be undertaken in the same case.

Lawyers who practice in jurisdictions (such as California) where a jury ultimately decides competence have expressed concerns that jurors will view the competence issue as a way of avoiding criminal liability. Surprisingly, however, counsel often do not elicit evidence (through mental health professionals, lawyers, or retired judges, all of whom have been called as experts on such issues) that the systemic response to declarations of incompetence is to try to achieve restoration of competence with the aim of finishing the case. Such evidence would help defuse the notion that the process involves an "out" for the accused.

Counsel who are used to making proportionality and comparison of punishment arguments at sentencing often censor themselves in the presentation of data that can remind a trier of fact (judge or jury) that the actuarial tables favor the resumption of the case when competence is at issue.

This theme may be less dubious to a trier of fact where the underlying disorder can be treated with medication, and where there is evidence that the accused has "gotten better" when medicated. Some experienced lawyers have recommended that their own experts consult with others who work in competence restoration programs that are likely to receive the accused. Competence restoration staffers are often more than happy to review their relative success rates, thus providing the foundation for some testimony on the issue. Hearsay objections can be circumvented through use of official records and official reports, as well as through the calling of administrators responsible for the programs at issue. This is not an area to neglect, as judges or jurors may have little idea what actually happens in the aftermath of a determination of incompetence.

It is also of some importance for counsel to be specific in describing how an accused's incompetence is compromising the defense — even if this statement is made in a submission under seal or in some other protected format. A generalized statement that the accused is unable to assist may be useful at an early time of crisis in the case, but it becomes less useful if it becomes necessary for the same lawyer to raise the client's incompetence a second or third time in the same case. Case law often requires a showing of change in circumstances, and the possibility that competence may have to be addressed again should be contemplated by counsel.

Conclusion

In many jurisdictions, the adjudication of an accused's incompetence to stand trial is taken care of through stipulations to the admission of experts' reports and other devices that have avoided the need for lawyers to get involved in and become acquainted with contested competence hearings or trials. Defense lawyers often assume that there is significant resistance to finding an accused incompetent even though the facts merit such a finding. While this may be a provable assumption, available evidence suggests that well-prepared lawyers have been able to demonstrate a client's incompetence by exhibiting care in preparing to present the relevant evidence. Some of the valuable lessons learned from successful competence litigations have been described in this writing in the hope of assisting other counsel when it comes to clients who are mentally incompetent to stand trial.

Excerpts from this piece appeared in Matthew Bender's California Criminal Defense Practice Reporter in November 2006. They are reproduced by permission.

Notes

1. In Washington v. Harper, 494 U.S. 210, 223 fn.9 (1990), the Court noted that it assumes psychiatrists (and other physicians) obey the ethics of the medical profession, citing specifically the "annotations especially applicable to psychiatry" of the American Psychiatric Association; see also the discussion of medical ethics in Virginia Sadock and Benjamin Sadock's Comprehensive Textbook of Psychiatry (8th ed.).
2. Federal Judicial Center, Reference Manual on Scientific Evidence 448 fn.37 (2d ed. 2000). The Reference Manual is considered an authoritative resource in the federal courts. It devotes an entire chapter to medical testimony.
3. Richard Rogers & Daniel Shuman, Fundamentals of Forensic Practice 157-161 (2005).
4. Gary B. Melton et al., Psychological Evaluations for the Courts 122 (2d ed. 1997). This subject is also covered in the new Third Edition.
5. Virginia Sadock & Benjamin Sadock, Comprehensive Textbook of Psychiatry 3285-86 (7th ed. 2000).
6. See Melton et al., endnote 4, at 150.
7. Id. at 130, relying on Medina v. California, 505 U.S. 437 (1992), which affirmed People v. Medina, 51 Cal.3d 870 (1990). The observation at issue was actually first set forth by the California Supreme Court in its Medina opinion.
8. Thomas Grisso, Competency to Stand Trial Evaluations: A Manual for Practice 41 (1988).
9. Rogers & Shuman, Fundamentals of Forensic Practice 405 (2005).
10. Thomas Grisso, Evaluating Competencies 12-13 (2d ed. 2002).
11. Id. at 13, emphasis in original.
12. Rogers & Shuman, Fundamentals of Forensic Practice 167 (2005); see Dusky v. United States, 362 U.S. 402 (1960).
13. Id. at 161.
14. United States v. Gigante, 982 F. Supp. 140 (E.D.N.Y. 1997); United States v. Gigante, 996 F. Supp. 194 (E.D.N.Y. 1998).
15. United States v. Duhon, 104 F. Supp. 2d 663 (W.D. La. 2000). This is a very useful case that has been cited with approval, usually on other issues. See, for example, United States v. Valenzuela-Puentes, 479 F.3d 1220, 1227 (10th Cir. 2007).

16. The writer of this piece has been involved in several publications suggesting the use of attorney-experts. Fortunately, some of these writings have been supported by other established defense counsel. See, for example, Iversen, Thomson & Philipsborn, 1368 Revisited: Can Your Client Rationally Assist You? (CACJ Forum, 1988, in two parts); Philipsborn, Assessing Competence to Stand Trial: Re-Thinking Roles and Definitions (American Journal of Forensic Psychiatry, Volume II, Issue One, 1990); Burt and Philipsborn, The Assessment of Competence in Criminal Cases: The Case for Cooperation Between Professions (published in the June 1998 issue of The Champion, as well as in CACJ Forum and California Death Penalty Manual). The last of these articles was cited by the U.S. District Court in Duhon, see endnote 15.
17. Many of the activities that would be contemplated to take place between a lawyer and client, including discussions of specific pleas, waivers of rights, and strategic decisions, are found in Godinez v. Moran, 509 U.S. 389 (1993). A useful discussion is also repeated in United States v. Duhon, supra note 15. The ABA Standards referred to here are the Standards on the Defense Function. The ABA Guidelines are the 2003 ABA Guidelines on the Appointment and Performance of Counsel in Death Penalty Cases.

Schizophrenia

What is schizophrenia?

Schizophrenia is a chronic, severe, and disabling brain disorder that has affected people throughout history. About 1 percent of Americans have this illness.[1]

People with the disorder may hear voices other people don't hear. They may believe other people are reading their minds, controlling their thoughts, or plotting to harm them. This can terrify people with the illness and make them withdrawn or extremely agitated.

People with schizophrenia may not make sense when they talk. They may sit for hours without moving or talking. Sometimes people with schizophrenia seem perfectly fine until they talk about what they are really thinking.

Families and society are affected by schizophrenia too. Many people with schizophrenia have difficulty holding a job or caring for themselves, so they rely on others for help.

Treatment helps relieve many symptoms of schizophrenia, but most people who have the disorder cope with symptoms throughout their lives. However, many people with schizophrenia can lead rewarding and meaningful lives in their communities. Researchers are developing more effective medications and using new research tools to understand the causes of schizophrenia. In the years to come, this work may help prevent and better treat the illness.

What are the symptoms of schizophrenia?

The symptoms of schizophrenia fall into three broad categories: positive symptoms, negative symptoms, and cognitive symptoms.

Positive symptoms

Positive symptoms are psychotic behaviors not seen in healthy people. People with positive symptoms often "lose touch" with reality. These symptoms can come and go. Sometimes they are severe and at other times hardly noticeable, depending on whether the individual is receiving treatment. They include the following:

Hallucinations are things a person sees, hears, smells, or feels that no one else can see, hear, smell, or feel. "Voices" are the most common type of hallucination in schizophrenia. Many people with the disorder hear voices. The voices may talk to the person about his or her behavior, order the person to do things, or warn the person of danger. Sometimes the voices talk to each other. People with schizophrenia may hear voices for a long time before family and friends notice the problem.

Other types of hallucinations include seeing people or objects that are not there, smelling odors that no one else detects, and feeling things like invisible fingers touching their bodies when no one is near.

Delusions are false beliefs that are not part of the person's culture and do not change. The person believes delusions even after other people prove that the beliefs are not true or logical. People with schizophrenia can have delusions that seem bizarre, such as believing that neighbors can control their behavior with magnetic waves. They may also believe that people on television are directing special messages to them, or that radio stations are broadcasting their thoughts aloud to others. Sometimes they believe they are someone else, such as a famous historical figure. They may have paranoid delusions and believe that others are trying to harm them, such as by cheating, harassing, poisoning, spying on, or plotting against them or the people they care about. These beliefs are called "delusions of persecution."

Thought disorders are unusual or dysfunctional ways of thinking. One form of thought disorder is called "disorganized thinking." This is when a person has trouble organizing his or her thoughts or connecting them logically. They may talk in a garbled way that is hard to understand. Another form is called "thought blocking." This is when a person stops speaking abruptly in the middle of a thought. When asked why he or she stopped talking, the person may say that it felt as if the thought had been taken out of his or her head. Finally, a person with a thought disorder might make up meaningless words, or "neologisms."

Movement disorders may appear as agitated body movements. A person with a movement disorder may repeat certain motions over and over. In the other extreme, a person may become catatonic. Catatonia is a state in which a person does not move and does not respond to others. Catatonia is rare today, but it was more common when treatment for schizophrenia was not available.[2]

"Voices" are the most common type of hallucination in schizophrenia.

Negative symptoms

Negative symptoms are associated with disruptions to normal emotions and behaviors. These symptoms are harder to recognize as part of the disorder and can be mistaken for depression or other conditions. These symptoms include the following:

"Flat affect" (a person's face does not move or he or she talks in a dull or monotonous voice) Lack of pleasure in everyday life
Lack of ability to begin and sustain planned activities
Speaking little, even when forced to interact.

People with negative symptoms need help with everyday tasks. They often neglect basic personal hygiene. This may make them seem lazy or unwilling to help themselves, but the problems are symptoms caused by the schizophrenia.

Cognitive symptoms

Cognitive symptoms are subtle. Like negative symptoms, cognitive symptoms may be difficult to recognize as part of the disorder. Often, they are detected only when other tests are performed. Cognitive symptoms include the following:

Poor "executive functioning" (the ability to understand information and use it to make decisions)
Trouble focusing or paying attention
Problems with "working memory" (the ability to use information immediately after learning it).

Cognitive symptoms often make it hard to lead a normal life and earn a living. They can cause great emotional distress.

When does schizophrenia start and who gets it?

Schizophrenia affects men and women equally. It occurs at similar rates in all ethnic groups around the world. Symptoms such as hallucinations and delusions usually start between ages 16 and 30. Men tend to experience symptoms a little earlier than women. Most of the time, people do not get schizophrenia after age 45.[3] Schizophrenia rarely occurs in children, but awareness of childhood-onset schizophrenia is increasing.[4,5]

It can be difficult to diagnose schizophrenia in teens. This is because the first signs can include a change of friends, a drop in grades, sleep problems, and irritability—behaviors that are common among teens. A combination of factors can predict schizophrenia in up to 80 percent of youth who are at high risk of developing the illness. These factors include isolating oneself and withdrawing from others, an increase in unusual thoughts and suspicions, and a family history of psychosis.[6] In young people who develop the disease, this stage of the disorder is called the "prodromal" period.

Are people with schizophrenia violent?

People with schizophrenia are not usually violent. In fact, most violent crimes are not committed by people with schizophrenia.[7] However, some symptoms are associated with violence, such as delusions of persecution. Substance abuse may also increase the chance a person will become violent.[8] If a person with schizophrenia becomes violent, the violence is usually directed at family members and tends to take place at home.

The risk of violence among people with schizophrenia is small. But people with the illness attempt suicide much more often than others. About 10 percent (especially young adult males) die by suicide.[9,10] It is hard to predict which people with schizophrenia are prone to suicide. If you know someone who talks about or attempts suicide, help him or her find professional help right away.

People with schizophrenia are not usually violent.

What about substance abuse?

Some people who abuse drugs show symptoms similar to those of schizophrenia. Therefore, people with schizophrenia may be mistaken for people who are affected by drugs. Most researchers do not believe that substance abuse causes schizophrenia. However, people who have schizophrenia are much more likely to have a substance or alcohol abuse problem than the general population.[11]

Substance abuse can make treatment for schizophrenia less effective. Some drugs, like marijuana and stimulants such as amphetamines or cocaine, may make symptoms worse. In fact, research has found increasing evidence of a link between marijuana and schizophrenia symptoms.[12,13] In addition, people who abuse drugs are less likely to follow their treatment plan.

Schizophrenia and smoking

Addiction to nicotine is the most common form of substance abuse in people with schizophrenia. They are addicted to nicotine at three times the rate of the general population (75 to 90 percent vs.
25 to 30 percent).[14]

The relationship between smoking and schizophrenia is complex. People with schizophrenia seem to be driven to smoke, and researchers are exploring whether there is a biological basis for this need. In addition to its known health hazards, several studies have found that smoking may make antipsychotic drugs less effective.

Quitting smoking may be very difficult for people with schizophrenia because nicotine withdrawal may cause their psychotic symptoms to get worse for a while. Quitting strategies that include nicotine replacement methods may be easier for patients to handle. Doctors who treat people with schizophrenia should watch their patients' response to antipsychotic medication carefully if the patient decides to start or stop smoking.

What causes schizophrenia?

Experts think schizophrenia is caused by several factors.

Genes and environment. Scientists have long known that schizophrenia runs in families. The illness occurs in 1 percent of the general population, but it occurs in 10 percent of people who
have a first-degree relative with the disorder, such as a parent, brother, or sister. People who have second-degree relatives (aunts, uncles, grandparents, or cousins) with the disease also develop schizophrenia more often than the general population. The risk is highest for an identical twin of a person with schizophrenia. He or she has a 40 to 65 percent chance of developing the disorder.[15]

We inherit our genes from both parents. Scientists believe several genes are associated with an increased risk of schizophrenia, but that no gene causes the disease by itself.[16] In fact, recent research has found that people with schizophrenia tend to have higher rates of rare genetic mutations. These genetic differences involve hundreds of different genes and probably disrupt brain development.[17]

Other recent studies suggest that schizophrenia may result in part when a certain gene that is key to making important brain chemicals malfunctions. This problem may affect the part of the brain involved in developing higher functioning skills.[18] Research into this gene is ongoing, so it is not yet possible to use the genetic information to predict who will develop the disease.

Despite this, tests that scan a person's genes can be bought without a prescription or a health professional's advice. Ads for the tests suggest that with a saliva sample, a company can

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determine if a client is at risk for developing specific diseases, including schizophrenia. However,

scientists don't yet know all of the gene variations that contribute to schizophrenia. Those that are known raise the risk only by very small amounts. Therefore, these "genome scans" are unlikely to provide a complete picture of a person's risk for developing a mental disorder like schizophrenia.

In addition, it probably takes more than genes to cause the disorder. Scientists think interactions between genes and the environment are necessary for schizophrenia to develop. Many environmental factors may be involved, such as exposure to viruses or malnutrition before birth, problems during birth, and other not yet known psychosocial factors.

Scientists are learning more about brain chemistry and its link to schizophrenia.

Different brain chemistry and structure. Scientists think that an imbalance in the complex, interrelated chemical reactions of the brain involving the neurotransmitters dopamine and glutamate, and possibly others, plays a role in schizophrenia. Neurotransmitters are substances that allow brain cells to communicate with each other. Scientists are learning more about brain chemistry and its link to schizophrenia.

Also, in small ways the brains of people with schizophrenia look different than those of healthy people. For example, fluid-filled cavities at the center of the brain, called ventricles, are larger in some people with schizophrenia. The brains of people with the illness also tend to have less gray matter, and some areas of the brain may have less or more activity.

Studies of brain tissue after death also have revealed differences in the brains of people with schizophrenia. Scientists found small changes in the distribution or characteristics of brain cells that likely occurred before birth.[3] Some experts think problems during brain development before birth may lead to faulty connections. The problem may not show up in a person until puberty. The brain undergoes major changes during puberty, and these changes could trigger psychotic symptoms. Scientists have learned a lot about schizophrenia, but more research is needed to help explain how it develops.

Scientists have learned a lot about schizophrenia, but more research is needed to help explain how it develops.

How is schizophrenia treated?

Because the causes of schizophrenia are still unknown, treatments focus on eliminating the symptoms of the disease. Treatments include antipsychotic medications and various psychosocial treatments.

Antipsychotic medications

Antipsychotic medications have been available since the mid-1950's. The older types are called conventional or "typical" antipsychotics. Some of the more commonly used typical medications include:

Chlorpromazine (Thorazine)
Haloperidol (Haldol) Perphenazine
(Etrafon, Trilafon) Fluphenazine
(Prolixin).

In the 1990's, new antipsychotic medications were developed. These new medications are called second generation, or "atypical" antipsychotics.

One of these medications, clozapine (Clozaril) is an effective medication that treats psychotic symptoms, hallucinations, and breaks with reality. But clozapine can sometimes cause a serious problem called agranulocytosis, which is a loss of the white blood cells that help a person fight infection. People who take clozapine must get their white blood cell counts checked every week or two. This problem and the cost of blood tests make treatment with clozapine difficult for many people. But clozapine is potentially helpful for people who do not respond to other antipsychotic medications.[19]

Other atypical antipsychotics were also developed. None cause agranulocytosis. Examples include:

Risperidone (Risperdal)
Olanzapine (Zyprexa)
Quetiapine (Seroquel)
Ziprasidone (Geodon)

Aripiprazole (Abilify)
Paliperidone (Invega).

When a doctor says it is okay to stop taking a medication, it should be gradually tapered off, never stopped suddenly.

What are the side effects?

Some people have side effects when they start taking these medications. Most side effects go away after a few days and often can be managed successfully. People who are taking antipsychotics should not drive until they adjust to their new medication. Side effects of many antipsychotics include:

Drowsiness
Dizziness when changing positions
Blurred vision Rapid
heartbeat Sensitivity to
the sun Skin rashes
Menstrual problems for women.

Atypical antipsychotic medications can cause major weight gain and changes in a person's metabolism. This may increase a person's risk of getting diabetes and high cholesterol.[20] A person's weight, glucose levels, and lipid levels should be monitored regularly by a doctor while taking an atypical antipsychotic medication.

Typical antipsychotic medications can cause side effects related to physical movement, such

as: Rigidity
Persistent muscle spasms
Tremors
Restlessness.

Long-term use of typical antipsychotic medications may lead to a condition called tardive dyskinesia (TD). TD causes muscle movements a person can't control. The movements commonly happen around the mouth. TD can range from mild to severe, and in some people the problem cannot be cured. Sometimes people with TD recover partially or fully after they stop taking the medication.

TD happens to fewer people who take the atypical antipsychotics, but some people may still get TD. People who think that they might have TD should check with their doctor before stopping their medication.

How are antipsychotics taken and how do people respond to them?

Antipsychotics are usually in pill or liquid form. Some anti-psychotics are shots that are given once or twice a month.

Symptoms of schizophrenia, such as feeling agitated and having hallucinations, usually go away within days. Symptoms like delusions usually go away within a few weeks. After about six weeks, many people will see a lot of improvement.

However, people respond in different ways to antipsychotic medications, and no one can tell beforehand how a person will respond. Sometimes a person needs to try several medications before finding the right one. Doctors and patients can work together to find the best medication or medication combination, as well as the right dose.

Some people may have a relapse-their symptoms come back or get worse. Usually, relapses happen when people stop taking their medication, or when they only take it sometimes. Some people stop taking the medication because they feel better or they may feel they don't need it anymore. But no one should stop taking an antipsychotic medication without talking to his or her doctor. When a doctor says it is okay to stop taking a medication, it should be gradually tapered off, never stopped suddenly.

How do antipsychotics interact with other medications?

Antipsychotics can produce unpleasant or dangerous side effects when taken with certain medications. For this reason, all doctors treating a patient need to be aware of all the medications that person is taking. Doctors need to know about prescription and over-the-counter medicine, vitamins, minerals, and herbal supplements. People also need to discuss any alcohol or other drug use with their doctor.

To find out more about how antipsychotics work, the National Institute of Mental Health (NIMH) funded a study called CATIE (Clinical Antipsychotic Trials of Intervention Effectiveness). This study compared the effectiveness and side effects of five antipsychotics used to treat people with schizophrenia. In general, the study found that the older typical antipsychotic perphenazine (Trilafon) worked as well as the newer, atypical medications. But because people respond differently to different medications, it is important that treatments be designed carefully for each person. More information about CATIE is on the NIMH website.

Psychosocial treatments

Psychosocial treatments can help people with schizophrenia who are already stabilized on antipsychotic medication. Psychosocial treatments help these patients deal with the everyday challenges of the illness, such as difficulty with communication, self-care, work, and forming and keeping relationships. Learning and using coping mechanisms to address these problems allow people with schizophrenia to socialize and attend school and work.

Patients who receive regular psychosocial treatment also are more likely to keep taking their medication, and they are less likely to have relapses or be hospitalized. A therapist can help patients better understand and adjust to living with schizophrenia. The therapist can provide education about the disorder, common symptoms or problems patients may experience, and the importance of staying on medications. For more information on psychosocial treatments, see the psychotherapies section on the NIMH website.

Illness management skills. People with schizophrenia can take an active role in managing their own illness. Once patients learn basic facts about schizophrenia and its treatment, they can make informed decisions about their care. If they know how to watch for the early warning signs of relapse and make a plan to respond, patients can learn to prevent relapses. Patients can also use coping skills to deal with persistent symptoms.

Integrated treatment for co-occurring substance abuse. Substance abuse is the most common co-occurring disorder in people with schizophrenia. But ordinary substance abuse treatment programs usually do not address this population's special needs. When schizophrenia treatment programs and drug treatment programs are used together, patients get better results.

Rehabilitation. Rehabilitation emphasizes social and vocational training to help people with schizophrenia function better in their communities. Because schizophrenia usually develops in people during the critical career-forming years of life (ages 18 to 35), and because the disease makes normal thinking and functioning difficult, most patients do not receive training in the skills needed for a job.

Rehabilitation programs can include job counseling and training, money management counseling, help in learning to use public transportation, and opportunities to practice communication skills. Rehabilitation programs work well when they include both job training and specific therapy designed to improve cognitive or thinking skills. Programs like this help patients hold jobs, remember important details, and improve their functioning.[21,22,23]

Family education. People with schizophrenia are often discharged from the hospital into the care of their families. So it is important that family members know as much as possible about the disease. With the help of a therapist, family members can learn coping strategies and problem- solving skills. In this way the family can help make sure their loved one sticks with treatment and stays on his or her medication. Families should learn where to find outpatient and family services.

Cognitive behavioral therapy. Cognitive behavioral therapy (CBT) is a type of psychotherapy that focuses on thinking and behavior. CBT helps patients with symptoms that do not go away even when they take medication. The therapist teaches people with schizophrenia how to test the reality of their thoughts and perceptions, how to "not listen" to their voices, and how to manage their symptoms overall. CBT can help reduce the severity of symptoms and reduce the risk of relapse.

Self-help groups. Self-help groups for people with schizophrenia and their families are becoming more common. Professional therapists usually are not involved, but group members support and comfort each other. People in self-help groups know that others are facing the same problems, which can help everyone feel less isolated. The networking that takes place in self-help groups can also prompt families to work together to advocate for research and more hospital and community treatment programs. Also, groups may be able to draw public attention to the discrimination many people with mental illnesses face.

Once patients learn basic facts about schizophrenia and its treatment, they can make informed decisions about their care.

How can you help a person with schizophrenia?

People with schizophrenia can get help from professional case managers and caregivers at residential or day programs. However, family members usually are a patient's primary caregivers.

People with schizophrenia often resist treatment. They may not think they need help because they believe their delusions or hallucinations are real. In these cases, family and friends may need to take action to keep their loved one safe. Laws vary from state to state, and it can be difficult to force a person with a mental disorder into treatment or hospitalization. But when a person becomes dangerous to himself or herself, or to others, family members or friends may have to call the police to take their loved one to the hospital.

Treatment at the hospital. In the emergency room, a mental health professional will assess the patient and determine whether a voluntary or involuntary admission is needed. For a person to be admitted involuntarily, the law states that the professional must witness psychotic behavior and hear the person voice delusional thoughts. Family and friends can provide needed information to help a mental health professional make a decision.

After a loved one leaves the hospital. Family and friends can help their loved ones get treatment and take their medication once they go home. If patients stop taking their medication or stop going to follow-up appointments, their symptoms likely will return. Sometimes symptoms become severe for people who stop their medication and treatment. This is dangerous, since they may become unable to care for themselves. Some people end up on the street or in jail, where they rarely receive the kind of help they need.

Family and friends can also help patients set realistic goals and learn to function in the world. Each step toward these goals should be small and taken one at a time. The patient will need support during this time. When people with a mental illness are pressured and criticized, they usually do not get well. Often, their symptoms may get worse. Telling them when they are doing something right is the best way to help them move forward.

It can be difficult to know how to respond to someone with schizophrenia who makes strange or clearly false statements. Remember that these beliefs or hallucinations seem very real to the person. It is not helpful to say they are wrong or imaginary. But going along with the delusions is not helpful, either. Instead, calmly say that you see things differently. Tell them that you acknowledge that everyone has the right to see things his or her own way. In addition, it is important to understand that schizophrenia is a biological illness. Being respectful, supportive, and kind without tolerating dangerous or inappropriate behavior is the best way to approach people with this disorder.

People with schizophrenia can get help from professional case managers and caregivers at residential or day programs.

What is the outlook for the future?

The outlook for people with schizophrenia continues to improve. Although there is no cure, treatments that work well are available. Many people with schizophrenia improve enough to lead independent, satisfying lives.

Continued research and understanding in genetics, neuroscience, and behavioral science will help scientists and health professionals understand the causes of the disorder and how it may be predicted and prevented. This work will help experts develop better treatments to help people with schizophrenia achieve their full potential. Families and individuals who are living with schizophrenia are encouraged to participate in clinical research. For up-to-date information about the latest NIMH-funded research in schizophrenia, see the NIMH Web site.

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For more information on schizophrenia

Visit the National Library of Medicine's MedlinePlus, and En Español

For information on NIMH supported clinical trials, the Clinical trials at NIMH in Bethesda, MD or visit the National Library of Medicine Clinical Trials Database

Information from NIMH is available in multiple formats. You can browse online, download documents in PDF, and order materials through the mail. Check the NIMH Web site for the latest information on this topic and to order publications.

If you do not have Internet access please contact the NIMH Information Center at the numbers listed below.

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7. A Lawyer Should Represent a Client Zealously Within the Bounds of the Law

Ethical Considerations

EC 7-1
The duty of a lawyer, both to the client and to the legal system, is to represent the client zealously within the bounds of the law, which includes Disciplinary Rules and enforceable professional regulations. The professional responsibility of a lawyer derives from membership in a profession which has the duty of assisting members of the public to secure and protect available legal rights and benefits. In our government of laws and not of individuals, each member of our society is entitled to have his or her conduct judged and regulated in accordance with the law; to seek any lawful objective through legally permissible means; and to present for adjudication any lawful claim, issue, or defense.

EC 7-7
In certain areas of legal representation not affecting the merits of the cause or substantially prejudicing the rights of a client, a lawyer is entitled to make decisions. But otherwise the authority to make decisions is exclusively that of the client and, if made within the framework of the law, such decisions are binding on the lawyer. As typical examples in civil cases, it is for the client to decide whether to accept a settlement offer or whether to waive the right to plead an affirmative defense. A defense lawyer in a criminal case has the duty to advise the client fully on whether a particular plea to a charge appears to be desirable and as to the prospects of success on appeal, but it is for the client to decide what plea should be entered and whether an appeal should be taken.

EC 7-8
A lawyer should exert best efforts to insure that decisions of the client are made only after the client has been informed of relevant considerations. A lawyer ought to initiate this decision-making process if the client does not do so. Advice of a lawyer to the client need not be confined to purely legal considerations. A lawyer should advise the client of the possible effect of each legal alternative. A lawyer should bring to bear upon this decision-making process the fullness of his or her experience as well as the lawyer's objective viewpoint. In assisting the client to reach a proper decision, it is often desirable for a lawyer to point out those factors which may lead to a decision that is morally just as well as legally permissible. The lawyer may emphasize the possibility of harsh consequences that might result from assertion of legally permissible positions. In the final analysis, however, the lawyer should always remember that the decision whether to forego legally available objectives or methods because of non-legal factors is ultimately for the client and not for the lawyer. In the event that the client in a non-adjudicatory matter insists upon a course of conduct that is contrary to the judgment and advice of the lawyer but not prohibited by Disciplinary Rules, the lawyer may withdraw from the employment.

EC 7-11
The responsibilities of a lawyer may vary according to the intelligence, experience, mental condition or age of a client, the obligation of a public officer, or the nature of a particular proceeding. Examples include the representation of an illiterate or an incompetent, service as a public prosecutor or other government lawyer, and appearances before administrative and legislative bodies.

EC 7-12
Any mental or physical condition that renders a client incapable of making a considered judgment on his or her own behalf casts additional responsibilities upon the lawyer. Where an incompetent is acting through a guardian or other legal representative, a lawyer must look to such representative for those decisions which are normally the prerogative of the client to make. If a client under disability has no legal representative, the lawyer may be compelled in court proceedings to make decisions on behalf of the client. If the client is capable of understanding the matter in question or of contributing to the advancement of his or her interests, regardless of whether the client is legally disqualified from performing certain acts, the lawyer should obtain from the client all possible aid. If the disability of a client and the lack of a legal representative compel the lawyer to make decisions for the client, the lawyer should consider all circumstances then prevailing and act with care to safeguard and advance

the interests of the client. But obviously a lawyer cannot perform any act or make any decision which the law requires the client to perform or make, either acting alone if competent, or by a duly constituted representative if legally incompetent.

State of New York
County of Oneida County Court

THE PEOPLE OF THE STATE OF NEW YORK

-against-

Notice of Intent to Proffer
Psychiatric Evidence

Indictment No. I2010-0000

John R. Doe,

Defendant.

PLEASE TAKE NOTICE that pursuant to §250.10 of the Criminal Procedure Law the above- named defendant intends to present upon the trial of this action psychiatric evidence of mental disease or defect in connection with the defense of lack of criminal responsibility by reason of mental disease or defect as set forth in Penal Law §40.15, and/or in connection with the defense of extreme emotional disturbance as defined in paragraph (a) of subdivision one of § 125.25 of the Penal Law.

Dated: March 20, 2010

Yours, etc.
Frank J. Nebush, Jr., Esq.
Oneida County Public Defender
Criminal Division
Attorney for John R. Doe
250 Boehlert Center
321 Main Street
Utica, New York 13501
Telephone: (315) 798-5870

To: Hon. Scott D. McNamara
Oneida County District Attorney

Jeanne Natale
Clerk, Oneida County Court

Oneida County Public Defender
Criminal Division

Authorization to Release Case Information

As the attorneys representing you in your pending matter, the Oneida County Public Defender, Criminal Division is prohibited from releasing any information you provide to us in confidence about your case to anyone without your express permission. This prohibition includes members of your family, spouse, children, relatives and friends. Family members often contact us directly about the status of a pending case and seek confidential information about the case. In order to protect your right to keep the information you provide confidential, our staff does not provide information to family members and relatives with the exception of the next date you are to appear in court, the reason for the appearance, a brief explanation of the nature of the court appearance, and the procedure the court and district attorney's office follows in particular cases (See the reverse side for an explanation of these procedures).

You may give us permission to provide information to specific family members, relatives or friends. This information may be as limited and specific as you choose. Many of our clients request that we do share information about their case with a spouse, parent or parents, a relative or friend who is particularly concerned about them. When this permission is given, we prefer to provide information to only one contact person who you have placed your trust in. Should you decide to release information about your case to a particular person, please complete this form and have a notary public witness your signature. **You may send this form to us at the address below, or give it to a member of our staff or the attorney assigned to represent you*.***

I DO NOT WISH TO AUTHORIZE THE RELEASE OF ANY INFORMATION PERTAINING TO MY CASE:

I HEREBY AUTHORIZE THE ONEIDA COUNTY PUBLIC DEFENDER, CRIMINAL DIVISION TO RELEASE INFORMATION ABOUT MY CASE TO:

Name of person to release information to:
Relationship to client (parent, spouse, friend, etc):
Address & Telephone #:

Type of information to be released to the above person (Check ALL that apply):
Court dates only:
Legal documents relating to the charges brought against me:
Discuss my case and the evidence against me:

Dated:

Signature

Subscribed and sworn to before me on this _____ day of _____, 20

Notary Public

Please print your name here

Send this form to:
Oneida County Public Defender-Criminal Division
250 Boehlert Center
321 Main Street
Utica, NY 13501

Oneida County Public Defender
Criminal Division
250 Boehlert Center
321 Main Street
Utica, New York 13501-1229
Telephone: (315) 798-5870
Fax: (315) 734-0364

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

TO: **Oneida County Sheriff**
Judd Road
Oriskany, New York

TO WHOM IT MAY CONCERN:

I, **John R. Doe**, the undersigned, hereby authorize my attorney(s),

Oneida County Public Defender, Criminal Division,

or their authorized representative(s) or employee(s), bearing this release or copy thereof, to obtain any information in your files pertaining to my:

MEDICAL AND PSYCHIATRIC RECORDS

I hereby direct you to release such information upon request of the bearer. This release is executed with the full knowledge and understanding that the information is for the use of the

Oneida County Public Defender, Criminal Division,

I hereby release both you as custodian of such records, and any department, agency, hospital or other repository of medical records; social service agency; employer; including its officers, employees, or related personnel -- individually and collectively -- from any and all liability for damages of whatever kind which may at any time result to me, my heirs, family, or associates because of compliance with this authorization and request for information or any attempt to comply with it.

..... **John R. Doe** .....

(Authorizing Signature) (Full Name-Printed or Typed) (Date)

Oneida County Public Defender
Criminal Division
250 Boehlert Center
321 Main Street
Utica, New York 13501
Telephone: (315) 798-5870
Fax: (315) 734-0364

AUTHORIZATION TO RELEASE INFORMATION

TO THE DISTRICT ATTORNEY OF ONEIDA

COUNTY

I, **John R. Doe**, the undersigned, charged by felony complaint dated February 1,2010 with Murder in the Second Degree, in violation of Section 125.25 of the Penal Law of the State of New York, for causing the death of Peter S. Doe on February 1, 2010 and represented in said matter by the Oneida County Public Defender, Criminal Division, hereby authorize my attorney(s), **Frank J. Nebush, Jr., Esq.**, and **the Oneida County Public Defender, Criminal Division** or their authorized representa- tive(s) or employee(s), bearing this release or copy thereof, to release any information in their files pertaining to me or my pending case which they, in their sole judgment, shall deem pertinent, to:

The District Attorney of Oneida County, his agents and employees, or any experts engaged, contracted with, or otherwise employed said Oneida County District Attorney

Including, but not limited to the following documents, reports, writings or materials checked off below. I understand that such information shared with the aforementioned District Attorney will be used in discussing a disposition of my case. I knowing and voluntarily consent to the release of such information and understand that no promises have been made or proffered in any manner regarding

disposition of the above charges.

X Criminal Records (including but not limited to, accusatory instruments, supporting depositions and Certificates of Disposition)

X Employment and Personnel File

X Education Records (including but not limited to academic achievement, attendance, athletic, personal history, and disciplinary records)

X Medical Records

X Psychological and Psychiatric Records

X Inmate Records

X Investigative reports and attorney work product prepared by the Oneida County Public Defender, Criminal Division in preparation for the defense of this case

X Reports, writings and documents prepared by agents, employees and experts engaged by the Oneida County Public Defender, Criminal Division

X Any treatment, rehabilitation, medical or psychiatric records in the possession of the Oneida County Public Defender, Criminal Division obtained while representing me in the above matter.

Date **John R. Doe**

NGRI PLEA **C.P.L. Section §220.15**

C.P.L. §220.15: Plea: plea of not responsible by reason of mental disease or defect.

§220.15 (1) Must enter a plea with both permission of the court and district attorney to the ENTIRE indictment.

District Attorney: Must state for the record that:

1. People consent to the plea
2. People satisfied that the affirmative defense of ngri would be proven by D at trial by a preponderance of the evidence,
3. Detail the evidence with respect to the charges in the indictment including psychiatric evidence known to the People,
4. Reasons for recommending the plea in detail

§220.15(2) Defense counsel must state on the record:

1. In his opinion D has the capacity to understand the proceedings and to assist in his own defense,
2. D understands the consequences of an ngri plea,
3. Whether D has any viable defenses other than ngri,
4. State in detail the psychiatric evidence available to D re: ngri defense.

§220.15(3) Court: Before accepting the ngri plea, must address D in open court and determine if he understands each of the following:

1. Nature of the charge(s) to which the plea is offered,
2. Consequences of the plea,
3. D has the right to plead not guilty,
4. D has right to trial by jury, assistance of counsel, to confront and cross-examine witnesses against him and the right not to be compelled to incriminate himself,
5. If he pleads ngri there will ne no trial and he waives the right to a trial,
6. If he pleads ngri the court will ask him questions about the charges in the indictment and he waives his right not to be compelled to incriminate himself,
7. The acceptance of the ngri plea is the equivalent of a an ngri verdict.

§220.15(4) Court: Must further determine that there is:

1. A factual basis for the plea,
2. The plea is voluntary and knowingly made and not the result of force, threats or promises,
3. Inquire whether Ds willingness to plead results from prior discussions between the Dist Atty and defense counsel,
4. Must be satisfied that the D:
    a. Understands the proceedings against him,
    b. Has sufficient capacity to assist in his own defense,
    c. Understands the consequences of an ngri plea.

§220.15(5) Court: Before accepting an ngri plea, the court must FIND and STATE each of the following on the record in detail:

a. That it is satisfied that each element of the charge(s) in the indictment would be established beyond a reasonable doubt at trial,
b. That ngri would be proven by the D at trial by a preponderance of the evidence,

c. That D has the capacity to understand the proceedings against him and assist in his own defense,
d. D's plea is knowing and voluntary and there is a factual basis for his plea,
e. Acceptance of ngri plea is required in the interest of justice.

§220.15(6). C.P.L. Section 330.20 governs once the plea is accepted.

Preiser Commentary Note: If the D somehow is able to defraud the court regarding the evidence to support an affirmative defense of mental disease or defect, the court has inherent power to vacate the plea and require D to stand trial. Lockett v. Juviler, 65 NY2d 182, 490 NYS2d 764 (1985).

NGRI PLEA **C.P.L. Section §330.20**

C.P.L. §330.20: Procedure following verdict or plea of not responsible by reason of mental disease or defect

Definitions:

§330.20(1)(c) **Dangerous mental disorder**

i. Currently suffers from a mental illness as defined by MHL 1.03(20)

a. MHL §1.03(20) Mental illness means an affliction with a mental disease or mental condition which is manifested by a disorder or disturbance in behavior, feeling, thinking, or judgment to such an extent that the person afflicted requires care, treatment and rehabilitation AND

ii. *That because of such condition he currently constitutes a physical danger to himself or others.*

§330.20(1)(e) **Examination order:** Psychiatric examination to determine whether D has a "dangerous mental disorder" or is mentally ill

§330.20(1)(f) **Commitment Order/Recommitment Order –** 6 months

§330.20(1)(g) **First retention order – 1 yr.**

§330.20(1)(h) **Second retention order – 2 yrs.**

§330.20(1)(i) **Subsequent retention order – 2 yrs.**

§330.20(1)(j) **Retention order –** 1st, 2nd, or subsequent retention order

§330.20(1)(k) **Furlough order –** temporary leave not exceeding 14 days w/ or w/o supervision

§330.20(1)(l) **Transfer order –** fr/ secure to non-secure facility

§330.20(1)(m) **Release order –** terminates in-patient but not commissioner's responsibility

§330.20(1)(n) **Discharge order –** terminates an order of conditions or unconditionally discharges D fr/ supervision.

§330.20(1)(o) **Order of conditions**-directs D to comply w/ a prescribed treatment plan

Or

Any other condition (i.e.-not to leave facility w/o authorization)

Special order of conditions is a separate document similar to an order of protection

Both are valid for 5 yrs, the court can extend for 5 more yrs.

§330.20(2) **Examination Order**

Upon entry of ngri plea or verdict; the court MUST immediately issue an examination order

2 qualified psychiatric examiners

Per subd 5: qualified psychiatrist or licensed psychologist

Defense psychiatrist or psychologist may be authorized by the court to be present

§330.20(4) **Examination order, duration**

1. Not exceeding 30 days
2. Can extend for 30 more days

§330.20(6) **Initial Hearing; commitment order**

W/in 10 days of receiving examination reports, court MUST conduct an initial hearing to determine the D's present mental condition.

Nebush **LEGAL NOTES**

Dist Atty must establish to the "satisfaction of the court' that D has a dangerous mental disorder or is mentally ill.

If court finds dangerous mental disorder, court must issue a commitment order.
If court finds mental illness w/o dangerous mental disorder – see subd 7

§330.20(7) Initial hearing civil commitment and order of conditions

D mentally ill but not dangerously mental ill, MHL Art 9 or 15 applies.
Court must issue order of conditions
AND
Order committing D to Comm/ MH
After that MHL applies, not C.P.L. Section

If D found not dangerously mentally ill or mentally ill, court must discharge D either unconditionally or subject to an order of conditions.

PREISER'S COMMENTARIES

A D found not responsible by reason of mental disease or defect d/n enjoy the same legal status as one who has been acquitted….the detailed scheme…mirrors the MHL but "creates new procedures for aspects of post verdict supervision applicable only to acquittees.

At the initial hearing, the burden of proof is on the Dist Atty to establish "to the satisfaction of the court" – i.e. by a fair preponderance of the credible evidence" that the acquittee has a dangerous mental condition or is mentally ill. People v. Escobar, 61 NY2d 431, 474 NYS2d 453, 1984.

Track 1- Dangerously mentally ill – commitment order/ secure facility/6 months/C.P.L. governs
Track 2 – Mentally ill w/o a dangerous mental disorder
Commitment order/ non-secure facility/MHL governs
Track 3 - Discharged

West's McKinney's Forms
Database updated February 2010

§ 722-c Form 1. Affidavit in Support of Ex Parte Motion by Assigned Counsel to Employ Expert Investigative Services

STATE OF NEW YORK
COUNTY COURT, COUNTY OF ONEIDA

People of the State of New York,
-against-
John R. Doe,
Defendant.

Index No.
[Name of Assigned Judge]
Affidavit

State of New York,)
County of) ss.:

Adam D. Attorney, being duly sworn deposes and says:
1. I am an attorney at law duly admitted to practice in the State of New York.

2. I was assigned as counsel to , the above named defendant on February 10, 2010 , by Hon. Jerome T. Justice, County Judge of County (the "County"), said defendant being charged with *[state the charges]* under Indictment No. .

3. That said assignment was made pursuant to CPL § 210.15 and County Law Article 18-B, the Court having previously determined that defendant is wholly destitute of means with which to employ counsel to defend him upon the trial of said indictment or to pay such incidental expenses as might be incurred in the conduct of his defense.

4. That during the month last past, I have commenced my investigation of the charges contained in said indictment, and in doing so, have, among other things, read the record on appeal containing the transcript of the testimony of the defendant's previous trial of said indictment. Further, I have extensively interviewed the defendant and have read records, pleadings, and documents related to said charges.

5. That as a result of my investigation of said charges, and in my preparation of the defendant's defense, I have determined that I have need for professional and expert investigative services to enable me to properly and adequately prepare and conduct the defense of the defendant. That because a conflict of interests exists between the defendant and the County Public Defender's Office, I cannot properly avail myself of the services of the investigator employed in the Office of the Public Defender of the County. *[state the nature of the conflict of interest]*.

6. That it is my professional and considered opinion that the defendant will be prejudiced in the defense of this indictment unless the expert and professional services of an investigator are provided to assist me in the investigation of certain aspects of the charges contained in said indictment.

7. That it would be improper and prejudicial to the rights of the defendant for me to disclose at this stage of the proceeding the exact nature of the investigative services required at this time. Further, I am unable to state the cost of such investigative services with any reasonable certainty.

8. That no prior application for the relief requested herein has been made to any Court.

WHEREFORE, deponent prays that an order be made, pursuant to County Law § 722-c, granting leave to deponent, as assigned counsel to the defendant above named, to employ, from time to time, such expert professional investigative services as may be required to enable deponent to adequately prepare and conduct the defense of the defendant, upon the indictment herein charging the defendant with *[state the charges]*, and that the reasonable cost of such investigative services to be so rendered be paid by the County upon subsequent Court orders to be made following submission of proper vouchers to the Court following the rendering of such services; and that the Court grant such other and further relief as may be just and proper in the circumstances.
[Signature]

Subscribed and Sworn to before me on day of , 20

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:

- ☐ Medical Record from (insert date) _____ to (insert date) _____
- ☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☐ Other: _____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ (Initials) I authorize _____ (Name of individual health care provider) to discuss my health information with my attorney, or a governmental agency, listed here:

_____
(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: ☐ At request of individual ☐ Other:	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

Instructions for the Use of the HIPAA-compliant Authorization Form to Release Health Information Needed for Litigation

This form is the product of a collaborative process between the New York State Office of Court Administration, representatives of the medical provider community in New York, and the bench and bar, designed to produce a standard official form that complies with the privacy requirements of the federal Health Insurance Portability and Accountability Act ("HIPAA") and its implementing regulations, to be used to authorize the release of health information needed for litigation in New York State courts. It can, however, be used more broadly than this and be used before litigation has been commenced, or whenever counsel would find it useful.

The goal was to produce a standard HIPAA-compliant official form to obviate the current disputes which often take place as to whether health information requests made in the course of litigation meet the requirements of the HIPAA Privacy Rule. It should be noted, though, that the form is optional. This form may be filled out on line and downloaded to be signed by hand, or downloaded and filled out entirely on paper.

When filing out Item 11, which requests the date or event when the authorization will expire, the person filling out the form may designate an event such as "at the conclusion of my court case" or provide a specific date amount of time, such as "3 years from this date".

If a patient seeks to authorize the release of his or her entire medical record, but only from a certain date, the first two boxes in section 9(a) should both be checked, and the relevant date inserted on the first line containing the first box.

Forensic Psychological & Psychiatric Evaluations in Criminal Defense: A Brief Review and Examination of the Practical Aspects

Dr. Norman J. Lesswing
Forensic Psychologist
Syracuse, NY

Forensic Psychological/Psychiatric Evaluations in Criminal Defense: Brief Review and Practical Aspects

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Relevant Areas for Evaluation:

- § 40.15 Not Responsible by Reason of Mental Disease or Defect (Insanity Defense):

  In any prosecution for an offense, it is an affirmative defense that when the defendant engaged in the proscribed conduct, he lacked criminal responsibility by reason of mental disease or defect. Such lack of criminal responsibility means that at the time of such conduct, as a result of mental disease or defect, he lacked substantial capacity to know or appreciate either:

  1. The nature and consequences of such conduct; or
  2. That such conduct was wrong.

  – Involves assessment of mental state at the time of the offense (MSO) that satisfies the above criteria.
  – Successful affirmative defense of Not Responsible by Reason of Mental Disease of Defect generally requires presence of severe and persisting psychosis before, during, and after the instant offense rather than a transitory emotional state.
  – Psychosis includes impaired perceptions of reality, hallucinations, delusional beliefs, and disorganized/confused thought processes.

- § 125.25(a) Extreme Emotional Disturbance:

  The defendant acted under the influence of extreme emotional disturbance for which there was a reasonable explanation or excuse, the reasonableness of which is to be determined from the viewpoint of a person in the defendant's situation under the circumstances as the defendant believed them to be.

  – Does not require a psychiatric diagnosis.

- Successful defense requires the defendant to have displayed heightened stress, perception of provocation, and temporary loss of impulse control.
- The role of sympathy for the defendant vs. the victim by the trier of fact.
- The question of providing ultimate issue opinion regarding this defense.

- Intoxication:

  - Problem with voluntariness.
  - Problem with abrogating intent.

- CPL Article 730 Examinations – Mental Disease or Defect Excluding Fitness to Proceed:

  Incapacitated person means a defendant who as a result of mental disease or defect lacks capacity to understand the proceeding against him or to assist in his own defense.

  - The determination of a defendant's capacity to assist counsel in his/her own defense can be complicated or incomplete <u>without</u> direct observational assessment by the examiner of the attorney interacting with the client regarding issues in defense of the criminal charges.

- Miranda Waivers:

  - Assessment of totality of the circumstances.
  - Role of video recordings of interrogation.
  - Need for assessment of intellectual/cognitive disability in some cases.

- Use of Forensic Psychological Evaluations in Plea Bargaining and Sentencing:

- Components of Forensic Evaluation:

  - Review of all discovery materials
  - Records, records, records!
  - Interviews with defendant
  - Collateral interviews
  - Psychological testing (if relevant)
  - Assessment of malingering

- Issue of Cultural Competence in Performing Forensic Evaluations