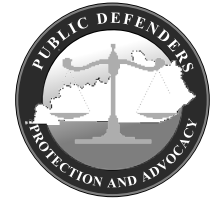

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MENTAL HEALTH MANUAL

9TH EDITION

Commonwealth of Kentucky
Department of Public Advocacy
Edward C. Monahan, Public Advocate

Introducing the DPA Mental Health Manual, 9th Edition

The purpose of the 9th Edition of DPA's Mental Health and Expert's Manual is to provide to counsel and/or trial team practical mental health information in as brief a space as possible. The team does not need to know all there is about mental health issues and the supporting science. What is important is to be able to spot the issues and then go to the true experts for guidance.

Counsel has the obligation to obtain as much information about the biopsychosocial history of the client as possible and use this wealth of information to incrementally develop the mental health evidence on behalf of the client. The information contained in the client's mental health history will allow counsel to develop theories of the case for culpability and sentencing and to choose the right professional(s) and lay people to support these theories.

This manual emphasizes several themes, including the importance of avoiding the impulse to "have the client shrunk" before counsel knows enough about the biopsychosocial history investigation. Without this history, counsel will not know what expert assistance is needed, what the expert is to do for the defense and how the expert will be used should the case go to trial. A copy of this manual can be found on DPA's Trumpet under "manuals."

I am grateful to those who have contributed to this and previous mental health manuals. Current contributors include Ed Monahan, Leo Smith, Robert Walker, Eric Drogin, Curtis Barrett, Jim Clark, Kelly Gleason, Robert Harp and Glenn McClister. Law students who provided research for this manual include Chad Hardin and William S. Daugherty, both from Brandeis Law School at the University of Louisville.

It is been a pleasure to work on this manual and I hope that it will be of help to the fine DPA employees who are providing the zealous advocacy for which DPA is well known. Thank you for the opportunity. Good verdicts to you all!

John Niland
November 2014

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Chapter 1: Identifying and Communicating with the Impaired Client

When observing indications of mental illness, counsel should not worry about assigning a particular diagnosis to the observed behavior. The focus should be more on observing the signs and then forwarding this information to the mental health consultant, "The important task is spotting notable behaviors and passing on the observation. The scientific names are provided only as an aid in understanding mental health professionals as they engage in their own jargon."¹

Counsel should not disregard what may be a sign of a disability and presume the client's behavior to be "normal" or "He seems O.K. to me" The behavior may actually be normal, but if counsel is going to make a mistake in her observation, the mistake should be in favor of the client by over reporting possible symptoms. Allow the mental health consultant to evaluate the behavior and assign a diagnosis when appropriate.²

Counsel should continually reevaluate the competency of the client throughout the case. Not only can the client's level of competency to stand trial change due to a deterioration in his condition, but the complexity of the case can increase as the case proceeds to pre-trial resolution or trial. The client's cognitive ability will likely not increase with the demands of the case.

Counsel should also consider the many stages of the proceeding that will require different levels of client competency such as competence to be arraigned, to assist with obtaining bail, to understand his rights, to intelligently waive those rights, to give a voluntary and truthful statement to an authority figure, to enter a plea and to speak to the court intelligently on his own behalf if he is to be sentenced.

When counsel detects the indicators of mental illness and/or intellectual and developmental disability in the client, it becomes important to note any time the client's behavior becomes "out of the ordinary." It sometimes becomes apparent that the indicators are often extremes of the same behavior, *i.e.*, unrealistically happy or sad, too little self-esteem or too much self-esteem, *etc.* Note them both.

This manual emphasizes the importance of the biopsychosocial history to the proper defense of the client. It also suggests a way in which to develop mental health evidence. While this topic is discussed in greater detail in Chapter 3, the individual steps are set out below:

Developing Mental Health Evidence

Counsel should:

1. Avoid the "I need to shrink my client" impulse.
2. Begin the representation with keen observation and a thorough biopsychosocial history investigation.
3. Avoid arranging for an evaluation early in the representation unless (1) client needs medical or pharmaceutical intervention; or (2) the client is psychotic and it is necessary to videotape his aberrant behavior with the aid of a mental health professional and videographer.
4. Let the data developed by the biopsychosocial history investigation dictate the team's mental health decisions.
5. Hire a consulting mental health professional to help understand the data as it is accumulated, assist with developing a working theory of the case, identify appropriate experts, assist with cross examination, *etc.*
6. Identify a working theory of the case. (This theory may change as the case develops).

¹ Deana Dorman Logan, *Learning to Observe Signs of Mental Impairment*, California Attorneys for Criminal Justice, 2001.

² Dorman, *id.*

7. Identify those mental health areas that are relevant to the working theory.
8. Identify mental health professionals who are experts in the theory areas and who can assist in evaluation of your working theory.
9. Draft and send a "referral letter" to each testifying expert identifying their role in the representation and what counsel needs them to evaluate.
10. Identify data from the investigation (including what the prosecution has) that the expert needs to make an evaluation and provide this to the testifying expert.
11. Identify conditions under which the evaluation is to be made, *e.g.*, does she need to cover facts of the crime? What testing, if any is to be done, *etc.*?
12. Use the experts but never abdicate to these experts the responsibility of developing the mental health evidence.
13. Avoid personality testing – Q: Can personality testing be dangerous? A: YES!
14. Avoid KCPC if possible. KCPC has an agenda and it is not to help the defense.
15. Limit access that KCPC and the Commonwealth have to your client. Developing your mental health evidence carefully will help do this.
16. Arrange for physical examination of the client, by an M.D. who can identify neurological deficits.
17. Do not be concerned about the diagnosis unless one is required such as is the case with IDD and FAS. Instead, focus on the client's story, not the label that the DSM-V might put on the symptoms.

Looking for Mental Health Issues

The First Steps:

- * Contact your mitigation specialist ASAP. The mitigation specialist should be visiting the client early and often, but this relationship should not be a substitute for a good relationship between counsel and the client.
- * Have all the team members who have contact with the client be on the lookout for signs of mental health problems.
- * If there is evidence of psychosis, consider videotaping the client's actions in the presence of a psychiatrist who can question the client to bring out the full extent of the psychosis. Counsel and the psychiatrist should have a clear understanding of the scope of the questioning, the topics to cover and those to be avoided, if any.
- * Medication—consider the appointment of a guardian if warranted. Advantages include: (1) you have the determination of impairment in a less adversarial proceeding; (2) the state has to deal with that finding throughout; (3) the guardian is entitled to sit at counsel table with the client.
- * Involuntary medication: See *Sell v. United States* 539 U.S. 166 (2003) (1) medically appropriate; (2) must not impair fair trial (no "zombie"); (3) least intrusive/debilitating to make accused competent. Just because the government wants to try the case is not sufficient for forced medication.

Observing Indicators of and Establishing Mental Health Problems

- * Observe the way the client walks, talks, reacts, responds *etc.* Does he shuffle in and out of the interview room as if he was wearing shackles?
- * What medications are prescribed for him now and in the past? Is he compliant with meds or is he "cheeking"?

- * Determine what if any medication you want the client to have—do we want the jury to see him as he was when he is alleged to have committed the crime or confessed, or do we want him to be as symptom free as meds can make him? Will a guardian appointed for the client help to eliminate counsel being in a conflict situation?
- * Get copies of the intake paperwork ASAP and interview those that made the arrest and those present when he was brought into jail and booked. How did he behave/look, what did he say? What did the jailors do in response? Did jail personnel use descriptive language that indicated that they thought the client was mentally ill?
- * Does he fail to show remorse? Consider that the apparent lack of remorse is due to his inability to tolerate the pain that comes with acceptance of responsibility. A juvenile client with a traumatic background may not be able to show emotion. An emotionless appearance was his way to cope in a dysfunctional family.
- * Denial? The client may not be in denial but may have a neurological deficit that reduces cognitive ability.
- * Does he show signs of, or is there an indication in his records that he suffers from ADD or ADHD such that he will have a hard time following what is going on in trial?
- * A mentally disordered client will often have poor insight (“I am ok, you are the one with the problem”). This may not be denial, but a neurological/cognitive deficit or symptom of brain dysfunction. Working with this client takes constant effort. Ignoring the symptom will not make the problems go away.

Mental Illness and Intellectual Developmental Disorder (IDD)

- * These are two different conditions and they should not be confused with each other. However, those with such disabilities are more likely to suffer from a mental illness also.
- * Consider a guardianship of the person that gets you an “incapacitated” finding early and helps to control the medication of the client. We have an ethical obligation to seek a guardianship for a client who is not competent. Also consider protective orders as ethically required in our zealous advocacy of the client.
- * Consider extending the protection afforded by the Atkins V. Virginia (prohibiting the death penalty for the “mentally retarded”) decision to the mentally ill, because the mentally ill are proportionately no more responsible for their actions than a person who suffers from IDD, and the person with Fetal Alcohol Syndrome suffers from frontal lobe damage (impaired executive function) is just as impaired as one who suffers from IDD.

Indicators of Mental Illness

Reality Confusion

- * Seeing things that are not there, voices;
- * Inappropriate giggling, nodding, speaking;
- * Everyone hates/loves me/is out to get me or irrational fears not related to genuine safety issues;
- * Inability to recognize people he should know;
- * False perception of smells and tastes;
- * Will not leave cell to visit with trial team.

Speech/Language

- * Manner of speech (very long answers, long answer/no information, changes idea in midstream, vague answers);
- * Inappropriate repetition of words, mixing up words or phrases, speaking “foreign languages”, “made up” words that are not accepted slang;

- * Pressured speech, talks too fast, interrupts inappropriately or speech is delayed or interrupted;
- * Mispronounced words, monotone, very formal;
- * Constant repeating of phrases that they hear (echolalia);
- * Writing very small or very large;
- * Provides “half answers”;
- * Changes subject in middle of a sentence when easily distracted.

Memory/Attention

- * Difficulty in remembering childhood;
- * Poor short term memory;
- * Extraordinary recall;
- * Erratic attention problem (ADD or other learning disabilities).
- * Problems concentrating or loses train of thought.

Medical Condition

- * Hypochondria, self injury/mutilation, problems sleeping, problems eating;
- * Headaches, ringing in ears may indicate a neurological deficit;
- * Suspicious physical wounds;
- * Changes in eating habits;
- * Blurred vision;
- * Ringing in ears;
- * Dizziness and/or nausea.

Emotional Tone

- * Anxious, suspicious, depressed, emotionally labile (dramatic emotional/mood swings);
- * Flat affect (emotionally dead);
- * Love you one minute, hate you the next;
- * Inappropriate laughter;
- * Overly pessimistic about his current situation;
- * Self loathing;
- * Client has “given up”, “has no hope” for the future.

Poor Insight

- * Denial of problems;
- * Denial of need for medication;
- * Poor self identity—“The jurors need to tell me that I was right (in committing the crime)”;
- * Either low self esteem or exaggerated opinion of self.

Physical Indicators

- * Agitated actions/ twitching;
- * Hyper vigilant (always on edge, eyes darting around, anticipating danger);
- * Inappropriate gate when walking, shuffling of feet not attributable to restraints;
- * Poor motor coordination.

Social Interaction

- * Inappropriate interaction with others (hugging, affection, advances, assaultive behavior);
- * Inappropriate response to social cues;
- * Uncomfortable sexual interaction with team members of opposite sex;
- * How does the client structure his free time in jail? Does he get along with others?

Working with the Challenging Client

- Be empathetic (without always agreeing with him) when he tells you something that may sound bizarre *e.g.*, “That (his reason) would certainly explain it” or “That may make a lot of sense” or “I can understand why you feel that way”.
- Give him some control - “How would you like things to be?”
- Do not patronize the client nor treat him like a child even if you think his true mental age is very low.
- If the client is distrustful, accept the lack of trust with the goal of changing the client’s attitude through actions, not just words (litigation of motions and weekend visits).
- Visit the client over the weekend and on holidays. This will raise counsel in the eyes of the client, and perhaps more importantly, raise the stature of the client in the eyes of his cell mates.
- Never appear to be unprepared or unsupportive of the client.
- Be realistic – “What are the chances of that happening?” “Why?”
- Deal with the client on his level—don’t expect him to rise to your level.
- Don’t give up. You are the adult in the relationship,
- Counsel should assume that the client will lie at some time(s) during the representation. Counsel should calmly accept this as a natural consequence of the client’s predicament rather than a personal insult directed towards counsel. It is situational, not personal.
- Never tell the client that they are “wrong” or that they are not feeling what they claim to feel. Instead, counsel may:
 - Acknowledge the client’s current feelings.
 - Point out that counsel has worked with many clients in the same situation who felt the same way.
 - “I have been able to help others who have felt the same way.”
 - Acknowledge that the client can see things differently than counsel.
 - Review the issues between counsel and client – without arguing – suggesting that the client or counsel will work together and may come to view things differently at a later time.
 - Assure the client that the issues will be revisited at a later time when client and counsel have both had a chance to consider.¹
 - Counsel may become frustrated with a client who has an excessively negative view of himself,

his current situation and his prospects for the future. While this pessimistic outlook may be entirely justified, the client’s ability to cooperate with his counsel may be impaired. The client’s negative view of himself, his current situation and his prospects for the future form a “cognitive triad” that is recognized by mental health experts. This negativity should alert counsel to the possibility that the client is clinically depressed and in need of treatment.²

- Accept collect calls from the jail in reasonable numbers and at reasonable times. Even if you are not in the office, prepare someone on your staff to talk briefly about non-confidential and non privileged matters.
- Read *I Am Not Sick, I Don’t Need Help!*, by Dr. Xavier Amador. Consider using the L.E.A.P. technique developed by Dr. Amador. With the L.E.A.P technique, counsel will Listen to what the client has to say, will Empathize with the client’s difficult situation, will Agree on a common goal that is in the best interest of the client and Partner together to achieve that goal.

The L.E.A.P. technique utilizes the act of “reflective listening”. This involves listening to everything the client says and then repeating it back to demonstrate you understand what you heard. *i.e.*, “What I hear you saying is:” Repeat back ALL that you hear, even the irrational parts of the client’s story.

The next step involves empathizing with the client’s feelings, goals and frustrations. If the client asks if you believe her, try to delay giving that opinion – “let’s talk about that later.” If you can’t delay, consider apologizing for any hurtful or disappointing effect your words might have. Acknowledge that you can be wrong, but for now you can agree to disagree.

Agree on a common goal such as improved jail conditions, perhaps different medication, a dismissal or a plea. If you cannot agree on goals, agree on what should be avoided. Partner with the client to achieve the agreed upon goal. It may be something as simple as partnering to have more team members visit him, if he will take his medication or improve his behavior in the jail.

Practice Note: The biopsychosocial history is critical in helping the team find indicators of IDD and proving an onset of the disability prior to age 18 or during the developmental period. However, just because the client may not have an I.Q. low enough to satisfy the definition of IDD does not mean the client is not impaired. A low I.Q. will still impact the way in which the client views the world and relates to the criminal justice system. Counsel must be able to paint the true picture of the client’s cognitive functioning and how it has impacted all facets of the prosecution’s case against the client.

If the client’s school and medical records show that he has an IQ of 70 or less, plus or minus 5; onset prior to 18 years of age and impaired adaptive functioning in areas of social skills, responsibility, communication, daily living skills, personal independence and self-sufficiency he likely suffers from IDD and all its associated problems. The same condition with post-18 onset is likely traumatic brain injury (dementia).

¹ Eric Drogin, *Breaking Through: Communicating and Collaborating with the Mentally Ill Defendant*, Kentucky Department of Public Advocacy Mental Health & Experts Manual, 2001.

² Drogin, *id.* at 1.

If the client has been exposed to prenatal alcohol, he may suffer the same level of frontal lobe damage as one who is IDD, but still have an I.Q. above the mandated level. Counsel should seek to extend the protections of Atkins v. Virginia to this client as he functions no better than someone with mild IDD.

Indicators of Intellectual Developmental Disorder (Also known as Intellectual Disability)

- the client acts younger than actual age;
- when in the free world he hangs out with a younger crowd;
- involved in sexual relationships with partners who are much younger;
- low frustration tolerance/poor impulse control;
- poor memory—if given the chance will choose the option they heard last;
- problems reading, writing, or telling time;
- difficulty focusing and is easily distracted;
- awkward or poor motor coordination;
- inability to count change in simple transactions;
- no driver's license or someone helped him with the test;
- someone else has always cooked, cleaned and taken care of basics;
- limited vocabulary for age level;
- difficulty understanding/answering questions;
- can't communicate events clearly in own words;
- inability to comprehend seriousness of situation and consequences;
- easily led or persuaded by others;
- naive eagerness to please which may lead to false confession;
- Have the client tell you the meaning of what you have told him;
- Ask him to read the indictment and see how accurately he does so;
- communicate with other members of the team about their observations of the client;
- Carefully review the records obtained by the mitigation specialist.
- Give the client a simple problem to solve, *e.g.*, If I buy a coke for 45 cents and give the clerk \$1.00, what coins should I received in change?
- If the client begins to deteriorate while awaiting trial, have your mitigation specialist talk to him on a regular basis.

The Client's Work History

Some people with IDD have work histories that, at first glance, would suggest that "he can hold a job so he is not a person with IDD". A characteristic of this work schedule is likely to be a series of low wage jobs of short duration. The client is energetic and wants to work and "be normal". He does not look disabled so is hired at the low end of the wage scale. His low I.Q. and adaptive impairments catch up with his desire sooner or later and is fired. He can get a job but he cannot hold a job, thus a long series of short term employment locations.

The Client and False Confessions

Those with IDD want to make others happy and this is particularly true of those in law enforcement. One way to ingratiate one's self with those in law enforcement is to tell them what they want to hear. The client's lack

of cognition will make it difficult to understand Miranda Warnings and to knowingly waive their rights. People with IDD are particularly vulnerable to the Inbau & Reid Method of Interrogation used by many police and sheriff's departments.

Observe the client's facial features for indication of Fetal Alcohol Syndrome

These can include:

- * short eye lid slits; a fold of skin next to the nose that covers the inside part of the eye;
- * short, flattened nose; undeveloped groove between the bottom of the nose and top lip;
- * thin upper lip, crossed eyes, drooping eye lids, small chin, long arms;
- * short, malformed ears, a small head or small jaw;
- * Just because the client has no facial signs of FAS, do not assume that there was no fetal alcohol exposure.

What if there are few or no indications?

- One cannot assume the client is not intellectually and developmentally disabled because he looks "normal."
- The client has spent his whole life learning how to appear to be "normal" and unimpaired. He will do the same with you.
- The notion of having the disability is offensive to those who are disabled and they will hide symptoms with a "veil of competence".
- The client will claim to have "learning disability" as this is how it was rationalized to him, usually in the school that did not want to accommodate the client's special needs because of the cost.
- "I have always been kinda slow" is something the client may say.
- The family will often use similar language, such as "he's not the sharpest knife in the drawer", etc. The family may also be embarrassed by the IDD.

Communicating with a Client who has Intellectual Developmental Disorder

- Keep the surroundings quiet and free from distraction.
 - Make eye contact before speaking and say the client's name.
 - Use simple language, repeat points, speak slowly and clearly, use short sentences.
 - Clearly identify yourself, explain why you are there.
 - Give one direction or ask one question at a time.
 - Don't limit the client's possible response to "yes" or "no" – ask open ended questions.
- Be patient for responses. Ask him to "tell me a time when...." not "were you ever....?" The "event" you hear in response may have never happened but you are more likely to get an accurate response.
- Avoid asking "do you understand?" He will generally just say "yes."
 - Ask the client to repeat back concepts, in his own words, to assure understanding.
 - Avoid suggesting what you want the answer to be as the client will want to please you.
 - Treat adults as adults – the client will not react well to patronizing attitude.
 - One of the safest ways of communicating with people with IDD is to use simple words in open-ended questions. Always ask questions that require them to explain their reasoning. If possible, have a social worker or an individual who is close to the defendant assist him or

her in interpreting what is being said and asked to ensure that the defendant understands the process.¹

Practice note: If counsel must go to the effort of having a social worker or someone close to the defendant explain the process to him, that should suggest to counsel that the client, because of his permanent disability, lacks the capacity to appreciate the nature and consequences of the proceeding against him or her or to participate rationally in his or her defense. KRS 504.060(4), RCr 8.06.

Challenging Prior Convictions

Counsel may be appointed to a person who, up until the present, has not been considered to be a person with IDD. The client may have prior convictions that now categorize him as a habitual offender. Consider using a writ of habeas corpus to challenge the validity of each of the prior convictions, especially if the final convictions occurred because of the client's disability. Following this approach will take time, but will provide the client with the aggressive advocacy to which he has been entitled all along.

Humanizing the Challenging Client

1. When referring to someone who is impaired, always lead with the proper name of the person and/or the word "person" followed by the condition itself. Do not refer to the client as "My intellectually disabled client" or "Johnny is retarded" or say "those IDD disabled people". Instead say, "Johnny is a person with intellectual and developmental disabilities". My client is a person with IDD" or "the people with IDD". People who are impaired or disabled are people first.

2. If co-counsel, upon returning from a jail visit with the client, remarks "[O]ur client is a jerk" or "Our client is an a-hole," lead counsel should suggest that a better, and more humanizing expression, might be "Our client is ACTING like a jerk" or "Our client is ACTING like an a-hole." None of us would like to be permanently labeled by our worst behavior. Counsel should then ask co-counsel "Why is he acting that way?"

Practice Note: When referring to the client's behavior or characteristics, try to focus on the "why" rather than the behavior itself. For example, the mitigation specialist might say "Even the client's family dislikes him". The very next question should be "Why?" Can this fact, if true, tell us something about the client or does it say more about the family? Either way, the trial team needs to find the answer to the question "Why?" If the lawyer says, "The client does not trust me", the very next inquiry must be "Why?" What would a thorough biopsychosocial history tell us about why the client does not trust counsel (or men, or people in authority or counsel himself). Is the client's lack of trust an indicator of a mental illness or does it suggest a problem in the way counsel is interacting with the client?

3. The client may not have an I.Q. low enough to meet the test for IDD, but if his intellectual functioning is below normal, life is more difficult for him. The good things he does, in spite of his limitations, are more significant and mitigating.

4. Many of our clients commit crimes that are impulsive in nature. The offenses are not planned nor fully thought through; they are "spur of the moment" acts. The frontal lobe of the brain that serves as a check and balance on the impulsive behavior is not developed until the mid 20's. Even if the client is past the mid-20's in age, the frontal lobe can be damaged by a number of insults before and after birth. These insults can reduce the brain's ability to mediate the impulsive behavior.

5. Consider the implication of the client's impairments, conditions, experiences, disabilities, illnesses and ailments collectively rather than individually. Their impact is more significant when taken together.

6. Counsel and the team have only to deal with the "enemy" posed by the client's mental illness. The client has many enemies challenging him, and he may perceive his lawyers as being among them.

7. Always remember that the client did not go through the cafeteria of life choosing his disabilities, impairments and disorders. In fact, by the time the client began making life decisions on his own, the way in which he viewed the world has been formed by decisions (for better or worse) made by other people. The client did not choose:

- to be born;
- his ancestors and their qualities;
- his genetics and predispositions;
- his brain chemistry;
- to be given birth by his particular birth mother;
- to be fathered by his natural father;
- whether or not mom drank or drugged during gestation;
- whether or not mom received pre-natal care;
- where he was born and under what circumstances – good or bad;
- his looks – both good and bad;
- his personality;
- his birth order;
- his level of cognitive functioning and speed at which his brain develops;
- his siblings;
- how he and siblings were treated as children;
- how mom was treated by significant males in her life;
- his level of nutrition;
- whether or not his needs were met during his first 3 years of life;
- often his ability to empathize or to show remorse;
- cognitive functioning, education, skills and attributes of caretakers;
- caretakers' abilities to care for an infant and child;
- where family lived, why and how often family moved;
- family income, if any, and opportunities denied because of poverty;
- ability of caretakers to provide moral guidance as role models;
- attitude of caretakers towards the value of an education;
- quality of neighborhoods – level of violence- quantity of role models;
- where he went to school;
- level of abuse and neglect during childhood and early adolescence;
- how his parents and caretakers were raised;
- the challenges of experiencing his mental illness, intellectual and developmental disabilities and annoying personality disorders that will influence his entire life. However, those who made the bad decisions are usually not around to accept their share of the blame and consequences.

¹ Drogin, *id* at p. 3, citing Denis Keyes, William Edwards & Timothy Dering, *Mitigating Mental retardation in Capital Cases: Finding the "Invisible" Defendant*, 22 Mental & Physical Disability Law Rep. 529-539 at 529 (1998).

8. "Our clients come to us with much baggage. It is our responsibility to patiently and thoroughly go through it all."²

Conclusion

Lead counsel and her team members will not possess the same level of education, training and experience as the mental health experts the team will rely upon. However, the team can learn to observe those indicators

of a client's mental problems and pass these on to the experts who can assign a label, if necessary. The opportunity, and ability to observe, is a critical element in the successful representation of the client.

Once the mental problems are identified, counsel can learn techniques to communicate with, and work with the client, towards a successful resolution of the case. During this time, the team must humanize the client in their own eyes; otherwise it will be impossible to do so for the judge, jury and prosecution.

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Chapter 2: Kentucky Law Digest on Mental Health Issues: Competency, Criminal Responsibility, GBMI, IDD, EED, Experts, Ethical Considerations

I. COMPETENCY TO STAND TRIAL (Mental State at Time of Trial)

A. Definition

1. RCr 8.06 - If upon arraignment or during the proceedings there are reasonable grounds to believe that the defendant lacks the capacity to appreciate the nature and consequences of the proceedings against him, or to participate rationally in his defense, all proceedings shall be postponed until the issue of incapacity is determined as provided by KRS 504.100. Pursuant to RCr 8.06, all proceedings (except grand jury proceedings) are to be postponed until the determination of competency is made. *Nelson v. Shake*, 82 S.W.3d 914 (Ky. 2002).
2. KRS 504.060(4) - "Incompetency to stand trial" means that, as a result of mental condition, lack of capacity to appreciate the nature and consequences of the proceedings against one or to participate rationally in one's own defense.
3. "The nature of the inquiry in a competency proceeding is: (1) whether the defendant is sufficiently coherent to provide his counsel with information necessary or relevant to constructing a defense; (2) whether he is able to comprehend the significance of the trial and his relation to it. The defendant must have an ability to confer intelligently, to testify coherently and to follow the evidence presented. It is necessary that the defendant have a rational as well as a factual understanding of the proceedings." *Commonwealth v. Wooten*, 269 S.W. 3d 857 (Ky. 2008), citing *Bishop*, 118 S.W. 3d at 163.
4. Consider the following list from the Group for the Advancement of Psychiatry: Competency to Stand Trial may involve the ability of a defendant to:
 - a. understand his current legal situation;
 - b. understand the charges against him;
 - c. understand the facts relevant to his case;
 - d. understand the legal issues and procedures in his case;
 - e. understand legal defenses available in his behalf;
 - f. understand the dispositions, pleas and penalties possible;
 - g. appraise the likely outcomes - this includes understanding a good offer
 - h. appraise the roles of defense counsel, the prosecuting attorney, the judge,
 - i. the jury, the witnesses and the defendant;
 - j. to identify and locate witnesses;
 - k. to relate to defense counsel;
 - l. trust and communicate relevantly with his counsel;
 - m. comprehend instructions and advice;
 - n. make decisions after receiving advice;
 - o. maintain a collaborative relationship with his counsel;
 - p. follow testimony for contradictions and errors;
 - q. testify relevantly and be cross-examined if necessary;

- r. challenge prosecution witnesses;
- s. tolerate stress at the trial and while awaiting trial;
- t. refrain from irrational and unmanageable behavior during the trial;
- u. disclose pertinent facts surrounding the alleged offense;
- v. protect himself and to utilize the legal safeguards available to him.

5. *A finding of a lack of competency was upheld where two experts acknowledged that defendant in light of her mild mental retardation would have difficulty participating rationally in her own defense in light of her problems processing information, e.g., "she would not know what questions to ask and could not recognize a lie and her cognitive deficits would interfere with her ability to realistically consider the nature and defenses available to her and the potential outcomes of trial". Commonwealth v. Wooten, id.*
6. Court's assessment as to whether defendant's request to represent himself had been competent and intelligent is whether defendant's competently waives his right to representation not whether he was actually competent to represent himself. *Commonwealth v. Berry*, 184 S.W.3d 63 (Ky. 2005).
7. *Mills v. Commonwealth*, 170 S.W. 3d 310 (Ky. 2005), *overruled on other grounds by Leonard v. Commonwealth*, 279 S.W.3d 151 (Ky. 2009). Trial court, in finding defendant to be competent to stand trial, relied on I.Q. score of 76. This case is an example of how important it is to investigate and litigate those constructs such as the Flynn Effect which may impact the actual I.Q. score. Please refer to the Intellectual and Developmental Disability Section of this manual for more information. Be aware of *Bowling v. Commonwealth*, 163 S.W.3d 361 (Ky. 2005) which held that the 8th Amendment was not implicated even though the statute defining mental retardation (IDD) did not reference the Flynn Effect and the five-point measurement of error.

B. Court's Right to Examination of Defendant

1. KRS 504.100(1) - If upon arraignment, or during any stage of the proceedings, the court has reasonable grounds to believe the defendant is incompetent to stand trial, the court shall appoint at least one (1) psychologist or psychiatrist to examine, treat and report on the defendant's mental condition. Court can order competency evaluation, *sua sponte*, at any time if reasonable grounds exist. *Johnson v. Commonwealth*, 17 S.W. 3d 109 (Ky. 2000).
2. Unlike criminal responsibility, there is no right of a prosecutor to have a defendant examined when competency to stand trial becomes an issue. *Bishop v. Caudill*, 118 S.W.3d 159 (Ky. 2003) and *Commonwealth v. Wooten*, 269 S.W. 3d 793 (Ky. 2007). *Hensley v. Commonwealth*, 305 S.W. 3d 434 (Ky. 2010).
3. Defendant's right to have a defense psychologist or psychiatrist participate in the examination: KRS 504.080(5).

C. Caselaw: Make sure that in your motion practice, you are federalizing the competency issue and making the record as to the statutory right and rights as protected by both the state and federal constitutions.

1. *Commonwealth v. Strickland*, 375 S.W.2d 701 (Ky. 1964). "[T]he test is whether he has substantial capacity to comprehend the nature and consequences of the proceeding

- pending against him and to participate rationally in his defense." *Id.* at 703. See also *Mattingly v. Commonwealth*, 878 S.W.2d 797 (Ky.App. 1993), *Osborne v. Commonwealth*, 407 S.W.2d 406 (Ky. 1966) and *Gilbert v. Commonwealth*, 575 S.W.2d 455 (Ky. 1978), reiterating the test for competency to stand trial.
2. *Dusky v. United States*, 362 U.S. 480, 80 S.Ct. 788 (1960). It is not sufficient that a defendant is oriented to time and place and has some recollection of events. The test is "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." 362 U.S. at 402, 80 S.Ct. at 789.
 3. *Pate v. Robinson*, 383 U.S. 375, 86 S.Ct. 836 (1966). Constitutional rights violated by the failure to conduct an adequate hearing on defendant's competence to stand trial.
 4. *Drope v. Missouri*, 420 U.S. 162, 95 S.Ct. 896, 43 L.Ed.2d 103 (1975). "It has long been accepted that a person whose mental condition is such that he lacks the capacity to understand the nature and object of the proceedings against him, to consult with counsel, and to assist in preparing his defense may not be subjected to a trial." 420 U.S. at 171, 95 S.Ct. at 903. The Court warned trial courts to be alert to indications that during trial a defendant's condition has changed. See also *Godinez v. Moran*, 509 U.S. 389, 113 S.Ct. 2680, 125 L.Ed.2d 321 (1993). A criminal defendant may not be tried unless he is competent.
 5. *Medina v. California*, 505 U.S. 437, 112 S.Ct. 2572, 120 L.Ed.2d 353 (1992). "It is well-established that the Due Process Clause of the Fourteenth Amendment prohibits the criminal prosecution of a defendant who is not competent to stand trial. The issue in this case is whether the Due Process Clause permits a State to require a defendant who alleges incompetence to stand trial to bear the burden of proving so by a preponderance of the evidence." 112 S.Ct. at 2574. Statute placing burden of proof on issue of incompetency to stand trial in criminal case upon defendant did not violate defendant's federal procedural due process rights. Furthermore, statute providing that defendants are presumed to be competent to stand trial did not violate defendant's federal procedural due process rights.
 6. *Cooper v. Oklahoma*, 517 U.S. 348, 116 S.Ct. 1373, 134 L.Ed.2d 498 (1996). Statute, which provided defendant was presumed to be competent to stand trial unless defendant proved incompetent by clear and convincing evidence, was held to violate right to due process under Fourteenth Amendment.
 7. *Lear v. Commonwealth*, 884 S.W.2d 657 (Ky. 1994). Trial had been continued three times. Defendant moved to continue stating that on the morning of trial he was sedated and claimed incompetent to stand trial. The claim was found to have no merit. "Reasonable grounds must be called to the attention of the trial court or must be so obvious that the trial judge cannot fail to be aware of them." *Id.* at 659.
 8. *Gabbard v. Commonwealth*, 887 S.W.2d 547 (Ky. 1994). The issues in this case related to the proper procedures in a trial court's determination of a defendant's competency to stand trial. "[T]he presumption that a defendant is competent to stand trial disappears when there are reasonable grounds to hold a competency hearing." *Id.* at 551. "[T]he Commonwealth cannot rely on Dr. Dane's report without giving Gabbard the right to cross-examine him." *Id.* A conditional plea reserving the right to appeal under RCr 8.09 can be used to review further a finding of competent to stand trial.
 9. A competency hearing is mandatory once the court ordered report is filed. Federal constitutional right to hearing attached once "substantial evidence of competency" is in the record. Client would then have both a constitutional and statutory right to the hearing. *Padgett v. Commonwealth*, 312 S.W.3d 336 (Ky. 2010). A finding as to competency must be reached unless properly waived. *Quarles v. Commonwealth*, 142 S.W.3d 73 (Ky. 2004). However, be aware of *Graves v. Commonwealth*, 283 S.W. 3d 252 (Ky. App 2005) where court backed off of this.
 10. Motion for New Trial based on lack of competency must be filed within 5 days after verdict. *Johnson v. Commonwealth*, 17 S.W. 3d 109 (Ky. 2000).
 11. Defendant not entitled to funds for mental health expert prior to evaluation at KCPC. *Jacobs v. Commonwealth*, 58 S.W. 3d 435 (Ky. 2001). [this needs to be challenged]
 12. See ABA Mental Health, IDD and Criminal Justice Standards for best practices. This resource can be found on line. It is dated but still has some good suggestions.
 13. Retrospective competency hearing is permissible when a formal competency hearing is not held during trial. *Johnson v. Commonwealth*, 103 S.W.3d 687 (Ky. 8003). Relevant factors in retrospective competency litigation. Mental health records at time of trial are critical as funds may be denied for current evaluation as not relevant. *Thompson v. Commonwealth*, 147 S.W.3d. 22, (Ky. 2004).
 14. Counsel should be sure that client is competent to be sentenced as an improper (and usually inflammatory) statement to the court by an impaired client can be disastrous. See *Hale v. Commonwealth*, 156 S.W. 3d 274 (Ky. 2005) for authority for court to make separate determination of competency to be sentenced.
 15. Proof by preponderance of evidence applied to both competency to stand trial and competency to enter a plea in non-death cases. *Chapman v. Commonwealth*, 265 S.W. 3d 156 (Ky. 2007).
- ## II. CRIMINAL RESPONSIBILITY (Mental State at Time of Offense)
- ### A. Definition
1. KRS 504.020
 - a. A person is not responsible for criminal conduct if at the time of such conduct, as a result of mental illness or intellectual disability, he lacks substantial capacity either to appreciate the criminality of his conduct or to conform his conduct to the requirements of law.
 - b. As used in this chapter, the term "mental illness or intellectual disability" does not include an abnormality manifested only by repeated criminal or otherwise antisocial conduct.
 - c. A defendant may prove mental illness or intellectual disability, as used in this section, in exculpation of criminal conduct.
 2. KRS 504.060(5) - "Insanity" means, as a result of mental condition, lack of substantial capacity either to appreciate the criminality of one's conduct or to conform one's conduct to the requirements of law.

B. Notice Requirements of Expert Testimony to Prosecutor and Court

1. Experts in General. Effective January 1, 2011, RCr 7.24 was amended to require the defense to disclose “a written summary of any expert testimony that the defense intends to introduce at trial. This summary must identify the witness and describe that witness’s opinions, the bases and reasons for those opinions, and the witness’s qualifications.” This rule does not cover witnesses the defense does not intend to call to the stand. This a *reciprocal* obligation not triggered until the defense has requested the same from the Commonwealth. If the defense does not first request this information from the Commonwealth, the obligation never comes to bear. Beware of standard discovery form orders routinely issued in many courts which impose blanket *mutual* discovery obligations on the parties and thus “infringe[s] on the election given the defendant under RCr 7.24(2).” *Penman v. Commonwealth*, 194 S.W.3d 237, 249 (Ky. 2006). If the defense chooses not to reveal its expert and has therefore decided not to ask the Commonwealth to reveal theirs under the rule, then it should make clear to the court that it wishes to follow RCr 7.24 as written.
2. RCr 8.07 - This new rule of criminal procedure effective January 1, 2013, introduced significant changes in the obligations of defense counsel in cases involving mental health issues.

C. Issues and Problems Surrounding Defense Notice Requirements and Compulsory Examination of the Defendant

RCr 7.24 used to include the procedures and notice requirements regarding mental health defenses. Effective January 1, 2013 that material was taken out of RCr 7.24, expanded, and put into a new rule, RCr 8.07. The new rule retains the idea of notice requirements found in the earlier version of RCr 7.24, but enhances those requirements in at least two important ways: (1) there is a new notice requirement regarding the purpose for the evidence. The defendant must disclose if the evidence will go to guilt or punishment or both. (2) The notice requirement for both insanity defenses and other mental health evidence was lengthened from 20 days to 90 days. The rule retains from RCr 7.24 the ability of the court to order the defendant to be examined, to order the defendant’s submission to an examination, and to order the exclusion of the defense evidence if the defendant does not cooperate.

Meanwhile KRS 504.070(1) retains the 20 day notice requirement (insanity and mental illness), KRS 532.135 retains a 30 day notice requirement (intellectual disability) and KRS 500.070 still prohibits a court from requiring “notice of a defense before trial time.” With regard to the conflict between these statutes and the criminal rule, two Constitutional questions arise. The first is a question regarding the separation of powers. Section 116 of the Kentucky Constitution authorizes the court to enact rules of procedure, but “[I]t would be a violation of separation of powers for this Court to exercise power properly belonging to another branch, e.g., adopting substantive law under the guise of enacting a procedural rule since the enactment of substantive law is the exclusive prerogative of the Legislature under our Constitution.” *Elk Horn Coal Corporation v. Cheyenne Resources, Inc.*, 163 S.W.3d 408, 423 (Ky.2005). Presumably this would not have been a problem, or been less of a problem, if the court had enacted a version of RCr 8.07 which kept the 20 day notice requirement contained in the statute. Requiring the defense to disclose the purpose of the evidence is a problem in any event.

The next, and more important, question becomes whether the rights given to a defendant under the Bill of Rights in the Kentucky Constitution may be superseded by a court’s power to impose procedures. KRS 500.070(2) says simply, “No court can require notice of a defense prior to trial time.” This should be understood as a statutory extension of the substantive Constitutional right of a defendant to be free from the compelled disclosure of defenses. Section 11 of the Kentucky Constitution Bill of Rights arguably prohibits a court from requiring any response to a criminal charge from a defendant other than the entry of a plea. In *L&N Rail Co. v. Commonwealth*, 66 S.W. 505 (1902), a case decided 11 years after the adoption of the current Constitution, the trial court refused to allow the defendant, charged with the criminal offense of allowing gambling on the premises, to enter a plea of “not guilty” and instead ordered the defendant to answer the specific allegations found in the criminal petition which had been filed in the case. The Court of Appeals, which was then Kentucky’s highest court, relying on the “evidence against” language in the second sentence of Section 11, held that,

“The defendant, under the constitution, cannot be required to give evidence against himself. He cannot, therefore, be examined by the state, against his will, as to the truth of the charges against him. To require him to answer the petition, and specifically admit or deny its allegations, is indirectly to make him give evidence against himself; for his admission of an allegation in the petition would dispense with proof of it by the state. Whether therefore, the prosecution is by penal action or indictment, a plea of not guilty, under the constitution, is the only answer that the defendant may be required to file, and puts in issue all the allegations of the petition.” *L&N*, at 507.

Section 26, the last section of the Kentucky Bill of Rights, says simply, “To guard against transgression of the high powers which we have delegated, We Declare that everything in this Bill of Rights is excepted out of the general powers of government, and shall forever remain inviolate; and all laws contrary thereto, or contrary to this Constitution, shall be void.” The power to regulate procedure in the Court of Justice is a “general power of government.” *Ex Parte Auditor of Public Accounts*, 609 S.W.2d 682, 684 (Ky. 1980).

There is also still the question, which was an issue under the previous version of RCr 7.24 as well, of ordering a defendant to cooperate with an examiner who is very likely to testify against him. While KRS 504.110(1) allows the court to order a defendant found to be incompetent to submit to treatment, neither KRS 504.070 nor 504.080 allow a court to order a defendant to submit to an examination. Under these statutes, if the defense chose not to cooperate with the Commonwealth’s expert, the Commonwealth’s expert could presumably be called to testify that the defendant would not cooperate. The defense had the option of deciding whether to adopt that tactic. In contrast, RCr 8.07(4)(a), like RCr 7.24(C) before it, allows a court to exclude defense expert evidence if the defendant fails to submit to a court-ordered examination. Section 11 of the Kentucky Constitution forbids compelling a defendant to give evidence against himself. See *L&N*, *supra*. This is, of course, also closely associated with the right to remain silent under the Fifth Amendment of the United States Constitution.

When appropriate, defense counsel should object to following the rule of procedure on Constitutional grounds and ask the court to make a ruling. When and if the court rules that it will

follow the rule, then defense counsel can comply without compromising the issue or endangering its own expert testimony. Counsel should put on the record that it is complying with the requirements of the rule only because the court has overruled the objection.

D. Right to Observe Commonwealth's Examination of the Defendant

1. *Cain v. Abramson*, 220 S.W. 3d 276 (Ky. 2007) while defendant had statutory right to procure his own expert to observe the court-ordered examination, exclusion of counsel did not violate defendant's Sixth Amendment right to counsel.

E. Burden of Proof

1. KRS 504.020(3) - "A defendant may prove mental illness or intellectual disability, as used in this section, in exculpation of criminal conduct."
2. *Tunget v. Commonwealth*, 303 Ky. 834, 198 S.W.2d 785, 788 (1947). Defendant has to "prove by a preponderance of the evidence."
3. "Preponderance" should not be defined in the instructions. However, "counsel [is] free to argue the preponderance burden to the jury." *Brown v. Commonwealth*, Ky., 934 S.W.2d 242, 247 (1996).
4. Introduction of proof of insanity by defense does not shift burden to prosecution to prove the defendant was sane, but, defense is then entitled to jury instruction on the issue. See *Wiseman v. Commonwealth*, 587 S.W.2d 235 (Ky. 1979), and *Edwards v. Commonwealth*, 554 S.W.2d 380 (Ky. 1977), and *Cannon v. Commonwealth*, 777 S.W.2d 591, 594 (Ky. 1989).

F. Instructions - RCr 9.55 states: *On request of either party* in a trial by jury of the issue of absence of criminal responsibility for criminal conduct, the court *shall* instruct the jury at the guilt/innocence phase as to the dispositional provisions applicable to the defendant if the jury returns a verdict of not criminally responsible by reason of mental illness *or* retardation, *or* guilty but mentally ill (emphasis added). *Benjamin v. Commonwealth*, , 266 S.W. 3d 775 (Ky. 2008) holds that better practice in murder prosecution involving intentional and wanton mental states as alternative theories of culpability, is to either set forth the separate theories on separate verdict forms or, when a combination instruction is given, require the jury to specify on the verdict upon which theory they find. (Query: Can counsel use the authority of this case to get more specific jury findings in other areas such as party type liability?) *Hatcher v. Commonwealth*, 310 S.W. 3d. 691 (Ky.App.2010). Trial counsel was ineffective for not objecting to the trial court's: (1) failure to provide a separate self-protection instruction; (2) failure to provide a definition of self-protection; (3) failure to instruct the jury on imperfect self-protection and (4) failure to provide the jury with a definition of Extreme Emotional Disturbance (EED).

G. Kentucky Caselaw

1. *Jewell v. Commonwealth*, 549 S.W.2d 807 (Ky. 1977), *overruled on other grounds in Payne v. Commonwealth*, Ky., 623 S.W.2d 867 (1981)).
 - a. Trial court erroneously excluded certified copy of judgment of another court finding defendant mentally ill. Id. at 811-812. See also *Smedley v. Commonwealth*, 138 Ky. 1, 127 S.W. 485, 488-489 (1910).
 - b. Brother and sister should have been allowed to in effect testify that defendant did not know right from wrong at time of killing.

- c. Wide latitude must be given to lay opinion on issue of insanity. *Jewell v. Commonwealth*, 549 S.W.2d at 811.

2. "[T]his Court has long allowed lay testimony in cases involving the sanity of the defendant." *Brown v. Commonwealth*, Ky., 934 S.W.2d 242, 248 (1996).
3. "Oftentimes, lay witnesses testifying as to the customary conduct of an accused more nearly reflect his mental capacity than the high sounding names tagged to imaginary self-induced complaints." *Wiseman v. Commonwealth*, 587 S.W.2d 235, 238 (Ky. 1979).
4. Even though a psychologist does not personally interview a defendant, he may testify at trial. The jury determines how much weight to give the testimony. "[A]n expert may testify as to what a third party said as long as that expert customarily relies upon this type of information in the practice of his or her profession." *Brown v. Commonwealth*, Ky., 934 S.W.2d 242, 247 (1996).
5. Evidence of mental condition before and after crime is admissible on issue of insanity. See *Moore v. Commonwealth*, 92 Ky. 630, 18 S.W. 833 (1892), and *Smedley v. Commonwealth*, 138 Ky. 1, 127 S.W. 485 (1910), and *Montgomery v. Commonwealth*, 88 Ky. 509, 11 S.W. 475, 476-477 (1889); *Buckler v. Commonwealth*, 541 S.W.2d 935 (Ky. 1976) and *Sharp v. Commonwealth*, 308 Ky. 765, 215 S.W.2d 983 (1949).
6. If there is any evidence of insanity, even that of lay witnesses, a jury instruction on insanity must be given. *Cannon v. Commonwealth*, 777 S.W.2d 591, 593 (Ky. 1989).
7. "We agree with the dissent and overrule *Corder v. Commonwealth* to the extent that it, even inferentially, requires evidence of insanity to be pinpointed at the moment of the crime before it can be submitted to the jury for decision." *Cannon v. Commonwealth*, 777 S.W.2d 591, 594 (Ky. 1989).
8. Convictions for assault in the third degree, wanton endangerment second degree, and resisting arrest were reversed. "Wyatt presented evidence that he was basically unconscious during this episode. Although extreme emotional disturbance may not mitigate a reckless assault on a policeman, even recklessness requires some intent. If there was insufficient mental capacity or no intent, there could be no violation of KRS 508.025, or any other offense requiring intent.... Under the instructions given by the court, the jury would have had to have found Wyatt guilty of the charges without regard to whether he was conscious of his acts. We find this unconscionable. If on retrial the evidence is practically the same, the court should submit to the jury an instruction, whereas the jurors may find Wyatt not guilty, if they believe from the evidence that he was indeed unconscious of his acts." *Wyatt v. Commonwealth*, 738 S.W.2d 832, 834-835 (Ky.App. 1987).
9. *Tibbs v. Commonwealth*, 138 Ky. 558, 128 S.W. 871 (1910). Evidence that defendant was a somnambulist and while in such state was without self-control and committed acts of which he had no recollection. Appropriate to give insanity instruction. See also *Watkins v. Commonwealth*, 378 S.W.2d 614 (Ky. 1964).
10. *Cooley v. Commonwealth*, 459 S.W.2d 89 (Ky. 1970). Defendant suffered epileptic seizures for eight years prior to the stabbing and was taking medication and undergoing treatment for this condition. Psychiatrist testified defendant

suffered from psychomotor epilepsy. One stage is a state of automatism during which the subject of the attack is not aware of his actions and of which he later has no memory. This state may last for a matter of seconds to a matter of days. No specific instruction on epilepsy was required as long as a general instruction on insanity adequately presented the issue.

11. *Smith v. Commonwealth*, 268 S.W.2d 937, 938 (Ky. 1954). "It is a well-recognized principle of criminal law that, if a person is unconscious at the time he commits a criminal act, he cannot be held responsible."
 12. *Jacobs v. Commonwealth*, 870 S.W.2d 412, 419 (Ky. 1994). "In spite of courtroom amusement, we fail to determine how asking a qualified expert witness in the field of psychiatry questions concerning belly dancing is relevant to the issues of this case and would have a bearing upon the expert's credibility as to her medical training and ability or the competency of the examination performed upon appellant... The Commonwealth's purpose of instituting this line of questioning and interjecting such trivia undermined the appellant's right to a fair trial... Such prosecutorial misconduct does not equate to properly disqualifying but only demeaning the defense expert in the minds of the jury."
 13. *Sanborn v. Commonwealth*, 754 S.W.2d 534, 544 (Ky. 1988), *overruled on other grounds by Hudson v. Commonwealth*, 202 S.W.3d 17 (Ky. 2006). "The prosecutor questioned an expert witness called by the defense about his fee, stating: 'and that's what you want the court to direct Henry County to pay you?' Such evidence served only to prejudice the jurors, citizens of Henry County, against appellant."
 14. *Mattingly v. Commonwealth*, 878 S.W.2d 797, 800 (Ky.App. 1993). Prosecutor misstated the test for insanity as being whether the defendant knew right from wrong *generally*, as opposed to whether she appreciated the wrongfulness of posing her daughter for photographs. The misstatement was magnified by the prosecutor's references to defendant's law-abiding life. Prosecutor argued that showed "[s]he had apparently known the difference between right and wrong."
 15. *Tate v. Commonwealth*, 893 S.W.2d 368 (Ky. 1995). Defendant was convicted of possession of controlled substance, robbery, and of being a persistent felony offender. The issue addressed by the Court was "whether drug addiction is a mental disease, defect or illness for purposes of KRS 504.020." The Court held, "[a]s there is dissension in the medical community as to whether addiction is a mental disease or whether it is merely a physical craving, appellee did not meet the initial burden showing that his criminal conduct was the result of mental illness or retardation as required under KRS 504.020(1)." *Id.* at 371. "We hold that a mere showing of narcotics addiction, without more, does not constitute 'some evidence' of mental illness or retardation so as to raise the issue of criminal responsibility, requiring introduction of the expert's controversial testimony or an instruction to the jury on that issue. Due to the fact that *no evidence was presented that Tate was in need of a fix at that time, there was an absence of the requisite evidence that at the time of the act charged*, Tate had an abnormal condition of the mind which substantially impaired his behavior. In this case, the weight of the evidence was to the contrary as appellee's attempt to obtain money legally and the arresting officers' testimony showed appellee's lucidity at time of arrest." *Id.* at 372 (emphasis added). "Therefore, the trial court did not err in excluding Dr. Pelligrini's testimony on the grounds of lack of relevancy as no *probative* evidence was offered from which a jury could reasonably infer that at the time of the criminal act, *as a result of mental illness or retardation*, appellee lacks substantial capacity to either appreciate the criminality of his acts or to conform his conduct to the requirements of the law." *Id.* at 373.
 16. *Cecil v. Commonwealth*, 888 S.W.2d 669 (Ky. 1995). Clinical psychologist allowed to give opinion that defendant "intentionally shot the victim." *Id.* at 674. He went on to state that the defendant "would not have shot the victim if a police officer had been standing at her elbow (a classic test for the 'irresistible impulse' or temporary insanity claim)." *Id.* The Court refers to KRE 702. Furthermore, "Expert witnesses such as Dr. Noonan can properly state opinions which are admissible concerning the sanity or insanity of criminal defendants." *Id.* at 675.
 17. *Port v. Commonwealth*, 906 S.W.2d 327 (Ky. 1995). The defendant was convicted of intentional murder but mentally ill, criminal attempt to commit murder but mentally ill, and wanton endangerment in the first degree but mentally ill. A defendant is entitled to directed verdict on defense of insanity if it would be clearly unreasonable for jury to find against the defendant on the issue of insanity. The mere presence of any evidence that defendant was sane at time the offense was committed does not necessarily enable issue of sanity to be submitted for jury determination; rather, evidence must be taken as a whole. Under the facts of this case the court found that it was not clearly unreasonable for any jury to find the defendant was sane at the time he entered the restaurant and shot two people. Witnesses testified that the defendant appeared to be in control during the shootings, police testified that the defendant acted rational when he was apprehended, and the defendant testified, that he chose to shoot the victims because they caused his frustration. See also *Brown v. Commonwealth*, 934 S.W.2d 242, 246-247 (Ky. 1996).
 18. In death penalty case, trial court cannot preclude death based upon pretrial factual determination of defendant's mental health. *Commonwealth v. Ryan*, 5 S.W.3d 113 (Ky. 1999), *abrogated on other grounds by Hoskins v. Maricle*, 150 S.W.3d 1 (Ky. 2004). But see KRS 532.140, prohibiting the death penalty for defendants with serious intellectual disability, and *Atkins*, below.
 19. *Welborn v. Commonwealth*, 157 S.W. 3d 608 (Ky. 2005) Court found that error was not palpable in prosecutor's improper jury argument which told jurors that the issue was not was the defendant mentally ill but did he know right from wrong. This case emphasizes the need to litigate improper jury arguments prior to trial if possible. Don't use a motion in limine to preclude the arguments. If it is a bad argument it is a bad argument and should be precluded prior to trial – there is no need for a side bar to discuss whether or not the argument was improper in the context of the evidence and the law.
- III. GUILTY BUT MENTALLY ILL
- A. Grounds for and Consequences of Finding Defendant Guilty But Mentally Ill.
1. KRS 504.130(1) "The defendant may be found guilty but mentally ill if: (a) The prosecution proves beyond a reasonable doubt that the defendant is guilty of an offense;

and (b) The defendant proves by a preponderance of the evidence that he was mentally ill at the time of the offense. (2) If the defendant waives his right to trial, the court may accept a plea of guilty but mentally ill if it finds that the defendant was mentally ill at the time of the offense.

2. KRS 504.140 Examination before sentencing. "If a defendant is found guilty but mentally ill, the court may appoint at least one (1) psychologist or psychiatrist to examine, treat and report on the defendant's mental condition at the time of sentencing."
3. KRS 504.150 Sentence for person found guilty but mentally ill. (1) The court shall sentence a defendant found guilty but mentally ill at the time of the offense to the local jail or to the Department of Corrections in the same manner as a defendant found guilty. If the defendant is found guilty but mentally ill, treatment shall be provided the defendant until the treating professional determines that the treatment is no longer necessary or until expiration of his sentence whichever occurs first. (2) Treatment shall be a condition of probation, shock probation, conditional discharge, parole or conditional release so long as the defendant requires treatment for his mental illness in the opinion of his treating professional

B. Kentucky Caselaw

1. Complaint that state has not complied with treatment provisions of statute, relief can be sought by mandamus rather than by post conviction writ. *Breeden v. Commonwealth*, 290 S.W.3d 690 (Ky.App. 2009).
2. Plea of Guilty but Mentally Ill treated just like plea of guilty as to violent offender statute imposing probation eligibility requirements. *Carey v. Commonwealth*, 104 S.W. 3, 783 (Ky.App. 2002).
3. The Supreme Court is "concern[ed] with the constitutionality and effectiveness of the GBMI verdict." *Brown v. Commonwealth*, 934 S.W.2d 242, 245 (Ky. 1996). "[I]t appears that the time may have arrived for this Court to evaluate that statute." *Id.* "We caution, however, that this decision does not put to rest the issues of the constitutionality of the GBMI statute and the content of the instructions – especially with regard to treatment – to be given to the jury in a GBMI case." *Id.* at 249. See the opinion for the arguments to make as well as the type of proof the Court is requiring.
 - a. Mental illness and extreme emotional disturbance are not the same thing. See *Sanders v. Commonwealth*, 801 S.W.2d 665 (Ky. 1991), and *Wellman v. Commonwealth*, 694 S.W.2d 696 (Ky. 1985).
 - b. Court recognizes the problem with GBMI and then denies it exists: Guilty but mentally ill jury instruction, relevant to charges of murder, kidnapping, and assault, did not allow for an improper compromise on jury's part in violation of defendant's due process rights. There was no indication that "but for" the guilty but mentally ill instruction, the jury would have found defendant not guilty by reason of insanity. A guilty but mentally ill offender is not less guilty than one who is guilty and not mentally ill. *Star v. Commonwealth*, 313 S.W.3d 30 (Ky. 2010).
 - c. *Commonwealth v. Ryan*, 5 S.W.3d 113 (Ky.1999), *abrogated on other grounds by Hoskins v. Maricle*, 150 S.W.3d 1 (Ky. 2004). Trial court's acceptance of a plea

of guilty but mentally ill provided no basis for a writ of prohibition to prevent trial court from enforcing order excluding the death penalty as sentencing option in capital murder prosecution. Court could not preclude death on basis of pretrial determination of the defendant's health. The Commonwealth is entitled to a full sentencing hearing with the full range of penalties allowed by law.

- d. *Breeden v. Commonwealth*, 290 S.W. 3d 690 (Ky. App. 2009). A defendant's allegations that the Department of Corrections had failed to comply with the statute governing sentences for persons found guilty but mentally ill, based on the Department's failure to provide proper psychiatric care could be raised by a writ of mandamus rather than in a post-conviction relief proceeding, to enforce the Department's duties under the statute.
- e. *Carey v. Commonwealth*, 104 S.W. 3d 783 (Ky. App. 2002). Violent offender statute imposing probation eligibility requirements applied to the defendant's plea of guilty but mentally ill although the defendant argued that such pleas was substantially different than a plea of guilty.

IV. INTELLECTUAL DEVELOPMENTAL DISORDER (IDD)

- A. Definition - KRS 504.060(7) - "Individual with an intellectual disability" means an individual with significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period and is a condition which may exist concurrently with mental illness or insanity.
- B. Notice that this definition contains the same three criteria used in the DSM-V.
- C. Capital Cases
 1. Federal Law - *Atkins v. Virginia*, 536 U.S. 304 (2002). Construing and applying the Eight Amendment in light of our "evolving standards of decency", we therefore conclude that such punishment is excessive and that the Constitution "places a substantive restriction on the State's power to take the life" of a mentally retarded offender.
 2. *Hall v. Florida*, 134 S.Ct. 1986 (2014). If a defendant is claiming intellectual disability and offers an IQ score in the range of 70-75, he must be allowed to offer additional clinical evidence of intellectual disability and adaptive deficits. In so holding, the Supreme Court (5 to 4 with Kennedy writing for majority and Alito for the minority) the Supreme Court specifically:
 - a. recognizes the potential inaccuracies of I.Q. testing,
 - b. approves the use of the standard error of measurement (± 5) if nothing in state statute prevents it. A statute that would prevent using the SEM would likely be unconstitutional under the majority's rationale.
 - c. acknowledges that one's I.Q. is more properly expressed in terms of a range rather than one number. "Intellectual disability is characterized by an I.Q. of approximately 70". *Atkins v. Virginia*, 536 U.S. 308, n.3 and slip at 20.
 - d. adopts the term of "intellectual [and developmental] disability" in place of "mental retardation"

- e. approves the consideration of “accepted clinical standards” in deciding the issue. Does this implicitly approve the Flynn Effect?
- f. references the DSM-V emphasis on developmental disabilities (adaptive deficits) over a strict I.Q. score. “It is not sound to view a single factor as dispositive of a conjunctive and interrelated assessment”, citing DSM-V at 37, (slip at 21).
- g. uses consensus of states (slip 12) and consensus among professionals in the field (slip 20) in analysis.

D. Kentucky Law

1. KRS 532.130 - Definitions for KRS 532.135 and 532.140

- a. An adult, or a minor under eighteen (18) years of age who may be tried as an adult, convicted of a crime and subject to sentencing, is referred to in KRS 532.135 and 532.140 as a defendant.
- b. A defendant with significant sub-average intellectual functioning existing concurrently with substantial deficits in adaptive behavior and manifested during the developmental period is referred to in KRS 532.135 and 532.140 as a defendant with a serious intellectual disability. “Significantly sub-average general intellectual functioning” is defined as an intelligence quotient (I.Q.) of seventy (70) or below.

2. KRS 532.135 - Determination by court that defendant has a serious intellectual disability

- a. At least thirty (30) days before trial, the defendant shall file a motion with the trial court wherein the defendant may allege that he is a defendant with a serious intellectual disability and present evidence with regard thereto. The Commonwealth may offer evidence in rebuttal.
- b. At least ten (10) days before the beginning of the trial, the court shall determine whether or not the defendant is a defendant with a serious intellectual disability in accordance with the definition in KRS 532.130.
- c. The decision of the court shall be placed in the record.
- d. The pretrial determination of the trial court shall not preclude the defendant from raising any legal defense during the trial. If it is determined the defendant is an offender with a serious intellectual disability, he shall be sentenced as provided in KRS 532.140.

3. KRS 532.140 – Offender with a serious intellectual disability not subject to execution; authorized sentences

- a. KRS 532.010, 532.025, and 532.030 to the contrary notwithstanding, no offender who has been determined to be an offender with a serious intellectual disability under the provisions of KRS 532.135, shall be subject to execution. The same procedure as required in KRS 532.025 and 532.030 shall be utilized in determining the sentence of the offender with a serious intellectual disability under the provisions of KRS 532.135 and 532.140.
- b. The provisions of KRS 532.135 and 532.140 do not preclude the sentencing of an offender with a serious intellectual disability to any other sentence authorized by KRS 532.010, 532.025, or 532.030 for a crime which is a capital offense.

- c. The provisions of KRS 532.135 and 532.140 shall apply only to trials commenced after July 13, 1990.

- 4. *Bowling v. Commonwealth*, 163 S.W.3d 361 (Ky. 2005). Our statutory scheme (1) prohibits the execution of a seriously mentally retarded offender as defined by the same three criteria established by the AAMR (now AIDD) and the American Psychiatric Association and approved in *Atkins*, (2) defines the criterion of “significantly subaverage general intellectual functioning” as an IQ of 70 or below, id; (3) places the burden on the defendant to allege and prove that he or she qualifies for the exemption, but does not establish standard of proof applicable to that burden; (4) requires that the issue be decided by a trial judge at least ten days prior to trial; and (5) is not retroactive but applied only to trials commenced after July 13, 1990.

- 5. *Bowling* also holds that “mental age” of a defendant although below 18 will not exempt him or her from death penalty exposure.

E. DSM-V and Intellectual Developmental Disorder

- 1. “DSM-V emphasizes the need to use both clinical assessment and standardized testing of intelligence when diagnosing intellectual disability, with the severity of impairment based on adaptive functioning rather than IQ test scores alone. By removing IQ test scores from the diagnostic criteria, but still including them in the text description of intellectual disability, DSM-V ensures that they (IQ scores) are not overemphasized as the defining factor of a person’s overall ability, without considering functioning levels. This is especially important in forensic cases.” *American Psychiatric Association* (2013).
- 2. It is important to note that IQ or similar standardized test scores should still be included in an individual’s assessment. In DSM-V, intellectual disability is considered to be approximately two standard deviations or more below the population, which equals an IQ score of about 70 or below. *Id.* (emphasis added).
- 3. IQ of 70 or below is required to be considered “[s]ignificantly sub-average intellectual functioning”. Taking into account possibility of measurement error an IQ of 70 represents a range of 65 to 75. (p. 37 of DSM-IV)

Resources: Counsel can access a number of excellent resources to aid in the representation of an impaired client. The manual published by AAIDD is referred to as “The Green Book” and is an invaluable resource in this area. These include: (1) *Intellectual Disability: Definition, Classification, and System Supports*, the 11th Edition of the AAIDD Manual (2010); (2) Burr, Cecil, James, Patton and Peoples, *A Practitioner’s Guide to Defending Capital Clients Who Have Mental Retardation*, The International Justice Project; (3) Cunningham, *Evaluation for Capital Sentencing*, Oxford University Press, 2010; (4) American Association on Intellectual and Developmental Disabilities (AAIDD).

4. Four Degrees of Mental Retardation

- a. Mild: IQ ranges from 50-55 to approximately 70 (85% of mentally retarded)
- b. Moderate: IQ ranges from 35-40 to 50-55 (10% of mentally retarded)
- c. Severe: IQ ranges from 20-25 to 35-40 (3%-4% of mentally retarded)

- d. Profound: IQ below 20 or 25 (1%-2% of mentally retarded)

- F. Evidence of defendant's mental retardation is admissible in a prosecution for reckless homicide. *Robinson v. Commonwealth*, 569 S.W.2d 183 (Ky. App. 1978).
- G. *Rogers v. Commonwealth*, 86 S.W.3d 29 (2002). Trial Court's refusal to allow mentally retarded murder defendant to present evidence concerning circumstance under which he confessed to offenses including murder was prejudicial and reversible error.
- H. *Bailey v. Commonwealth*, 194 S.W. 3d 296 (Ky. 2006), in which the defendant's confession was ruled involuntary, lists the relevant factors concerning both the accused and the interrogation. Factors characterizing the accused include age, education, intelligence, and linguistic ability. Factors relevant to the interrogation for purposes of assessing the voluntariness of a confession include length of detention, lack of advice concerning Constitutional rights, repeated or prolonged nature of questioning, overly coercive techniques such as sleep and food deprivation, or the use of humiliating tactics.

V. EXTREME EMOTIONAL DISTURBANCE

A. Statutes

- 1. Murder - KRS 507.020(1)(a)
- 2. Assault - KRS 508.040(1)

B. Requirement of Written Notice

- 1. KRS 504.070(1) (notice of defense) does not specifically include extreme emotional disturbance.
- 2. RCr 8.07 (notice of expert testimony) does not specifically include extreme emotional disturbance.
- 3. But see *Coffey v. Messer*, Ky., 945 S.W.2d 944 (1997). The Court held that "[w]hen the defendant intends to introduce expert mental health evidence to prove that defense, the provisions of RCr 7.24(3)(B)(i) and (ii) are triggered." *Id.* at 946-947 (emphasis added). One would assume this is true of the new RCr 8.07 as well.
- 4. See also *Stanford v. Commonwealth*, 793 S.W.2d 112 (Ky. 1990). Court agreed trial court properly excluded from guilt phase "certain evidence relevant to the mitigating factor of extreme emotional disturbance" due to failure to comply with notice requirements of KRS 504.070 (1). The evidence excluded was that defendant had a long-term history of depression, paranoid schizophrenia and borderline personality disorder. Court noted that this was a death penalty case and that "much of the testimony excluded during the guilt phase" was admitted during the penalty phase. 793 S.W.2d at 115.
- 5. See also *Johnson v. Commonwealth*, 103 S.W. 3d 687 (Ky. 2003) reasoning that while evidence of EED does not act as a complete defense it does act as a defense to the higher charge brought by the Commonwealth and does bear on his or her guilt.

C. Definition

- 1. *McClellan v. Commonwealth*, 715 S.W.2d 464, 468-469 (Ky. 1986). "Extreme emotional disturbance may reasonably be defined as follows: Extreme emotional disturbance is a temporary state of mind so enraged, inflamed, or disturbed as to overcome one's judgment, and to cause one to act uncontrollably from the impelling force of the extreme emotional disturbance rather than from evil or malicious

purposes. It is not a mental disease in itself, and an enraged, inflamed, or disturbed emotional state does not constitute an extreme emotional disturbance unless there is a reasonable explanation or excuse therefore, the reasonableness of which is to be determined from the viewpoint of a person in the defendant's situation under circumstances as defendant believed them to be." See also *Hudson v. Commonwealth*, Ky., 979 S.W.2d 106, 108 (1998) and *Dean v. Commonwealth*, 777 S.W.2d 900, 909 (Ky. 1989), *overruled on other grounds by Caudill v. Commonwealth*, 120 S.W.3d 635 (Ky. 2003).

- 2. *Stanford v. Commonwealth*, 793 S.W.2d 112, 115 (Ky. 1990). "These cases teach that extreme emotional disturbance is not established by evidence of insanity or mental illness, but require a showing of some dramatic event which creates a temporary emotional disturbance as opposed to a more generalized mental derangement."

D. Expert Testimony

- 1. Defense expert failed to define what she meant by extreme emotional disturbance. "Unless such testimony is directed to the concept of extreme emotional disturbance as defined by Kentucky law, as expert's opinion in his regard does not 'assist the trier of fact to understand the evidence or to determine a fact in issue,'" *Talbott v. Commonwealth*, Ky., 968 S.W.2d 76, 85 (1998).
- 2. *Manning v. Commonwealth*, 23 S.W. 3d 610 (Ky. 2000). Medical examiner testimony supported evidence of EED in that the nature of the victim's wounds indicated they were inflicted by someone who was emotionally charged. The defendant had been abused and threatened by the victim. NOTE: This case highlights the importance of medical examiner testimony and the need to interview the M.E. early in the case. Counsel can determine what the expert can say in support of the theory, be prepared for the testimony that will contradict the theory. At least counsel can identify (1) the opinions that the expert will opine, (2) opinions that he or she cannot give and (3) determine if a Daubert hearing is needed. Counsel should confirm that the M.E. will not make a reference to an "execution style slaying" which they love to volunteer. Remember under RCr 7.24 the Commonwealth must furnish the summary of the testimony of an expert it expects to call to the stand if requested by the defense.

E. Caselaw

- 1. "We have also held that mental illness and extreme emotional disturbance are not the same thing..." *Sanders v. Commonwealth*, 801 S.W.2d 665, 679 (Ky. 1991).
- 2. "Evidence of mere 'hurt' or 'anger' is insufficient to prove extreme emotional disturbance." *Talbott v. Commonwealth*, Ky., 968 S.W.2d 76, 85 (1998).
- 3. "The Commonwealth still has the burden of proof, but in order to justify an instruction on the lower degree there must be something in the evidence sufficient to raise a reasonable doubt whether the defendant is guilty of murder or manslaughter." *Gall v. Commonwealth*, 607 S.W.2d 97, 108 (Ky. 1980), *overruled on other grounds by Payne v. Commonwealth*, 623 S.W.2d 867 (Ky. 1981). See also *Sanders v. Commonwealth*, 801 S.W.2d 665, 679 (Ky. 1991).
- 4. Extreme emotional disturbance is not a defense to wanton murder. *Todd v. Commonwealth*, 716 S.W.2d 242, 246 (Ky. 1986).

5. The absence of extreme emotional disturbance is not an element of the crime of murder. See *Wellman v. Commonwealth*, 694 S.W.2d 696, 697 (Ky. 1985), and *Sanders v. Commonwealth*, 801 S.W.2d 665, 679 (Ky. 1991). However, "once evidence of EED is introduced, the absence thereof becomes an element of the offense of murder." *Coffey v. Messer*, Ky., 945 S.W.2d 944, 946 (1997).
6. "Extreme emotional disturbance, if present, merely mitigates a charge of murder, but permits an instruction on voluntary manslaughter, and should be left to the jury." *Morris v. Commonwealth*, 766 S.W.2d 58, 60 (Ky. 1989). See also *Haight v. Commonwealth*, Ky., 938 S.W.2d 243, 248-249 (1997).
7. Instruction on extreme emotional disturbance may be waived by trial counsel. *Davis v. Commonwealth*, Ky., 967 S.W.2d 574, 578 (1998). *Commonwealth v. Hagen*, 41 S.W. 3d 828 (Ky. 2001). An instruction on reasonable doubt with respect to the EED issue is required when there is evidence authorizing an instruction on EED.
8. It is wholly insufficient for accused defendant to claim defense of extreme emotional disturbance based on gradual victimization from his or her environment, unless additional proof of triggering event is sufficiently shown. The event which triggers the explosion of violence must be sudden and uninterrupted. *Foster v. Commonwealth*, 827 S.W.2d 670 (Ky. 1992). *Hunt v. Commonwealth*, 304 S.W.3d 15 (Ky. 2009).
9. Extreme emotional disturbance required jury to place themselves in actor's position as he believed it to be at the time of the act, and if jury finds existence of extreme emotional disturbance, offense of murder is reduced to manslaughter in the first degree. *Holbrook v. Commonwealth*, 813 S.W.2d 811, 815 (Ky. 1991), *overruled on other grounds by Elliot v. Commonwealth*, 976 S.W.2d 416 (Ky. 1998).
10. Separate instruction on extreme emotional disturbance and definition of extreme emotional disturbance are necessary. *Holbrook v. Commonwealth*, 813 S.W.2d 811, 815 (Ky. 1991), *overruled on other grounds by Elliot v. Commonwealth*, 976 S.W.2d 416 (Ky. 1998).
11. Defendant was convicted of assault in the third degree, wanton endangerment in the second degree, and resisting arrest. "KRS 508.040 allows mitigation for those offenses involving intentional conduct as described under KRS 508.010, 508.020, or 508.030 (first-, second-, and fourth-degree assault). It is clear that the legislature in enacting 508.025, coupled with 508.040, did not intend to allow for mitigation for assaulting a peace officer while under extreme emotional disturbance." *Wyatt v. Commonwealth*, 738 S.W.2d 832, 834 (Ky. App. 1987).
12. *Morgan v. Commonwealth*, 878 S.W.2d 18 (Ky. 1994). Defendant convicted of murdering his wife. Trial court refused to give instruction on extreme emotional disturbance. Conviction affirmed. Defendant did not testify. "There was no evidence that at the time of the act of homicide, there was some event, some act, some words, or the like to arouse extreme emotional disturbance which is absolutely necessary. ...[A]n extreme emotional disturbance instruction is justified 'when there is probative, tangible and independent evidence at the time of the [defendant's] act which is contended to arouse extreme emotional disturbance.'" *Id.* at 21. See also *Hudson v. Commonwealth*, Ky., 979 S.W.2d 106, 109 (1998), and *Tamme v. Commonwealth*, Ky., 973 S.W.2d 13, 36-37 (1998).
13. *Hunter v. Commonwealth*, 869 S.W.2d 719 (Ky. 1994). Amount of evidence necessary to warrant penalty phase instruction on extreme emotional disturbance is lower than amount necessary for guilt phase instruction on the same point. *Id.* at 726 (see also KRS 532.025(2)(b) (2)).
14. *Whitaker v. Commonwealth*, 895 S.W.2d 953 (Ky. 1995). The defendant was convicted of murdering his wife. Evidence indicated that the defendant had gone to his wife's place of employment, asked her to sign some tax documents, and then shot her in the head at close range. The defendant claimed at trial that he could not recall the actual shooting. Instructions on extreme emotional disturbance and first-degree manslaughter were rejected by the trial court. As to the denied instructions the court found no error. The court found that there was no evidence to indicate the defendant was under the influence of extreme emotional disturbance or that any circumstances existed at the time of the killing to provoke such a disturbance. "Evidence of extreme emotional disturbance must be definite and nonspeculative." *Id.* at 954. The court stressed that there "must be an event triggering the explosion of violence on the part of the defendant." *Id.*
15. *Greene v. Commonwealth*, 197 S.W.3d 76 (Ky. 2006). When the defense offers evidence of EED, the absence of EED becomes an element of the offense and the burden shifts to the Commonwealth to disprove it beyond a reasonable doubt. The Commonwealth does not have to offer proof if such proof is already present. *Holland v. Commonwealth*, 114 S.W. 3d 792 (Ky. 2003).
16. *Spears v. Commonwealth*, 30 S.W. 3d 152 (Ky. 2000). Although the Commonwealth must prove every element of murder beyond a reasonable doubt, the Commonwealth need not affirmatively disprove EED unless the evidence of EED is so overwhelming that it necessitates acquittal on the charge of murder.
17. *Fields v. Commonwealth*, 44 S.W. 3d 355 (Ky. 2001). Evidence of mental illness does not preclude a finding of EED for the purposes of reduction intentional killing from murder to first degree manslaughter and it is relevant to a subjective evaluation of reasonableness of defendant's response to provocation.
18. *Springer v. Commonwealth*, 998 S.W. 2d 439 (Ky. 1999). There is no definite time frame involved between triggering event and killing as a basis for finding EED so long as the triggering event remains uninterrupted.
19. *Benjamin v. Commonwealth*, 266 S.W. 3d 775 (Ky. 2008). When reviewing whether or not an instruction on EED should have been given to the jury, the reviewing court can look at all circumstances leading up to and surrounding the commission of the crime.
20. *Hudson v. Commonwealth*, 979 S.W.2d 106 (Ky. 1998). Court held that defendant's explanation for the required "EED trigger" must provide a reasonable explanation for the triggering event.
21. *Hodge v. Commonwealth*, 17 S.W. 3d 824 (Ky. 2000). The mere resistance by the victim of an armed robbery did not suffice to override the evil and malicious purpose which triggered that resistance, nor did it constitute a reasonable explanation or excuse for an emotional state so enraged

inflare or disturbed as to cause the defendant to kill the victim.

22. *Wyatt v. Commonwealth*, 738 S.W. 2d 832, 834 (Ky. App. 1987). Legislature in enacting KRS 508.025 coupled with 508.40 did not intent to allow for mitigation for assaulting a peace officer while the defendant claims to be under an Extreme Emotional Disturbance. KRS 508.40 allows mitigation for those offenses involving conduct as described in KRS 508.10, 508.020 or 508.030.

VI. EXPERTS

A. Sufficient Showing by Trial Counsel - Mental Health Consultant

1. *Binion v. Commonwealth*, 891 S.W.2d 383 (Ky. 1995). Prior to trial, the defendant indicated that he was going to present an insanity defense. The trial judge ordered that Kentucky Correctional Psychiatric Center conduct an examination to determine if defendant was competent to stand trial. The examining psychologist found the defendant competent to stand trial and then the trial judge ordered another evaluation to determine if the defendant was criminally responsible at the time of the crimes. "The trial judge indicated that if it was determined that a question existed regarding Binion's sanity at the time of the crimes, he would grant the motion to provide a defense mental health consultant." *Id.* at 384. Later, "the trial judge overruled Binion's request for an independent defense mental health consultant. The trial judge ultimately determined that Binion had been provided with a neutral examination which he considered sufficient to meet due process requirements." *Id.* at 385. The appellate court first held that, "the trial judge properly required Binion to submit to an initial evaluation through KCPC." *Id.* The KCPC report "cataloged a variety of mental problems and experiences in the mental history of the defendant." *Id.* The appellate court went on to hold that, "the appointment of Dr. Smith as a *neutral mental health expert* was *insufficient* to satisfy the constitutional requirement of due process because the services of a mental health expert should be provided so as to permit that expert to conduct an appropriate examination and assist in the evaluation, preparation and presentation of the defense. The benefit sought was not only the testimony of a mental health professional, but also, the assistance of an expert to interpret the findings of the expert used by the prosecution and to aid in the presentation of cross-examination of such an expert. The defendant was deprived of his right to a fundamentally fair trial and due process without such assistance... [Due process] also means that there must be an appointment of a psychiatrist to provide assistance to the accused to help evaluate the strength of his defense, to offer his own expert diagnosis at trial, and to identify weaknesses in the prosecution's case by testifying and/or preparing counsel to cross-examine opposing experts." (emphasis added) *Id.* at 386. See also *Harper v. Commonwealth*, Ky., 978 S.W.2d 311, 314 (1998).
2. *DeFreece v. State*, 848 S.W.2d 150 (Tex.Cr.App. 1993). Even if harmless error analysis applied, failure to appoint psychiatrist to assist murder defendant in preparing defense was not harmless where assistance of expert to interpret voluminous medical records could have assisted defense counsel in cross-examining state witness, only contested issue at trial was sanity, and jury deliberated for five hours before convicting defendant.

3. Electroencephalogram (EEG) - *United States v. Hartfield*, 513 F.2d 254 (9th Cir. 1975). Defense in this attempted armed robbery case was entitled to money to have an EEG run when the defendant's defense "turned on his mental condition." *Id.* at 258.

B. Insufficient Showing by Trial Counsel

1. *Simmons v. Commonwealth*, 746 S.W.2d 393 (Ky. 1988). In this case, on a joint motion, the appellant was transferred to the Kentucky Correctional Psychiatric Center for an evaluation. A psychiatrist found the appellant to be competent to stand trial. The psychiatrist testified in behalf of appellant at the guilt phase of the trial and a social worker testified at both the guilt and the sentencing phase. "Appellant requested that funds be provided for the appointment of two independent psychiatrists, two independent psychologists, and one licensed clinical social worker to examine him." The court held that, "the appellant failed to show a necessity for the expert assistance he requested. He stated in general terms only that expert assistance was needed to prepare adequately for trial and possible sentence hearing. He did not state the names of any doctor or social worker that he desired to examine him, nor did he furnish any estimate of the costs. He further did not state what he expected to show or in what manner the requested assistance would be of any specific benefit to him. He made no challenge to the competency of Dr. Ravani or that Dr. Ravani was uncooperative with him or was not available for consultation. The only objection that he made to the examination by Dr. Ravani, pursuant to the court order, was that the information given to Dr. Ravani would not be treated with confidentiality but, nevertheless, he used Dr. Ravani as a witness in his behalf. The Commonwealth presented no psychiatric evidence in support of any aggravating factor in his capital murder cases." The court held "that appellant was provided competent expert psychiatric and social worker assistance, which he utilized in his trial and that he failed to establish that further expert assistance was reasonably necessary for his defense."
2. *Smith v. Commonwealth*, 734 S.W.2d 437 (Ky. 1987). The trial judge denied funds to the defendant to hire a defense pathologist and for a crime scene or ballistics expert. "Here Smith seeks to prove his mental state by the testimony of either a ballistics expert or a crime scene reconstruction witness... We do not believe that the expert assistance Smith claims he needed had anything to do with his defense which was that the murders were wanton, rather than intentional. The evidence he believed he needed was available through the use of state experts and facilities. He did not take advantage of the assistance available. At trial he cross-examined both the firearms examiner and the police sergeant in charge of the investigation of the homicides. The firearms examiner indicated that he had discussed the case with and cooperated with the defense attorney. Under the circumstances, it does not appear that the services of an independent ballistics expert were reasonably necessary." *Id.* at 447- 448. Additionally, there was no reversible error due to the denial of funds to obtain the testimony of a psychologist regarding the defendant's intelligence. "Nothing in his behavior or in the content of his confession indicates his inability to understand. There was no showing that the assistance of an expert would produce anything that was reasonably necessary for his defense." *Id.* at 450. The court went on to point out that the defendant "did not rely on or

pursue an insanity defense and the record is devoid of any indication of mental disease or defect." *Id.* at 450.

3. *Todd v. Commonwealth*, 716 S.W.2d 242 (Ky. 1986). Defendant was indicted for *wanton* murder. Intoxication is not a defense to *wanton* murder. Therefore, a defendant does not have a right to an independent psychiatrist to aid in presenting defense or mitigation of intoxication. Extreme emotional disturbance is not a defense to the crime of *wanton* murder. Therefore, the defendant did not have the right to an independent psychiatrist to aid in presenting mitigation of extreme emotional disturbance. The court pointed out that nothing had been filed by the appellant to indicate that he intended to raise insanity as a defense. The defendant "had a history of treatment for mental health problems. *He could have submitted those records to have established before the lower Court a definite proclivity towards possible insanity*; however, instead on his own request these were filed on a sealed basis, to be opened only for appellate review. Nevertheless, we cannot review these records and make a determination on the factual matter of Mr. Todd's history when the trial court has not had the similar prior opportunity; this is axiomatic of appellate practice." (emphasis added) *Id.* at 247. The defendant had been examined in the Kentucky Correctional Psychiatric Center. The court pointed out that the defendant had also failed to seek that the Kentucky Correctional Psychiatric Center report be expanded to include the specific finding on the question of sanity. "The absence of this information does not in and of itself automatically trigger the need for a *second* evaluation by an independent agency." *Id.* at 247.
 4. *Rackley v. Commonwealth*, 674 S.W.2d 512 (Ky. 1984), *overruled on other grounds by Bedell v. Commonwealth*, Ky., 870 S.W.2d 779 (1994). "Appellant moved for further psychiatric examination because the report indicated that the appellant had stated that he had blackout spells when he drank to excess (hardly a rare malady). The further reason given was that the attorney for the appellant felt that his client was 'psychologically weak.' ...This assertion of error is without merit." *Id.* at 514.
 5. *Kordenbrock v. Commonwealth*, 700 S.W.2d 384 (Ky. 1985). "From a perusal of the hearing and other statements, it appears that the underlying basis for psychiatric testimony was primarily for the penalty phase of the trial... We do not believe a defendant in a case such as this has a right to a psychiatric fishing expedition at public expense, or an in-depth analysis on *matters irrelevant to a legal defense* to the crime." (emphasis added) *Id.* at 387.
- C. Continuance for Examination - *Hunter v. Commonwealth*, 869 S.W.2d 719 (1994). "The first issue is the trial court's denial of defense motions for continuances, resulting in insufficient time for appellant to be examined thoroughly by a mental health expert. This violation of due process deprived appellant of the opportunity to explore fully (a) present competency, (b) possible guilt phase defenses, (c) penalty phase medication evidence, and/or (d) possible exemption from the death penalty because of mental retardation." *Id.* at 720.
- D. Necessary Expense - *McCracken County Fiscal Court v. Graves*, 885 S.W.2d 307 (Ky. 1994). This case was a capital murder case. Time spent by defendant's psychologist in hallway outside courtroom, waiting for opportunity to give testimony by avowal outside the presence of jury was not chargeable to county as a necessary expense because it was reasonable to assume that the avowal would not occur until the end of the jury's normal day, and the psychologist could have returned to his office until that time. However, the time spent by the defendant's psychologist, observing as the defendant was interviewed by the prosecution's psychiatrist, was a necessary expense required to be paid by the county. Under KRS 504.080(5), the defendant's expert had a right to participate in the state's examination and, therefore, the defendant's availing himself of what the law provided in his interest must be considered a necessary expense. The court "believed [t]hat whether a defendant avails himself of this opportunity is strictly a matter of legal strategy to be decided by defendant and his counsel. It is not a question for the defense expert to decide; nor is it a question for the trial court." *Id.* at 313.
- E. *Ex Parte* Procedure
1. KRS 500.070(2) - "No court can require notice of a defense prior to trial time."
 2. *Ake v. Oklahoma*, 470 U.S. 68, 105 S.Ct. 1087, 84 L.Ed.2d 53 (1985). "When the defendant is able to make an *ex parte* threshold showing to the trial court that his sanity is likely to be a significant factor in his defense, the need for the assistance of a psychiatrist is readily apparent." 470 U.S. at 82-83, 105 S.Ct. at 1096, 84 L.Ed.2d at 66.
 3. In Jefferson County, "counsel for a person who is financially unable to pay for...experts...may request funds for those services in an *ex parte*, in camera application to the judge...." JRP 604B. In Fayette County, "a defendant in a pending criminal proceeding, who is a needy person as defined by KRS Chapter 31, may apply *ex parte* to the Court for the payment of...expert... services necessary for an adequate defense." RFCC 8B.
 4. *Brooks v. State*, 385 S.E.2d 81 (Ga. 1989). "While exercising that right, a defendant also has the right to obtain that assistance without losing the opportunity to prepare the defense in secret. Otherwise, the defendant's 'fair opportunity to present his defense,' acknowledged in *Ake*, will be impaired... It is clear that in making the requisite showing defendant could be placed in a position of revealing his theory of the case. He therefore has a legitimate interest in making that showing *ex parte*... We find, further, that under ordinary circumstances, the trial court can evaluate the necessity for expert assistance without the benefit of cross-examination of the defendant by the state. We affirm the trial court's order that an application for funds be presented to the court in chambers. The matter will be heard *ex parte*. The state may submit a brief, which will be considered at the time of the *ex parte* hearing. The *ex parte* proceeding shall be reported and transcribed as part of the record but shall be sealed in the same manner as are those items examined *in camera*." *Id.* at 84.
 5. *McGregor v. Oklahoma*, 733 P.2d 416 (Okla., 1987). In this case, an evidentiary hearing was scheduled to determine whether the defendant was entitled to a court-appointed psychiatrist under the holding of *Ake v. Oklahoma*. The defendant filed a motion requesting the district court to hold the hearing *ex parte*. The trial court overruled the motion and the defendant petitioned the appellate court for a writ prohibiting inclusion of the district attorney at the hearing and ordering the district court to conduct the evidentiary hearing *ex parte*. The court stated, "we are compelled to agree with the petitioner's assertion that there is no need for an adversarial proceeding, that to allow participation, or even presence, by the State would thwart the Supreme Court's attempt to place indigent defendants, as nearly as

possible, on a level of equality with non-indigent defendants." *Id.*

6. *Corenevsky v. Superior Court*, 204 Cal.Rptr. 165 (Cal., 1984). The court held that counsel for the county funding source for expert funds was not entitled to be present at the *ex parte* hearing. Such a "procedure would create unnecessary conflicts of interest; in any event, county counsel's presence cannot be permitted because such petitions are entitled to be confidential." *Id.* at 172.

7. *United States v. Sutton*, 464 F.2d 552 (5th Cir. 1972). The purpose of the *ex parte* motion for funds is to "insure that the defendant will not have to make a premature disclosure of his case." *Id.* at 553.

8. *Marshall v. United States*, 423 F.2d 1315 (10th Cir. 1970). "The manifest purpose of requiring that the inquiry be *ex parte* is to insure that the defendant will not have to make a premature disclosure of his case." *Id.* at 1318.

- F. Presence of Defense Expert During Examination by Prosecution's Expert - *Sanborn v. Commonwealth*, Ky., 975 S.W.2d 905 (1998). The court noted approvingly that defense counsel obtained a court order requiring presence of the defense expert during the interviews conducted by the prosecution's expert.

VII. POTENTIAL SOURCES OF EVIDENCE FOR DEFENSE (See Chapter on Biopsychosocial Investigation).

- A. Records of Prior Hospitalizations - Example - Central State Hospital, Our Lady of Peace, Kentucky Correctional Psychiatric Center
- B. School Records - Often these contain an IQ score, reference to learning disabilities and special needs. These may be best source since the records go a long way in rebutting claim by prosecutor of malingering.
- C. Mental Health Professionals
 1. Psychiatrist
 2. Psychologist, neuropsychologist – Very careful use of psychological testing – no personality testing.
 3. Social Worker
 4. Mitigation Specialist.
 5. Consulting or testifying, Testifying witnesses may be opinion or teaching witness. See Chapter on "Experts".
- D. Family, Friends, Teachers, and Neighbors - Case of *Jewell v. Commonwealth*, 549 S.W.2d 807 (Ky. 1977), *overruled on other grounds by Payne v. Commonwealth*, Ky., 623 S.W.2d 867 (1981)), allowed opinion evidence by lay witnesses, defendant's brother and sister, on issue of sanity.
- E. Arrest Slip along with criminal history. Prior crimes may be symptoms of condition. Example - An arrest slip-stating defendant is "slow."
- F. Jail Records. Example - Medication records
- G. Defense Attorney's Investigator. Example - An investigator transports a defendant to and from court. Investigator develops sufficient contact with a defendant to describe his mental condition.
- H. Pretrial Report. Example - The report has notation that defendant was incoherent and unable to complete the interview.

- I. Social Security Records. Example - Report of Administrative Law Judge finding defendant to be schizophrenic and qualifying for disability payments.
- J. Juvenile Court Records. Example - Psychological testing. Evidence of abuse from parent or other family member.
- K. Discovery. Example - Investigative letter describing interview by detective with neighbor who details bizarre behavior of the defendant.
- L. Booking Photo
- M. Medical screening form at time of arrest
- N. Psychiatric/psychological records of immediate family members
- O. Audiotape of district court arraignment. Example - Defendant rambling that he is "Jesus."
- P. Videotape of circuit court arraignment

VIII. ETHICAL CONSIDERATIONS WHEN REPRESENTING MENTALLY ILL CLIENTS

- A. Kentucky Rules of Professional Conduct (KRPC)
 1. RULE 1.14 CLIENT WITH DIMINISHED CAPACITY
 - a. When a client's capacity to make adequately considered decisions in connection with a representation is diminished, whether because of minority, age, mental impairment or for some other reason, the lawyer shall, as far as reasonably possible, maintain a normal client-lawyer relationship with the client.
 - b. When the lawyer reasonably believes that the client has diminished capacity, is at risk of substantial physical, financial or other harm unless action is taken and cannot adequately act in the client's own interest, the lawyer may take reasonably necessary protective action, including consulting with individuals or entities that have the ability to take action to protect the client and, in appropriate cases, seeking the appointment of a guardian ad litem, conservator or guardian.
 - c. Information relating to the representation of a client with diminished capacity is protected by Rule 1.6. (Confidentiality) When taking protective action pursuant to paragraph (b), the lawyer is impliedly authorized under Rule 1.6(a) to reveal information about the client, but only to the extent reasonably necessary to protect the client's interests.
- B. ABA Model Code of Professional Responsibility - EC 7-12

"Any mental or physical condition of a client that renders him incapable of making a considered judgment on his own behalf casts additional responsibilities upon his 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, his 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 interests, regardless of whether he is legally disqualified from performing certain acts, the lawyer should obtain from him all possible aid. *If the disability of a client and the lack of a legal representative compel the lawyer to make decisions for his client, the lawyer should consider all circumstances then prevailing and act with care to safeguard and advance the interests of his client.* But obviously a lawyer cannot perform any

act or make any decision which the law requires his client to perform or make, either acting for himself if competent, or by a duly constituted representative if legally incompetent" (emphasis added).

C. Right of Defendant to Waive Insanity Defense

1. *Dean v. Commonwealth*, 777 S.W.2d 900 (Ky. 1989).

- a. "[C]ounsel must respect the defendant's authority to make critical decisions concerning his defense." *Id.* at 908. Court cited as authority EC 7-7 of the *ABA Code of Professional Responsibility* which had been adopted by SCR 3.130 and was in effect at the time the case was decided.
- b. "[T]he decision to assert the defense of insanity may seriously compromise a defendant's chosen alternative defense, as well as threaten his liberty and reputational interests and other legal rights." 777 S.W.2d at 908.
- c. "If, after counsel has fully informed the defendant of relevant considerations bearing on the decision to forego the insanity defense, the defendant insists on an ill-advised course of action, counsel should bring the conflict to the attention of the trial court by seeking a determination of whether the accused is capable of voluntarily and intelligently waiving the defense." *Id.*
- d. "Even if a defendant is found competent to stand trial, he may not be capable of making an intelligent decision about his defense." *Id.*

e. "If the trial judge determines the defendant is incapable of voluntarily and intelligently waiving the defense of insanity, counsel must proceed as the evidence and counsel's professional judgment warrant." *Id.*

f. "If the defendant is found capable of waiving the defense, both counsel and the trial court must proceed according to the defendant's wishes." *Id.*

2. *Jacobs v. Commonwealth*, 870 S.W.2d 412, 418 (Ky. 1994). "Therefore, we hold that upon retrial, should there be a conflict between Jacobs and defense counsel concerning asserting the defense of insanity, and should there be a question as to Jacobs' mental capacity, although found competent to stand trial, the trial court shall hold a hearing as to Jacobs' ability to voluntarily and intelligently understand and waive such defense, and such hearing shall be on the record, and upon the finding of the trial court as to Jacobs ability to voluntarily and intelligently understand and waive such defense, defense counsel shall be bound. Said otherwise, on this particular issue, it is the trial court who shall determine if the defendant is the master of his own defense and pilot of the ship."

NOTE: In same case Kentucky Supreme Court later granted defendant's request for a writ of prohibition which reversed trial court's ruling that the hearing need not be *ex parte*. Unfortunately the opinion is unpublished.

For additional information and consult the DPA Trial Law Notebook and Evidence Manual as well.

Chapter 3: Developing Mental Health Evidence

It is rare that defense counsel will encounter a case of capital murder, or other serious felony, in which the mental health of the client is not an issue. For many years it was the practice, of both seasoned and novice attorneys, to develop mental health evidence by delegating the task to a psychologist or psychiatrist with requests such as “Go shrink my client”, “Go run a full battery of tests and tell me what I’ve got” or even “Go see the client and let me know what my defense is.”¹

Lawyers are often criticized for failing to start investigating, or otherwise preparing for a case, until the last minute. Nevertheless, while the fact investigation and biopsychosocial history investigations should be initiated as soon as representation begins, the evaluation of the client by an expert witness should not. The use of experts should be driven by the data developed by the biopsychosocial history investigation.

Practice Note: Delaying the evaluation of the client by proposed testifying experts will allow counsel some “breathing room.” Gone will be the stress of finding someone to do an evaluation while counsel knows little about the case or the client. Postponing any evaluation will allow counsel to make a more intelligent choice about who to hire and what the expert should be asked to do. When the biopsychosocial history investigation has been essentially completed, and a working theory developed, counsel will know if she needs a psychologist, a neuropsychologist, or a psychiatrist. Please see the chapter in this manual on “Witnesses” for a discussion of the differences between these experts. After reviewing the biopsychosocial history investigation counsel may find that no mental health expert is required. If an expert is required, counsel will likely then know how any expert should be used. Should the expert serve as a teaching expert without an evaluation of the client? Should the expert render an opinion following a review of the records without an interview of the client? If there is a personal interview, will the facts of the crime need to be discussed? What records will be provided to the expert? All of these questions will be answered by counsel’s analysis of the information generated by the social history investigation. Any decision that counsel makes should be made only after a thorough investigation beginning with a social history.²

There are three exceptions to this rule that counsel should delay retaining a mental health expert until the biopsychosocial history investigation is essentially completed: (1) the floridly psychotic client, (2) the client in need of immediate psychiatric treatment, and (3) the consulting expert.

The Floridly Psychotic Client: Counsel will want to memorialize any psychotic behavior the client exhibits while in jail if this behavior comes near the time of the offense. The recording of this behavior will likely require a psychiatrist or psychologist who can question the client in the presence of a videographer who captures the sights and sounds of the psychotic behavior. This will be necessary because the client’s psychosis may fade with time, medication and/or elimination of stressors, etc. The judge or jurors will better appreciate the full dimensions of the client’s appearance, thoughts and behavior if they can see these for themselves. Any attempts to describe the client’s behavior orally will likely fall short. Counsel must advise the mental health expert as to the areas of questioning and what areas, if any, should be avoided when conducting the videotaped interview. Videotaping may eliminate the difficult decision facing the trial team: “Do we medicate to alleviate the stress and discomfort of the symptoms or does the jury need to see just how mentally ill the client actually is?”

The Client Who is in Need of Psychiatric Treatment: Counsel will not want the client to suffer unnecessarily from the symptoms and discomfort of his mental illness. If any psychotic behavior has been captured on video, the trial team may hire a treating psychiatrist who can evaluate and

prescribe any necessary medication. Emphasis is placed on the word “treating” as each expert will have his or her job in the defense of the client. Experts should generally not have more than one job or “wear more than one hat”, as their motives and directives will be different from one another. For example, the treating expert will generally not also act as a testifying witness unless she was treating the client prior to the offense. This treating expert can assure the jury that the client’s behavior is not motivated by his current legal problems. The consulting expert will generally not testify as she has been exposed to so much of the privileged and confidential communications as well as work product developed by the rest of the team.

The Consulting Expert: While the trial team will hopefully be able to identify mental health issues that arise during the investigation, it is not likely that the team will be able to fully understand the significance of the vast amount of material that is generated by the biopsychosocial history. The consulting expert can assist with the review of mental health records. She can brainstorm possible theories of the case for culpability and mitigation and provide opinions on the validity of these theories. She might also suggest expert witnesses and areas of cross exam of state’s witnesses. The team may consider retaining a neuropsychologist as a consultant. The neuropsychologist can evaluate for neuropsychological impairment and administer neuropsychological test batteries that may be necessary. However, it is most important that at least one of the team members be well versed in brain science, theories of child development and consequences of abuse and neglect of a child.

Counsel is Responsible for Developing the Mental Health Evidence

Counsel should not abdicate to the expert the role of developing mental health evidence under the false impression that “He/ or she knows more than I do about this stuff.” The expert will certainly know more than counsel about the science underlying mental health diagnosis, causes and possible treatment. However, the development of evidence, theories of reduced culpability and mitigation as well as the overall application of the facts to the law of the case is to be guided by lead counsel, with the assistance of the defense team.

What Can Go Wrong with Just “getting the client shrunk”?

The selection of experts should be driven by the data developed by the biopsychosocial history investigation. If counsel “sends in a shrink” prior to the completion of this investigation, the problems that can result are many, and include:

1. Counsel will not know what kind of mental health expert is needed. The term “shrink” used in the phrase “I need someone to shrink my client” confirms that counsel (a) is not sure if she needs a psychiatrist, a psychologist, neuropsychologist or other expert, (b) counsel does not know what the expert will be looking for, (c) counsel does not know what she wants the expert to do when interviewing the client, (d) counsel does not have any social history records to provide background for the expert, and (e) generally, counsel no longer has control of the case.
2. The valuable Chapter 31 funding may be wasted. If counsel retains a “shrink” and tells that shrink to go “shrink” the client, the “shrink” will do what he or she normally does in their clinical practice.
3. The psychiatrist will conduct a subjective interview of the client for a period of time he deems sufficient to arrive at a diagnosis without benefit of the biopsychosocial history that will take months to prepare.
4. The psychologist will likely administer a battery of psychologist tests in addition to the interview. The results of these tests may provide information that is helpful to the defense, harmful to the defense or irrelevant to the defense. This is because the defense team has not developed working theories for the defense of the client—either in culpability or sentencing. The defense cannot give the expert

¹ Niland, J., *The Role of the Forensic Social Worker in Developing Mitigation Evidence*, Handbook of Forensic Mental Health with Victims and Offenders”, Springer Publishing Company, LLC. (2007) p.129.

² *Wiggins v. Smith*, 539 U.S. 510 (2003).

sufficient guidance as to what issue to evaluate. Accordingly, what the expert provides the defense may not relate to the best theory of the case. Counsel will then be forced to go back to the court, hat-in-hand, and ask for more funding because the first round of funding produced little that counsel can put before the jury. Conventional diagnostic testing procedures are of minimal usefulness in many forensic contexts.¹

5. What may prove to be worse than an evaluation that does not help is one that actually hurts the defense. Without guidance from lead counsel, a psychiatrist may talk to the client about the facts of the crime because that is what he does to determine if the client was sane at the time of the alleged offense. However, insanity may not actually be a viable defense in the case and the expert's discussion about the facts of the crime may prevent the defense from being able to call the expert to the stand. If called to the stand, his conversation with the client may prove to be disastrous on cross examination.
6. Without guidance from the defense, the psychologist (the psychiatrist will rarely administer tests) will likely administer a full battery of tests including personality inventories such as the Minnesota Multiphasic Personality Inventory (MMPI) or the Millon Clinical Multiaxial Inventory III (MCMI-III). These test results will rarely be helpful to the defense and can be used by the Commonwealth against the client. The MMPI contains 567 items that will take the client 60-90 minutes to answer. The results may suggest that the client suffers from one or more personality disorders, often anti-social personality disorder (APD). This is a disorder that the prosecution will use to the disadvantage of the client.

Please refer to the chapter in this manual on personality disorders for a discussion of ways in which to challenge the APD diagnosis. However, the best way to deal with the diagnosis is to avoid it being made in the first place, especially by one's own expert. After a review of the psychologist's findings, counsel may ultimately decide that the information developed by the testing is irrelevant or that calling the witness to testify would not be helpful. Again, the resources have been wasted with no benefit to the client or the defense team.

7. If defense counsel offers mental health evidence that comes as a result of an interview of the client, this will likely allow the state to conduct a similar examination of the client, with the right to administer tests. These tests may be limited to those administered by the defense or may be any testing of the Commonwealth's choosing. Either situation is not good as the state sponsored evaluation rarely works to the benefit of the client.

Kentucky Correctional Psychiatric Center (KCPC)

Some defense counsel may find it easier just to "send the client to KCPC." This is a phrase that should be avoided along with "I need someone to shrink my client." While there may be exceptions, a good general rule is: Avoid KCPC if possible.

Chapter 31 should provide funding to provide the indigent client with mental health experts. KRS 31.185. While this section of the Code refers to counsel's right to use state facilities for the "evaluation of evidence," when hiring mental health experts, counsel is not "evaluating evidence" such as would be the case with ballistics comparison. Rather, counsel is ensuring the client's right to a fair trial, the right to present a defense, the right to effective assistance of counsel under the Sixth and Fourteenth Amendments and right to due process under the Fifth and Fourteenth Amendments to the United States Constitution. The client's right to develop mental health evidence properly is a constitutional right.

KCPC should be avoided for a number of reasons. First and foremost is that KCPC's doctors will do what they want to do and they will administer the tests that they want to administer and they will gather records that they want to gather. Asking the court to send the client to KCPC for an evaluation is an abdication of counsel's obligation to properly develop the mental health evidence on behalf of the client.

Should the prosecution ask that the client be sent to KCPC in order to rebut a defendant's mental health evidence that comes as a result of a mental health evaluation, the scope of the KCPC exam should be litigated and limited to the scope of the evidence which the defense intends to offer. If the prosecution's right to an exam is based upon its right to rebut, the evaluation and testimony should be no broader than the defense testimony. The referral letter will be most helpful in limiting the scope in that counsel can show the court exactly what the defense expert was asked to do. The Commonwealth's expert should also be limited to the scope of the defense evidence.

Should KCPC not in advance agree to comply with a court order properly and constitutionally limiting the scope of its examination, the client should not be subjected to that examination.

What is a Preferred Way to Develop Mental Health Evidence?

1. The first contact that counsel should make after appointment is with the client to begin developing the trusting relationship that is so important to a successful resolution of the case. The second call should be to the mitigation specialist who will perform the biopsychosocial history investigation. If the client is not facing the possibility of death, Chapter 31 funding may not be as readily available. However, counsel should still attempt to get funding from the court or gather as much information on the client's history as possible. The information developed by this investigation will drive the selection of theories and those experts who will help assist counsel in developing those theories.
2. The team should consider retaining a mental health consultant who can help the trial team understand the significance of data discovered by the biopsychosocial history investigation. The consultant can suggest and/or evaluate working theories of the case and suggest expert witnesses who can evaluate the theories with the possibility of testifying at trial. The selection of the final theories will be the responsibility of counsel, not the consultant. As defense counsel will be most interested in the client's cognitive deficits, brain dysfunction and brain damage, the neuropsychological evaluation can be very important to the defense team's ability to tell the client's story. It would be wise for the team to consider a consultant who is familiar with neuropsychological issues.
3. Counsel should also consider retaining a medical doctor to perform a physical examination of the client. A neurologist retained for this purpose will also be able to administer a mental status assessment, an assessment of the 12 cranial nerves, assessment of the motor system, reflexes and sensations along with "hard" physical signs of neurological impairment. The medical doctor should be asked to examine for medical problems with psychiatric symptoms. Out of 658 psychiatric outpatients, 9.1% were medical disorders producing psychiatric symptoms. Examples include speech or memory disorders caused by diabetes, anxiety caused by thyroid disease.²
4. The team should develop working theories of the case for both culpability and sentencing. The team should develop a strategy to coordinate these theories so that they are not inconsistent with each other. The team will not want their theory in the culpability phase to be "He did not do it" and the theory in sentencing to be "O.K., he did it and these are all the reasons why he did it." A mitigation theory for an innocence case can be difficult – if the jury did not accept what

¹ Melton, G.B., Pertila, J. Poythress, N.G. & Slobogin, C., *Psychological Evaluations for the Courts: A Handbook for Mental Health Professionals and Lawyers* (Guildford Press 1997) at 45. Cited by Burr, et al., *A Practitioner's Guide to Defending Capital Clients Who Have Mental Disorders and Impairments*, The International Justice Project, Chapter 9 at 147.

² Hall, RCW, Gardner, ER, Popkin, NK, et al., *Physical Illness Presenting as Psychiatric Disease*, Arch. Gen. Psychiatry. 1978. 35:1315-1320.

the team was saying in the first phase, selection of the proper mitigation theory is important. The sentencing theory might be “You did not accept what we told you in the culpability phase and while we still maintain his innocence, you will need to know a great deal about our client before you sentence him,” or “You will hear all the reasons why he became a suspect in this case.”

5. Once a working theory has been developed based upon the biopsychosocial history the trial team will know (1) which mental health expert(s) need to be retained to develop the part or parts of the theory, (2) the purpose and the scope of the evaluation to be conducted, (3) whether or not any testing needs to be done, (4) what areas of inquiry the expert should avoid and (5) the records that are relevant to the evaluation and that should be provided to the expert.

The team will not be waiting on pins and needles for the results of an unguided evaluation that may be of no help at all

As stated previously counsel should not abdicate the development of mental health evidence to the experts. Guidance should come from the trial team to the expert in the form of a referral letter. Below the reader will find two sample referral letters. One is directed to the consulting expert and the other would be directed to the testifying expert. The scope of these letters is very different. The scope of the letter to the consulting expert is entirely too broad to be directed to the testifying expert. Conversely, the referral letter to the testifying expert is far too narrow to be directed to the consulting expert.

The letter to the testifying expert must be focused and narrowly drawn to direct the testifying expert to do only what is necessary to evaluate one or more narrowly focused issues that support the working theory of the case. Drafting a referral letter takes much time and effort. However, when the letter is drafted, the trial team will understand its case much better and will appreciate how the testimony of this well chosen expert will help to advance the theory of the case. The expert to whom the letter is addressed will also know what he is to do and will avoid what he is not to do.

The Referral Letter

Practice Note: Below is a sample of a referral letter to a consulting psychologist. This expert will not testify for many of the same reasons that the mitigation specialist will not testify. These team member will be involved in brainstorming of the case, will have access to all confidential and privileged communications and all work product developed by the trial team. SHOULD EITHER OF THESE WITNESSES TAKE THE STAND, THERE IS GREAT DANGER THAT THESE PRIVILEGES WILL BE WAIVED. This letter hopefully contains most of the elements of a referral letter to a consultant. SOME OF THESE MAY NOT APPLY TO YOUR CASE. THIS LETTER SHOULD BE INDIVIDUALIZED TO YOUR CASE AND ONLY THOSE ELEMENTS THAT ARE RELEVANT SHOULD BE INCLUDED!

Dear Dr. Jones (consulting neuropsychologist):

I have been appointed by the judge of the Circuit Court of Kenton County, Kentucky to represent Roger Smith. Mr. Smith has been charged by indictment alleging that he committed an intentional murder while in the course of the commission of a robbery. This is a capital offense and the Commonwealth is seeking the death penalty. My co-counsel is Carol Johnson. I am assembling the team members who will defend Mr. Smith against the indictment and I anticipate the need for a consulting psychologist to serve as a member of the defense team. If you are hired, I will ask you to do the following:

- Meet with the client and client’s family and report your observations to designated members of the defense team;
- Conduct a neuropsychological interview with the client;
- Meet in person or by phone as needed with counsel and other members of the defense team;

- Review and evaluate documents and records that relate to the client’s history that have been gathered by the team’s mitigation specialist;
- Consider and evaluate our client’s competency to stand trial, to understand and knowingly waive her Miranda rights and voluntarily give her statement to investigators (should his competency become an issue in the case);
- Consider and evaluate our client’s criminal responsibility at the time of the alleged offense (should insanity be an issue in the case);
- Consider and evaluate the possibility of any lesser included offense as opposed to the offense charged. You will also be asked to brainstorm and evaluate theories of culpability and sentencing;
- Consider and evaluate whether or not the client was acting 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 circumstances as the defendant believed them to be;
- Consider and discuss the possibility that Mr. Smith suffers from Intellectual and Developmental Disabilities and /or exposure to fetal alcohol;
- Advise the team of any additional mental health experts that are indicated and what requests should be made of these experts. You will need to provide evidence, by affidavit, to assist the defense team in establishing the threshold showing of necessity for the funding of these additional experts. Any affidavits will be presented at an *ex parte* proceeding before the court.
- Review and evaluate reports of mental health consultants who have examined our client on behalf of the office of the Commonwealth Attorney. I will ask that you determine whether or not any examination was performed properly and in accordance with accepted scientific and ethical standards, including the *ABA Criminal Justice Mental Health Standards*;
- Receive and review any raw data (all recordings, notes, test protocols and unprocessed responses), test scores and reports generated by evaluator(s) to determine if the tests were properly chosen, properly administered, properly scored and properly interpreted;
- Assist defense counsel in finding weaknesses and errors in the prosecution’s analysis of our client on any issue;
- You will not be asked to testify at trial.

I am enclosing a copy of the Uniform Offense Report that summarizes the Commonwealth’s investigation of the charges against Mr. Smith. Should this report, or anything else, alert you to the existence or appearance of a conflict that would prevent your assisting the defense, please let me know as soon as possible.

Should you be hired, you will be considered as one who is employed to assist the defense team in the rendition of professional legal services to Mr. Smith. Any information that comes to you will be by reason of the attorney-client relationship and protected by Rule 503 of the Kentucky Rules of Evidence. We would expect you to strictly observe the privileged and confidential nature of this information.

Prior to my moving for funding to hire you I will need from you the following:

- (1) a copy of your *curriculum vitae*;
- (2) your hourly fee and an estimate of the total fee that you will require;
- (3) the names and addresses of 3 lawyers with whom you have consulted in criminal cases in the past;
- (4) any reasons why you cannot or should not be associated with this case.

Thank you for your time and attention and I look forward to hearing from you,

Sincerely,

Lawyer

The Testifying Expert

Practice Note: One of the features of the referral letter is to narrowly focus the scope of the testifying expert's examination of the client. A narrow focus is important as the scope of the defense examination may well dictate the scope of the Commonwealth's examination. The Commonwealth may have the right to rebut the defense evidence that will authorize a personal evaluation of the client. However, the limited waiver of the client's Fifth Amendment should be limited to what is required to rebut and nothing more. Choose from the following list, or add to your letter, those requests that are appropriate for your particular case. Not all will apply, nor is this list exhaustive.

Dear Dr. Jones (testifying expert):

Thank you for agreeing to conduct an evaluation of our client, Roger Smith. The offense alleged is a capital offense and the State is seeking the death penalty. My co-counsel is Carol Johnson. As an evaluating psychologist, I will ask you to do the following:

[CHOOSE ONLY THOSE REQUESTS THAT ARE RELEVANT TO YOUR CASE. THIS LETTER SHOULD NOT BE SENT TO A TESTIFYING EXPERT UNTIL SUCH NEED IS INDICATED BY YOUR BIOPSYCHOSOCIAL HISTORY]

- Meet with the client and/or other relevant parties as necessary, and orally report your observations to designated members of the trial team. **[If this witness is a teaching witness who will not meet with the client then edit the language accordingly.]**
- Provide your opinion only on the following issue(s)

- Conduct those standardized tests that we mutually agree are appropriate for the purpose of your evaluation of the issues identified above.
- Consider and evaluate the client's competency to stand trial (should this be an issue);
- Consider and evaluate the client's competency to (a) understand (b) knowingly, (c) voluntarily and (d) intelligently waive her Miranda rights and (e) voluntarily give her statement to law enforcement.;
- Consider and evaluate the client's criminal responsibility at the time of the alleged offense, including responsibility for any lesser included offense. Specifically, you will be asked to determine whether or not at the time of the conduct charged and as a result of a severe mental disease or defect, Mr. Smith did not know his conduct was wrong.
- Consider and evaluate whether or not the client was acting 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 circumstances as the defendant believed them to be.
- Consider and evaluate the client's ability to recognize the risks associated with his conduct or to appreciate such risks and to avoid such conduct once the risk was appreciated.
- Consider whether or not the client suffers from Intellectual and Developmental Disabilities and/or exposure to fetal alcohol.

You will also be asked to meet in person or by phone as needed with counsel and other members of the defense team; review and evaluate documents and records that relate to the issue(s) described above.

I am enclosing a copy of the Uniform Offense Report received from the prosecution. Should you need any more information about the State's

investigation please let me know so that we can determine if a conflict exists for any reason.

- You will be asked to advise the team as to any additional mental health experts that you determine are indicated and what requests should be made of these experts. You will need to provide evidence, by testimony or affidavit for the court, to help establish the threshold showing of necessity for the funding of these additional experts.
- You will be asked to review and evaluate reports of mental health witnesses who have examined our client on behalf of the prosecution. I will ask that you determine whether or not any examination was performed properly and in accordance with accepted ethical and scientific standards, including the *ABA Criminal Justice Mental Health Standards* and similar standards.
- You will be asked to receive and review any raw data, test scores, interpretations and reports generated by state sponsored evaluator(s) to determine if the tests were properly chosen, properly administered, properly scored and properly interpreted;
- You should be prepared to testify at trial, if necessary. You may also be asked to testify concerning your findings that support any pre-trial suppression motions that are filed.
- Communications between you, the client and the defense team shall be deemed privileged and confidential unless and to the extent those privileges are waived by your testimony.

Would you kindly contact me so that we can provide you with those records that are relevant to this referral? We will also need to discuss (a) the nature of your anticipated evaluation of our client and (b) a schedule for completing your evaluation.

We have been given a trial date of ____/____/____. The defense must give to the prosecution a minimum of 90 days notice of its intent to offer expert evidence relating to a mental disease or defect or any other mental condition of the defendant bearing on the issues of guilt, and/or punishment.

Would you kindly contact me upon receipt of this letter? Prior to my moving for funding to hire you I will need from you the following:

- (1) a copy of your *curriculum vitae*;
- (2) your hourly fee and an estimate of the total fee that you will require.

If at any time you conclude, for any reason, that you cannot or should not be associated with this case, please notify me immediately. I look forward to hearing from you.

Sincerely,

Lawyer

Give Your Experts The Relevant Materials They Need

Counsel will be able to utilize the consultant to help understand the historical information discovered by the biopsychosocial history investigation. The consultant will also be able to advise counsel as to what records should be provided to the testifying expert. It would be easy just to give the testifying expert the whole file or the report of the mitigation specialist or all records generated as a result of the biopsychosocial history investigation and just say "Have at it!" However, this is rarely the best approach for several reasons: (1) In the more serious cases, the volume of records will be great and counsel will not be able to afford (nor will most experts have the time) to review all records. (2) Many of the records collected will not be relevant to the referral question the expert has been given. (3) Any records that are provided to a testifying expert will likely become discoverable by the prosecution. Defense counsel must anticipate that the first question when the Commonwealth begins its cross examination of your expert will be: "Let me see your file." The bio/psych/social history will likely contain information that should not be

disclosed to the prosecution. The time counsel spends in scrutinizing records provided to the expert will avoid complications later in trial.

Certainly, the expert should receive all documents that are relevant to the referral question. The consulting expert will help the trial team to determine what is relevant. The expert should receive all documents that the prosecution possesses and that are in any way relevant to the referral question. If there is a doubt about the relevance of a document that the state possesses, give it to the expert out of an abundance of caution. Counsel does not want his own witness to be “blindsided” by the Commonwealth with a record of which the witnesses is unaware. Counsel must anticipate (and avoid) another question on cross examination: “Would that document I just showed you change your opinion?”

Counsel may be presented with an opportunity to guide the examiner, even one chosen by the prosecution, to reach the right conclusion by making sure that the relevant records are considered by the examiner prior to forming the opinion. The following is a real life example of how this process can work: The client, Michael, was charged with a serious sexual assault upon an infant. Michael was a person with severe Intellectual and Developmental Disabilities (called mental retardation at that time). He had a profoundly low IQ and his adaptive functioning was severely impaired. The records all supported this history as well as the legal conclusion that Michael was a person with IDD and not competent to stand trial. There was also the issue of whether or not Michael, at the time of the offense, understood that what he did was wrong.

The trial court ordered an evaluation when the motion raising Michael’s competency was filed. George R. Sornberger, then the Trial Division Director of Kentucky’s Department of Public Advocacy (DPA), and one of Michael’s attorneys, with the assistance of a consulting psychologist, forwarded relevant records to the state psychologists who were to perform the evaluation. These evaluators rarely concluded that a defendant was not competent to stand trial. However, faced with the mountain of records that supported that exact conclusion (records that they would not have obtained on their own), the state psychologists concluded that Michael was indeed a person with IDD. They also concluded that Michael was not, and would not, become competent to stand trial. After reading the report from the psychologists, the prosecution moved to dismiss the indictment against Michael.

If the client has been the subject of prior testing by a mental health professional, your expert (a consultant and/or testifying expert) should have not only the test results and the examiner’s report, but she should also receive what is referred to as the “raw data” or “test data.” Raw data may include all recordings, notes and test protocols relating to prior tests. This raw data will allow counsel’s expert to tell if the tests were administered, interpreted and scored properly. The procedure for the handling of raw data is covered by the ethical principles governing the practice of psychology.¹

Practice Note: The easiest way for defense counsel to obtain the release of the raw data is with a release signed by the client. If the state wants the test data from a defense expert who is to testify, counsel should insist on a court order following a hearing at which counsel can object to the release of the data as a violation of his Fifth and Fourteenth Amendment Rights.

The customary procedure is for the raw data to go directly from the test giver to your expert and not to the attorney. The test givers are understandably protective of these standardized tests. There is a concern that if the tests “get out” not only may the copyright be violated, but the tests could be studied with the obvious resulting problems.²

¹ See Standard 9.04, *Release of Test Data*, and 9.11 *Maintaining Test Security* and related provisions of American Psychological Association, *Ethical Principles of Psychologists and Code of Conduct*, 57 Am. Psychol. 1060-73, December, 2002, effective June 1, 2003.

² Eric Y. Drogin, *Evidence and Expert Mental Health Witness: A Jurisprudent Therapy Perspective*, 2000 Wiley Expert Witness Update, 295-313 (E. Pierson, ed., 2000).

Aren’t We Just Making the Client Look More Dangerous?

Counsel will naturally be concerned about the “double edged sword” aspect of mitigation. “By showing the jury all of the insults to the client’s brain with the resulting damage, both temporary and permanent, aren’t we just making him more dangerous in the eyes of the jury?”

Counsel is justified in being concerned. The jurors before whom the case is tried have not been conditioned to look at the human side of bad and often violent behavior. Jurors may often react with their “gut” rather than a compassionate heart as counsel often will. We know from the Capital Jury Project that many jurors come to a decision on punishment while still in the guilt phase of the trial.³

However, counsel can consider a number of ways in which to neutralize this problem. She can consider:

1. In jury selection, talk to the jurors about what each juror does for their children and perhaps more importantly, what each juror would not do to their children and why. Talk to them about whether or not their thoughts apply to all children – such as the client – or only their children. There exists a theory that jurors think differently about a stranger’s child than they would about their own, so counsel must meet this head on in *voir dire*. Hopefully, the defense can pick a jury that will be properly horrified at the life experiences of the client. Counsel can remind the jurors, “You would not have tolerated anything like this happening to your child. You would not tolerate this happening to the child of a friend. You would not tolerate this happening to a stranger’s child – in fact, if you were present when this was happening to Johnny, the client, you would reach out to stop it. But you were not there when these things were happening to Johnny, but you are here now. Now you have the power to reach out and help Johnny when you could not before.”
2. The defense can “front-load” mitigating evidence during the culpability phase of the trial. Counsel should consider carefully whether or not this evidence will open any doors to damaging evidence that can otherwise be suppressed.
3. If the client is young, the jury must understand that his brain has not been fully developed and when the client does reach his mid 20’s that he will likely be a different person, a person with a fully developed brain and one that can moderate the impulsive behavior that may be relevant to the offense.
4. The client will “age out.” The science tells us: Antisocial personality disorder has a chronic course but may become less evident or remit as the individual grows older, particularly by the fourth decade of life. Although this remission tends to be particularly evident with respect to engaging in criminal behavior, there is likely to be a full decrease in the full spectrum of antisocial behaviors and substance use.⁴

Practice Note: This language is found in the DSM-5 section on antisocial personality disorders. However, the language is broad enough so that it can be applied to all criminal behavior. Consider retaining an expert who can teach the jury about the impact of ageing generally – particularly with males- so that the reference to antisocial personality disorder can be avoided.

5. Drug therapies are available to treat some aspects of violent behavior. The drug phenytoin, a drug used in treatment of epilepsy, when administered in low doses was found to reduce the impulsive behavior in Texas prison inmates diagnosed with antisocial personality disorder. The drug was not effective for those whose behavior was premeditated rather than impulsive.⁵

³ William J. Bowers & Wanda D. Foglia, *Still Singularly Agonizing: Law’s Failure to Purge Arbitrariness from Capital Sentencing*, 39 Crim. L. Bull. 51, 174–75 (2003).

⁴ *Antisocial Personality Disorder-Development and Course*, Diagnostic and Statistical Manual of Mental Disorders (5th ed.) American Psychiatric Association. (2013), at p. 662.

⁵ Barratt, Ernest, S., et al., *Phenytoin in Impulsive and Premeditated Aggression: A Controlled*

6. Hopefully, the trial team will have identified the client's mental health problems that are of concern to the public. Once problems have been identified, solutions can be suggested so as to ease the concern of jurors. In the capital case, the prison system can provide safety and security in an environment that is free from the stressors that may have induced the client to commit the crime. In the non-capital case, counsel can argue that the client will likely benefit little from incarceration. By joining the free world, the client can continue to work, support his dependents, pay taxes and obtain community based treatment for his disability and/or impairment.
7. Throughout a trial, counsel should attempt to humanize the client so that the jurors can see the client as a human being, rather than as the Commonwealth will describe him. Counsel should regularly interact with the client in a friendly and affirming way. Should counsel show that they are not afraid of the client, then hopefully the jurors will see that they have no reason to fear him. The client should not go out of his way to interact with courthouse personnel, but to the extent he naturally can, he should be encouraged to do so in a respectful manner.
8. Carefully consider which of the state witnesses-usually police officers, sheriff deputies, or jailers- who have come into peaceful and cooperative contact with the client. These professionals have been trained on how to deal with suspects who pose a danger. Should the client have had peaceful and cooperative interaction with one or

more of these witnesses, counsel should consider leading them on cross examination telling this story: (1) you interacted with client; (2) he was peaceful and cooperative; (3) you have been trained in how to deal with those who pose you a danger; (4) self-protection is critical part of your training; (5) had you felt that client was a danger, you would have taken steps to neutralize this danger; (6) you took no steps with client because you felt he posed you no danger.

Conclusion

Perhaps the most important element of properly developing mental health evidence is to find out as much about the client's life story as is possible and let this information guide you. This is accomplished by performing a thorough biopsychosocial history investigation. This investigation is usually performed by a trained and experienced mitigation specialist. Even when funding has been denied always ask for a mitigation specialist. Counsel should seek out as many sources of information as possible.

The data produced by this investigation will provide counsel with information necessary to develop theories of culpability and mitigation. The investigation will help counsel avoid all of the tragic consequences that flow from having someone "shrink" the client. Counsel will have access to a number of tools that will assist in telling the client's life story, but these tools must be used carefully and they should never cause counsel to lose sight of the need to humanize the client by a vivid telling of his life experiences and conditions. Tell the story and paint the picture!

Study, The Journal of Clinical Psychopharmacology, Vol. 17, No. 5 (1997).

Chapter 4: Psychological Testing

“Psychological tests are tools.”¹ The rules for choosing these tools are different for the clinical psychologist who is treating a patient in private practice than for the forensic psychologist who is part of a criminal defense team. If a mental health expert is unable to recognize this distinction it is time to look for another expert.

The clinical psychologist will use standardized tests to obtain a large amount of information in order to treat the patient. The forensic psychologist does not need testing to gather history as the biopsychosocial history investigation conducted by the mitigation specialist provides the information needed. The referral letter will tell the expert what to evaluate. The biopsychosocial history will also suggest to the trial team possible theories of the case (working theories). “If you have thirty minutes to see a patient, spend twenty-eight minutes on history, two minutes on the examination and no time on the skull X-ray or EEG.”²

As discussed above, the defense team will send the chosen expert a focused referral letter asking the expert to evaluate for specific conditions that appear to support the theory of the case. If testing is necessary, the tests should be relevant to the working theory or not administered at all. For example, if the expert is asked to evaluate for Intellectual and Developmental Disabilities, then a test of his Intelligence Quotient (I.Q.) would be required along with instruments and interviews that would evaluate his adaptive functioning. The Wechsler series of intelligence tests may be used to assess I.Q. should there be a question of Intellectual and Developmental Disabilities. The WAIS IV for those age 16-89 and WISC IV for ages 6-16.

Many clinical psychologists will insist on administering a personality test such as the Minnesota Multiphasic Personality Inventory (MMPI) that has been described earlier in this manual or a Millon Clinical Multiaxial Inventory III (MCMI-III). “These tests provide a composite description based on many people who have answered questions in a similar way rather than in an individualized assessment. These tests do not help to explain a client’s life or his experiences in an effective way, and there is a high risk that statements endorsed in the test will be taken out of context to portray the individual negatively.”³

The MMPI provides to the clinician a large amount of information and many consider it to be “the gold standard” in the clinical practice. The MMPI may very well serve as the “gold standard” in the clinical practice, but it is not necessary in the forensic case. Defense counsel is defending the client against a serious charge. She is not treating the client for a mental health condition. Some psychologists are afraid of being challenged by the prosecution if an MMPI was not administered. The expert must not allow the prosecutor to confuse the clinical with the forensic practice and need only explain to the prosecution that the results of the personality test would not be relevant to the referral question for which she was to evaluate. This is yet another benefit of the focused referral letter.

Research has questioned the validity and reliability of these [personality] tests in a forensic setting.⁴

Clinical psychologists may refer to themselves as forensic psychologists simply because they are consulting with the prosecution or defense. This does not mean that the expert fully understands the difference between the clinical and forensic practices. If your testifying expert insists on administering one of these personality inventories, then choose another expert. A clinical psychologist was once asked why she administered both an MMPI and a Hare Psychopathy Checklist-R after being specifically

instructed not to administer either of these. She replied, “I wanted to know what to stay away from.” Counsel had previously told her what to “Stay away from those tests!” Instruments such as these may suggest that the client has an antisocial personality disorder (the prosecution will call him a sociopath) or worse. While a diagnosis of APD may tell counsel little about how the client will behave in the future, one can be assured that the prosecution will use these labels to make the jury fear the client.

By administering the tests, the psychologist made it impossible to “stay away from” the tests and test results should she testify. Her test results would certainly be harmful to the defense. As generally is the case, the biopsychosocial history provided counsel with the same results as the tests did. These tests will provide us nothing that will humanize the client or mitigate the client’s sentence.

In addition to the other problems with the MMPI it is important to note that none of the personality inventories have been normed or assessed for use in a jail setting. The MMPI is not normed for use with people with an I.Q. under 80, and it is not appropriate for individuals with significant intellectual disabilities, brain damage, learning disabilities or problems with reading comprehension or language.⁵

Some mental health experts utilize projective personality tests. These are referred to as “inkblot” tests. The inkblots are very unstructured and subjective and give the evaluator very wide latitude in analyzing the responses. The reliability and validity of these tests are questionable and are among the least reliable and scientifically weakest of the psychological tests.⁶

Neuropsychological Testing

Neuropsychology is also the study of brain-behavior relationships. The most important evaluation may be the physical exam performed by a neurologist where the expert tests each of the cranial nerves and reflexes. The physical exam may be supplemented by written test instruments administered by a neuropsychologist. These tests may identify and measure cognitive deficits, brain dysfunction and brain damage. The neuropsychologist can use a standardized battery such as the Halstead-Reitan Neuropsychologist Battery or the Luria-Nebraska battery or a flexible battery of testing. The flexible battery tests will vary according to the expert and the reliability and validity of the evaluation will depend on the tests given. Personality inventories such as the MMPI and the MCMI-III are not administered as a part of a neuropsychologist battery of tests.

As defense counsel will be most interested in the client’s cognitive deficits, brain dysfunction and brain damage, the neuropsychological evaluation can be very important to the defense team’s ability to tell the client’s story.

It is also important for the team to consider as a consulting expert, one who thoroughly understands neuropsychology so that neuropsychological issues can be adequately identified, brainstormed and developed into working and possibly trial theories of the case for culpability, mitigation or both.

A chart which lists the different types of tests is included in this chapter with special thanks to The International Justice Project.

Testing may be valuable to the defense in particular cases, but the tests must be carefully chosen, administered, interpreted and scored. Neuropsychological batteries of tests are generally safer to administer because personality inventories are not a part of the standard set.

Malingering

The common response of prosecutors to test results offered by the defense is that the client is malingering – faking good or faking bad or just plain faking. Counsel should anticipate the claim of malingering and deal with it head-on. A neuropsychological examination will likely contain one or more tests of malingering, including the Rey-15, Rey Word Recognition

¹ Burr, Dick, et al., *Psychological Testing*, A Practitioner’s Guide to Defending Capital Clients Who Have Mental Disorders and Impairments, at 147.

² Sahs, Adolph in Caplan, L., & Hollander, J. J., *The Effective Clinical Neurologist*, (Butterworth/Heinemann 2001) at 25 as cited in Burr, *Id.* at 148.

³ Burr, et al., at 154.

⁴ Burr, et al., at 155.

⁵ Burr, et al., at 155.

⁶ Burr, et al., at 156.

Test, Portland Digit Recognition Test, Dot Counting, and Symptom Validity Test. These tests evaluate the client's level of effort when answering the test questions. Each should be able to be completed without error by most unimpaired people.¹ The answer to some of the test questions are so simple and obvious that someone would have to be faking in order to get them wrong.

The level of effort given by the client when taking such a test is critical. The client's mood may affect his level of effort. If the client is depressed, if he has a very negative view of himself, his current situation and his future, he will be very depressed and his performance will suffer. It may be wise to treat the mood disorder before any neuropsychological tests are administered.

"Norming"

Psychological tests are "normed" meaning that the tests have been given to a large number of similar people so that test designers can determine what score is "normal" and what results are not normal. This is often expressed in a bell curve where "normal" results are seen in the middle of the curve at the top and those that are above normal or below normal are shown on opposite sides.

The process of norming a test is important because if the test is given to people who are not similar to the test subject (the client) the test results may not be relevant to the client. In such an event, the evaluator does not know if the client's test results are normal or not.

Practice Note: A challenge to the results of a state sponsored test may be that the test was not normed on a group of people that is similar to the client. For example, the MMPI is not normed on subjects who were in jail so we don't know what test results are "normal" for people similar to our client, *i.e.*, people in jail. Did the client's incarceration have an effect on his ability to properly answer the questions on the test? What was the client's mood, state of mind at the time the test was administered?

Each test requires test protocols, meaning the proper way in which the test should be administered. If the test is not administered in accordance with the test designer's protocols, the results might not be reliable – reliability and validity are key to the value of the test results.

Tests are often scored by hand and not by the hand of the psychologist who administered the test. This task is sometimes delegated to an assistant who may not have the same experience or motivation as the psychologist. Make sure to have your expert obtain the raw or test data and confirm that the test was properly chosen (is there a "fit" between the test and the claim being made by the Commonwealth)? Was it properly administered following the applicable protocols? Was it properly scored and are the individual scores properly added when necessary? Was it properly interpreted when considering the client's bio/psychosocial history and other results that should be considered?

Observation and Recording of the Testing Process

The mental health community has concerns about third parties being present when a person is being administered standardized test instruments. Concerns over third party presence include: (1) presence is inconsistent with standardized test protocols, (2) it can affect the examinees' test performance, (3) it creates the potential for distraction or interruption, and (4) it can pose a threat to test security.²

While one could write at length on the positions taken by the various psychological organizations most, if not all, of the forensic positions refer to civil litigation and not criminal defense. It certainly can and should be argued that the client's Fifth and Sixth Amendment rights should control. These rights are compromised by an evaluation that is not honestly and correctly performed. The only way to ensure this is to (at a minimum) have a psychologist or neuropsychologist present during any prosecution

sponsored evaluation guided by a court order limiting the scope of the examination to the scope of the examination performed by a defense testifying expert. Any position on third party presence taken by a test administrator, or these organizations, must certainly recognize and observe the Constitutional rights of the client..

The American Bar Association has said: "When the scope of the evaluation is limited to defendant's present mental competency, *the defense lawyer* (emphasis added) has a right to be present during the evaluation." When the scope is not limited to competency, the defense attorney may be present only with the evaluator's prior approval, and if present, may only actively participate if requested by the evaluator. The prosecutor is never allowed to be present during an evaluation of the client. All court ordered evaluations of the client initiated by the prosecution should be audio or videotaped for use by the defense. The prosecution can get a copy, but the defense can seek protective order from the court, asking for a redaction of certain portions prior to the tape being delivered to the prosecution.³

Certainly, any concerns that the court would have regarding the presence of a third person (assuming that the defense lawyer were not allowed to be present) during an evaluation would be satisfied by specifying that third person be a psychologist or neuropsychologist. Such a professional would have an interest in protecting the security of the tests and would have no interest in interfering with the administration or otherwise skewing the results.

Practice Note: It is suggested that counsel obtain a court order limiting the scope of the prosecution's examination to the scope of the examination that the defense testifying expert conducted. The Commonwealth has only the right to rebut what the defense testimony will be so its exam should be similarly limited. Fishing expeditions and the administering of personality inventories or subjective projective testing should not be allowed – assuming that the defense has wisely chosen not to have these administered by its psychologist. As the right of the Commonwealth to rebut hinges on a limited waiver of the client's Fifth Amendment privilege, the Commonwealth should have no communication with its expert until the defense expert takes the stand and testifies (thus waiving the Fifth Amendment privilege). Only then should the Commonwealth be allowed to talk to its expert and receive the results of any testing. The defense should be given the results of any testing as soon as completed, prior to the prosecution receiving anything from its expert as the evaluation results are from *the client* and the Fifth Amendment privilege has not yet been waived by the defense expert taking the stand and testifying.

Brain Imaging

There are two different types of imaging processes available. These are anatomical images and functional images.

The anatomical images will show us what the brain actually looks like and will show counsel the actual brain itself. The viewer can see the size, shape, holes or other malformations of the brain. Anatomical images will help to understand how the physical brain has changed in appearance over time.

Functional images will tell us how a brain is working in real time. This result is achieved by injecting substances into the brain that will reveal blood flow, metabolism, how much glucose (fuel) the brain is using in comparison to other parts of the brain or in comparison with a "normal" brain. These images are usually quite colorful. They may reveal which parts of the brain may be functioning at a different level than normal, but the image will not tell why.

¹ Burr, et al., at 156.

² *Presence of Third Party Observers During Neuropsychological Testing*, Official Statement of the National Academy of Neuropsychology (2001).

³ ABA Criminal Justice Mental Health Standard 7-3.6, *Procedures for Conducting Mental Evaluation* (1989).

Types of Anatomical Imaging Films

X-rays – the most commonly used. The denser tissue absorbs more x-ray energy and the softer tissue absorbs less x-ray energy resulting in the contrasting views. The air appears black, bones appear white and muscle and other soft tissue appear to be gray in color.

Magnetic Resonance Imaging (MRI) – The MRI requires no injections of tracers or radiation. Magnets detect radio wave signals from the body's naturally occurring protons and a computer pulls the images together, providing greater details than CT images. Minute changes over time can be detected with the better details. Views of the surface and subsurface of the brain can be seen. While the MRI does not show brain metabolism, it can show greater content of the brain and inflammation or bleeding.

Computer Axial Tomography (CAT scan) – this combines x-rays from many angles. Can provide a cross section of the brain and identify tumors and structural problems.

Types of Functional Imaging

Positron Emission Tomography (PET) – radioactive isotopes are injected into the blood stream. The isotopes emit detectable positrons. The positrons flow with increased or decreased blood flow and indicate, with multi-colored dimensional images, brain functioning when a person speaks, listens to music, processes information, and responds to stimuli. The PET is more versatile than the SPECT scan, the period between a test and retest are shorter, a more detailed image is produced with a higher degree of resolution and provides a better picture of deep brain structures. The PET can be combined with an MRI to show both function and structure.

Single Photon Emission Computed Tomography (SPECT) – this imaging process is similar to a PET scan, but detects a different type of photon. It provides lower resolution than a PET scan. The tracing ability is more limited than a PET scan, and it is less expensive as fewer staff are required and no onsite cyclotron is required to produce the images as the tracers deteriorate more slowly,

Functional MRI (fMRI) – depicts images of blood flow as it is occurring. It is much faster than the PET scan and will show changes in very fine parts of the brain. It can highlight activities such as thought, perception and action.

Electroencephalograph (EEG) – electrodes are placed on the scalp. The graph measures patterns of electrical activity in the brain and can highlight relative strength in different parts of the brain at the same time. It is fast, but with lower resolution. It can be combined with a MRI to pinpoint location.

Admissibility Issues

Neurological imaging has reliability and “fit” limitations resulting in admissibility problems at trial. Some of the limitations counsel will have to address include:

1. the image can provide only after-the-fact data;
2. the image may suggest only one explanation for the client's behavior;
3. the reading of the images is subjective;
4. Correlations between brain function and the “why did he do what he did?” question are not solid. Images are not “diagnostic” of anything and cannot be used to diagnose a particular condition.
5. There may not be a “fit” between the test results and the defense theory. The tests tell the jury “something” but that “something” may not be relevant to the theory of defense. The issue is “A” but the image shows us “B.”
6. “Very little is known about brain plasticity, which means that no one can say what a brain should look like in an adult who suffered a childhood traumatic brain injury. The brain may adapt or repair itself in some situations and not in others or may adapt by “recruiting” parts of the brain to do tasks not typically associated with that task.” Burr, et al at p. 160.

Practice Note: Brain images may not be diagnostic of anything but defense counsel is usually not interested in a diagnosis anyway. We are interested in explaining behavior regardless of what the condition is called. Should the testimony devolve into a contest between the state's expert (the white knight) and the defense expert (the whore), the defense will lose. Consider using the image to affirm the results of neuropsychological testing, life experiences or conditions that counsel is able to establish by other evidence and testimony. Lay experts may be particularly credible.

7. Brain imaging of people with major mental illnesses more often than not appear normal. MRI scans of 6200 psychiatric inpatients at McLean Hospital found positive findings, meaning an abnormal MRI image in only 1.6 per cent of patients.¹

Practice Note: Brain imaging can cause counsel to lose focus of the client's story, thinking that the client's life experiences can be reduced down to a very pretty and colorful image. Telling the client's story to the jury and painting vivid pictures of the client's life experiences can be more effective.

Conclusion

Brain images can serve as one of the tools to show a jury the condition and functioning of a brain at the time of the scan. Hopefully, counsel will then be able to relate these images back to the time of the alleged offense. Do not ask the images to perform a scientific function that they are not able to perform reliably. Images may become a part of the client's story, but at the current level of sophistication and reliability, certainly not the whole story.

¹ Burr, et al., citing Rauch, S.L & Renshaw, P.F., *Clinical Neuroimaging in Psychiatry*, 2 Harvard Review of Psychiatry 297 (1995).

Chapter 5: Fundamentals of Biopsychosocial Evaluation in Forensic Cases: An Overview and Guide for Attorneys

Robert Walker, M.S.W., L.C.S.W.

This overview of biopsychosocial evaluations (sometimes called ‘social history’) is intended to inform attorneys about what to look for in asking for mitigation reports and to guide the efforts of mitigation information collection. The article is perhaps too long for many, but it includes the basic features of what a biopsychosocial should contain. There are three mental health evaluations that have use in forensic environments: psychiatric evaluations, psychological assessments and biopsychosocial evaluations. Statutes and individual court practices influence which of these three is relevant in various proceedings. The psychiatric evaluation typically focuses on the diagnosis of mental disorder or mental state of a defendant. The psychological assessment uses various instruments to outline and define personality traits, emotional or psychological disorders and intellectual capacity. The biopsychosocial is the integrative assessment of an individual that brings medical, psychological, social, familial, educational, economic and cultural factors into a comprehensible evaluation of the person. It can either precede other more specific evaluations or it can serve as the summative assessment that blends findings from other reports. Where the psychiatric is performed only by psychiatrists and psychologicals by psychologists, the biopsychosocial is performed by clinical social workers, psychologists and other nonmedical behavioral health professionals. When correctly performed, the biopsychosocial evaluation summarizes all the significant factors in a defendant’s life and *presents the most salient characteristics in comprehensible ways*.

In clinical settings outside the forensic realm, the biopsychosocial evaluation summarizes the person’s development and current living situation so as to set the stage for treatment. Nonclinical uses of clinical information, however, appear to be on the increase. However, what one learns in the context of treatment is likely to be very different from what is learned in forensic processes. Clinicians need to be reminded that hearing a client describe events does not mean that those events are true or that the clinician has some unique capacity to make a determination about their truthfulness. The clinician must be wary about overstepping the bounds of the role as an expert and placing himself or herself as the arbiter of truth before a jury or judge – particularly when that clinician has been involved in *treating* the individual before assuming a forensic role.

What is at issue here is not the use of behavioral health experts, but the proper way to go about using biopsychosocial information in forensic settings. The recommended way to do this is *not to use existing evaluations which have been written out of context*, but to conduct evaluations with the forensic situation clearly defined as the purpose and audience of its findings. This discussion of the ingredients of a biopsychosocial is intended to increase the level of professional competence and personal confidence in these evaluations. *Thoroughness is the essential factor* and the clinician who pays attention to detail with all have no reason for anxiety about psychiatric opinions that vary from the biopsychosocial. Well developed psychiatric opinions should cover the same ground as that covered by the biopsychosocial evaluation.

The Purpose of a Forensic Biopsychosocial

The purpose of a forensic biopsychosocial is four-fold: 1) to present salient clinical features in a narrative context, 2) to present a plausible portrait of the person that invites empathy, 3) to offer a comprehensible context for the actions taken by the individual and 4) to appraise the individual’s potential for change or rehabilitation.

1. The Narrative Context: In clinical settings, professional descriptions of a “client” are often collages of information about his or her key life events, symptoms, thought processes and qualities of emotion and mood. There is a *conceptual order* to the clinical document that

follows agreed upon formats for describing clients’ level of functioning. By contrast, there is merit to using a *historical or narrative structure* for presenting information in forensic evaluations so that jurors can begin to understand the *evolution of the person in the environment*. From a defense perspective, the clinician should define the individual’s psychiatric or psychosocial disorders in the context of the individual’s history. The juror can begin to make inferences about causes and effects based on the narrative of events. Most of us understand our own lives in the context of our “story,” the events that have occurred and the things we have done and, since jurors are generally “lay” people, it makes sense to build upon their accustomed ways of understanding life. Life events can begin to delineate mitigating circumstances that can influence the court’s understanding of the crime.

2. Plausible Portrait: The prosecution’s presentation of facts in a criminal proceeding is designed to show the *differentness* of the defendant from the rest of us. There is a circularity to its argument: the person’s acts demonstrate his or her barbarity and the very barbarity of the individual helps explain why he or she could have done what he or she is accused of. The intent of prosecution is to convince the juror of the “otherness” of the criminal, the demonic quality; it is designed to prevent any empathic feelings, for if one can *identify with the criminal*, then punishment becomes harder to decide. Defense strategies, on the other hand, attempt to diminish the willful quality of the defendant and so they either demonstrate the degree to which the defendant was a victim or they aim at establishing the image of a real person with whom the jury can identify. The task is to present a *plausible* person – neither too demonic nor too helpless. The forensic portrait should capture the degree to which the individual truly has available choices and the degree to which he or she recognizes and acts on those choices.
3. Environmental Context: No one exists in a vacuum. The art of forensic assessments lies in the conveyance of the texture of the defendant’s world. Choices always seem abundant from the position of a courtroom long after the crime has been committed. One of the goals of the forensic biopsychosocial is to render the constraints of the individual’s world. The evaluation should define the specific features of the environment, both during the defendant’s development and during the period when the crime was committed.
4. Rehabilitation Potential: The evaluation should describe the individual’s strengths or redeeming features that point towards a possibility of positive change with appropriate support or treatment services. A very bleak and tormented life might show considerable potential for growth and development in spite of all the grim historical events. Prognostic statements should be framed in terms of realistic potentialities.

These four purposes guide the organization, the content, and the tenor of the evaluation and, as mentioned above, they must be adjusted to the particular legal context of the evaluation.

Procedural Guidelines

The preferred practice is to *use clinical procedures to produce forensic documents, not to just make forensic use of clinical documents*. In other words, the forensic evaluation should be a *special clinical procedure that is distinctly set apart from clinical functions per se*. The reasons for this include the ethical concerns about the degree to which the client understands the context for personal disclosures. An evaluation that took place as part of treatment is quite different in its impact upon the client’s decisions about disclosure. When the individual has made these disclosures as a part of treatment, there is generally a very different motivation from what one might see in forensic settings. One cannot assume that the disclosures made in the course of clinical discussion would necessarily be made in the forensic case. Ethical and legal dimensions of

these evaluations must be followed in strict order in order to not compromise either client's privacy or liberty interests or the professional's credibility. There are six major steps in conducting the forensic biopsychosocial assessment.

1. securing a proper court order or a contract (the context for the evaluation);
2. obtaining informed consent and permission to evaluate the individual;
3. obtaining proper releases of information and obtaining the records from relevant sources;
4. performing the evaluative interviews and observations;
5. reviewing the content and impressions with the individual (and counsel if this is a defense case); and
6. submission of the report and findings.

Item 5 might disturb some evaluators – particularly if there is a belief that the individual is going to try to exercise editorial control. This is not at all the intent; it is merely a way of keeping the process honest, accountable and properly focused. If the evaluator cannot look the individual in the eye while giving the content of findings and opinions, then there is reason to be concerned. Given that the liberty interest or even life of the individual might depend upon those findings and opinions, it seems worthwhile to give the individual the opportunity to hear them first hand and at least respond to them.

The Six Steps of Evaluation

1. **Proper Order or Contract – the Context for the Evaluation:** The evaluator should be crystal clear about who is requesting the assessment and the exact uses that are envisioned for the report. The evaluator should have a clear understanding with the attorney as to the desired goal and the methods of defense that the attorney is planning to use. Much grief can be avoided by having this frank discussion at the very beginning of the case, rather than later when a clash of values or approach has arisen. The clinician must establish the parameters of truthfulness that are not to be abridged in the process. Wise forensic practice flourishes neither in rigid ethical purity nor in meretricity. It is not the business of the mental health professional to raise concerns about the purely legal dimensions of the case, but ethical issues can be cause for great concern and should be resolved prior to beginning the assessment of the defendant.
2. **Informed Consent:** The defendant should be given clear and relevant information about the nature of the evaluation and then legal context within which it will be done. Often the individual has but a crude understanding of the processes involved in court proceedings and all of the evaluations that might be enlisted. The evaluator has an ethical duty to explain this in detail irrespective of what the attorney might or might not have done. The evaluator should also obtain permission to interview family members and other collaterals. Technically, this permission is not required, but, in the interest of preserving an ethically sound relationship with the defendant and family, it is advised to seek it. Once the interviewer has established contact with collaterals, there is a duty to obtain their informed consent and permission to participate in the assessment. The consent must be in written form.
3. **Releases of Information and Review of Records:** The evaluator should obtain authorization to release any and all medical or psychological records from the defendant's previous providers to the clinician. This should include records from inpatient stays, residential care for substance abuse or other disorders and any and all outpatient records. Criminal records, evidence of placement in group homes, foster care or other social service interventions in the individual's youth are helpful. The more information the clinician has, the better the evaluation.

4. **The Evaluation:** The actual evaluation might be conceived of as a process rather than a discrete interview. The evaluation consists of six major elements:
 - a) There will be numerous interview sessions. This allows for questioning from different perspectives and within differing contexts, thus giving the clinician the opportunity to check the reliability and consistency of critical responses.
 - b) Collateral interviews with family members and sexual partners are critical. Where possible, these interviews should be conducted as home visits. Obviously, time constraints limit one's ability to do this, but much can be learned from seeing the defendant's home and from experiencing his or her culture in an immediate way. The perspectives gained from other family members are also crucial in forming meaningful impressions of the family of origin and the veridical strength of the defendant's version of this past.
 - c) Police reports, investigative reports, witness statements and factual evidence should be reviewed by the clinician. This information should be viewed as simply one version of the reality – not the absolute truth to which one tries to get the defendant's responses reconciled.
 - d) The interviews with the defendant will involve taking the life and health history and doing a mental status examination. The full content of this part of the biopsychosocial will be reviewed below.
 - e) The various reports and records from other providers should be integrated into the clinical assessment. Part of the task of a forensic biopsychosocial is to assimilate disparate professional opinions, histories of treatment and other assessments into a coherent picture. Differences of perspective should be accounted for and reconciled where possible. Where this is not possible, the differences of opinion should be explained as such and the underlying assumptions or biases of evaluators can be discussed.
 - f) Research data should be applied to any clinical opinions about the defendant. The clinician should even cite contradictory research findings and show how and why one perspective on this is chosen over the others. Citations should be from empirical research, not "authorities" who have propounded theories or vogueish "disorders" in popular books.
5. **Reviewing the primary findings and conclusions with clients and with attorneys before finalizing written reports.** Reviewing materials serves one kind of ethical function in regard to clients and yet another with regard to attorneys. The evaluator should be seen as an agent of the attorney and thus, all ultimate responsibility for conclusions about the case should be integrated into the defense argument.
6. **The submission of the report should be to attorneys only.** The report should be well-written and polished to convey maximum attention to the details of the case and the importance of findings and conclusions.

The Biopsychosocial Format and Content

1. **Identifying Information and Context of the Evaluation:** The clinician should state the individual's full name, age, sex, race, marital status, address, and occupation and location where and when the interviews have been conducted. This section should also include a very brief synopsis of the case.

Example: "Ms. Jane Logan Doe, a 27 year old white female, separated, who lives at 233 Locust Street in Lexington, Kentucky. She was interviewed on three occasions in the Metro Detention Center in Lexington, Kentucky on the dates of 21 November 2003, 3 December and 9 December 2003.

She has been charged with the homicide of her brother, John Doe, on 10 January, 2003. There are two other co-defendants in the case and all were reportedly involved with John Doe in drug dealing."

The location of the interviews can be of great importance, both to the clinical findings and to the conduct of the defense around those findings. Interviews that are conducted in correctional facilities leave their imprints, but they are sometimes difficult to interpret. It is often difficult to ensure even a bounded confidentiality in correctional settings since the clinician is not in control of the environment.

The evaluator should state the specific context for the evaluation. This includes a statement of the charges facing the individual, the status of the case at the time of the evaluation, the party who requested the evaluation and the questions that the biopsychosocial assessment has attempted to answer.

Example: "Ms. Doe has been convicted of manslaughter and is currently awaiting sentencing before Judge Tenzing Norgay, XX Division, Jefferson Circuit Court in Louisville, Kentucky. This evaluation was undertaken at the request of her attorney and it addresses the mitigating factors behind the commission of the crime, including the impact of numerous previous traumas on her at the time of the commission of the crime."

II. The Defining Reason for the Evaluation – Presenting Problem: There are two principal presenting situations for forensic evaluations: 1) situations that call for opinions to guide the determination of guilt or innocence and 2) situations that call for information to assist in mitigation. The presenting circumstance provides clear guidance for the kind of exploration that the clinician should undertake.

A. The clinician should elicit the individual's understanding of the circumstances of the referral and the reason for the evaluation. The salient features of the individual's view should be recorded in his or her own words in quotes. The individual's accounting of the facts is important, but, perhaps, even more important to the evaluative process is the rationale that the individual gives to the events. The individual's attributions of intentionality to others can be significant as it can provide leads to family or social relationships that might have had significant impact on the individual's behavior.

B. The clinician should either distill a brief account of the events as they are defined by official reports or simply give evidence of having reviewed witness statements, police reports and any other factual evidence. This is done as a way of grounding the evaluation and also as a way of showing the court that the clinician is aware of the "official" version of events and has not blindly followed the defendant into a swamp of distortion.

III. Early Personal and Nuclear Family History: This part of the biopsychosocial establishes the basic developmental and core family features from birth through adolescence. It encompasses the genetic, cultural, social and interpersonal aspects of the early family environment and the role that these elements will play in the formation of the adult character.

A. Genetic influences and intergenerational trends: The most effective way to obtain and represent all of the genetic loads on character formation is through the use of a *genogram*. This simple graphic tool lets the jury and other evaluators see the accumulative quality of genetic and intergenerational influences that are of a destructive nature. By representing the three generations preceding the defendant, one can observe a pattern of biological factors that can become a part of mitigation in defense process.

The genogram offers the clinician one device for selective representation of traits and trends in the family. For example, if the case involves a crime where alcohol or drugs were a factor, then the genogram can focus on the presence of drug or alcohol problems in the family. Likewise, seizure

disorders, mental retardation, learning disabilities and other traits can be selected for their relevance to the issue at hand.

B. Nuclear family characteristics: The nuclear family contains numerous elements of relevant history. Among the more important influences of the family is the degree to which violence was a part of the environment. There are two aspects of violence that are particularly relevant to the forensic biopsychosocial evaluation: 1) being a victim of violence as a child and 2) witnessing violence toward other family members. Both of these should be explored in any evaluation of defendants charged with violent offenses. Particular attention should be paid to the age at which the individual was exposed to the violent behavior, as evidence suggests that the earlier the trauma, the greater the likelihood of damage to the formation of self. At later years violence damages emotional systems and behavioral learning, but, in early development, it acts directly on identity and self. Normal development calls for an interplay of natural biological processes with environmental nurturance: violence truncates natural potential.

Sexual abuse has effects on the development of self and self concept, the emotions and behavior that are similar to those of violence. The earlier the age of exposure, the greater the likelihood of damage to self. Later exposure is more likely to be correlated to Post-Traumatic Stress Disorder than to damage to the formation of self. The individual who was exposed to sexual abuse in childhood carries a heightened risk of being sexually or physically abused in adulthood. This is attributed to the victim's tendency to adopt survival techniques in childhood that become counterproductive in adulthood. The coping style of being avoidant or dissociative can lower the individual's ability to defend herself against the intrusions of a perpetrator.

With sexual and physical abuse, the clinician should assess the degree to which the child was subjected to threat and fear. The research on psychological symptoms resulting from abuse suggests that terror is one of the more powerful contributors to pathology. Violent acts might have been infrequent and brief in duration, but a pervasive atmosphere of fear and intimidation, threat, and pernicious attitude toward the child can be profoundly damaging to the evolving sense of self. Persistent and pervasive fear is now understood as having effects on brain areas (the hippocampus and the amygdala) that direct and retrieve memories and activate arousal. The assessment of terror in the individual's life is one of the pivotal factors in understanding the individual's world view and capacity to think, feel, and behave.

Another ingredient that is a significant contributor to symptoms and distorted self formation is the element of objectification involved in sexual abuse. Paradoxically, we humans seem to be better equipped emotionally to deal with abusive acts that are *personally directed* versus those that are the result of merely using us as objects of gratification. The clinician should assess the degree to which the individual was subjected to a perpetrator's instrumental style of sexual or physical abuse.

As appealing as the signal events of abuse can be in the forensic evaluation, the combined influences of other factors such as neglect, substance abuse or dependence and rigidity of parental beliefs and behaviors should be examined. There are few "single bullet" hypotheses that can explain complex human behaviors and the successful forensic evaluation will pay heed to the multiplying effects of various factors rather than merely settling with the most obvious one. Sexual trauma at an early age (ages 4-7) combined with neglect offers one of the most potent ways to destroy the evolving self. Not unlike the recent attention to psychiatric comorbidities, the combinatory effects of destructive interpersonal and familial relations deserves close attention in the forensic evaluation. The question that arises from this inquiry is "what adversity did the individual face in meeting the challenges of development and what are the probably effects of the missing fundamental biopsychosocial 'nutrients' to that development?" A sophisticated assessment of the abuse phenomena will

conflate 1) the history of specific abuse with 2) the elements of terror and instrumentality and with 3) the ambient environment of neglect.

In many forensic cases, the individual will have had foster placements during childhood. These placements, along with other early residential treatment placements should be explored in some detail. Early foster care can have ramifications on the degree to which the child found dependable and reliable attachments. Some foster placements are very positive and others merely repeat abusive experiences for the child.

Procedural Tips

The clinician who wishes to obtain a useful early history of personal and family events will adopt a noncommittal posture that makes untiring use of generally open-ended and sometimes presumptive questioning. The clinician should be very cautious about the even subtle display of affect during this questioning process since it possible to influence the individual's account of sensitive matters. There should be very few questions that can be answered with "yes" or "no" and the clinician should not provide answers through the content of the question. The style ought to be so matter of fact as to not give the individual suggestions of desired content.

The *least* advised way to get abuse information is to ask, "Were you abused as a child?" The defendant situation provokes intense motivations to see self as a victim of others. For the clinician to walk into this with simplistic questions *is to do a disservice to the individual*. The task for the forensic evaluator when working for the defense is to avoid stereotypy; simplistic questions exaggerate the superficial traits of the individual and thus contradict the intent of the process.

C. Early development and personal events. There are four domains that should be covered in this section: 1) prenatal factors (if known), 2) early childhood development and adaptations, 3) middle childhood and 4) adolescence.

1. **The individual's prenatal conditions** can be relevant to the understanding of cognitive ability, impulse control and other aspects of the adult personality. This information is obviously not easy to obtain in most cases and it can be subject to substantial distortion. It is, nonetheless, an important area for inquiry and, should there be any relevant findings, they should be identified in the report. Among the features that can be relevant are: pre- and perinatal maternal use of alcohol, tobacco, cocaine and marijuana. These substances have been shown to influence fetal and early childhood development of cognitive capacity, behavioral controls and emotion regulation.

If obtainable, the individual's developmental milestones should be correlated with norms. Delays in development are not uncommon among individuals who are affected by violence and who perpetrate crimes. These findings, when discoverable, should be referenced but used with care in forming clinical conclusions.

2. **The early childhood** of the individual can show traits that are significant to the clinical impression of the adult defendant. Early incidents of aggressive behavior – particularly when accompanied by injurious aggression – are among the more reliable indicators of antisocial personality formation. When these traits are accompanied by quasi-adult or truly adult sexual behaviors during early childhood, the likelihood of antisocial personality becomes all the greater. Other early childhood adaptations should be evaluated and compared to later behaviors. This can be helpful in sorting out the contributions of temperament and signal events in shaping later adaptive patterns. In general, the more persistent and earlier the trait (particularly the more antisocial ones), the greater the likelihood of it being resistive to change in adulthood. There should be inquiry into symptoms of early childhood disorders such as enuresis, phobias, sleep problems, and communications problems.

3. As the child moves into **school years**, there are more measures of social and intellectual adaptations. Early social patterns

should be assessed including: the types of friends, form of socialization (one-on-one or small group), relations with adults, younger children, and older children (including exposures to harmful influences of older children). The clinician should be sensitive to the progressive features of the individual's intellectual adaptations and expressed abilities. Changes or halts in progress can be indicators of signal events in the child's life and can prompt further inquiry. The changes in content as grades increase can also be an explanation for gradual decreases in school performance. If the child grew up in an abusive environment, it can be helpful to learn whether he or she had the ability to garner surrogates from teachers, other adults, school counselors, etc.

4. **Adolescence** is perhaps the watershed for markers of many adult problem behaviors – particularly for antisocial and personality disordered individuals. Personality begins its final packaging during this period of development and patterns of adaptation to pleasurable experiences, social and other stressors and the challenges of responsibility are significant to the development of the adult personality. Among the themes to be explored are: educational attainments, the onset and character of sexual relationships, drug and alcohol exposures, and socialization.

It is not uncommon to see changes in the individual's academic performance during adolescence. Lay wisdom attributes this to the various psychological dimensions of the teen experience, but the clinician should also be sensitive to the increased demand for abstract thinking in high school material. Poor academic adaptations can be indicators of poor parental support for education, disturbed home environments, fundamental cognitive incapacities, drug and alcohol use or, more likely, several of the above combined. This period of academic performance should be reviewed carefully and correlated to other events in the individual's life.

During adolescence the individual begins to develop interest in sexual relationships. For some this transition is gradual and tentative while for others it is abrupt and decisive. It can be very important to capture the emerging patterns of sexual relating in the adolescent. Partner battery and sexual assault begin to emerge in adolescence for some individuals and the clinician should be attentive to these adult-like disorders in the adolescent. The assessment should also explore the degree to which the individual evidenced dependency in early dating patterns.

Adolescents should be assessed carefully for they can provide cues about the degree to which the individual might have internalized controls that can be built upon in treatment. Drugs and alcohol are attractive mood modifiers to the adolescent and the clinician should evaluate for the presence of abuse and even dependence during this period of development. The drug and alcohol history will need close evaluation (see below) but important information can be obtained from the use of *presumptive questioning* about adolescent behaviors.

Presumptive questioning seems at first glance to be judgmental. This is not at all the purpose of the approach. The purpose is to provide a permissive setting for the individual to disclose what he or she knows is wrongful or problematic behavior. It actually has the paradoxical effect of normalizing the individual's world and it conveys that the clinician understands that world. When the individual has not fought and/or has not had problematic sexual behaviors, he or she will report this and the focus can move on. This form of questioning should only be used where the individual presents with defensive style and antisocial traits that need clarification.

IV. Adult History: The history of adult functioning covers nine major areas: 1) marital and/or partner relationships, 2) parenting or caregiver roles and behaviors, 3) patterns of substance use and other compulsive behaviors, 4) educational attainments, 5) vocational attainments, 6) current living environment, 7) economic security and status, 8) social and recreational pursuits, and 9) religious or spiritual values.

1. Marital and/or partner relationships: The evaluation of partnering should encompass a history of relationships plus a depiction of current ones. There are seven major dimensions to the evaluation of marital and partner relationships: a) mate selection, b) role definition, c) expectations of the partner and relationship, d) attachment behaviors, e) conflict resolution, f) relationship dissolution, and, in certain cases, g) domestic violence and where indicated, h) lifestyle or sexual orientation. Throughout each of the seven, the clinician should be sensitive to patterns and themes rather than just isolated facts. Relationships are, in some respects, difficult to assess due to the contributions of the other person (who might not be available to the evaluator). Patterns that repeat over several relationships, however, make for defensible inferences.

A. *Mate selection:* This item shows marked sex or gender differentials in forensic populations. Lay thinking assumes that people make active choices about partnering and that the resultant relationship is the product of free choice. Among forensic concepts, one of the more enduring and pernicious ones is *the belief that domestic violence victims continually seek out abusive partners*. The clinician is strongly encouraged to discard this notion. A realistic appraisal of the woman's *actual choices in partnering* need close review; she very rarely has the range of healthy choices available that we believe she has. When we add to the formula some of the preconditions within which a poor woman operates, the situation takes on a grimmer prospect. If she is from lower socioeconomic strata, she earns little money and *has great economic need for a male wage earner*. If she has a child or children, this need is all the greater. As an uneducated, low wage earner, she is less likely to be mixing with upwardly mobile males. Furthermore, the disparity between her wage and that of males in her class is very great.

The concept of free mate choices has meaning with males and it is viable to use this in the biopsychosocial evaluation. In cases where domestic violence persists over multiple relationships, we can assume *not* that the woman is seeking abusive partners, but that *the man is seeking likely victims*. This notion should not surprise us; perpetration of abuse is closely allied with other deliberative steps towards domination of partners. Why would it not influence mate selection?

B. *Role definition:* The clinician will want to evaluate the roles that the defendant has taken in marital or partner relationships. Primarily, this involves an examination of the distribution of power and control among the partners. In addition, the clinician will need to assess the boundaries of partners with each other. Are there signs of enmeshment or disengagement? These two concepts, for all their theoretical frailties, still have some merit in appraising the degree to which individuals are constructively engaged in the relationship. Over involvement in the affairs of one can suggest enmeshment while withdrawal and avoidance can suggest disengagement.

C. *Expectation of the partner and the relationship:* It is useful to understand what the individual expects from spouses or partners and what he or she sees as needs that should be met in the relationship. This sometimes must be framed in a historical way. *E.g.*, "When you first got married, what kinds of things did you think your wife should do for you?" and, "later on, did your thinking change about this?" – "How so?"

D. *Attachment behaviors:* The clinician should examine the ways in which the couple came together and stayed together. What was the attractive element and did the individual know what it was at the time? The clinician will need to examine the degree to which engagement is sustained through stressful events. Attractive force between the two can be a function of companionability, interpersonal need and sexual attraction. Sexual and romantic dimensions should be explored to ascertain the degree to which they motivated the forming of the relationship and the degree to which they play a part in the current status of the relationship. Sexual behavior needs detailed inquiry when there is evidence of sexual parameters to the crime, when there is evidence of sexual dysfunction or where the defendant has raised a sexual concern

about the relationship. A brief sexual behavior assessment is appended to this document in the form of a series of questions that can be asked in cases where sexual crimes may be the problem.

E. *Conflict resolution and communication styles:* The clinician needs to explore how conflict arises in the relationship, over what issues and by what methods are they resolved. Defendants might have need to either exaggerate or deny conflict in the relationship. This is an area in which collateral information is very important. Even in undisturbed relationships individuals exhibit substantial distortion about the kinds, causes and results of conflict. The clinician should use presumptive questioning in some cases with this issue. *E.g.*, "When you and your wife are really angry with each other, what's it usually about?" "When you are arguing with each other, what usually brings it to an end?" "Who brings it to an end?"

F. *Relationship dissolution:* The clinician should obtain a history of the individual's ending of relationships. It is useful to know whether there is mutual consent or whether the defendant or the other is usually responsible for ending the relationship. This item can be useful in forming inferences about dependence. It is also useful to know whether the dissolution was the result of violence or other infraction by the defendant such as extramarital affairs or other illicit pursuits versus a long pattern of not getting along.

G. *Domestic violence:* When there is reason to believe that domestic violence played a role in the defendant's life *a full domestic violence assessment should be undertaken*. This will involve a review of patterns of violence from either the perpetrator or victim perspective as indicated by the individual's situation. When the defendant is a victim of domestic violence, the full history of abuse should be explored in great detail since there is evidence that victims are likely to have histories of childhood abuse in addition to their adult experiences. Likewise, perpetrators typically have violent and abusive backgrounds. When domestic violence is a part of the defendant's presentation, this issue should receive prominent treatment in the biopsychosocial evaluation.

H. *Sexual orientation:* The individual's sexual orientation should be referenced but it is not necessarily significant. Failure to note it can be very damaging when the prosecution attempts to use it in a stigmatizing way when the individual is gay or lesbian. The clinician should be familiar with cultural features of gay and lesbian lifestyles so that inferences about partnering can be informed. Gay and lesbian relationships have features that might appear pathological when viewed without an understanding of their differences from hetero couples.

2. Parenting and Caregiver Roles: The clinician should evaluate the various caregiver or parental roles that the individual has. Again, as with other topic areas, this should be done historically and in the current circumstances. Patterns of caregiving can be important in forming a clinical picture of the individual and they can be significant mitigating factors in the sanctioning process. The impression of criminality can be greatly diminished by a history of careful and concerned parenting in a situation of great adversity. Parenting is difficult to assess with only the defendant's information and thus collateral data is very important. Among the themes that should be explored are: the quality of the parental attachment to the child, the degree of involvement in the child's schooling and recreational activities, the methods for insuring the health, safety and security of the child, and the methods for handling discipline. Have the defendant's children been removed by Protective Services? For what period of time? Was this due to acts committed by the defendant or because of a failure to adequately protect the children from harm caused by others? What steps were taken by the individual to remedy the situation and did this result in a return of the children?

Other caregiver roles should be explored including whether the defendant is responsible for the care of adults who cannot provide for their own needs. This might include elderly relatives of adults with disabilities.

3. Patterns of substance use and other compulsive behaviors: It is not uncommon for defendants to have drug and/or alcohol abuse histories. The assessment of these issues requires attention to detail as the ramifications of the different patterns can be of considerable importance in estimating the degree of impairment and rehabilitation potential. The clinician should view the substance use history from a developmental perspective since there is evidence that the timing of initiation of routine use constitutes a significant marker for the degree of addictive disorder. Among the factors involved in the assessment of substance use are the following: a) the substances that have been used by the defendant and the quality of mental state that the substance provides (*i.e.*, satiation, stimulation, etc.), b) the age of first exposure and recurrent use, c) the quantity used, d) the frequency and concentration of used substance, e) efforts to control or stop the use of the substances, and f) changes or shifts from one substance to another. As a general rule, the earlier the use of substances, the greater the likelihood of entrenched addictive pattern and the less likely the recovery from it.

In forensic evaluations, the cluster of behaviors typically associated with substance use (such as criminal conduct to procure or pay for substances) are as important as the use itself. Furthermore, the distinction between abuse and dependence is sometimes difficult to determine in forensic cases when the individual might have made many changes (at least temporary ones) since the charges. In these cases, the clinician is put in the position of determining what the level of use was some weeks, months or even years ago – a daunting task considering the potential distortions that the defendant and family can bring to bear in these circumstances. The substance use disorder should be examined in the context of all the features of the individual's lifestyle to help in determining the degree to which substances are central or peripheral in his or her life. As part of the assessment of substance use, the clinician should also evaluate the defendant's risk factors for HIV infection.

In addition to substance use, the clinician should assess for the presence of other behaviors that possess addiction-like qualities. This includes compulsive behaviors that are hedonic such as gambling, risk-taking behaviors (fast driving), compulsive sexual acts and other behaviors that appear to have a compulsive quality that interfere with social or vocational pursuits.

4. Educational attainments: The clinician assesses educational attainments with an eye to three dimensions in the individual's performance: a) social and cultural influences on education interests and attainments, b) family pressures and disturbances that might have affected attainments, and c) intellectual ability. The clinician should track the individual's school performance through early grade school, middle school and secondary grades. It is useful to note the point at which the individual began to perform poorly. Typically, this is around late middle school or high school years. This is cause for further evaluation since there can be any number of inferences to draw from this. The failures can be due to any one of a combination of all of the three dimensions noted above. The clinician should pay particular attention to the cultural factors in the individual's nuclear home and community as this can be a very powerful determinant to education performance.

5. Vocational attainments: The individual's vocational history should be assessed with attention on the long and short term patterns of employment. Is there evidence of a pattern of frequent job changes with intervals of unemployment in between? Is there, on the other hand, a pattern of sustained employment with ever increasing levels of responsibility? How does the individual end his employment and what are the reasons for leaving a job? Is the work gainful? Is the level of employment commensurate with the individual's level of education attainment? The clinician should also assess the degree to which the work environment forms the socializing network for the individual. Work relationships have become among the strongest in our contemporary

culture and the exploration of these can reveal important aspects of the individual's level of functioning.

6. Current living situation: "Current," as it is used here, means at the time of the commission of the crime. The clinician should obtain a clear picture of the living environment within which the defendant lived at the time of both the crime and the signal events that led up to it. The home space should be evaluated for safety and privacy. Housing environments where there is a high incidence of drug related crime and shootings have obvious effects on the mental and emotional state of their inhabitants. Crowding in the home environment should also be examined.

7. Economic security and status: The defendant's economic circumstances should be elucidated in the assessment. The individual's income sources should be documented and compared or contrasted to expenses. The accounting for an individual's financial resources can lead to many other lines of inquiry on both the expense and revenue sides. This can include hints about gambling, extramarital affairs, drug abuse, prostitution and other illicit forms of income.

Spending patterns need to be evaluated although most clinicians tend to avoid this area of inquiry. Unsecured loans are common among poor people and the accumulated debt from these loans should be evaluated as to its extent and purpose. These loans are often taken out to relieve debts to other creditors and the combined interest should be noted. The clinician should also sum the defendant's entire known debts. The clinician should note whether the individual has any form of health insurance or whether he or she might be eligible for Medicaid or Medicare.

8. Social and recreational pursuits: The assessment should include reference to any form of social outlets that the defendant has by history. This would include the individual's circle of friends or peers (constructive or unconstructive), formal group allegiances, self help group participation, and any signal friendships. The evaluation should also note any recreational activities that the individual has pursued including sports, hobbies or other activities.

9. Religious or spiritual values: The individual's religious values can be a significant contributor to behavior patterns, though not always in expected ways. Decisions about remaining in relationships, child discipline, sexual conduct and drug taking or drinking are the more likely areas that might show religious underpinning. The logic of a crime might elude the examiner until he or she investigates the religious value system that can motivate extreme stances that then lead to crises. The juror might be perplexed about an individual remaining in a destructive relationship until he or she learns that the individual has the belief that eternal damnation follows from divorce or separation. Religious or spiritual beliefs are among the most powerful (if inconsistent and illogical) that a person has and the biopsychosocial should evaluate these with care.

V. Risk Assessment: The individual must be assessed for the degree of risk for 1) harm to self, 2) harm to others and 3) victimization by others. This tripartite risk assessment should be longitudinal and developmental where indicated. For example, in some cases the defendant will have a lengthy history of violence towards others while in other cases the violence is a new behavior. Violence and suicidality should be evaluated in the context of the individual's development and environmental factors and should be examined for duration over time. In doing this, the clinician is assessing whether the risk factors constitute *traits* of the individual versus *states* of mind that arose in reaction to unusually stressful events.

Suicidality and aggression are virtually inseparable from histories of childhood physical and/or sexual trauma so that risk in one dimension often leads to risk in others. *What is important is the clear delineation of the proportions of risk that surround the individual's life prior to the crime and subsequent to it.* This should include reference to those factors that might limit or diminish risk in the individual. For example, if the violence has only occurred when the individual has been intoxicated on alcohol, extensive treatment for the drinking problem might lower risk. If the

individual has done well in structured environments and has only committed isolated acts of harm when living alone, then risk might be diminished by the use of structured residential programs.

1. *Harm to self – suicidality:* Suicidality is difficult to assess with much objectivity in forensic cases since there are so many factors that propel the defendant toward a suicidal stance. These stressors can either fuel a genuinely lethal suicidal disposition or can merely motivate ploys to elicit sympathy. In either case, the science of prediction is insufficiently endowed to allow for dismissal of even the most transparent threats. It is, therefore, axiomatic that the clinician *should take all suicidal threats seriously* as if they were direct expressions of actual intent. *Suicidality is the one finding that can place a duty to care on the clinician even while in the process of merely evaluating the individual for forensic purposes.* Threats to other made in the context of the evaluation create duties to warn and protect, but the presence of suicidality creates the duty of care. This duty of care might be discharged by using any number of supports in the individual's family or residential setting along with medical and/or verbal therapies. The duty does not immediately impose a need to use inpatient care but it does mean that *some* reasonable plan of care is put in place.

2. *Harm toward others:* It should be self-evident that a forensic biopsychosocial should thoroughly explore the individual's risk for harm to others. The predisposing risk factors for this are much the same as for suicide with several additions: learning disabilities (particularly low verbal processing), closed head injury or other trauma to the brain, and ADHD. When the clinician assessed this area of the individual's history, a developmental approach is recommended. Violence rarely arises out of nothing; there are almost always many precursor behaviors or a history of violent acts that precede the current one. This item should be explored using the method of *presumptive questioning* mentioned above. The clinician should be inquiring into early violent or abusive acts as a way of determining the degree to which the aggression is integrated into personality versus a reaction to extreme circumstances. One of the better ways to do this is to ascertain how early the aggression is manifested in the individual. In general, the earlier the pattern, the greater the likelihood of its incorporation into personality and the greater the likelihood of its future expression. The assessment of risk for harm to others should be expressed "high," moderate" or "low" risk language as opposed to predictive statements. The risk should also be stated with contingencies. For example, the individual might have a low to moderate risk while on medication, but high when off of it. An individual's risk factors might diminish dramatically with removal from the particular community. The prediction of future acts, violent or otherwise, is poorly grounded in empirical data and, given the weightiness of decisions in forensic cases, predictive statements should always be guarded and qualified.

There are five dimensions of the assessment of violence of aggression: A) the biological and genetic influences, B) the early childhood exposure to violence either as a witness or victims, C) the development pattern of violence in the individual, D) the thought processes associated with violent behavior and E) the outcomes and consequence for violent conduct.

A. *Biological and genetic influences:* While many clinicians might be reluctant to consider biogenetic loading on violent conduct, it is nevertheless, a topic that must be explored. There is considerable evidence that pronounced antisocial traits have strong biogenetic transmission factors. The clinician should make use of genograms to assess the extent of familial history of violence and aggression. Another biological factor that should be incorporated into the risk assessment for harm to others is closed head injury or other brain trauma.

B. *Childhood experiences:* The literature is complex on this matter as with most in the forensic areas, but, as a general rule, childhood exposure to violence is correlated with adult expression of violent behavior. While it is an unsupported hypothesis to suggest that childhood victims become adult perpetrators, it is nonetheless true that adult

perpetrators have in most case been victims. Clearly, the combination of genetic predisposition with childhood exposure to violence is an indicator of very high risk for adult violence behavior. When the defendant's crimes are sexual in nature, it is likely that there have been childhood sexual abuse incidents or the witnessing of sexual violence during childhood. It is rare, though possible, for adult sexual criminality to arise in the absence of childhood exposure to this behavior.

C. *Developmental patterns:* This history of early childhood should be taken in a careful sequence with particular attention to pre-adolescent expression of violent behavior. As socialization patterns ramify in adolescence, the clinician should be looking for those antisocial acts that are most influenced by social environment versus those that pre-date gang or other social involvements.

D. *Thought processes:* The earliest literature on the antisocial personality identified thought patterns that marked these individuals as different from others. The clinician should examine the thinking behind violent acts to determine the degree to which violence is dissonant or congruent with self. In general, the degree to which violence is integrated into the view of self is correlated with the individual is likely to persist in violent acts in the future.

E. *Outcomes and consequences:* The clinician, in taking a history of the individual's violent behavior, should note what actual harm was caused – the level of injury etc. This refers to the actual harm done to others. When the defendant reports not knowing what harm he has caused, one can be reasonably sure of denial. The clinician should also assess whether weapons were used against others and, if so, what harm resulted. The clinician will also want to assess what sanctions have resulted from previous violent acts. This will include an evaluation of the degree to which the individual has experienced consequences and learned from them.

3. *Risk of victimization:* The individual's risk for being victimized is an important part of risk assessment. This should include an assessment of risk while in detention where appropriate. Due to disorder, alleged offense or other factors, the individual might be at greater risk than others in correctional facilities. Likewise, the individual who is on bail during the evaluation should be assessed for risk factors in his or her home or residential setting. Domestic violence victims are likely to be at heightened risk for further harm from a variety of sources unless they have made arrangements that protect their safety and security. As a general rule, the greater the history of abuse victimization, the greater the risk for future harm as well.

VI. Mental Status: The mental status assessment is a systematic representation of observed behaviors, thinking patterns and emotional qualities in the individual. This assessment consists of both informal and formal evaluative procedures. In assessing cognitive capacity it is useful to follow the standard mental status questions pertaining to memory, judgment and abstracting ability. The responses must be interpreted in the context of the individual's current circumstance and cultural background, however. There are eight components to the mental status assessment.

1. *Appearance:* The clinician should note the individual's appearance in concrete terms, paying attention to hygiene, grooming and appropriateness of clothing (appropriate to the individual's culture). The clinician should also form an impression of whether the individual appears his or her stated age.

2. *Affect, emotion and mood:* The clinician should identify the individual's generally sustained emotional tone and inquire about the individual's reported mood. The reported mood should be reconciled with observed affect. The individual's tenor of emotion and range of expressed emotion should be integrated with her or his history and presenting situation. The mental status assessment should pay attention primarily to the individual's qualities *at the time of the interviews*, but should view

these findings in the context of the individual's history. Incongruities between expressed emotion and life situation or thought processes point toward the need for further evaluation.

3. *Motor activity:* The clinician should assess the individual's displayed motor activity. This includes the degree of agitation, restlessness or, conversely, the lack of usual activity. It will also include observation of tics, repetitive motions, unusual gaits and any other unusual postures or movements. In depressed persons, psychomotor retardation might be evident

4. *Speech and qualities of verbal expression:* The clinician should examine the ways in which the individual links ideas and sentences, the volume of verbal activity and the vocabulary used by the individual. The linkage of sentences and ideas can evidence disorder in thought process caused either by affective disorder or thought disorder. The association of one thought with another can be heavily influenced by mania, depression, or schizophrenia. Does the individual produce a huge or very small quantity of words? Are answers typically elaborated on or merely answered with a word or two? The clinician, in evaluating this field should be attentive to the qualities of the expressive ability, not so much to actual content or meaning of the thoughts.

5. *Thoughts, perceptions and beliefs:* The clinician will assess the content and meaning of the individual's expressed ideas. This includes three components: a) expressed worries or preoccupations, b) perceptions and c) fundamental beliefs that have influence over behavior.

6. *Cognitive status:* The assessment of cognitive status and capacity is one of the more complex and worrisome features of the biopsychosocial assessment. The individual's cognitive capacity can be significant to a finding of guilt or innocence and can, to a lesser extent be relevant to sentencing. The individual's cognitive integrity is in some respects the heart of the biopsychosocial assessment as all of the individual's biological, social, developmental and environmental factors shape the fundamental cognitive abilities that govern how an individual navigates in the world. The clinician will want to ground observations in formal assessment questions and/or references to the individual's history. The cognitive status should be evaluated in the following areas:

A. *Level of consciousness:* When the individual is not alert, she or he should be assessed for intoxication or other phenomena that can alter consciousness.

B. *Orientation:* The clinician should explore the individual's orientation to self, place and time when there are indications of disturbance of thinking, as in schizophrenia or dementia. Orientation to time should be carefully judged if the individual is in an institution. Living in these environments destroys both reference to date, day of week and even time of day and it destroys the significance of the passage of time. Orientation to time becomes, therefore, meaningless.

C. *Attention and concentration:* The individual's degree of attending should be assessed. This can be done by giving her or him an exercise such as subtracting aerial sevens from 100 or repeating key phone numbers backwards. Impairment of concentration can be either indicative of serious mental disorder or simply high levels of stress and preoccupation. When the clinician observes attentional deficits, the individual's history should be consulted to see if there are situational or developmental factors relevant to this phenomenon. Initial indication of impairment should result in further testing to obtain a more discriminating picture of the condition.

D. *Language comprehension:* The individual should be able to identify phenomena or objects. If there is evidence of inability to do this, it might be an indication of serious cognitive impairment secondary to tumor, head injury or mental disorder. The individual's basic ability to read and write should be assessed. Does the individual comprehend the words and concepts used in the interview? Again, as with other aspects of the

biopsychosocial, the clinician should be aware of cultural factors that can influence these findings.

E. *Memory:* The clinician should examine the individual's memorial capacity for short term, intermediate term and long term functions. All memorial impairments must be reconciled with history findings. Short term memory is assessed by giving the individual three unrelated words to recall in three to five minutes. If the individual fails to do this, the test should be done again two or three times throughout the interview. Long term memory is assessed by obtaining information from the individual's past (as in several years ago). Intermediate memory tests should focus on events that are days to weeks old. Memorial disorder requires very careful assessment. Deficits can be either attributable to psychological (trauma) or neurological events (strokes, head injury, etc.) or psychiatric illness (schizophrenia). Memory is a complex cognitive process and is influenced by many factors. The safest clinical path is to depict it accurately and thoroughly, but to be parsimonious in drawing causative inferences.

F. *Fund of information:* The individual's fund of basic information about the world should be assessed, but in the context of his or her world. This might mean that the individual has an abundant fund of information about her extended family, but hasn't a clue who is president of the United States. One can ask the individual to give the number of nickels in a dollar and other money related questions. The clinicians should move from personal spheres to public ones in assessing this area of cognition.

G. *Calculation:* Appropriate to the individual's level of education, he or she should be evaluated for basic arithmetical ability. Simple addition and subtraction equations can be used for this purpose. One can ask the individual to make change on imagined purchases.

H. *Spatial representations:* The individual should be asked to make Bender-Gestalt drawings on a plain white sheet of paper to detect signs of certain neurological deficits. These include simple geometrics as well as a clock face, cross figure and intersecting wavy lines.

I. *Abstraction:* The individual's ability to work with abstract ideas is an important part of overall cognitive capability and it should be assessed within the context of the individual's educational and cultural background. Abstraction is tested by the use of proverbs and reasoning exercises that call for the detection of similarities in named objects. One of the advantages of using proverbs is that they can be adjusted to different cultural contexts when indicated.

J. *Judgment:* The clinician should assess the individual's quality of judgment as evidenced in the traditional questions about why people pay taxes, why cars are licensed, what would he or she do with a stamped addressed envelope that was on the sidewalk, etc. The responses on these items give one the feel for the way in which the individual makes judgment decisions.

The mental status becomes all the more critical when the individual gives multiple history events that might suggest impaired cognitive ability. When there is a collection of these events, the clinician should use great care in capturing the specific qualities of the individual's thinking, feeling and acting and render those in the context of brain functioning. It is not uncommon in forensic populations to discover an individual born and raised in poverty who also has a likelihood of fetal exposure to alcohol, tobacco and/or drugs, physical and/or sexual abuse, poor educational supports and adult exposures to a variety of unconstructive environments. All of these factors can contribute to impaired cognitive ability and this is why it is so critical to assess this domain so thoroughly.

VII. Medical Conditions: The individual should be assessed for health problems with particular attention to those disorders that might have impact on mental functioning. Individuals with chronic and largely untreatable conditions can be subject to mood disorders, distortions in thinking and heavier problems. The biopsychosocial assessment should include a review of systems so that the clinician can detect unnoticed

disorders that might require either a referral for treatment or that might influence a clinical impression of mental disorder.

VIII. Functional Assessment: Individual who present with significant levels of impairment and diagnoses of major mental disorder need to be assessed for their level of functioning. This is done because diagnosis and clinical descriptors alone fail to capture the degree to which disorder interferes with the individual's life. A functional assessment identifies those areas daily living that are impinged upon by disorder or condition. The clinician should also assess the individual's adaptive strengths that can be built upon in either treatment or rehabilitative care. Even simple social skills or avocational interests should be reviewed for their potential as positive factors in the individual's future.

IX. Integrative Assessment and Clinical Impression: The integrative assessment of the individual needs to account for all the disorders and significant findings of the preceding headings. The integrative assessment should show how all the parts of the history work together to produce a life with which others can identify. Severity must be shown, but made familiar, not bizarre. If there is substance abuse, it must be woven into the fabric of the individual's existence, not left hanging as a separate and independent pathology.

Lastly, the integrative assessment draws inferences about the degree of freedom within which the individual lived. It delineates constraints in the person's life; constraints caused by cognitive impairment, by heritable mood disorder, by poverty, by being the repeated victim of battery, etc.

It renders the individual as one who is making decisions, but in a very limited world of options.

X. Recommendations: The clinician should state those services or settings from which the individual might take benefit. This is most important in sentencing processes where the court must consider rehabilitation potential. It is foolish to offer prognoses given the level of impairment of most forensic cases, but a description of services that the individual can benefit from is a realistic undertaking. These recommendations should be specific and should relate clearly to the salient features of the individual. They should be feasible and not idealistic.

Conclusion

The biopsychosocial is a complex evaluative tool that can bring greater depth and realism to the handling of forensic cases. In defense strategies, it can form the backbone of the humanistic defense where the pain and suffering of the defendant can be translated into meaning food for thought in the juror. One of the ironies of the process is this: in order for the assessment to adequately render the humanity of the defendant, it must first make use of the most detached clinical processes. Strong feelings (positive or negative) on the part of the examiner in the assessment phase can lead to distorted findings and these distortions can have profound consequences for the life or freedom of the defendant and for the conscience of the clinician.

Chapter 5: Appendix - Guidance for a Sexual History in Cases Involving Capital Crimes with Sexual Involvement

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Purpose

This guide is for mitigation specialists or investigators when working with male clients whose charges include sex crimes. The point of the questions is to obtain a detailed picture of the sexual interests and motivations of individuals with charges involving sexual offenses. The goal is to learn about patterns and trends in the sexual conduct. The earlier childhood items help by identifying whether childhood exposures either in the form of abuse or developmentally inappropriate sex occurred. These experiences can contribute to lifelong behaviors that can be very destructive.

Interviewers are encouraged to carefully record client responses and share them with the defense team during case reviews. Notice that the language of the questions avoids terms like 'abuse', 'harm' or other morally judgmental labels. The point is to try and get a matter-of-fact discussion going. Being matter-of-fact about the sex acts is one way to get there. You will also see the use of language like "did you find yourself doing..." and this is used for the same point – to get at a non-accusatory presentation of sexual history.

This interview should be prefaced by saying something like this to the client:

"One of the things that we find really helpful in putting together everything that might have any influence over how your case goes is to have a complete history of all the sexual things that you've been exposed to and all the things you have experienced. So I'm going to be asking you some very detailed questions starting in early childhood and going right up to pretty much the present day. Do be mindful of one thing. If you decide to hold back information (and some folks do) it can leave a hole in your case that we cannot get out of. You never know what the prosecution has learned about you from someone else. If we learn it from the prosecution, we are in trouble. So, it will help, no matter how embarrassed you might be about some of this – to be as direct and forthcoming as possible. The only folks who will see this are those working on your case FOR you. It will be kept confidential and will only be used in court if you agree to do so."

Interview questions:

Now, take me back in time – back let's say to maybe the 1st or 2nd grade.

What is the earliest time in your childhood that you remember any kind of sexual touching or acting?

How old were you then?

Describe what happened. [Find out who did what to whom and what was the result? Was this something witnessed, heard, or did it happen to the client? Any repercussions?]

Did any adult have sexual contact with you? How so? What happened? What happened afterwards? More contact like this or was it a one-time event?

Let's move forward a bit and go to say the 4th or 5th grade, what sexual kinds of things did you run into then?

As I asked you earlier, did any adult have sexual contact with you? How so? What happened? What happened afterwards? More contact like this or was it a one-time event?

Did you ever play "doctor" with girls or boys and examine each other's parts? Did it ever go beyond that? How so?

Okay, that's helpful, now as folks go into adolescence, things get trickier about sex. Talk to me some about your first teenage experiences with any kind of sex acts.

How old were you when you first masturbated to the point that you came?

Who gave you your first handjob? First experience receiving oral sex?

Who was your first girlfriend? What sex acts were you able to do with her? Did you get to feel her breasts? Get to touch her private parts? Oral sex?

How did this relationship pan out? How long were you with her? Did she pull out or did you pull out of the relationship? Why?

What sexual contact did you have with any males? Any mutual masturbation? Anything more than that? Did you ever find yourself sort of feeling interested in guys even though you were mostly interested in girls?

When did you first get to see porn? What was it – film, video, magazines? Were you able to get to porn often? Or was that a rare event? What were your thoughts about porn?

Let's turn to your more adult periods in life. Who was your first major sex partner? How long were you with him/her? Talk a bit about the ways you all had sex.

[If with a female]

Who initiated sex between the two of you? What did she do that most turned you on?

What about the other way around? What did you do that she really liked?

What sex positions did you find yourself using most of the time?

What position is your favorite?

How did you get her to do it the way you wanted it?

Did you ever find that you liked some rougher sex along with your day-to-day sex? (pulling hair, slapping, spanking, pinching, finger poking, etc.)

Did she do oral sex for you? And you for her?

What about anal sex? How often did that come up?

What did you most like her to be like for you sexually? Did you want her to dress up, put on a show for you or just be herself?

Did she watch porn with you? Did you hide it from her?

Did she want sex more than you did? Or was it the other way around?

Did you ever find yourself having her have sex with someone else while you watched?

Did you ever have another woman along with your partner – a threesome? Or another man for a threesome?

How often do you find yourself feeling a need for sex? (every day, 2x week...what frequency)

[If with a male]

Who initiated sex between the two of you? What did he do that most turned you on?

Who was in the leader role in sex between the two of you? Did you all switch off?

What did you do that he really liked most?

What sex positions did you all use most of the time? Did you both do the same things or did you have roles – like did one of you mostly want oral sex and the other wanted anal?

Or did both of you want pretty much the same?

What position is your favorite?

How did you get him to do it the way you wanted it?

Did you like some rougher sex along with your day-to-day sex? (pulling hair, slapping, spanking, pinching, finger poking, roughhousing, wrestling etc.)

What did you most like him to be like for you sexually? Did you want him to dress up – go tranny for you - put on a show for you or just be himself?

Did he watch porn with you? Did you hide it from him?

Did he want sex more than you did? Or was it the other way around?

Did you ever have a threesome or group sex?

While in the relationship, did you have sex with strangers or near strangers?

How often did you find yourself feeling a need for sex? (every day, 2x week...what frequency)

More general questions

How many times in your life have you paid for sex? Did you use protection?

About how many sex partners have you had in your life?

When you masturbate, do you usually have porn on?

When you masturbate, what do you think about?

What is the most vivid fantasy you have about a sex act?

How do rape fantasies work for you?

Do you find yourself fantasizing about younger people – even youth?

What bodily detail turns you on the most? Any fetishes?

Would you say you are obsessed with sex? Have you ever worried that something is wrong with you sexually?

After having had sex with someone, what feeling do you have?

Do you find yourself closer to your partner or that person?

Or do you just want to be alone afterwards?

Do you find it easy or difficult to please your partner after you've already come?

Have you ever been sexually violated? Anyone ever touch you against your will? Force you into a sex act that you told them you did not want?

Do scenes of violence make you horny or turn you off from sex?

If it turns you on somewhat, how does it do so? What really gets you horny about the violence?

Is there anything else you can tell me about your sex life that might help us understand the situation you are facing? Anything you need to ask me about any of this?

Thanks for being truthful with me about all of this. I know it is difficult, but it is important.

Chapter 6: Trauma, Neglect, Abuse, and the Brain

Counsel will always be trying to understand and explain why the client did what he did. The explanation will most always be found in the client's brain. The health and attributes of the brain will be based upon genetics and the influences of the client's environment all as discovered by the biopsychosocial history investigation. It is difficult, if not impossible, to fully explain the client's behavior to a fact finder without a thorough biopsychosocial history investigation. The information derived from this investigation will be critical in developing the theories of culpability and mitigation.

The results of traumatic experiences and other adverse conditions of the client's life may not completely explain "Why he did what he did." However, the impact of traumatic life experiences can influence development and functioning of the brain and the brain's ability to plan effectively, use good judgment, control impulses and emotions. Traumatic experiences can be considered as risk factors for the criminal behavior that underlies the charged offense.

What To Look For In The Biopsychosocial History

Traumatic experience can include:

- physical and sexual abuse;
- verbal and emotional abuse;
- psychological abuse;
- physical, emotional, medical neglect and abandonment;
- emotional incest (unhealthy role playing between child and caregiver);
- abuse of others in the presence of the client;
- traumatic injuries (injuries suffered in combat, accidents, assaults, and self-inflicted injuries) resulting in neurological and cognitive impairment;
- exposure to toxic substances and conditions that can cause a wide range of physiological and neurological harm;
- natural disasters such as hurricanes, earthquakes or fire;
- life threatening illness such as heart attack or cancer.

The client is often not an accurate historian of the traumatic experiences in her life. These experiences may be painful to recount. She may think they were just a part of her "normal" childhood and not worthy of mention. She may be protecting the abuser(s).

Caregivers may also be in denial about their involvement or just want to hide their bad behavior. The true story may have to be found in records from institutions, CPS, independent observers or those who have divorced out of the family and who want to "dish some dirt." Confirmation of abuse and neglect by independent sources is critical as the self report by the client is always subject to challenge by the prosecution. "She did not complain about it when it was supposed to be happening. She is just making it up now to get herself out of trouble."

Risk Factors for Harm from Traumatic Experiences

It is important to identify risk factors for harm because the incidents of PTSD (the diagnosis of PTSD will be discussed later in this chapter) in the general population is low, 5-6% in men and 10-14% in women.¹ While low in the general population, incidents of PTSD are likely very high in our client population so these low percentages may mean little. In order to compare them, one must identify the risk factors present. The more risk factors and traumatic experiences that can be found, the more persuasive and credible will be the explanation for the client's behavior, without a need for a diagnosis of PTSD.

¹ Burr, et al., fn.3 page 39 and Ozer, E.J. et al., *Predictors of Post Traumatic Stress Disorder and Symptoms in Adults: A Meta-analysis*, 129 Psychol. Bull. 52 (2003) reviewing results from 68 studies that included seven predictors for PTSD.

The risk of trauma and its debilitating symptoms increase progressively with the total number of risk factors to which one is exposed. A biopsychosocial history investigation should include assessment of all trauma exposures with careful attention paid to the number, type, magnitude, circumstances and dynamics of traumatic exposures for any individual client.² Counsel should also consider the impact of the traumatic events along with the cumulative effect of the client's other cognitive impairments. What types of support system, if any, was available to the client before, during and after the trauma was experienced? It may be that the trauma was inflicted by the people who should have been providing the support.

Why will a tragic experience cause trauma in one person but not another? Relevant risk factors, the victim's resiliency and effective support systems (or lack thereof) may provide the answer. Some research tells us that the three most significant risk factors for PTSD are (1) prior psychiatric history, (2) childhood abuse and, (3) family history of mental illness.³

Counsel should also consider the client's":

- cultural influences that impact the perception of and coping with stressors;
- the impact of genetics on the client's behavior. Males with a history of child abuse and the genotype monoamine oxidase A (MAOA) were more likely to exhibit antisocial behavior. Maltreated males with low MAOA activity were three times as likely to be convicted of violent crimes by age 26 as males who had been maltreated but had the normal gene for MAOA

Practice Note: The obligation of counsel to conduct a thorough investigation is a recurring theme in this manual and it is a critical one. The lack of resources should not dictate if a biopsychosocial history investigation is conducted. Make the lack of resources the judge's problem by asking for the funding. If she gives you Chapter 31 funding for the investigation, then the investigation can be performed. If she tells you "NO" then the problem becomes her problem. Counsel's responsibility is to preserve the issue by continually asking the court for the resources before and during trial. The need for resources becomes more apparent as the case proceeds, particularly during trial. Always let the judge know how counsel's ability to provide the effective assistance of counsel, as mandated by the Sixth Amendment to the United States Constitution, is compromised by the lack of funding for the necessary investigation.

Use your funding motions to both humanize the client and educate the judge about the client's condition in life. Work to change the picture of the client and her condition. The judge may begin to view the client (and your request for funding) in a different and more favorable light. Let the judge know that the standard of practice to which you aspire, and your client deserves, is a high one.

The apparent lack of resources does not make the problem go away. Should funding not be approved, counsel will need to be creative in finding ways to obtain a bio/psychosocial history. Does the client's past criminal/mental health record suggest that a prior investigation can be obtained? Will any social work students be available as volunteers to assist? Whatever is found in this way can be used to show the court just how much additional information needs to be obtained by a thorough investigation.

² Burr, et al., id at p42-43, citing Bromet, E., et al., *Risk Factors for DSM-III-R Post Traumatic Stress Disorder: Findings from the National Comorbidity Survey*, 147 Am.J. Epidemiology 353 (1998).

³ See Brewin, C., et al., *Meta-Analysis of Risk Factors for Posttraumatic Stress Disorder in Trauma Exposed Adults*, 68 J. Consulting & Clinical Psychol. 748 (2000) surveying results from 77 studies that involved combined sample sizes ranging from 1,000 to 11,000 subjects.

Potential Traumatic Experiences Suffered by Infants

Traumatic experiences can occur at any time during and after gestation. The investigator should be on the lookout for traumatic experiences caused:

Prior to Birth:

- drugs and alcohol ingested by the mother prior to birth causing Fetal Alcohol Spectrum Disorders (FASD);
- physical injuries the fetus suffered prior to or during the birth process;
- lack of proper pre-natal care.
- All substances- good or bad- are coming to the fetus through the mother. If she is not taking care of herself, there is little chance that the needs of the fetus are being met.
- teratogens (agents that can cause birth defects).

Practice Note: The hospital records, including a blood screen of the birth mother, are critical. The APGAR score will be helpful in understanding the infant's neurological condition at the time of birth. Counsel will want to know the blood alcohol content of the birth mother when admitted to the hospital.

Post Delivery Trauma

Infants and young children are naturally more vulnerable than those who can care for themselves. They are completely reliant on the caregiver who must be attuned to the needs of the infant. Traumatic experiences can come in the form of:

- physical abuse;
- emotional abuse;
- physical, emotional and nutritional neglect. Attachment disorder is discussed in several Chapters of this manual. The first 36 months of the infant's life are critical to the well adjusted child. The mitigation specialist and counsel should pay close attention to the conditions of the client's life during these months. Understanding the infant's experiences during this period is critical in understanding why the client views and interacts in the world;
- abuse of others in the presence of the child;
- environmental trauma from toxins;
- environmental toxins such as the toxic neighborhoods in which the client was raised. Socio-economically disadvantaged African Americans living in urban areas are at heightened risk for traumatic exposures.¹ physical trauma from accidental injuries;
- injuries that are intentionally inflicted by the client or 3rd parties;
- medical trauma from natural causes such as brain tumors;
- exposure to sudden or unexpected death of others;
- combat in a war zone.

The Developing Brain and Trauma

Many empirical studies, and a great deal of clinical data, indicate that when young children are neglected and/or subjected to repeated abuse, they experience traumatic stress, which compromises brain development and endocrine function. Traumatic stress interferes with the development of neural circuits connecting critical areas of the brain. These neural circuits are essential for normal physiological, cognitive, psychological, emotional and social development.²

¹ Alim T. et al., "An Overview of Posttraumatic Stress Disorder in African Americans", 62 J Clinical Psychol., 801 (2006) as cited in Burr, et al., "The Impact of Trauma on Capital Clients, A Practitioner's Guide to Defendant Capital Clients who have Mental Disorders and Impairments, at 37-38.

² Heide, K.M., & Solomon, E.P., *Biology, Childhood Trauma and Murder: Rethinking Justice*, International Journal of Law and Psychiatry 29(3), 220—233.

When evaluating the client's cognitive status at the time of the offense, counsel should consider not only the traumatic brain injuries that the client may have suffered, but also any delayed or prevented development caused by abuse and/or neglect. In addition, the science tells us that the brain does not complete its basic development until age 23-25 years. (This helps to explain why auto liability rates decline for drivers age 25 and older.) The last part of the brain to develop is the frontal lobe of the cerebral cortex, and the juvenile cannot speed up the process no matter how hard he tries. This is the area of the brain that is critical in evaluating information, making judgments and thoughtful decisions, planning and organizing responses. The cerebral cortex is the part of the brain that puts the brakes on the limbic system, allowing us to think before we act impulsively.³ If this part of the brain is damaged, the client is likely to act impulsively. Impulsivity plays a large role in criminal behavior.

Practice Note: Consider using brain development science when representing a juvenile during a transfer hearing. Legislatures and courts have grown accustomed to using a "legal fiction" that a juvenile who has done something bad and scary is, as if by magic, suddenly a "little adult." Challenge the concept of the juvenile transfer hearing. Please refer to the resources section of this chapter for a motion that challenges the juvenile transfer proceedings.⁴ Also look for opportunities to extend the application of *Roper v. Simmons* to those up to age 25, basing the argument on brain science.

The brain grows more rapidly during the last three months of pregnancy and the first year of life than at any other time. The brain more than doubles in size during the first postnatal year.⁵

The new brain is forming billions of new cells and in order to make room for new cells, old ones are "pruned" away on the premise that "you use it or lose it." Portions of the brain that are more active grow more cells while cells in parts of the brain that are not as active are eliminated. Very young people can play musical instruments or speak foreign languages so much easier than the elderly as newly created brain cells are focusing in the areas in which the child is active. Traumatic stress interferes with the normal operation of the pruning process.⁶

Childhood trauma can cause long term changes in the brain that can affect memory, learning, ability to regulate affect and social development along with smaller total brain volumes and brain abnormalities that can be seen on an EEG. Stress can destroy brain cells and inhibit the growth of new ones. The Amygdala (responsible for emotions, impulses, empathy) can be 8-10% smaller than normal as a result of stress.⁷

Practice Note: What is the culpable mental state alleged in the indictment? How do all of the client's impairments impact his "consciousness" and "awareness" in forming the mental state? These are two critical terms used in defining the culpable mental states. Read the indictment in every case. What does the statute require and what was the state of the client's thought process at the time of the offense? How did all of his life experiences influence his "consciousness" and "awareness"?

Childhood Neglect and Reactive Attachment Disorder

"The foundation for all human interaction is learned during the first year of life (not later than the first 36 months) when the caregiver hopefully meets the infant's basic needs for food, physical comfort and human contact. The ability and/or willingness of the caregiver to meet these

³ Heide and Solomon, *id.*

⁴ See also, Fabian, Jon Matthew, *Applying Roper v. Simmons in Juvenile Transfer and Waiver Proceedings: A Legal and Neuroscientific Inquiry*. International Journal of Offender Therapy & Comparative Criminology, 55(5), 732-755 (2011).

⁵ Solomon, E.P. and Heide, K.M., *Childhood Trauma, Biology and Justice: Implications for Juvenile Justice, Corrections and Reentry*, Criminal Psychology, J.B. Helfgott, ed., vol. 4, (Praeger Publishers: Westport, Ct.), 2013, pp. 121-144.

⁶ Heide, K.M. and Solomon, Eldra, P., *Biology, Childhood Trauma and Murder: Rethinking Justice*, International Journal of Law and Psychiatry, 29 (2006) 4.2, pp. 220-233.

⁷ Carrion, V.G. et al., *Attenuation of Frontal Asymmetry in Pediatric Posttraumatic Stress Disorder*, Biological Psychiatry, 50, (2000) pp. 943-951.

needs is critical because the infant cannot do this on her own. She can only alert the caregiver to the need by crying or similar behavior. A good caregiver is attuned to the infant's needs and shifting physiological and emotional states. By being able to read each other's signals and respond appropriately, the infant develops a secure attachment which represents a "secure base" in the world.¹ Ideally, the caregiver and infant can read each other's signals and respond appropriately. If the caregiver is unwilling and/or unable to respond to these needs, the secure attachment and the infant's ability to properly respond with others in the future is in jeopardy. The bond that develops forms the foundation for all future emotional and social connections between the child and other human beings. Babies whose needs are not met learn that they cannot count on other human beings to respond to their needs and to comfort them."²

Attachment depends on communication between the right brain of the mother and right brain of the infant. If the primary caregiver is an emotionally healthy person attuned to the internal experience of the child, her right brain responds empathically to the child's emotional states. Her responses regulate the child's emotional states. This process supports development of the child's right brain which is critical in learning to self-regulate and to deal with stress and emotion.

The quality of early attachment between the child and caretaker affects brain development and behavior. A child who does not form this important attachment often does not feel compassion and empathy for others. They become distrustful and may remain disconnected from other people. The failure to attach can form the basis for personality disorders such as anti-social personality disorder which is most often seen in males and borderline personality disorders that is more often seen in females. The inability to empathize is both a consequence of failed attachment as well as a symptom of these disorders.

Early trauma in childhood attachment experiences alters the structures, neurotransmitters, chemicals and connectivity of the brain. The neurobiological affects of childhood neglect equals and even surpasses the impact of abuse and related trauma and impacts the ability of the brain to regulate response to stress.³

Practice Note: The American public has for years been sensitized to the harmful effects of physical and sexual abuse. While counsel should be alert for indicators of abuse, it is possible that neglect of a client while a child is even more harmful.

Trauma and Depression in Successive Generations

Childhood trauma is associated with increased risk for depression in adolescence and in adulthood. The effects of depression are a good example of how child maltreatment is often transmitted from one generation to the next. Many maltreated children grow up to be depressed adults who become mothers. The more depressed the mother, the less responsive she is to the child, and the greater the behavioral problems of the child. Such neglected children may become depressed adults and repeat the cycle for yet another generation. When depression decreased in the mother, child behavior problems decreased.⁴

Practice Note: Counsel, or hopefully the mitigation specialist, if funding is provided for one, should investigate the client's entire life, but especially during his first 36 months. Red flags to look for include the involvement of foster homes, a parent who is involved with alcohol, drugs and criminal activity and frequent moves of the family. The mother may want to be a good caregiver but may not be available, either emotionally or physically, because of her own problems. While many foster parents provide a loving and caring home for their foster children, others do not. The client did not choose this life into which he was born, but the client will face the

consequences of failures and bad decisions of those whose job it was to care for him. The neglected child may fare worse than the abused child.⁵ Counsel and the mitigation specialist should always be prepared to ask the "W Questions": Who, What, When, Where, and most importantly, Why did this happen, why does the client act this way, why did he do what he did?

Several years ago the writer acted as faculty at a capital defense program. In the assigned break-out group were seven trial teams. These teams were assigned to this one break-out session because they all had something in common: each intensely disliked their client. We discussed the quality of life each of the clients experienced during the first 36 months of life and established that each client was raised in miserable conditions with problem caretakers. It is probable that these experiences formed the basis of personality disorders that made the client a problem for his trial team. With this understanding, each team was better able to humanize the client and see that he did not choose to be the way he was. The annoying behavior was a consequence of something the client did not choose. It was not a personal affront to the lawyers and team members.

Childhood Abuse

Child maltreatment (neglect and abuse) appears to be the single most preventable cause of mental illness and behavioral dysfunction in the United States.⁶

"[C]hronic childhood abuse takes place in a familial climate of pervasive terror, in which ordinary caretaking relationships have been profoundly disrupted. Survivors describe a characteristic pattern of totalitarian control, enforced by means of violence and death threats, capricious enforcement of petty rules, intermittent rewards and destruction of all competing relationships through isolation, secrecy and betrayal."⁷ Look for signs of coercive control and imposed isolation of the child.

A desired goal of positive child development is to obtain a coherent and positive sense of self, a sense of competency and autonomy where the child can function well and independently in a safe and secure world. The abuser deprives the child of this secure structure.

Survivors of severe early childhood maltreatment often develop a simple cognitive style, have difficulty regulating their emotions, are impulsive and make poor decisions.⁸

As described above, the caregiver becomes a source of victimization but also a source of solace. The abuse is random and unpredictable, interspersed with words and acts of kindness that are severely needed by the child.⁹

When exposed to situations where the brain senses danger such as violent behavior towards a child, the endocrine system produces a stress hormone called cortisol. This hormone acts to provide fuel for the brain cells so that the child can respond effectively to the perceived danger. Exposure to continual violence in the home can cause the release, over time, of too much cortisol which can prevent normal brain development and predispose children to using maladaptive coping strategies.¹⁰

Why Are Traumatic Memories So Vivid?

Most normal memories go through a process whereby the memories are temporarily stored in two places within the limbic system – (1) the event itself is stored in the hippocampus and (2) the associated emotion is stored in the amygdala. When memories are processed in the normal fashion,

⁵ Heide and Solomon, *supra* citing Hildyard & Wolfe, 2002.

⁶ De Bellis, Michael, Spratt, Eve & Hooper, Stephen, "Neurodevelopmental Biology Associated with Childhood Sexual Abuse", *Journal of Child Sexual Abuse*, 20(5), pp. 548-587 (2011).

⁷ Herman, J., *Trauma and Recovery*, Harper Collins (1992).

⁸ Solomon, E.P. and Heide, K.M., *Childhood Trauma, Biology and Justice: Implications for Juvenile Justice, Corrections and Reentry*, Criminal Psychology, J.B. Helfgott, ed., vol. 4 (Praeger Publishers, Westport, Ct.), 2013, pp. 121-144.

⁹ Burr, et al., *The Impact of Trauma on Capital Clients*, A Practitioner's Guide to Defendant Capital Clients who have Mental Disorders and Impairments, at 37-38.

¹⁰ Solomon and Heide, *id.*

¹ Hiede, *citing* Bowlby, 1988.

² Heide and Solomon, *id.*

³ Corbin, James, *Reactive Attachment Disorder; A Biopsychosocial Disturbance of Attachment*, *Child and Adolescent Social Work Journal*, 24(6), pp. 539-552 (2007).

⁴ Stroufe, A. & McIntosh, J., "Divorce and Attachment Relationships: The Longitudinal Journey." *Family Court Review*, 49 (3), pp.464-473.

they can be used in evaluating and understanding future experiences, *i.e.*, “I know what happened in the past and under similar circumstances the same should happen again. I can learn from my experiences.”

However, traumatic events can overwhelm the brain’s capacity to process information in the normal way. These traumatic events, along with the images, sights, smells, sounds and sensations may be stored in the right limbic system indefinitely and can generate vivid image “flashbacks” of the traumatic experiences accompanied by the same thoughts and feelings as when originally experienced.

The passage of time may soften the impact of unpleasant experiences. The traumatic event is different and may be triggered by a thought, sight, smell or sounds and when recalled, can be just as terrifying as when originally experienced. The response to the traumatic memory originates in the amygdala (a part of the limbic system) where emotions and the “fight or flight” response are produced. The portion of the brain responsible for rationality and judgment (executive functions of the frontal cortex) is not activated so the response to the memory of the traumatic event is an emotional one, not a rational one. The emotion is not moderated by the executive function and this may cause problems for the victim – your new client!

Diagnosis and the DSM-V

The DSM-V sets out the diagnostic criteria for PTSD and distinguishes between those who are older than 6 years and those who are 6 years and younger. While the DSM-V may be invaluable in a clinical practice, it has not been written to assist defense counsel in a forensic way. The criteria are rather dry and impersonal. They do not tell the client’s story nor can they vividly paint the picture of the traumatic events in the client’s life. See Chapter 13 for a more detailed discussion of DSM-V.

For example, which of the following descriptions would be most persuasive to a listener, especially a juror?

Example 1

DSM-V diagnostic criteria: The client was exposed to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:

1. she directly experienced the traumatic event(s)
2. she witnessed, in person, the event(s) as it (they) occurred to others.¹

OR

Example 2

“And then he turned on her. She couldn’t recall the words. Perhaps at the time there had been no words, or she hadn’t heard them, there was only the crack of the smashed bottle, like a pistol shot, the stink of whisky, a moment of searing pain which passed almost as soon as she felt it and the warm blood flowing from her cheek, dripping on the seat of the chair, her mother’s anguished cry, “Oh God, look what you’ve done, Rhoda. The blood! They’ll never take it back now. (a new chair bought for the abusive father and that was delivered in the wrong color) They’ll never change it.”²

Rhoda is the victim, but in the eyes of her mother, who enables and covers for the father’s violent assault, it is all Rhoda’s fault. The picture painted by the author P.D. James is powerful and without reference to any dull diagnostic criteria. The more we try to relate the client’s experiences to some dry element of the DSM, the less impact it will have on the listener.

The DSM is often used as a cook book that best fits the theory of the prosecution. A prosecutor might say, “These are the diagnostic criteria listed in the DSM-V, a/k/a ‘the bible’. The defendant does not meet any of these criteria; if he appears to meet any of them, then he is ‘faking

good’ or ‘faking bad’, *i.e.*, he is malingering and one can never trust a malingerer. The only diagnostic criteria which he truly possesses are those that tell you he is a sociopath. Be afraid, be very afraid! You cannot trust the defense. Their witnesses are all professional whores. Believe what we tell you because we represent you, the people.” Jurors will generally do what the prosecution wants them to do.

The defense should not care what the condition is called or what label is given to horrible experiences or a lifetime of trauma. We can get unnecessarily bogged down in the losing debate of whether the client suffers from PTSD, Complex PTSD, Type III PTSD or DESNOS (Disorders of Extreme Stress Not Otherwise Specified). Counsel should focus on what happened, why it happened and how it helps to explain the behavior of the client. We should tell the story of the client and put those jurors into the same room with Rhoda where she suffered trauma and humiliation at the hands of both of her pathetic parents and carried scars for the rest of her life.

Complex PTSD

While counsel should focus on telling the client’s story and painting the picture of the client’s traumatic experiences instead of fighting over diagnostic criteria for a particular diagnosis, including PTSD, it is important to be aware of terms currently used.

Traumatic experience can lead to Post Traumatic Stress Disorder (PTSD). During traumatic experiences, individuals typically feel overwhelmed by intense emotion and pain. They may feel terrified, powerless and helpless. Later, they relive the experience in nightmares, intrusive thoughts and flashbacks

Long-term childhood maltreatment can lead to complex PTSD, a chronic form of PTSD. In complex PTSD, trauma survivors commonly experience additional symptoms, for example, difficulty regulating emotions, poor self –concept and depression. They tend to be impulsive, aggressive toward themselves or others, and may suffer from chronic feelings of shame and self-blame. Individuals with complex PTSD often have difficulty maintaining long term relationship and may have only superficial connections with others.

Disassociation is a defense mechanism used by some individuals with complex PTSD. When a person experiences overwhelming trauma, he tends to divert his attention from what is happening. With repeated trauma, the child may learn to disassociate from his frightening reality and becomes numb to the outside world or use drugs or alcohol to help do the job. The drugs or alcohol can naturally present problems of their own. The long term victim of childhood abuse may be constantly in survival mode with inability to tell if perceived threats are dangerous or not.³

Traumatic Stress in the Military

Those serving in the armed forces, especially in combat situations, face a unique combination of risk factors before, during and after their service and are often reluctant to seek help. Risk factors include:

Pre-Trauma Stressors: childhood sexual or severe physical or emotional abuse, lack of social and family support, pre-existing psychiatric disorder(s), female gender, low socioeconomic status, lower level of education, lower intelligence, race, reported abuse in childhood, family history of psychiatric disorders, report of previous traumatic experience(s), poor training or preparation for traumatic event.⁴

Peri-Trauma Stressors: The extent of trauma can also be influenced by stressors occurring or existing at the time of the current trauma including the intensity and duration of the traumatic experience, the type of trauma, high perception of death, age at trauma, others in the community affected by the trauma, and disassociation. It is theorized that cortisol, the stress

¹ *Post Traumatic Stress Disorder*, Desk reference to the Diagnostic Criteria from DSM-5, 309.81 (F43.10) at p. 143.

² James, P.D., *The Private Patient*, Vintage Books (2009) at p. 7.

³ Solomon and Heide, (2013).

⁴ Hopewell, C. Alan, *PTSD After Iraq and Afghanistan*, Capital Trial Mitigation, A Program for the Defense (Center for American and International Law: Plano, Texas), July 28, 2012.

hormone released during periods of stress, acts as a counterbalance to adrenaline that is also released during traumatic experiences. Should the soldier have a low level of cortisol (because of multiple releases of cortisol early in life) in his or her system, the adrenaline can act unchecked.

Nature of Trauma Stressors: These can include high combat intensity, prolonged duration of combat, high cumulative exposure to combat, heavy casualties in the unit, sudden exposure to combat, first exposure to combat and high threat of exposure to nuclear, biological and chemical warfare (NBC exposure).

Post traumatic stressors: These will include the ongoing stressors of life, lack of social support, bereavement, major loss of resources and children at home.

Post Deployment Stressors: The service person can also experience stressors during the deployment phase of her career. These can include leaving a job, finding a job, children and child care, home and car repairs, household finances, work and transportation problems.

It would be hoped that one who has been exposed to traumatic experiences during military service would receive immediate and high quality care for any resulting condition. However, many soldiers do not complain of their experiences because of the “stoic warrior” culture that exists in the military. Reasons given for not seeking help include: “It would be too embarrassing”; “It would hurt my career”; “Other unit members would have less confidence in me or treat me differently”; “Leaders would blame me for the problem”: “I would be seen as weak”: “I don’t trust mental health professionals”; “Mental health care does not work.”¹

One who evaluates a soldier who has experienced traumatic stress should obtain at a minimum: (1) biopsychosocial history, (2) physical and neurological examination, (3) history of prescription medication use, history of illegal drug use, (3) possible biological or chemical exposures, (4) a minimal mental health exam, (5) brain scans (head injuries, particularly frontal lobe) and complete laboratory work-up.²

Survey results suggest that immediate family members of combat-exposed soldiers with high levels of PTSD are at risk for developing secondary traumatic stress.³

Explaining Behavior

*Why did she do what she did? Those who have suffered severe traumatic stress are often on alert and ready to respond to real or perceived danger and they may instantly respond by resorting to “fight or flight”—or becoming immobile and/or numb (disassociate) if neither fight nor flight is available. If a person can neither run away or fight the threat, disassociating is what is left. A common strategy is to numb intense feelings with alcohol, drugs or food. These maladaptive coping strategies often impair social (can’t get along with others) and occupational functioning (can’t hold a job) and appear to be or contribute to symptoms of anti-social behavior. The drugs or alcohol may combine to impair judgment and to reduce inhibitions.”*⁴

The Abusive Adult Relationship

Counsel may be confronted with a situation where a female client continues in an abusive relationship. “Why does she stay with that guy?” Young victims of maltreatment often grow up to be adult victims. Untreated survivors of childhood abuse and/or neglect typically grow up to have a poor self-concept, low self esteem, difficulty regulating their emotions and difficulty in making thoughtful decisions. Many women who were victims of child maltreatment lack self-confidence and feel dependent on others to make decisions, decisions that are often not in their best interests.

¹ Hopewell, *id.*

² Hopewell, *id.*

³ Herzog, J. Everson, R. & Whitworth, J., *Do Secondary Trauma Symptoms in Spouses of Combat-Exposed National Guard Soldiers Mediate Impacts of Soldiers’ Trauma Exposure on their Children?*, Child and Adolescent Social Work Journal, 28 (6) pp.459-473.

⁴ Heide and Solomon, *supra*.

They may believe they are bad people who deserve to be mistreated. Many victims are individuals who have learned to turn their rage on themselves. These qualities make it very difficult to develop mature, healthy relationships. Many survivors of trauma become involved with abusive partners and become battered women or victims of crime.⁵

In explanation of “Why does she stay with that guy?” counsel should consider that a “traumatic bond” has taken place between the victim and her abuser. The victim may become intensely loyal to the abuser. The investigation should focus on actions that allow the abuser to maintain coercive control over his victim, keeping her in isolation thereby cutting off access to those who might offer help. The abuser may resort to continual acts that humiliate the victim or put her in fear for her life. As a result, the “fight or flight mechanism” is almost always on or may be conditioned to trigger more easily.⁶ Individuals can become overwhelmed by their pain and intense feelings and may feel powerless and helpless.⁷ Once an abuser “has succeeded in establishing day-to-day, bodily control of the victim, he becomes a source not only of fear and humiliation, but also of solace. The hope of a meal, a bath, a few kind words, or some other ordinary creature comfort can become compelling to a person long enough deprived.”⁸ The abuser is able to maintain control while the victim has lost control over her life.

But Why Did he Stab her 57 times?

When stress increases, aggression increases. Aggressive behavior stimulates the release of stress hormones. This forms a “positive feedback loop” for aggressive behavior.” Stressors can rapidly generate and exacerbate violent behavior. Once in the “positive feedback loop” the aggressor continues to act out violently until the rage has ended.

Practice Note: When counsel has a case where the client has apparently engaged in “overkill” aggression such as the infliction of multiple stab wounds, consider this “feedback loop” as an explanation. Medical examiners are familiar with this concept and should be asked about this possible explanation. There likely exists a great deal of emotion involved in such an act.

The client is charged with shooting her husband six times during a domestic argument. Lay witnesses testify that your client probably planned the crime to gain insurance money and the prosecutor cites such overkill as evidence of your client’s violent character. However, your expert explains the application of battered woman syndrome and specifically, the client’s core belief that her husband was “larger than life in death” and would be able to pursue and kill her even after he received several gunshot wounds.⁹

Client with Poor Work Record

Clients who have poor work records are often labeled as “lazy” and “no good.” Counsel should consider that the client’s ability to hold a job may be impaired by an inability to concentrate or distraction from flashbacks. Depression, panic attacks, phobias and substance abuse may add to the burden.¹⁰

The Antisocial Client

Early traumatic stress can lead to increased blood flow to the amygdala, a part of the limbic system responsible for emotions, impulses and the “fight or flight” impulse. The increased blood flow can cause the amygdala to over-respond. Physiological hyper-arousal, distress and anxiety may

⁵ Solomon and Heide (2013).

⁶ Burr, *et al.*, *The Impact of Trauma on Capital Clients*, A Practitioner’s Guide to Defending Capital Clients who have Mental Disorders and Impairments, at 51.

⁷ Heide, K.M., Solomon, E.P., *Biology, Childhood Trauma and Murder: Rethinking Justice*, International Journal of Law and Psychiatry 29, pp. 220-244 (2006).

⁸ Herman, J., *supra*.

⁹ Clark, James J. and Monahan, Ed, *Decisions for Integrating the Expert into the Case: an 8-Step Process*, DPA Mental Health and Experts Manual, *8th Edition (2005) at p. 9-2, citing Lenore Walker, *Terrifying Love: Why Battered Women Kill and How Society Responds*. (1989).

¹⁰ Ruth, Douglas D., “*PTSD in the Forensic Setting*”, DPA Mental Health and Experts Manual, chap. 17-2.

result leading to intense emotional reactions. As the individual gets older, the hyper arousal may change to physiological hypoarousal which is a characteristic of those with antisocial personality disorder. "It has long been known that violent male offenders with antisocial personality disorder have low levels of the stress hormone cortisol."¹

Practice Note: The term "sociopath" is an old term for what is now called "anti-social personality." It is suggested that counsel get the court to preclude the prosecution from using the term "sociopath" on the basis that it is outdated, no longer used in the DSM-5 and therefore not relevant. It can be argued that it is also unfairly prejudicial to the client. Prosecutors use either term to scare jurors and sociopath sounds very much like "psychopath" and once that term is attached to your client great and unreasonable harm is already done. The more you fight it the more the jury can focus on it.

Do not use a Motion in Limine to preclude the use of this phrase. Even if the motion is granted the prosecution will still have an opportunity to use the term at trial if it can later convince the judge to allow its use. Move to preclude the use of the term altogether. If it is an irrelevant, dated and prejudicial term before trial (regardless of the context in which the prosecution will try to use it) the court should preclude its use.

Terms like sociopath, psychopath, and antisocial personality have no mitigating value. They should be challenged when used by the prosecution and the defense should avoid their use when referring to the client. Personality inventories that can suggest the existence of these disorders should also be avoided, especially by defense psychologists.

Cause and Effect

The theme of a current cable television advertisement goes something like this: If a person does not have cable television, he will become bored. If he becomes bored, he will yearn for excitement. If he yearns for excitement he will engage in risky conduct, if he engages in risky conduct bad things will happen. If bad things happen, even more bad things will flow from that bad event, not only to him but to others. So on and so on.

This pattern of relationship can be applied to many mitigation themes. When considering the possible consequences of extreme traumatic neglect it can be said that: If a child suffers early trauma, from extreme neglect, the child will suffer from insecure attachment and compromised right brain development. If a person lacks secure attachment and right brain development she will not view the world as a safe and secure place. If she does not view the world as a safe and secure place she may lack empathy for others and will also experience intense feelings, depression and self harmful behavior. If the person lacks empathy for others and

¹ Solomon and Heide (2013) *id.*

experiences intense feelings, depression and self harmful behaviors she may resort to drugs. If she resorts to drugs her inhibitions may become lowered. If her inhibitions are lowered then she will likely engage in some form of crime, possibly violent crime. The more risk factors that are present the more likely this chain of events will occur.

Extreme Emotional Disturbance

Evidence offered by the defense suggesting that an assault or murder was committed under an extreme emotional disturbance (EED) is important in most murder and assault cases in Kentucky. The defendant must have acted under the influence of an extreme emotional disturbance for which there is 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.

The traumatic experiences, not necessarily a diagnosis of PTSD, can provide the explanation for the client's disturbance. Although helpful, an expert witness is not necessary to lay the foundation for EED. Fortunately, the reasonableness of the excuse is to be determined from the viewpoint of the defendant – a subjective test. This allows the introduction of all of the evidence surrounding the traumatic events and how and why the disturbance was extremely emotional for him. Some victims of traumatic experiences may be continually under the influence of an extreme mental or emotional distress. The "fight or flight" response has been triggered so many times that it "sticks" in the "on" position.² Some suggest not to make eye contact with strangers when in unfamiliar neighborhoods. Eye contact may have neutral meaning to most people, but it may be a sign of aggression, with threatening overtones, to someone who has become hyper-vigilant as a result of traumatic lifetime experiences.

Conclusion

Our clients lead lives that were chosen by others, beginning with decisions made prior to their birth and on up to adolescence when the client finally begins making decisions on his or her own. By that time, their view of the world (for better or worse) has been shaped by those earlier decisions. Unfortunately, the decisions made by some caretakers are to abuse and neglect the child. These and other lifetime traumatic experiences can influence the formation, development and operation of the brain. Counsel need to find out as much about the biopsychosocial history of the client as possible and use this information to develop mental health evidence that will document brain impairment and support persuasive theories for both culpability and mitigation.

² Heide, K.M., Solomon, E.P., *Biology, Childhood Trauma and Murder: Rethinking Justice*, International Journal of Law and Psychiatry 29, pp. 220-244 (2006).

Chapter 7: Neurobiology for the Defense Team

All behavior originates with activity in the brain. This conception of a never-ending interaction between the organism (brain) and its environment is the scientific basis for nearly all mitigation evidence and social history investigation in one way or another.”¹ The importance of the biopsychosocial history in gathering evidence of the client’s life experiences cannot be overstated.

Practice Note: The Guide developed by the International Justice Project cited above is an excellent resource for criminal defense lawyers.

Fortunately, lawyers do not need to know all there is to know about neurobiology – the study of the brain, the body’s central nervous system (CNS) and peripheral nerves which go to the extremities. While counsel must be able to spot where brain condition and/or function are involved in a case, she will have access to experts with whom to consult and who can explain the relevant brain issues to counsel and a jury. As noted many times in this manual, it is best to conduct the biopsychosocial history investigation before hiring any experts in the case. The first expert to be hired will likely be a consulting (non-testifying) psychologist with a good understanding of the relationship between neurobiology and behavior.

The Law Catching Up with the Science

In advocating zealously for the client, as we are ethically obligated to do, counsel should push the law to catch up with the science. The law has been catching up with the science in a number of legal areas such as the Supreme Court’s banning of the execution of the intellectually and developmentally disabled in *Atkins v. Virginia*, 536 U.S. 304 (2002) as well as those who were under the age of 18 at the time of the offense. *Roper v. Simmons*, 543 U.S. 551 (2005).

The Court relied on brain science in both of these cases and counsel should consider all appropriate ways to extend these holdings as far as ethically possible to clients whose brains function no better than those persons with IDD and/or who are under the age of eighteen.

Uses of the Science

Where counsel in *Atkins* and *Simmons* saved their clients from execution in post-trial litigation, defense counsel at the trial level can also use evidence of the client’s impaired brain. This evidence can be critical in challenging the *mens rea* alleged in the indictment such that a lesser offense might be more appropriate in the culpability phase and also as mitigation during sentencing. It is, however, important to consider “front-loading” as much of this mitigating evidence as jurors make up their mind on sentencing while evidence is still being offered in the culpability phase.²

Counsel should remember that “front-loading” evidence can also open doors that the team has worked very hard to keep closed so the decision to “front-load” must be consistent with counsel’s overall trial strategy.

The Brain and Its Parts

The brain can be divided into four parts, each having a distinct function:

BRAINSTEM: This controls the blood pressure, heart rate and body temperatures. It is located at the very base of the brain and is the first part of the brain to form after conception. This is the most primitive part of the brain and if it is not functioning, we are not living.

MIDBRAIN: controls sleep, appetite and other basis functions.

LIMBIC SYSTEM: This includes the amygdala, hypothalamus and hippocampus. The limbic system controls emotions, impulses and the “fight or flight” emotions in the brain. Think of the roles of emotions and impulsive behavior in relation to criminal activity.

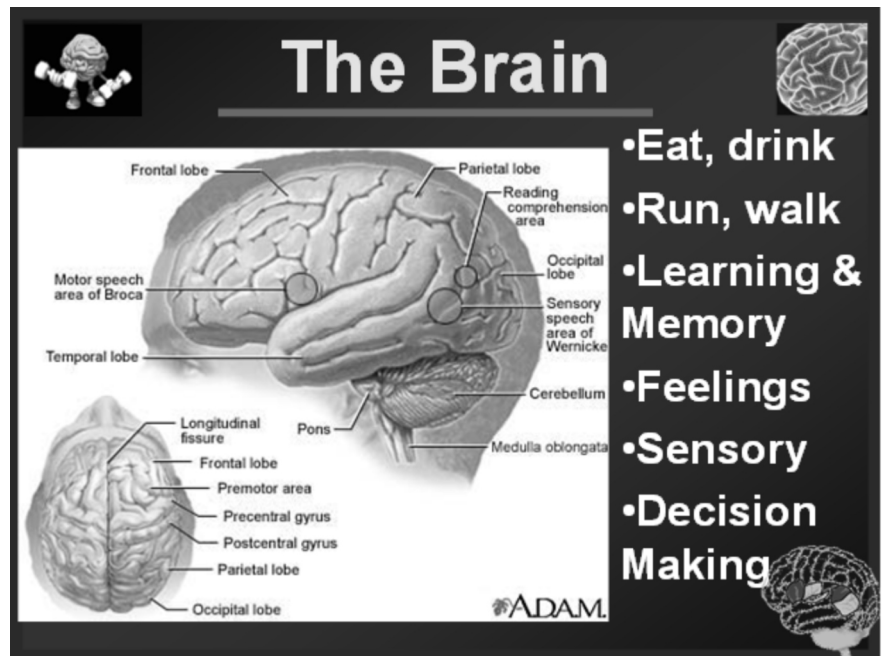
CORTEX: The cortex includes the frontal, parietal, occipital and temporal lobes and controls decision making, logic, planning, cognitive and executive functions. These are all functions associated with behavior – both good and bad. Specifically, the occipital lobes, located in the back of the skull, are involved in visual perception, ability or inability to recognize objects and faces.

Practice Note: Consider how an impaired occipital lobe might impact the reliability of an eye witness.

“The frontal lobes are to the brain what a conductor is to an orchestra, a general to an army, the chief executive officer to a corporation. They coordinate and lead other neural structures in concerted action.”³

From these descriptions, it is apparent that the two areas of the brain that will most impact criminal defense are the limbic system and the cortex – primarily the frontal lobe of the cortex. The emotions and impulses come from the amygdala in the limbic system and it is the job of the frontal lobe to moderate these impulses and emotions along with controlling the client’s decision making, logic, planning and cognitive functions. If the client is impaired in either of these areas, problem behavior may ensue, but also can be explained.

Practice Note: The most important neurological relationship for defense counsel to remember is the relationship between the amygdala and the front lobe. Our fears, impulses, emotions, empathy and sex drive originate in the amygdala. The executive functions of the frontal lobe are responsible for decision making, logic, planning, judgment and moderating the activity in the amygdala. Just consider the relevancy of these activities to both good and bad behavior. If either or both of these parts of the brain are impaired or not developed, problems will ensue.



Choice

In representing those charged with crimes it is important for counsel to be able to humanize the client in their own eyes. If counsel is not able to humanize the client it will be difficult to do so for the jury. Prosecutors like to tell jurors that “He had a choice! He made the choice and he must

³ Goldberg, E., *The Executive Brain: Frontal Lobes and the Civilized Mind*, (OUP 2001), at 2.

¹ Burr, Dick, et al., *The Brain and its Relationship to Behavior*, A Practitioner’s Guide to Defending Capital Clients Who have Mental Disorders and Impairments, International Justice Project (2012).

² William J. Bowers & Wanda D. Foglia, *Still Singularly Agonizing: Law’s Failure to Purge Arbitrariness from Capital Sentencing*, 39 Crim. L. Bull. 51,174–75 (2003).

be punished for the choices he made!" This is true in part. However, it is important to understand that our clients actually lead lives that were chosen for them by someone else. How so? The client did not choose his neurobiological makeup anymore than he chose to whom he was born, who is mother is, who is father is, whether or not his mother drank during gestation, his intelligence, his genetic make-up, how his parents treated each other, how they treated him during his early years, how well (or poorly) they took care of his needs as an infant, who his siblings are, how well they were treated, how financially stable the family was, where he lived, how often he moved, where he went to school.

Certainly, at some point, the adolescent begins to make choices of his own. However, these choices are made by a brain that was formed by decisions and/or conditions over which he had no control.

Brain Development

The brain is made up of billions of brain cells also called neurons. The purpose of the cells is to communicate between each other and different parts of the brain. This communication is aided by chemicals in the brain called neurotransmitters. A cell will communicate with another cell by "spitting" a neurotransmitter (brain chemical) across the synapse which is the space between the cells. This communication can go from cell to cell over long distances within the body. The message will go from the part of the body to the brain or from the brain to another part of the body. The message will be either to excite the receiving cell or inhibit the receiving cell, with the goal of taking some action or avoiding an action.

When the brain is young, billions of cells are being created and discarded in a process called "pruning." This act of pruning or elimination of cells is based upon a "use it or lose it" principle. The more the brain focuses on a particular activity (good or bad) the more cells are created in that area and "pruned" in areas that are not being used. The pruning of some cells allows the remaining and increasing number of cells to communicate better. The early lifetime experiences of the human brain are critical.

Often the experiences and conditions to which our clients are exposed early in their lives are not good. So, instead of brain cells being created to focus on activities such as playing a musical instrument or learning new languages or honing academic skills, the creation and pruning of the client's brain cells are directed away from these positive areas and focused perhaps on anti-social behavior, avoiding, or surviving family violence or coping with poverty and other stressors. Poverty can deny to a person opportunities to experience positive experiences that would create more brain cells in those positive areas. Jurors are often heard to say, "When I was very young, my family was poor and I turned out OK." Is the juror actually "OK"? Compared to what and who? If he is "OK," how much would the juror's life (and brain) been enriched by those opportunities that a higher socio/economic status could provide?

Counsel may be able to easily identify impairment to the brain caused by some traumatic injury, but she should also look for the less obvious lack of proper brain development caused by abuse, neglect and exposure to violence. Brain wiring is influenced by our early experiences through the creation and elimination of brain cells and the secretion of various chemical in the brain. These experiences affect how we later plan, learn from experience, make decisions based on logic, moderate our "flight or flight" impulses and allow the brain to communicate between different parts of the brain and body. If we are not able to learn from experience, we keep doing the same bad things over and over again. If the brain cannot moderate the fight or flight impulse, it may get stuck in that mode with hyper vigilance being the consequence.

Neurotransmitters

Neurotransmitters are chemical messengers in the brain and include:

Serotonin – the master impulse moderator for emotions and drives and helps to put the brakes on aggressive impulses coming from the amygdala. This is the "feel good" chemical in the brain.

Endorphins – these are the brain's natural opiates and responsible for the "floating calm" one experiences.

Adrenaline – this is the brain's alarm hormone. It helps the brain recognize danger and organizes the body to respond during a "flight or flight" sensation.

Dopamine – helps to control the brain's pleasure and control centers and is involved in drug addiction.

Acetylcholine – fundamental role is in alertness, wakefulness and mood.

Gamma Aminobutyric Acid (GABA) is prominent in the frontal lobes and is involved in inhibiting (neurotransmitters will either "excite" or inhibit) behavior and is also involved in stimulating brain maturation.

The neurotransmitters serotonin, adrenaline and dopamine are particularly important to the criminal defense lawyer's understanding of the client's behavior. Any excess or deficiency of neurotransmitters in the brain can influence behavior in a negative way.

Myelin

The different parts of the brain communicate with each other through the neurons or brain cell via the cell's axon. Think of the axon as the telegraph line in the communication process. The axon, or brain's telegraph line, is ideally coated with a white substance called myelin or a myelin sheath, similar to insulation on the line. The axons in the brain are not completely coated with myelin until a person is in their early to mid-20s. One can imagine a telegraph line or an electrical line that has frayed or incomplete insulation. Any resulting static or interference with the communication will lessen the effectiveness of that communication. Likewise, when the electrical signals are sent from cell to cell, the effectiveness of the communication is reduced until the myelination of the axon is complete.

The Amygdala

The amygdala is a part of the limbic system from where the brain's impulses, emotions, social and sexual impulses originate. It is also designed to act in short term emergency situations—such as when one is confronted with danger. "Do I run or do I stand and fight"? The prefrontal cortex helps the amygdala determine if the threat is real or not. Once the danger passes, the brain control returns to the cortex. The problem with clients who are exposed to emergency situations over and over (threats of violence) is the "flight or flight" response does not turn off. It gets "stuck" and the client can become hyper vigilant. This is one reason why we are told not to establish eye contact with people in potentially dangerous neighborhoods. What might be a casual, or even friendly, eye contact with one person, might be perceived as a threatening "stare" to one who is always in a fight or flight state of mind.

Prefrontal Cortex

This is located in the front part of the skull, behind the forehead and is the last of the brain parts to mature. This maturation process is not completed until a person is into their mid-20s, similar to full myelination. The prefrontal cortex is responsible for (1) judgment and reasoning, (2) forward thinking and appreciation of the consequences of actions; (3) ability to identify and express emotions; (4) empathy, regret and ethical decisions; (5) regulating impulses and inhibition and (6) assessing threats and responses to those threats as seen in the "fight or flight" situations.

The prefrontal cortex can become damaged in a number of ways, including: (1) emotional trauma, abuse and neglect in children, (2) physical trauma to the brain associated with risky behavior. Clients with poor impulse control often engage in such risky behavior, (3) heredity, (4) chemical (neurotransmitter) imbalance, (5) damage from drug dependence, (6) environmental hazards such as lead, mercury, pesticides and "huffing" of inhalants which can cause permanent damage.

When the client's prefrontal cortex is impaired he or/she may exhibit (1) lack of perseverance, (2) poor judgment, (3) inability to access emotions

– flat affect in even the most emotional of times, (4) trouble learning from experiences. Cortisol is a brain chemical that is excreted during a “flight or fight” situation. This chemical can be helpful, but if the fight or flight become chronic and too much cortisol is excreted into the system, the brain’s ability to learn from experiences can be impaired and normal brain development can be compromised.

When the prefrontal cortex is damaged or underdeveloped, the brain’s ability to moderate impulsive behavior is compromised possibly leading to the commission of impulsive criminal acts by the client. The science of impulsivity is one of the most exciting areas of criminal defense.

Impulsivity Research

It is important to comment on the literature that discusses the relationship between impulsivity and the culpable mental states. This literature tells us that with truly impulsive conduct the brain does not have sufficient time to act “intentionally” or “knowingly.”¹

Impulsive acts are unconscious at the time they are committed; they may become known to the self through introspection.² If the act is shown to have resulted from impulsive aggression, this argues against premeditation. On the other hand, impulsivity could support culpability where recklessness (*i.e.*, mindlessness) rather than “conscious indifference”) is an element of the crime.³

Often the biopsychosocial history will reveal that the client suffers from some impairment which reduces the ability of the frontal cortex to moderate the impulsive behavior originating in the amygdala. This explanation may help to reduce the client’s apparent intentional behavior to reckless conduct.

Also, the client’s case is better served if the client’s conduct can be described as “impulsive” rather than “premeditated.” While impulsivity can be explained by several neurological constructs, premeditation just scares jurors.

Consider the case where the client is charged with intentionally causing injury or death to a child. Is not the situation usually one where the caregiver (usually mamma’s boyfriend) is young, possibly cognitively impaired, smoking a joint, and has no child care skills or experience? The baby is crying incessantly with the caregiver ultimately “snapping.” A hand impulsively strikes the child before the accused is conscious of what he has done or is aware of his conduct. Certainly in most cases there is no intent to cause bodily injury to the child. The caregiver wants the child to stop crying. Many of these tragic cases are overcharged and resolved with sentencing which exceeds what is fair and just.

Counsel will often become frustrated by a client who shows no emotion even during the most emotional of times, before or during trial. This inability may be related to his life experiences rather than a lack of emotion. The client may not be able to access the emotion although it is present somewhere in the brain.

Orbitofrontal Cortex

This part of the brain is located behind the eyes and links the rest of the cortex, the limbic system, the hypothalamus and brain stem. It is important in its own right in regulating mood, social adjustment, responsibility and empathy. Early damage to the OFC appears to result in poor acquisition of moral and social rules.

The Juvenile Brain

The juvenile client is often presented with a serious dilemma. The part of the brain (amygdala) that creates impulses, sexual drive and emotions is fully developed and racing at full speed. However, the prefrontal cortex that has the job of slowing down these urges is not fully developed and

may have been damaged in some way. The consequences are generally not good. Counsel needs to understand the relationship between these different parts of the brain and appreciate how the brain condition is impacting the client’s behavior.

The Supreme Court of the United States wrote in *Roper v. Simmons*, 543 U.S. 551 (2005) that under the “evolving standards of decency” test, it was cruel and unusual punishment to execute a person who was under the age of 18 at the time of the murder. Writing for the majority, Justice Kennedy cited a body of sociological and scientific research that found that juveniles have a lack of maturity and sense of responsibility when compared to adults. Adolescents were found to be overrepresented statistically in virtually every category of reckless behavior. This reckless behavior can be explained in part, by the failure of the underdeveloped and/or impaired prefrontal cortex to control impulses and emotions.

Auto liability Insurance companies know from an actuarial analysis that when a male driver becomes 25, the premiums for liability coverage can be reduced. This money saver can usually be explained by the fact that the brain has become fully developed by age 25. The myelin is fully coating the brain cell’s axons so hopefully the brain is communicating well between the various parts. Perhaps more importantly, the executive functions of the prefrontal cortex are working properly to inhibit the impulses and emotions from the amygdala.

Practice Note: Counsel should challenge the transfer of a juvenile client to adult court, utilizing the juvenile brain science. No matter how badly the judge and prosecutor want to see a juvenile be tried and punished like an adult, the child is NOT an adult and the brain science can help show that with proper brain development, the juvenile may become a different person. Counsel should not be limited in applying brain science to those who are under age 18, but should instead look for every opportunity to extend the same protections as far as a fair reading of the science allows.

Counsel should also be looking for ways to extend the protections afforded those with Intellectual and Developmental Disabilities (formerly “mental retardation”). The science tells us that those whose brains are damaged by exposure to fetal alcohol may suffer damage to the executive function of the prefrontal cortex. The level of functioning is no more effective than one with IDD even though the I.Q. score is above the 70 I.Q. “cut off.”⁴

Practice Note: Contained in the accompanying resource section is a motion seeking to prohibit the execution of a client with FASD on the basis that their executive functioning is not greater than a person with IDD regardless of their I.Q. score.

Injuries to the Brain

The brain can be injured in many ways. The prefrontal cortex is behind the forehead and the most exposed and unprotected part of the skull (#fights, car and motorcycle accidents). Traumatic injuries can occur through external trauma but also internally from rapid movement of the brain within the skull or brain laceration from sharp edged bones within the skull. Please refer to Chapter 6, “Trauma,” for a discussion on ways in which the brain can be injured.

Neurobiology of Drug Addiction or Dependence

Most drugs of abuse activate the reward system in the brain – take the drug and you will feel great. A person wants to feel great again so the drug is taken again. The problem is that with subsequent doses the reward or pleasure is not as great as the first time so the drug is taken more often and/or in higher doses in order to get the same feeling. At some point, the addict begins to use in order just to feel “normal” without any “high.”

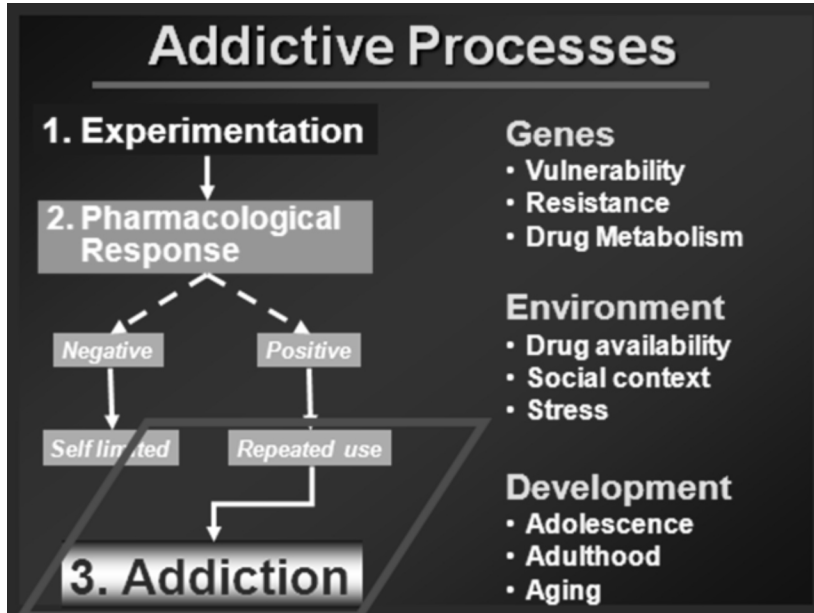
¹ Stanford M.S. and Felthous, A. R., *Introduction to this Issue: Impulsivity and the Law*, Behav. Sci. Law 26: 671-673 (2008).

² Barratt, Ernest, S., and Felthous, Alan R., “*Impulsive versus Premeditated Aggression: Implications for Mens Rea Decisions*,” Behav. Sci Law 21: 619-630 (2003).

³ Barratt and Felthous, *supra* at 628.

⁴ Streissguth, A.P., Barr, H.M., Kogan, J. & Bookstein, F.L., *Understanding the Occurrence of Secondary Disabilities in Clients with Fetal Alcohol Syndrome (FAS) and Fetal Alcohol Effects (FAE)*, (1996), also Novick Brown, Natalie J., et al., “*A proposed Model Standards for Forensic Assessment of Fetal Alcohol Spectrum Disorders*,” 38 Journal of Psychiatry and Law 383, 390 (2010).

The brain circuits that normally control reward, inhibition, motivation, learning and memory are rewired. Addiction becomes a disease of compulsion. When a person becomes addicted, he cannot refuse to take the drug. Judgment and control are no longer relevant in helping to control the compulsive act. A problem with drugs that can be smoked, such as crack cocaine, is that the “reward” is very quick and intense. The many capillaries in the lungs move the drug into the blood stream and then to the brain almost instantly. Laboratory studies have shown that mice, once addicted, will choose the drug over food until death occurs.



Practice Note: KRS 501.80 provides: Intoxication is defense to a criminal charge only if such condition either: (1) negates the existence of an element of the offense; or (2) is not voluntarily produced and deprives

the defendant of substantial capacity either to appreciate the criminality of his conduct or to conform his conduct to the requirement of the law.

Intoxication and addiction are two separate concepts that may overlap. The client who is addicted may very well be intoxicated at the time the charged crime is committed. While intoxication is generally not a defense to a crime, there are exceptions. Under KRS 501.080 (2) if the client is involuntarily intoxicated to the point of insanity, his intoxication will serve as a defense. Likewise, if his intoxication, involuntary or voluntary, is a defense if it negates the *mens rea* alleged in the indictment. If the client's intoxication negates his intent to commit a crime that requires intentional conduct, this is a defense. However, the voluntary intoxication is not a defense to a charge of wanton conduct if the client is “unaware” of the risk his conduct creates because he is intoxicated. Perhaps the client is guilty of wanton conduct, but this is certainly better than being guilty of an intentional crime.

As pointed out earlier in this chapter, it is the duty of counsel to extend protections of the law as far as possible. If the Commonwealth alleges that the client's intoxication was voluntary, what if the client is truly addicted? Is the act of consuming the drug, including alcohol, truly voluntary? At what point does “voluntary” become “involuntary”? If the client was introduced to drugs when very young and becomes addicted as a result. Is this voluntary?

Conclusion

All behavior is explained by brain condition and function. It would be an impossible task for defense counsel to have a complete understanding of the science of neurobiology. However, it is important for counsel to understand those parts of the brain that are routinely involved when a crime is committed and relate the condition of these brain functions to life experiences and conditions as shown by the client's biopsychosocial history.

Chapter 8: Toxins and Teratogens which Damage the Brain Fetal Alcohol Spectrum Disorders

Alcohol is the most potent neurodevelopmental cause of functional birth defects in the western world.¹ There is no safe level of consumption of alcohol when the fetus is in the womb. The more alcohol consumed the greater the potential damage to the fetus.²

Alcohol consumed at different stages of gestation may impair the part of the fetus that is developing at that time. The adult mother, hopefully, has a full sized and fully functional liver that helps to process and detoxify alcohol she consumes. Her fetus is not so lucky. The mother's placenta allows for a free entry of alcohol into the fetus at a time when enzymes that are necessary for the liver to detoxify the alcohol have not yet developed. The fetus is bathed in alcohol.

The range of permanent brain impairment from fetal alcohol exposure makes up the Fetal Alcohol Spectrum Disorders (FASD). Think of FASD as a continuum of conditions from alcohol exposure. On this continuum counsel will find:

(1) **Fetal Alcohol Syndrome (FAS)** representing the severe end of the FASD spectrum. FAS is a leading cause of preventable Intellectual and Developmental Disabilities (formerly mental retardation) as well as other cognitive impairment. Approximately half of children with FAS are Intellectually and Developmentally Disabled, but nearly all have serious cognitive, learning, attention and behavioral problems. Although these functional deficits are first observed during childhood, they persist throughout life and may worsen over time.³

Those afflicted with FAS *may* have abnormal facial features, growth problems and central nervous system impairment. However, "only about 20-30% of affected individuals actually have the 'characteristic faces'."⁴ FASD can cause problems with learning, memory, attention span, communication, vision or hearing, impulsive behavior, etc. These symptoms may lead to difficulties in school and the criminal justice system and limits the client's interpersonal skills.

(2) **Alcohol-related Neurodevelopmental Disorder (ARND)**. Those impaired by ARND might have intellectual disabilities, problems with behavior, memory, attention, judgment and poor impulse control.

(3) **Alcohol-Related Birth Defects (ARBD)**. People with ARBD may have problems with their heart, kidneys, or bones, with hearing, or with a combination of these symptoms.

(4) **Partial Fetal Alcohol Syndrome (PFAS)**. Children with PFAS have confirmed prenatal exposure to alcohol. Their faces look different and they experience one of the following: (1) growth problems, (2) unexplained learning problems or (3) behavioral problems.⁵

Importance of FASD to the Public Defender

Those who qualify for assistance from a public defender may very well be in the group of people who are at risk for exposure to prenatal alcohol. Mothers who: (1) receive little or no prenatal care, (2) are unemployed, (3) socially transient, (4) have lost children to foster or adoptive care due to neglect, abuse or abandonment are more likely to have high alcohol use patterns that could affect a pregnancy.⁶

Practice Note: Please refer to the chapter in this manual on Neurobiology for a discussion of the importance of the frontal lobes and the executive functioning of the brain. The executive functions originate in the frontal

lobes and are important in helping a person to reason, exercise good judgment, plan and carry out tasks, as well as control the emotions and impulses originating in the amygdala. Without a fully functioning frontal lobe, impulsive and emotional behavior may go unchecked. Please refer to the chapter in this manual on Culpable Mental States for a discussion of the significance of the frontal lobes to the client's mental state at the time of an alleged crime.

The biopsychosocial history investigation of the client's life is critical to a proper resolution of the case. If counsel finds an indication of maternal drinking, investigate the possibility of cognitive impairment caused by alcohol exposure even if the client does not have the facial features associated with FASD.

In order to obtain a just and effective resolution of the case for the client, keep in mind that the impairment the client suffers is not something he or she chose. Both counsel and the probation officer must be able to humanize the client and approach the resolution of his case with compassion and understanding.

The client's brain damage will not only impact the offense with which he is charged, but his ability to comply with any terms of probation. Do not agree to a resolution that will just set the client up for failure. In order to successfully complete a period of probation or parole, the client will need extensive assistance and supervision as well as an understanding of the challenges he faces in complying with terms set by the court. Conditions of probation should be realistic in light of the disability.

Hopefully the probation officer sees the importance of preventing a client from reoffending. Statistics show that reoffending is much lower following the successful completion of a realistic probationary period.

Recognizing FASD

As has been stated many times in this manual, the biopsychosocial history investigation is a primary source for indication of exposure to prenatal alcohol exposure. Getting a mother to admit that she drank while pregnant may be difficult, especially if mom can see how impaired her child has become along with the criminal justice sanctions facing her child.

Practice Note: Should the mother be reluctant to discuss her drinking while she was pregnant, consider the following approach:

(1) **Normalize the behavior:** "We all enjoyed having a few drinks back in the day, I liked bourbon, how about you? Lots of women did the same thing."

(2) **Sympathize with the lack of awareness:** "Many women would party before they even knew they were pregnant, was that the same with you? "I may have also."

(3) **Emphasize the newer research:** "We did not know then what we know now about drinking and pregnancy and I am sure you did not know either. No one knew that a fetus could be harmed in as little as 22 days even with "normal drinking";

(4) **Individualize the discussion:** How far along were you when you found out? Do you remember when you stopped drinking? Could you tell me more?

Birth records can be critical in establishing exposure. A blood screen with an ETOH level will be invaluable and perhaps an APGAR score will show the newborn's neurological functioning shortly after birth.

Practice Note: Unfortunately the birth hospital custodian may tell the mitigation specialist that the records have been destroyed. When faced with such a reply, consider that while the destruction of records may have been destroyed according to law, proper destruction can be expensive and it may have been cheaper to warehouse records rather than to destroy them. Refusing to take "NO" for an answer (along with a bouquet of flowers for the soon-to-be best-friend records custodian) may lead to the records being found in an old warehouse. Also consider as a source,

¹ Rich, S.D., *Shifting Diagnostic Paradigms for Improved Treatment and Surveillance of Fetal Alcohol Spectrum Disorder in DSM-V*, Child and Adolescent Psychiatry Society of Greater Washington Newsletter, Fall-Winter 2012.

² Burr, et al., *Broken Brains and Neurological Disorders*, A Practitioner's Guide to Defending Capital Clients Who Have Mental Disorders and Impairments. The International Justice Project.

³ Burr, et al. at page 74.

⁴ Rich, *id.*

⁵ http://www.americanbar.org/groups/child_law, March 26, 2014.

⁶ *Fetal Alcohol Syndrome: Guidelines for Referral and Diagnosis*, National Center on Birth Defects and Developmental Disabilities, (July 2004).

the client's juvenile and adult records or prior evaluations from school, military and other state or federal institutions.

ADHD

Attention Deficit-Hyper Activity Disorder (ADHD) is one of those conditions often read in client's records. It is also a term that members of the public, judges, jurors and probation officers have heard for many years to the point that a diagnosis of ADHD may have little impact. Jurors might roll their eyes and think "Everyone says they have ADHD, so what"? However, ADHD may be an indicator of fetal alcohol exposure and if so, the alcohol has damaged the executive function of the brain so that the impulsive and hyper-active part of the brain – the amygdala - goes unchecked. The stimulant, Ritalin, (methylphenidate) has long been prescribed to treat ADHD.

Why would a stimulant be given to someone who is already too active? The drug stimulates the activity in the frontal cortex of the brain where the executive functions originate in the hopes that the executive functions will act to control the impulsive behavior. ADHD may indicate that the executive functions of the cortex have been damaged by prenatal alcohol exposure. ADHD may provide counsel with a way to explain the consequences of prenatal alcohol exposure.

Facial Dysmorphology

The client may exhibit facial characteristics that suggest that alcohol damaged parts of the face during gestation. In this chapter, the reader will find pictures of children and adults all of whom exhibit some of the abnormal facial features associated with an FASD condition. These characteristics may include: (a) a small head, (b) a low nasal bridge, (c) impairment in the structure of the eye that gives the eye a "squinting" appearance or an almond shaped look, (d) a flat mid-face, (e) a smooth philtrum which is the double ridged space between the nose and top lip, (f) a short nose or, (g) an underdeveloped jaw or chin.

The body's facial features are formed during the first three months of gestation and mom may not know she is pregnant so she continues to drink. Alcohol can cause malformation and brain abnormalities to embryos that are only three to 4 weeks old and about the size of FDR's ear on a Roosevelt dime. If mom continues to drink, other parts of the brain and central nervous system will be damaged depending on what is being formed at the time. Brain development is ongoing during gestation.

The features seen in the child may be outgrown as the face develops over time, so again, the apparent absence of facial signs does not mean that the brain has not been damaged. The facial signs may be very subtle and identifying them may require expert assistance with the aid of computer software.

On the following pages, the reader will see two pages depicting facial features of those impaired by fetal alcohol. The drawing of the young man shows the features of a young child who has been exposed to fetal alcohol. As most of your clients will be older, it is important to pay close attention to the second page containing twelve pictures of boys, girls, men and women. The caption asks the critical question: "Which person has brain damage from prenatal alcohol exposure?" Several of the pictures show fairly obvious facial features that would suggest a FASD. Most of the people in the pictures appear to be normal and free from such facial features. All twelve had been exposed to fetal alcohol, so counsel cannot assume that just because the facial features are absent or not obvious that there has been no exposure.

The type of crime alleged to have been committed may also act as a sign that the client is disabled by FAS. Those with this disability have difficulties controlling their impulses so impulsive crimes such as shoplifting and vandalism are common. The disability is embarrassing so the client may hide his disability by acting smarter than he is or taking credit for being a leader in a criminal activity when in fact all his brain will allow him to do is follow the lead of others. . A client with FAS may hang around with a

younger age group than his own. Specifically, he may not be successful in sexual relationships with those his own age, so he may search out to a partner who is much younger and who is more inclined to agree to a sexual relationship.

Lawyers may often think, "He looks and sounds pretty smart to me and he says he understands everything I tell him." The client does not want the lawyer to recognize his disability so, in spite of the consequences, the client will "act normal." Don't ask the client if he understands what you told him, ask him to explain back what you told him and the significance in his case. The response may very well be revealing.

The Diagnosis of FAS

The diagnosis of FAS is a medical diagnosis and requires a team approach. The team will consist of a minimum of a medical doctor, psychologist and a neuropsychologist. Each should be knowledgeable about the Fetal Alcohol Spectrum Disorders. Reliable assistance finding a local diagnostician and/or information on the disability can be obtained from:

Kathryn Kelly, Project Director
FASD Legal Issues Resource Center
Health Sciences Administration
University of Washington
180 Nickerson Street, Suite 309
Seattle, WA 98109
(206) 616-5408
faslaw@u.washington.edu

The diagnosis of FAS can be made if the following are present:

- (1) Growth deficiency;
- (2) facial features associated with FAS;
- (3) Central Nervous System (CNS) damage, and ;
- (4) confirmed prenatal alcohol exposure.

Elsewhere in this chapter, it is suggested that (with some exceptions) counsel should not be concerned with the label (diagnosis) that the mental health community places on a set of symptoms or diagnostic criteria. Counsel should be more interested in describing the conditions and experiences of the client's life and how they relate to his symptoms and explain his behavior. Two of the possible exceptions to this rule involve Intellectual and Developmental Disabilities and Fetal Alcohol Spectrum Disorders. Counsel will need to establish the presence of IDD to obtain an exemption from execution under *Atkins v. Virginia*, 536 U.S. 304 (2002). As with IDD, counsel will need to establish one of the disorders on the FASD spectrum in order for the criminal justice system to attach full significance to the mother's drinking during gestation. If gestational drinking can be established, counsel must still vividly describe the common sense consequences of the client's tiny brain being bathed in alcohol by a mother who did not know better. The full impact of the condition will come with establishing a diagnosis of FAS.

The DSM-5 refers to FASD as a Neurodevelopmental Disorder associated with Prenatal Alcohol Exposure (ND-PAE) under the diagnostic category "Specified Other Neurodevelopmental Disorders (315.8).

Significance of FAS Diagnosis

While the traditional definitions of Intellectual and Developmental Disabilities do not require counsel to establish a cause for the disability as long as it originates during the developmental period or prior to age 18, counsel may find it easier to persuade a prosecutor, judge or jury that IDD exists if the disability can be traced to a specific cause such as fetal alcohol exposure. Establishing a diagnosis of IDD will exempt the client from execution pursuant to *Atkins v. Virginia*.

The significance of brain impairment by fetal alcohol is not limited to exemption from the death penalty. Evidence of impairment can be relevant to pre-trial, culpability and sentencing issues. Evidence of

impairment can be relevant to the client's competence to stand trial (especially his ability to assist counsel), competence to enter a plea, to be sentenced, to understand what is left of his Miranda Rights, to waive those rights and to give a voluntary *and truthful* statement to authorities. Those with FAS are eager to please others and especially those who are in positions of authority, *i.e.* law enforcement. They are particularly vulnerable to the Inbau & Reid method of interrogation used by many police and sheriff offices. These predispositions, when combined with the need to hide the cognitive disability, may easily lead to a false confession.

Also, counsel should consider how the impairment to the brain has affected the client's ability to:

- (1) control his impulsive behavior,
- (2) form the intent to commit the offense charged (was it actually his conscious objective to cause the result or engage in the conduct?),
- (3) fully understand the consequences of his actions,
- (4) his ability to perceive the risks associated with his behavior,
- (5) his ability to consciously disregard the risks in his conduct, *i.e.* was his culpable mental state actually that required for a lesser included offense and not the more serious offense that is charged?

Beyond Atkins and Hall

What happens when prenatal exposure to alcohol has been confirmed, and the client has impairments in adaptive behavior but his I.Q. is above 75 (applying standard error of measurement)? Please refer to the "Resources" section of this manual for a motion that seeks to extend the exemption found in *Atkins v. Virginia* to those impaired by FASD and who have an I.Q. *above* the state required "cut-off." The theory of this motion is that fetal alcohol exposure can damage the executive functioning of the brain to the same extent as a person who suffers from IDD. While the I.Q. score is above the mandated level, the damage to the executive functioning of the brain so severely compromises the client's adaptive behavior that he functions as one with IDD in spite of his elevated I.Q. score.¹

Fetal alcohol exposure is a major cause of brain impairment. Counsel should consider the possibility that a client has been exposed during gestation in each case until the possibility has been reliably ruled out. The biopsychosocial history investigation is critical to establishing alcohol exposure. When exposure has been confirmed counsel must apply the consequences of the client's brain impairment to all aspects of counsel's representation of the client.

Pesticides

Pesticides work by interrupting or destroying the interactive processes of the nervous system, including functioning of the neurochemical and neuroelectric systems of the brain.² Each class of pesticide may work differently and produce different short term and long term symptoms and consequences that will influence cognitive ability and behavior.

Should pesticide exposure be suggested, the trial team's mitigation specialist will want to determine from as many sources as possible:

- (1) the type of exposure to the specific toxic agent, (farm field, hazardous waste dump?)
- (2) the duration of exposure,
- (3) how much of the toxic agent was ingested, absorbed or inhaled,
- (4) the vulnerability or susceptibility of the client to the exposure.³

¹ Novick Brown, Natalie J., et al., et al., *A Proposed Model Standard for Forensic Assessment of Fetal Alcohol Spectrum Disorders*, 38 Journal of Psychiatry and Law 383, 390 (2010) and Streissguth, A. P., Barr, H. M., Kogan, J. & Bookstein, F. L., *Understanding The Occurrence of Secondary Disabilities in Clients with Fetal Alcohol Syndrome (FAS) and Fetal Alcohol Effects (FAE)* (1996).

² Freedman, D., et al., *Broken Brains and Neurological Disorders*, A Practitioner's Guide to Defending Capital Clients Who Have Mental Disorders and Impairments, The International Justice Project. (December, 2010).

The client and his family may not be good providers of this information. The mitigation specialist should interview farm owners, fellow workers, those who supplied and applied the toxic agents along with agricultural extension agents, local farm supply houses, EPA, HUD, fire departments, local universities, newspapers, television and radio stations and local medical clinics. A search of the local courthouse for records of civil litigation may be helpful.

Practice Note: It is possible that the mitigation investigation (biopsychosocial history) may uncover evidence that will prove embarrassing to the state, county or local governments or pillars of the local community. Counsel may convince the Commonwealth that embarrassing disclosures can be avoided by resolving the case to the client's benefit.

Toxic chemical compounds by themselves can be harmful to the central nervous system impacting cognition and behavior. However, one compound when combined with another can be as much as one thousand times as great as either compound alone. For example, while malathion is considered comparatively safe, should a person be exposed to both malathion and parathion, the effect of the malathion is enhanced nearly 400 times because parathion inhibits the enzymes that break down malathion in the body.⁴

Exposure to Metals

High level exposure for all metals can lead to cognitive impairment effects. However, exposure to lead and mercury at any level can result in cognitive and behavioral effects. Significant exposure to these two metals while *in utero* or in early childhood can be a cause of Intellectual and Developmental Disabilities.

Lead has been recognized as causing neurological damage for many years. There is no safe level of lead exposure and ingestion in children results in life-long decrease in I.Q. as well as increases in behavior problems. Lead paint is commonly found in older homes and the dirt surrounding some smelter sites.

Mercury is found in a number of products and manufacturing processes. It has been used as a fungicide to treat seeds. It will accumulate in fish and will pass along to humans who eat the fish where it passes the blood brain barrier and accumulates in the brain. Mercury will also pass the placenta barrier so fetuses can be exposed.

Testing for Impairment from Exposure to Metals

As with exposure to other toxins, teratogens and agents, counsel should first confirm the extent of exposure through the biopsychosocial history investigation. After conferring with the trial team's consulting expert, counsel should draft a referral letter to an experienced and qualified forensic neuropsychologist telling her what issue the defense needs her to evaluate. Counsel and the expert should discuss and agree upon any testing that will need to be done in order to confirm or rule out neuropsychological impairment from toxic exposure. Personality testing is not necessary to evaluate for neuropsychological impairment.

When drafting the referral letter, counsel should keep in mind the potential influence that neuropsychological impairment may have on all aspects of the client's case: pre-trial, trial, and sentencing. Counsel may also consider long bone x-rays that may reveal exposure of the client to lead earlier in life. Blood levels can test for more recent exposures. Structural and functional imaging may also be considered.

Organic Solvents

Solvents are used in many manufacturing processes to extract, dissolve or suspend non-water soluble materials. It is like using turpentine or paint thinner to dilute oil based paint brushes or to clean brushes when oil based paint has been used. These have been known to cause damage to the brain and peripheral nervous system (nerve system extending into the

³ Freedman, D., *id.* at 77.

⁴ Freedman, *id.* at 78.

extremities) since the 1970's.¹ Workers who have been exposed to solvents over time (chronic) experience fatigue, irritability, memory impairments, sustained alteration in mood, emotional instability, diminished impulse control and deterioration in cognitive functioning.

The solvents damage the brain by breaking down minute parts of the system. They can break down the myelinated nerve fibers and cause axonal swelling. The myelin fibers are the white matter of the brain that coats the axons which allows one neuron (cell) to communicate with another. The axons are the part of the brain cell that is also involved in communication.

Workers can be exposed to solvents by skin contact or inhalation. Examples of solvents are toluene, benzene, chloroform, chloroethene,

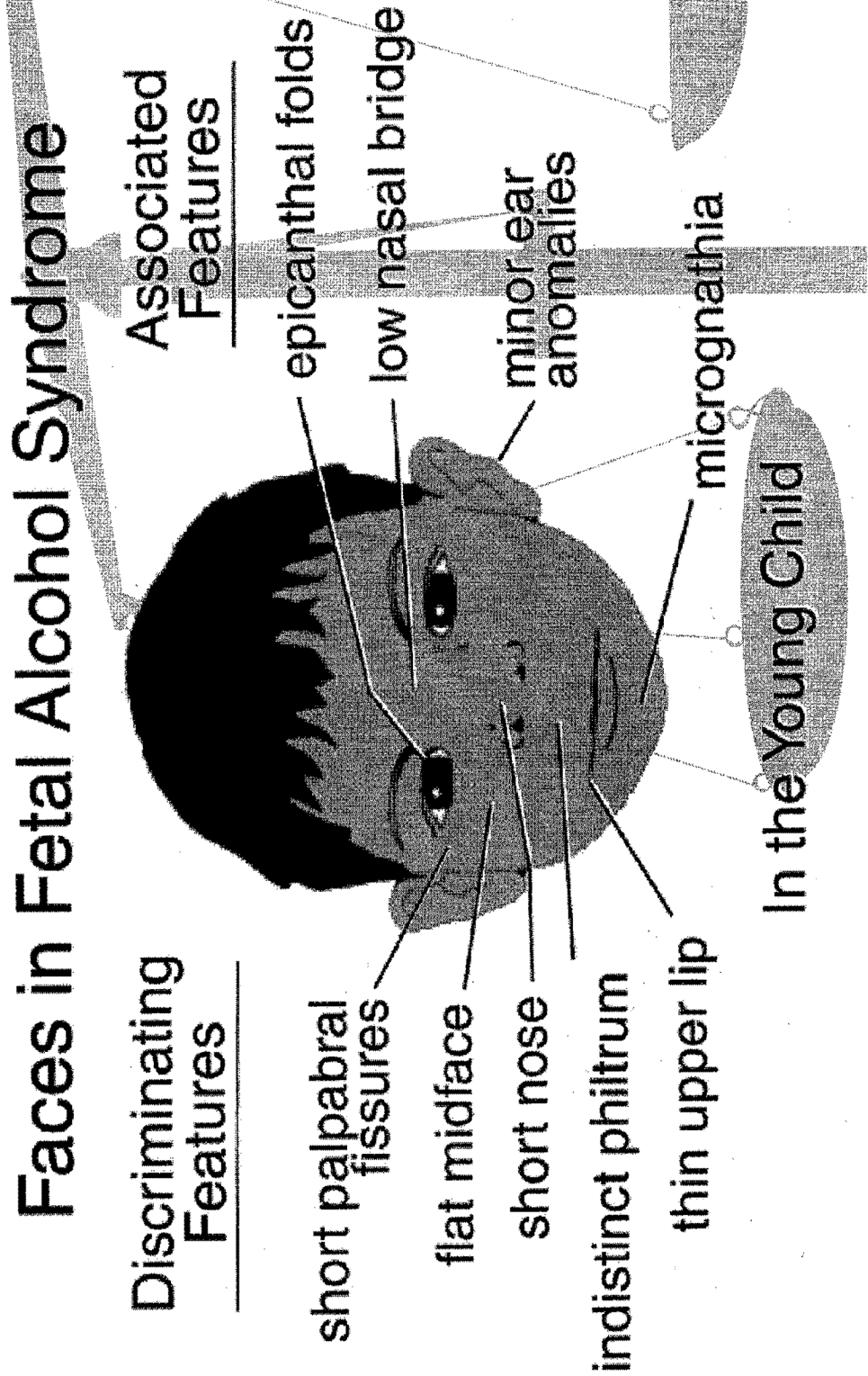
chloroethane (TCE), acetone, hexane, xylene. These solvents are toxic and exposure to these can have damaging effects on the client's central nervous system. While confirming exposure, counsel should find out if the client was provided with any safety equipment designed to protect from injury.

Conclusion

As with damaging prenatal alcohol exposure and exposure to pesticide, metals and solvents, counsel should consider the impact of these on the pre-trial, trial and sentencing issues in the client's case.

¹ . Freedman, *id.* at 82.

Facial Features in Fetal Alcohol Syndrome



Which Person Has Brain Damage From Prenatal Alcohol Exposure?



They all do . . . and they want you to know it was PREVENTABLE.

Chapter 9: The Brain and Culpable Mental States

This chapter will discuss the culpable mental states as defined in KRS 501.020 and hopefully show how client information obtained through the biopsychosocial history might be utilized in ensuring that the true mental state forms the basis of a fair and just resolution of the charges against the client.

Defense counsel may be in the habit of not looking at the mental state alleged in the charging instrument. However, a clear focus on the mental state that is alleged is critical. Questions counsel should consider asking in each case include:

1. What mental state is alleged?
2. Why did the client do what he did?
3. What was he thinking at the time of the act?
4. How can we use information developed through the biopsychosocial history to challenge the *mens rea* and obtain a reduction in the charges against the client consistent with his actual mental state?

Culpable Mental States Defined

The severity of an offense is determined by the offender's culpable mental state at the time of the offense. Prosecutors will often allege that an offense was committed "intentionally" when a lesser mental state (and accordingly a lesser offense and possible sentence) is more appropriate. The Kentucky Penal Code sets out the Culpable Mental States at KRS 501.020, beginning with the most culpable state (intentional) down to the least culpable (reckless). Specifically the different states are defined as:

1. **INTENTIONAL:** A person acts intentionally...with respect to a result or to his conduct ...when it is his CONSCIOUS (emphasis added) objective to cause the result or engage in the conduct, *i.e.*, he wanted to do it, he knew what he was doing and he did it.
2. **KNOWING:** A person acts knowingly...with respect to conduct or circumstances when he is AWARE (emphasis added) that his conduct is of that nature or that the circumstances exists.
3. **WANTON:** A person acts wantonly, with respect to a result or circumstance, when he is AWARE of and consciously disregards a substantial and unjustifiable risk. The risk must be of such a nature and degree that disregard thereof constitutes a gross deviation from the standard of conduct that a reasonable person would observe in the situation. (This lengthy element will be referred to hereafter as "gross deviation from reasonable conduct").
4. **RECKLESS:** A person acts recklessly with respect to a result or to a circumstance when he fails to perceive a substantial and unjustifiable risk that the result will occur or that the circumstance exists and is a gross deviation from reasonable conduct.

Observations About the Mental States

1. It is important to distinguish between offenses committed by a person's engaging in the conduct itself from offenses which require a particular result to be achieved, such as a murder. It is the difference between a conduct offense and a result of conduct offense.
2. "Knowing" conduct is not relevant to a "result" offense such as murder. In a case where murder is alleged, the alleged mental state applies to the result, *i.e.*, did the victim die, not did the offender fire a weapon? The offender may have intentionally fired a weapon, but if it was not his objective that his intended (or another) victim die, it is not murder. The firing, or mere possession of the weapon may constitute crimes with a less than intentional mental state required.
3. The definitions of "wanton" and "reckless" have the convoluted language describing a requirement that the mental state amount to a gross deviation from a reasonable (objective) standard of conduct.

It is unlikely that juries can distinguish a deviation that is gross from one that is not gross, but it is highly likely that each juror will find that any offensive conduct in your case is indeed gross. Perhaps the more reasonable way to analyze this language is to ask "How irresponsible was the accused acting under the circumstances"? If it is arguable the behavior is a "deviation," but not a "gross deviation" from reasonable conduct then perhaps a lesser included offense is appropriate.

4. While a murder cannot be committed "knowingly" in Kentucky, it can be committed "wantonly" if the wanton conduct (which includes the gross deviation from reasonable conduct language) is accompanied by conduct "which creates a grave risk of death." If the defendant is driving a motor vehicle, the murder becomes wanton if the conduct constitutes an extreme indifference to human life. Wanton conduct + "grave risk of death" = wanton murder. Wanton conduct + "grave risk of death" + "extreme indifference to human life" = wanton murder if driving a motor vehicle.
5. If an accused is "unaware" of his conduct solely because he is intoxicated, his intoxication is not a defense to the charge.
6. The terms "AWARE" and "CONSCIOUS" are emphasized in the definitions above. This is because the defense can use these terms to relate the client's mental health to the *mens rea*, hopefully in the culpability phase of the trial (frontload), but surely in the sentencing phase. "AWARE" and "CONSCIOUS" are synonyms for "cognition." Many of our client's life experiences and insults will impact their cognition and thus their ability to be "AWARE" and "CONSCIOUS" of the nature and result of their conduct.

Application of the Mental States to Murder (capital offense)

KRS 507.020(1) defines one form of murder as intentionally causing the death of a person while not under the influence of an extreme emotional disturbance (EED). Intent is the CONSCIOUS objective to cause the result – "I wanted him to die." Even if the killing was done intentionally, if done under the influence of an extreme emotional disturbance (EED) then the proper verdict is First Degree Manslaughter which drops the possible conviction from capital murder to a Class B felony. Extreme emotional disturbance provides a reasonable explanation or excuse for the conduct of the accused. If the defense evidence raises evidence of EED, then the absence of it becomes an element of the offense that the prosecution must negate beyond a reasonable doubt. EED is discussed more thoroughly in Chapter 2 of this manual.

The importance to the client of his mental state at the time of the offense can be seen as the punishment for the offense declines along with the decline in the mental state and accordingly, the severity of the crime.

KRS 507.020(2) defines a different type of murder, one that requires "only" a wanton state of mind, but requires that the defendant actions created a "grave risk of death." If the defendant was driving a motor vehicle, his causing the death of another can amount to wanton murder if he was operating his vehicle under circumstances "manifesting an extreme indifference to human life."

Section 2 refers to operating a motor vehicle, but wanton murder is not limited to vehicular homicides. Typical examples of wanton murder include shooting into a crowd, an occupied building or car, placing a time bomb in a public place or derailing a speeding train. These could also be examples of intentional murder depending upon what the client was thinking at the time.

If an accused is aware of a risk and consciously disregards the risk that another person would die, it is likely that a jury would find that the accused acted indifferently to human life. Research tells us that jurors cannot distinguish between knowing and reckless conduct.¹ It is highly improbable that a juror would be able to make other fine distinctions in such an

¹ Owen Jones, *Sorting Guilty Minds*, New York University Law Review (November, 2011).

emotionally charged situation especially if those distinctions would benefit the accused.

KRS 507.030 First Degree Manslaughter (Class B Felony)

An offense of first degree manslaughter does not require a lesser mental state than intentional, but rather a lesser objective. Where murder involves the conscious objective to cause death, First Degree Manslaughter specifies the intent to cause serious physical injuries.

A second type of First Degree Manslaughter involves an intentional killing, but one committed under an extreme emotional disturbance. EED is discussed elsewhere in this chapter and more thoroughly in Chapter 2.

KRS 507.040 Second Degree Manslaughter (Class C Felony)

This statute requires a mental state of “wanton,” but without the extreme indifference to human life as is required in the wanton murder statute. Accordingly, the elements of Second Degree Manslaughter require that the offender:

1. was AWARE of and CONSCIOUSLY disregarded;
2. a substantial and unjustifiable risk of death; and
3. the conduct was a gross deviation from reasonable conduct.

KRS 507.050 Reckless Homicide (Class D Felony)

The mental state of “reckless” is distinguished from wanton conduct in one easy to remember element. Wanton conduct means that the accused knew of the risk and made the conscious decision to ignore the risk. When one is reckless, he failed to perceive or did not know or realize there was a risk in his conduct. His failure to perceive the risks can often be explained by some cognitive impairment as will be shown later in the case of Kenneth Wayne Jackson. Counsel can explain such cognitive impairment by describing the client’s inability to be AWARE of or CONSCIOUSLY evaluate the risks associated with his conduct. The more counsel knows about the client’s biopsychosocial history the more she will be able to identify those impairments that impact the client’s culpable mental state.

Summary of the Mental States

While counsel should strive to remember the complete definitions of the culpable mental states, it is convenient to memorize a shorthand version which can help to clarify the distinctions “in the heat of battle.”

<u>Mental State</u>	<u>Shorthand</u>
Intentional	“I wanted to do it and I did it”
Knowing	“I was aware of what I was doing”
Wanton	“I was aware of the risk, but did it anyway”
Reckless	“I failed to perceive a risk in what I did”

Remember that wanton and reckless both contain the element relating to the gross deviation from reasonable conduct.

Extreme Emotional Disturbance

KRS 507.020 and 507.030 extreme emotion disturbance (EED) is discussed at length in Chapter 2. However, suffice it to say EED is an important consideration in cases of murder and assault. Murder (a capital offense) if committed under an extreme emotional disturbance is punished as First Degree Manslaughter under 507.030 and the degrees of assault are also reduced if EED is found. KRS 507.020 provides:

“...if he acted under the influence of an 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.”

The mental health of the accused is critical in the analysis of whether or not he was acting under the influence of an extreme emotional

disturbance. However, EED and mental illness are not the same thing and just because the client is mentally ill does not mean that *per se* he was acting under an extreme emotional disturbance.¹ However, evidence of mental illness does not preclude a finding of EED and such evidence is relevant to a subjective evaluation of reasonableness of the defendant’s response to provocation.² Even if evidence of the client’s mental health is not admissible on the issue of EED at the culpability phase of the trial, it is certainly admissible at sentencing.

Objective v. Subjective Standards

Defense counsel will always hope that the statute requires a subjective (what was I thinking?) standard rather than an objective (reasonable person) standard. We have seen that a “reasonable person” standard is required in the statutes defining wanton conduct and reckless conduct, i.e., “...standard of conduct that a reasonable person would observe in the situation.” The problem is that our clients often do not act reasonably and we want to be able to explain to the jury why this is the case. This is why an emphasis on the terms “AWARE” and “CONSCIOUS” are so important!

Counsel will be able to provide this mental health explanation when the required standard is a subjective one such as that found in the EED language of KRS 507.020. With EED the reasonableness of the explanation for the defendant’s disturbance is determined from the viewpoint of a person in the defendant’s situation and under the circumstances as the defendant believed them to be. This language is consistent with the language in *Fields, supra*, and should give counsel much latitude in offering mental health evidence during the culpability phase of the trial in which evidence of EED is offered.

While counsel will attempt to “front load” the client’s mental health evidence wherever possible the ability to offer this evidence during sentencing should not be limited. Front loading is important as the Capital Jury Project tells us that jurors often make up their minds about culpability AND sentencing before any evidence in sentencing is even heard. The defense’s mitigating evidence may likely fall on deaf ears should you not front load, subject to the dangers of opening doors that should remain closed.

Impulsivity Research

Practice Note: KRS 501.030 provides (in part)

“A person is not guilty of a criminal offense unless: (1) He has engaged in conduct which includes a voluntary act...”

This section requires, as do some other jurisdictions, that the criminal act be a voluntary or as stated in the Kentucky Crime Commission/LRC Commentary “The main purpose of this provision is to confirm and codify several common law principles of universal acceptance.”

If an act is truly “impulsive,” is it a “voluntary act” under KRS 501.010, which defines the term as “a bodily movement performed consciously as a result of effort or determination...”?

A practical example of this concept comes from Hamilton County, Ohio (Cincinnati) where prosecutors are no longer seeking death in some infant death cases. Prosecutor Joe Deters was quoted as saying: “the challenge in these cases is always intent. And intent...is a very subjective thing.” We have found over time that cases where a defendant loses his temper and it’s a one punch case jurors don’t want to give the death penalty on it.”³

Would this act even be murder in Kentucky? KRS 507.030 describes First Degree Manslaughter as intentionally causing serious physical injuries. In the impulsive case, is there a “voluntary act” sufficient to constitute “intent?” sufficient even to support a First Degree Manslaughter

¹ *Sanders v. Commonwealth*, 802 S.W.2d 665, 679 (Ky.1991).

² *Fields v. Commonwealth*, 44 S.W.3d 355 (Ky.2001).

³ *Changing tactics with child-killers*, Kentucky *Enquirer*, Northern Kentucky edition, February 11, 2014 at A6.

indictment? Was the client's intent to cause serious physical injury or to get the child to stop crying?

Using Mental Health Evidence

How does counsel take the hopefully large volume of material developed by the biopsychosocial history investigation and put it to use in the defense of the client? One approach is to begin by asking these questions: (a) Why is he the way he is? "Why did he do what he did?" "What was he thinking at the time of the act?" Understanding why he is the way he is and why he did what he did will help us to identify the evidence that will help a jury understand the client's conduct and hopefully humanize him in their minds. It will also help to warn counsel about what information is not likely to be helpful. Finding out what he was thinking at the time will help us to relate the facts to the alleged mental state. If the mental state alleged in the indictment is too high, then the client is over charged.

Counsel will need to integrate the client's mental health evidence with the statutory culpable mental states. How can the two worlds merge together? As discussed above, one way is to look at the two words that have been emphasized in this chapter: "AWARE" and "CONSCIOUS." These two words describe attributes of the cognitive brain. The more the brain is impaired, the less able it is to be aware of and do things consciously. Are consciousness and awareness the same in everyone? Or are they different with each person, determined by a variable number of conditions and life experiences, the presence, quantity or quality of which are found in the biopsychosocial history?

Discovering the Mental Health Evidence

This topic is also covered elsewhere in this manual, but is important to briefly put the discovery of mental health evidence in context with the culpable mental states. Where do we look for such relevant mental health evidence? First, counsel will start with a thorough interview with the client, realizing that the client is often not a good historian. He will likely be reluctant to talk about heretofore private and terribly embarrassing facts of his life without a trusting relationship being first formed with the defense team. The investigation would proceed with in-depth interviews of family members, realizing that the family may be non-existent or dysfunctional. Remaining family members want to hide any embarrassing information and their possible contribution to the client's current situation.

The investigation would then proceed to the community in which the client was raised, *i.e.*, friends, employers, schools, gangs, etc. The mitigation specialist and counsel would then interview those who knew the client and obtain records from schools, neighborhoods institutions, healthcare providers and military when applicable.

The defense team would be looking for information including (a) genetic predispositions to particular conduct, (b) in *utero* injury, (c) physical and emotional trauma, injuries and insults, and environmental trauma.

Practice Note: The issue of impulsivity is particularly important in Kentucky in light of KRS 504.020 which provides that a person is not responsible for criminal conduct if at the time of such conduct...he lacks the substantial capacity...to conform his conduct to the requirements of the law." This prong is often referred to as the "irresistible impulse" prong. Mental illness is defined in part at KRS 504.060 as the "substantially impaired capacity to use self-control, judgment or discretion." Should the client commit an impulsive crime, and his impulsivity is due to a life experience or condition which impairs his ability to use self-control or judgment, does this not raise a defense under KRS 504.020?

Developing the Mental Health Evidence

Counsel should proceed cautiously and with deliberation when developing the mental health evidence. The worst thing that can be done is to rush out and "Get someone to shrink the client so that I can see what I got!" This is the wrong approach on many levels because before the

biopsychosocial history is almost fully developed counsel will not (a) know what kind of mental expert to hire, (b) know what evaluation will support a working theory of the case; (c) know what the expert should do or discuss when evaluating the client. By rushing the evaluation just so the client "can be shrunk," counsel will likely waste funds and often compromise one or more experts such that they cannot be used at trial.

Please refer to Chapters 3, "Developing Mental Health Evidence," for a more in- depth discussion of how to develop mental health evidence.

Practical Application of Mental Health and the Mental States – The case of Kenneth W. Jackson

Kenneth W. Jackson (KWJ) is severely mentally ill. His older brother Roger would harass KWJ by giving him a "noogie" or a "Dutch Rub." All of us younger brothers know how annoying noogies can be, but at the same time the noogie is relatively harmless. Kenneth wanted to get back at Roger and according to his statement "wanted to hurt his brother just like his brother hurt him." When Roger was asleep, KWJ hit him in the head with a ball peen hammer. Unfortunately, Roger died. KWJ was charged with intentional murder. At first glance, counsel for KWJ could think that the client knew he was hitting his brother on the head with a hammer and people die when hit on the head with a hammer. KWJ should know this, so he killed his brother intentionally. At least this was the prosecution's theory.

However, defense counsel understood the culpable mental states and came to the conclusion that KWJ was overcharged. She arrived at this conclusion by asking and answering the following questions:

1. Was it KWJ's conscious objective to kill Roger? No, because KWJ said he wanted to hurt Roger just as Roger had hurt him. KWJ would not and did not die from a noogie no matter how relentless Roger was while living. From this answer we can conclude that the act was not intentional and, as a "knowing" state of mind is not relevant in a murder case, we can move from murder onto the lesser offenses.
2. Did KWJ want to cause Roger serious physical injury? It can be argued that since KWJ was not seriously injured by Roger, and KWJ only wanted to do to Roger what Roger had done to him, that therefore serious physical injury was not KWJ's conscious objective. No on First Degree Manslaughter.
3. Was KWJ aware of a substantial risk that Roger would die from being hit in the head? No, he wanted to hurt Roger like Roger had hurt him. He did not consciously disregard a known risk because he did not know the risk existed. This was not a wanton act and therefore not Manslaughter in the Second Degree
4. Because of his mental illness, did KWJ fail to perceive a substantial risk that Roger would die as a result of being hit in the head? Yes. According to the statement of KWJ, his mental state appears to be consistent with the element of Reckless Homicide, a class D felony. Roger's death was a tragedy, but a careful analysis of Kenneth's mental state avoided a second tragedy.

A Mental Health/Culpable Mental States Worksheet

How does counsel integrate the results of the bio/psychosocial history into the criminal case? One approach is to ask and answer the questions in the following abbreviated worksheet. The following questions will hopefully get counsel headed in the right direction:

1. What is the culpable mental state alleged in the charging instrument?
2. What evidence in the bio/psychosocial history suggests some form of impairment in the brain?
3. Do the impairments have a source in genetics, lack of proper brain development, trauma or improper brain function due to a mental illness?
4. What part of the brain is impaired?

5. What is the role of that part of the brain in proper cognitive functioning?
6. How does the impairment impact the client's ability to be AWARE of or CONSCIOUS of his conduct and the result(s) of his conduct?
7. How does the impairment impact the client's conscious ability to perceive risks associated with his conduct?
8. What lesser included offenses are suggested by counsel's evaluation of the client's cognitive functioning?

Intoxication and Culpable Mental States

Practice Note: KRS 501.80 provides: Intoxication is a defense to a criminal charge only if such condition either: (1) negatives the existence of an element of the offense; or (2) is not voluntarily produced and deprives the defendant of substantial capacity either to appreciate the criminality of his conduct or to conform this conduct to the requirement of the law.

Intoxication and addiction are two separate concepts that may overlap. The client who is addicted may very well be intoxicated at the time the

charged crime is committed. His intoxication, involuntary or voluntary, is a defense if it negates the *mens rea* alleged in the indictment. If the client's intoxication negates his intent to commit a crime that requires intentional conduct, this is a defense. The voluntary intoxication defense is justified only where there is evidence reasonably sufficient to prove that the defendant was so drunk that he did not know what he was doing.¹

Conclusion

The thorough analysis of the charged mental state in relationship to the actual mental state of the client at the time of the offense is a critical element of counsel's ethical duty to provide the client with aggressive representation. Fortunately, this analysis can be most interesting as the client's mental state will be unique to him/or her and even more unique and interesting given the facts of the case. The time counsel spends in conducting a thorough analysis of the actual mental state(s) will often be rewarded with a more accurate, fair and just resolution of the charges pending against the client.

¹ *Harris v. Commonwealth*, 313 S.W.3d 40 (KY 2010).

Chapter 10: Personality Disorders

It is rare that defense counsel will encounter a serious felony case, and particularly a capital murder case, that does not present one or more mental health issues. The mental health conditions will often fall into categories of mental illness and personality disorders. When developing mental health evidence in a criminal case: (1) it is better to focus on the causes of the symptoms that help to explain client's behavior rather than choosing a name that the current edition of the DSM gives to the symptoms, *i.e.*, a diagnosis, and (2) if assigning a diagnosis is unavoidable, the client is better served if the symptoms can be related to a mental disorder rather than a personality disorder. Some of our clients do suffer from one or more personality disorders, but these are not mitigating and should be avoided. If the client is labeled with a personality disorder, it is important to remember that the client did not choose to suffer from a personality disorder any more than he wants to suffer from a mental illness.

Prosecutors like to label symptoms as personality disorders because they put the client in the worst possible light and they scare the jury. There is a belief that a personality disorder cannot be treated. However, some disorders will "age out" such that the disorder will become less of an influence on behavior.¹

Counsel should try to avoid the stigma of the personality disorder by avoiding any testing that will suggest a disorder. Counsel must be prepared to challenge a prior diagnosis utilizing the results of a thorough biopsychosocial history conducted by the defense.

The DSM-5, like its predecessors, lists diagnostic criteria for mental illness and personality disorders. Defense counsel should avoid the DSM when possible (unless arguing intellectual disability for the purpose of excluding the death penalty). While the manual may be helpful in the clinical practice of the mental health professional it is not often helpful in the criminal defense lawyer's forensic practice. The diagnostic criteria are dry and do not tell the client's story. If the defense gets into a debate with the prosecution over the existence of a diagnosis, guess who wins?

The DSM is better used by the prosecution in litigating its theory of the case which often goes like this: "These are the diagnostic criteria listed in DSM-5, a/k/a 'the bible'. The defendant does not meet any of the criteria relating to mental illness. If he appears to meet any of them, he is malingering. The only diagnostic criteria which he has are those that tell you he has an antisocial personality. You must be afraid, be very afraid! You cannot trust the defense, and their witnesses are all professional whores. Believe what we say because we represent you, the people." Jurors will generally do what the prosecution wants them to do.

However, when challenging a diagnosis of a personality disorder, counsel must understand the criteria for that alleged disorder as set out in the current DSM. Counsel, having performed a thorough biopsychosocial history, (something that the state expert has not done) will often be able to refute or neutralize the diagnosis.

The Major Personality Disorders

The diagnostic criteria for "General Personality Disorder" are:

1. An enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture. The pattern is manifested in two (or more) of the following areas:
 - a) Cognition (*i.e.*, ways of perceiving and interpreting one's self, other people and events).
 - b) Affectivity (*i.e.* the range, intensity, lability and appropriateness of emotional response).
 - c) Interpersonal functioning.
 - d) Impulse control.

2. The enduring pattern is inflexible and pervasive across a broad range of personal and social situations.
3. The enduring pattern leads to clinically significant distress or impairment in social, occupational or other important areas of functioning.
4. The pattern is stable and of long duration and its onset can be traced back at least to adolescence or early adulthood.
5. The enduring pattern is not better explained as a manifestation or consequence of another mental disorder.
6. The enduring pattern is not attributable to the physiological effects of a substance (*e.g.*, a drug of abuse, a medication) or another medical condition (*e.g.* head trauma).²

This definition seems to suggest that anything the client has been doing for a long time that the mental health professional finds to be irritating, constitutes a personality disorder. It is important to note that the behavior must be long lasting and counter to what would be expected of the client's culture. Just because the client has done bad things in his or her life does not mean he or she has a personality disorder.

Thirteen specific and unspecified personality disorders are grouped into four clusters based on "descriptive similarities." These clusters are Cluster A which includes the Paranoid, Schizoid and Schizotypal Personality Disorders. Cluster B includes the Antisocial, Borderline, Histrionic and Narcissistic Personality Disorders. Cluster C includes the Avoidant, Dependent and Obsessive-Compulsive Personality Disorders. Finally, there is also a category for "other." The writer believes that the Cluster B disorders are those that the defense will most often encounter in the criminal justice system.

Those disorders that fall into the Cluster B category are likely the most challenging for defense counsel. Accordingly, this chapter will focus on the disorders within that cluster and will discuss methods to challenge a prejudicial diagnosis that has no basis in fact, or to humanize a client who does have the disorder and has been diagnosed accurately.

As the behavior underlying a disorder is required to be "enduring," the diagnosis of a personality disorder requires an evaluation of the client's long-term patterns of functioning going back to childhood. While the DSM suggests it is possible to make the diagnosis after one interview, "it is often necessary to conduct more than one interview and to space these over time."³ The importance of a thorough psycho-social history in making an accurate diagnosis of personality and mental disorders is discussed later in this paper.

While the DSM-5 has left the diagnostic criteria for personality disorders the same, the APA is considering a plan to reduce this number.⁴

Cluster B Disorders

The Cluster B Disorders include Antisocial Personality Disorder (APD), Borderline, Histrionic and Narcissistic Personality Disorders. APD will be discussed in detail as this is a diagnosis that is often seen in the records of our criminal clients. The client with the Borderline Personality Disorder and Narcissistic Personality Disorder are likely the most challenging clients that counsel will ever represent. However, counsel should look at the annoying behavior of this and other disorders as symptoms of the client's disorder rather than personal affronts to the lawyer. The behavior may be symptoms of one or more emotionally painful experiences or neglectful conditions that the client did not choose and would prefer not to have endured. We must humanize the client in our own eyes before we can humanize him to the jury.

Avoiding the Diagnosis

This chapter will provide suggestions of how to challenge a faulty diagnosis and humanize the client even when the diagnosis is accurate. It is

² *Id.*

³ *Id.* at 647.

⁴ <http://www.dsm5.org/Documents/Personality%20Disorders%20Fact%20Sheet.pdf>.

¹ American Psychiatric Association, (2013) *Diagnostic and Statistical Manual*, 5th ed., (hereinafter, *DSM-V*), Washington, D.C. at p. 661.

important for counsel to avoid there being a current diagnosis by carefully developing the mental health evidence and limiting the state's access to the client.

Counsel will generally see a personality disorder diagnosis in two situations: (1) the client's prior records will contain a previously made diagnosis, and (2) a diagnosis made by a state's expert during the pending litigation. Counsel is limited to challenging the prior diagnosis while humanizing the client as discussed in this chapter. Counsel should develop the mental health evidence in such a way that the state does not have a chance to make a current diagnosis. Please refer to the chapter of this manual entitled "Developing Mental Health Evidence" for suggestions on how to avoid opening the door to a state sponsored mental health exam.

Practice Note: Counsel can avoid a current diagnosis of a personality disorder in two ways: (1) Counsel should carefully develop the mental health evidence as set out in Chapter 3 of this manual. She should write a referral letter to a testifying expert asking that the expert evaluate for a particular issue. Personality testing is not relevant and should not be administered. Counsel should avoid the administration of personality inventories. This will help to eliminate a suggestion that the client has a personality disorder. (2) If the state is given an opportunity to evaluate the client, any testing that the state gives must be limited to that which the defense has administered. The state has only the right to rebut. Since the defense has not administered a personality inventory, the state should not be allowed to administer such tests.

Antisocial Personality Disorder (APD)

Pinning the label of APD on our clients is a favorite past-time of many mental health professionals and most prosecutors. This is a diagnosis that can scare jurors. This is particularly true if the prosecution can use the old term "sociopath," formerly used in the DSM publications. Counsel should move by a pre-trial motion to prevent the state from using this archaic, but dangerous sounding term.

Practice Note: Counsel may fall into the habit of referring to all pre-trial motions relating to evidence as a "motion in limine." Even when an in limine motion is granted, all you generally get is a chance to argue the motion, at trial, just prior to the offer of the evidence. A judge may be reluctant to grant your motion at that time and keep the unfairly prejudicial evidence out of the hearing of the jury. File the motion, but entitle it a "Motion to Preclude Evidence." The admissibility of bad evidence should not be dependent on whether or not the prosecutor can make the evidence relevant or lay some other foundation. Bad evidence should not be admissible, period! If it should be kept out at trial, it should be precluded in advance of trial. If overruled, counsel should still plan on re-objecting during the trial itself prior to the offer of the evidence.

Counsel may also be able to successfully challenge the reliability of the diagnosis of APD.¹ This diagnosis has two separate areas of diagnostic criteria. These criteria look to behavior prior to the age of 15 to see if the client's behavior suffices as "conduct disorder" which is discussed at page 469 of the DSM-5. Conduct disorder includes acts involving (1) aggression to people and animals, (2) destruction of property, (3) deceitfulness or theft and (4) serious violation of rules such as running away from home or truancy. One can clearly see a difference in severity between the first three criteria and the last. The running away from home and truancy were added to the list of criteria because not enough females were diagnosed with conduct disorder.

The diagnostic criteria for APD would then be (in addition to conduct disorder prior to age 15) a pervasive pattern of disregard for and violation of the rights of others occurring since age 15 years, as indicated by three or more of the following in a person who is at least 18 years of age:

1. Failure to conform to social norms with respect to lawful behaviors as indicated by repeatedly performing acts that are grounds for arrest.

2. Deceitfulness, as indicated by repeated lying, use of aliases or conning others for personal profit or pleasure.
3. Impulsivity or failure to plan ahead.
4. Irritability and aggressiveness as indicated by repeated physical fights or assaults.
5. Reckless disregard for the safety of self or others.
6. Consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations.
7. Lack of remorse as indicated by being indifferent to or rationalizing have hurt, mistreated or stolen from another.

There is contained within the list of the diagnostic criteria a caveat that the occurrence of antisocial behavior must not occur exclusively during the course of a schizophrenic or bi-polar episode.

The General Diagnostic Criteria for Personality Disorders generally contains two caveats to consider before making the diagnosis (1) The enduring pattern is not better accounted for as a manifestation or consequence of another mental disorder, and (2) The pattern is not due to the direct physiological effects of a substance (drug abuse, a medication) or a general medical condition (e.g., head trauma). These general caveats are not listed in the diagnostic criteria for APD specifically, although there is justification for doing so, as will be shown.

It is important for defense counsel to have a good understanding of the client's biopsychosocial history so that when faced with a diagnosis of APD, counsel may be able to show that another condition is responsible for the behavior, not APD. The state's experts will often take the lazy approach. They will note criminal behavior in the client's past and, combined with the current charge, conclude that the client is APD. The biopsychosocial history will often show that the state's conclusion is wrong.²

It is apparent from viewing the diagnostic criteria that the best practice is for the evaluator to have the benefit of a thorough biopsychosocial history before considering a diagnosis of APD. It is rare that an evaluator, particularly someone hired by the state, will take the time to develop such a history.

Challenges to an APD diagnosis can include:

1. The client was older than 15 at the time of the apparent conduct disorder. If the alleged 'antisocial' behaviors began after your client was fifteen, then APD would not be a proper diagnosis.³
2. The client was under the age of 18 at the time the diagnosis of APD was made.
3. The behavior was exhibited exclusively during the course of a schizophrenic or bipolar episode, or the evaluator did not have sufficient data to rule out a schizophrenic or bi-polar episode that would explain the behavior. If some neurological impairment of other contributing condition occurring after age 15 explains your clients' actions, the diagnosis is not correct.⁴
4. The pattern of behavior was not enduring and/or is not present over a wide range of situations. APD does not mean that the client did some isolated bad things during his life. APD means that the client committed a number of bad acts over a long period of time and across a wide spectrum of situations. This is who he is, not what he did on occasion.
5. An explanation exists for the before-age-fifteen conduct disorder other than that the client had a Defiant Personality Disorder during early childhood:

² John H. Blume and David P. Voisin, *Avoiding or Challenging a Diagnosis of Antisocial Personality Disorder*, The Champion (April, 2000).

³ Blume, J., *The Elements of a Competent and Reliable Mental Health Examination*, Mental Health and Experts Manual, 8th ed., Ch. 5 at p.2.

⁴ Blume, *id* at p. 2.

¹ DSM-V, p. 659.

- a) Was the client coerced into committing the acts by a more dominant personality in terms of age and/or intelligence?
 - b) Was the client running away from home or was truancy caused by abuse at home or at school?
 - c) Was the client a person with intellectual and developmental disabilities and embarrassed that he could not keep up with his classmates?
 - d) Was the behavior influenced by the client's social or cultural background or, more importantly, was he merely doing what was necessary to survive in a world that he or she did not choose? For example, was he lying or stealing because he had to survive in the circumstances he found himself in?
 - e) Can the behavior be viewed as something that was done to protect the client or others?
 - f) Do other life experiences, impairments or limitations create an inability to conform to social norms and behave as society wants the client to behave? Do these explain his behavior?
6. The apparent anti-social behavior is a Post Traumatic Stress response or is merely a symptom of his Bipolar Disorder, Major Depression, Schizophrenia, Delusional Disorder, Intellectual and Developmental Disabilities, frontal or temporal lobe damage, exposure to fetal alcohol or, learning disability or the effects thereof. Again, the defense is usually better served by showing a mental illness as an explanation for the behavior rather than letting the state paint the picture of a scary personality disorder.
 7. Even if the client is truly a person with APD, does that really tell the fact-finder anything or does it merely suggest that he shares traits in common with others? Studies suggest that about 3 out of 4 inmates in a typical prison facility can be diagnosed with APD.
 8. Those who do have APD will "age out." "Antisocial personality disorder has a chronic course but may become less evident or remit as the individual grows older, particularly by the fourth decade of life. Although this remission tends to be particularly evident with respect to engaging in criminal behavior, there is likely to be a full decrease in the full spectrum of antisocial behavior and substance use."¹

Some mental health professionals are quick to diagnose a person with APD because he has done bad things in his life. A quality of a good forensic expert is one who will look for alternate explanations for this label.

The DSM-V can help here as well:

"Antisocial personality disorder appears to be associated with low socioeconomic status and urban settings. Concerns have been raised that the diagnosis *may at times be misapplied* to individuals in settings in which seemingly antisocial behavior may be a part of a protective survival strategy. *In assessing antisocial traits, it is helpful for the clinician to consider the social and economic context in which the behaviors occur.*"²

Prosecutors like to label our clients as APD because the belief is that these disorders cannot be treated. In addition to the "ageing out" as discussed above, there is research that suggests that the impulsive acts of a person with APD can be reduced with medication.³ Drs. Barratt and Felthous described research performed at the University of Texas Medical Branch in the late 1980's on inmates in the Texas prison system. It was found that by administering a small dose of Dilantin (phenytoin) to both a control group and a group of those with APD, the impulsive acts of those with APD could be reduced, but the drug had no effect on the group whose APD were characterized by premeditated actions.⁴

¹ DSM-V, *id.* at 661.

² DSM-V *id.* at p. 662. (emphasis added)

³ Barratt, Ernest S. and Felthous, Alan R., *Impulsive versus Premeditated Aggression: Implications for Mens Rea Decisions*, Behav. Sci. Law 21:619-630 (2003).

⁴ Barratt & Felthous, *id.*, at page 625.

If counsel is facing a diagnosis of APD, consider if the character traits are impulsive or premeditated. The impulsive behavior is preferred.

Reactive Attachment Disorder

The major personality disorders will certainly be seen in the mental health records of many clients charged with serious crimes. Counsel must do everything possible to challenge the unwarranted diagnosis attributed to the client. However, there will be situations where no matter how hard the defense challenges the diagnosis of APD, it may be an accurate one. How can we humanize a client that the state will describe as a remorseless criminal without a conscience?

As part of the attack upon the defendant the prosecution will often tell the jury that "he had a choice" and that his choice was to commit a violent crime. One way to attempt to humanize the client in this situation is to acknowledge that certain choices were in fact made by the client. However, those conditions and life experiences that shaped the client and made him who he was at the time of the crime were more than likely made by genetics, parents, caregivers, siblings and others over whom the client had no control. The explanation for the client's behavior may be found in the condition known as Reactive Attachment Disorder or simply Attachment Disorder.

This disorder is briefly described in the DSM-IV-TR and DSM-V. The Diagnostic Features state that, "Reactive attachment disorder of infancy or early childhood is characterized by a pattern of markedly disturbed and developmentally inappropriate attachment behaviors, in which a child rarely or minimally turns preferentially to an attachment figure for comfort, support, protection, and nurturance. The essential feature is absent or grossly underdeveloped attachment between the child and putative caregiving adults."⁵ Unfortunately, the Diagnostic Features as outlined by the DSM-V are not adequate to alert the criminal defense practitioner to the significance of this disorder. Reactive Attachment Disorder is an example of the truthfulness of the expression "childhood matters." How our clients are treated before, during and after birth has a significant impact on the development of their brains and personalities. "It is the experiences of childhood that express the potential of the brain."⁶

During the first 36 months of life humans learn to trust others and to feel a sense of security in their world. This feeling will customarily arise from the bonding that the infant has with the caregiver (usually the mother) and the love that the caregiver feels and exhibits for the child. This interaction tells the infant that he/or she is safe and the caregivers can be trusted to meet the child's needs when they arise. When the infant expresses a need (usually by crying) the caregiver satisfies the need (feeding, holding, diaper changing) and a sense of trust and reliance (healthy attachment) is created by those interactions. As the needs of the child are routinely met, the healthy attachment becomes a secure attachment and the infant's development can take on a normal course.⁷

However, when the needs are not met, often because of parental neglect, the necessary attachment to the caregiver is not formed and the message to the child is that she is on her own, she cannot rely on anyone else to meet her needs, she can trust only herself and she must be in control in order to meet the needs. The lack of trust is replaced by anger and rage and her very survival depends on her ability to control and meet her needs.

Some of the causes of attachment disorder include:

- neglect
- abuse
- separation from the primary caregiver
- changes in the primary caregiver
- frequent moves and/or placements

⁵ DSM-V, *id.*, at 266.

⁶ Bruce D. Perry, M.D. www.childtrauma.org.

⁷ Allen, K., *Attachment Disorder*, Capital Mitigation Seminar, Center for American and International Law, (August 26, 2006).

- traumatic experiences
- maternal depression
- maternal addiction to drugs or alcohol
- undiagnosed, painful illness such as colic, ear infections, etc.
- lack of attunement between mother and child
- young or inexperienced mother with poor parenting skills

Counsel has likely represented clients who could not trust the trial team, exhibited an unreasonable level of anger, was hyper-vigilant to minor or misperceived threats, had difficulty telling the truth even when the truth would serve them better, appeared to have no conscience about their criminal behavior and no empathy for those who were harmed. Reactive Attachment Disorder may provide an explanation; and while it is not termed a “Major Personality Disorder,” it can be the cause for an antisocial personality, a borderline personality or a narcissistic personality. These are among the most difficult of clients to represent. In order to fully understand who the client is, a thorough biopsychosocial history developed by a competent mitigation specialist is critical. What was the client’s life like during the first 36 months of life? Why?

Counsel might ask, “Why are those charged in the criminal justice system so often suffering from attachment disorder?” A bulletin from the Office of Juvenile Justice and Delinquency Prevention’s Study Group on Serious and Violent Juvenile Offenders devoted two years to analyzing the research on risk and protective factors for serious and violent juvenile offenders, including predictors of juvenile violence derived from the findings of long-term studies.¹ The predictors of juvenile violence were arranged in five domains: individual, family, school, peer-related, and community and neighborhood factors. It has been shown that attachment disorder is most commonly caused by abuse, neglect or disinterest by the caregiver, usually the mother. The family sector risk factors are:

- parental criminality
- child maltreatment
- poor family management practices

- low levels of parental involvement
- poor family bonding and family conflict
- parental attitudes favorable to substance use and violence
- parent-Child separation

If one were to compare the common causes of Reactive Attachment Disorder with those Family Factors identified in the OJJDP Bulletin, the similarities are striking. Neglectful parenting yields children with problems they did not choose in life. While counsel will want to avoid a conclusion that the client suffers from a personality disorder, at least the client with such disorders can be humanized in the eyes of the fact-finder.

The diagnosis of attachment disorder is not what is important. If counsel stresses the disorder, the state will just use it as proof of a resulting major personality disorder like APD. What is important is a thorough description of the client’s first 36 months of life and how these help to explain her behavior.

Conclusion

The state will often try to attach a personality disorder label on the client. This label may scare jurors who will conclude that the defendant is bad, has been bad since birth and will always be bad. Counsel should avoid the opportunity for the state to make a current diagnosis by very carefully developing the mental health evidence that is in support of the defense theory of the case.

It is important for defense counsel to challenge the incorrect diagnosis and to neutralize any harm of the accurate one. The biopsychosocial history will often give the defense information that will show the diagnosis is incorrect and that the diagnostic criteria can be explained by the presence of other conditions other than anti-social behavior.

Counsel must be able to humanize the client and show that even if the diagnosis is accurate, this was not a condition chosen by the client. The cause of the symptoms is rooted in the neglect and abuse which occurred during the child’s early years. As the client grows older, the bad behavior will likely stop. The client should be understood, not feared, and his behavior explained.

¹ Hawkins, J.D., et al., *Predictors of Youth Violence*, Juvenile Justice Bulletin, U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention (April 2000).

Chapter 11: Expert Witnesses

Many in the forensic world have fallen into the habit of referring to anyone who is retained to assist in a case as an “expert.” Mental health professionals comfortably refer to themselves as “experts.” The term sounds very good (especially to the “expert”) and is a convenient short hand for a person we would otherwise refer to as a “mental health professional.” However, just because a professional has a license, an active clinical practice and has testified for the prosecution, the defense, or both, does not mean that he or she is a competent forensic expert.

Who is a “Forensic Expert”?

The term “expert” is used frequently in this chapter but it is important for counsel to remember that just because someone is referred to as an “expert” does not mean that the person actually fits that description. The “expert” may fail to qualify as such for several reasons: (a) she may not be qualified as an expert by “knowledge, skill, experience, training or education” as is required by KRE 702; (b) she may not be able to offer an opinion as an expert if that opinion is not based upon (1) sufficient facts or data or, (2) her opinion is not the product of reliable principles and methods; or (3) she has not applied the principles and methods reliably to the facts of the case.

All lawyers have nervously awaited the determination of the judge as to whether or not the “expert” satisfies the elements of KRE 702 (1) (2) & (3) and can render an opinion.

The mental health professional may have sufficient experience, training and education to obtain the license that is required for a clinical practice in their chosen field. Whether or not the mental health professional is a competent forensic expert is a determination that counsel – not the professional – should make. This decision should be based, in part, on whether or not the professional appreciates the differences between clinical practice and forensic practice.

Can the professional appreciate the following?

- that the biopsychosocial history investigation, rather than personality test data, will provide the team and professional with the information necessary for any opinions requested;
- that in the forensic case, a litigation approach rather than a therapeutic approach must be taken in acting on behalf of the client;
- that great care and effort has gone into the drafting of the referral letter to the professional and this letter sets the parameters of the professional’s role in the case;
- that it is lead counsel’s obligation to direct the development of the mental health evidence and identification of theories and themes, and that this role cannot be abdicated to the mental health professional;
- that generally a diagnosis based on the DSM-V is less important than the story of the client’s life experiences and conditions that help to explain who he is and why he does what he does;
- that a primary goal of the defense is to humanize the client, and that a part of this process is to identify reasons why the client does not have an antisocial personality just because he has done bad things in the past and the DSM-V checklist seems to fit;
- the different way in which jurors view witnesses who testify for the defense as opposed to the prosecution;
- the need to be prepared, for tricks that prosecutors use in cross examination;
- the need to prepare his direct testimony and cross examination;
- the need to prepare for a 702/705 hearing at which time he will establish his qualifications to testify as an expert, establish the

reliability of his opinions and support his opinions with sufficient facts or data;

- the teaching aspect of his testimony so that he avoids talking over the heads of everyone just to show how smart he is;
- that rules of privilege, confidentiality and work-product protect communications and defense-generated information unless and until the expert testifies;
- the importance of intellectual curiosity, and awareness of the current literature on the issue identified in the referral letter;
- that anything that the expert takes to the witness stand is subject to discovery and immediate use by the prosecution on cross examination;
- the need to disclose to defense counsel any “skeletons”: problems in his background or potential conflicts of interest;
- that counsel may have a number of witnesses to coordinate, especially in the sentencing phase of trial, and that the anticipated date and time for his testimony is subject to change;
- that the payment process for experts does not always work as smoothly and quickly as he would like.

If the professional cannot appreciate all of these, then he may not be the professional that the defense needs to hire as its expert. He may be very intelligent, with sufficient education and training to allow him to maintain a clinical practice or testify for the prosecution, but not the defense.

In return, counsel should be willing and able to provide the expert with the following:

- a referral letter outlining exactly what the expert is being asked to do and not do;
- adequate time to do what is asked;
- a straightforward description of the Chapter 31 funding process;
- the name of the lawyer who is leading the defense team;
- the person who will act as the liaison between the team and the expert;
- all relevant information that the expert will need in order to comply with the requirements of the referral letter;
- a commitment from defense counsel that steps will be taken to protect the witness from unreasonable and abusive cross examination;
- clear theories of the case for both the culpability and sentencing phases and the role of the expert in evaluating these theories. This should be set out in the referral letter;
- a commitment to provide the expert with all records that are relevant to the referral question and any information that the prosecution possesses so that the expert will not be “blindsided.”¹

Practice Note: Some prosecutors have very little of substance to use in cross examination of the defense expert and they will resort to abusive tactics on cross, often nothing more than loud and abusive attempts at character assassination. The defense expert is entitled to just as much respect as any other witness – defense or prosecution. The resources section for this chapter contains a motion to preclude unfair cross examination. The protection of the good defense witness is important as few will be willing to continue to testify in defense cases if they know the defense will not try to protect them from unfair cross examination.

¹ For an excellent discussion of the process for using experts in a criminal case, see Clark, J. and Monahan, E., *Decision-Rules for Integrating the Expert into the Case: An 8-Step Process*, DPA Mental Health and Experts Manual, 8th ed., (2005).

Counsel will only know what to ask the expert to do if the attorney understands the client's biopsychosocial history and has an understanding of the possible mental health theories that will form the basis of the guilt/innocence defense and/or theory of mitigation. Beginning with the biopsychosocial history and letting the data developed by that investigation direct the development of the mental health evidence will help counsel avoid the mistake of that many attorneys make, *i.e.*, telling a mental health professional to "go shrink my client and tell me what you think."

Avoid the Impulse to "Shrink the Client"

Often the first instinct of many lawyers is to call a psychologist or psychiatrist (many don't know the difference between the two disciplines) and tell her to "Go shrink the client and tell me what we got." Here are some problems with that approach:

1. Counsel has not given direction to the mental health expert because he, himself, is unsure as to what he wants or needs from the expert.
2. Counsel has not obtained the biopsychosocial history and relevant records on the client that will give the lawyer and the expert some idea as to the client's mental health history.
3. Without needed direction, the expert may very well run a full battery of psychological tests, the results of which may not be relevant to the working theory of the case or, worse, be harmful.

For example, the expert may conclude that the client is suffering from a mental illness that might help explain why he committed the acts with which he has been charged. This is good. However, without your guidance and the benefit of a biopsychosocial history, the psychologist may decide that he needs more information so he administers a Minnesota Multiphasic Personality Inventory (MMPI). This can be bad.

While the MMPI will not likely have any relevance to the issue outlined in the referral letter, prosecutors routinely select isolated responses from the MMPI to paint a negative picture of the client. While the reputable scientist knows that MMPI test data (scales) should be read together and not individually, individual responses are used by prosecutors to make the client appear to be a malingerer, a liar, a sociopath or worse. Judges are not inclined to prevent this misuse, reasoning that it was "our expert" who administered the test or the defense "opened the door" by giving the Commonwealth access to the client.

One approach that counsel might consider consists of the following steps:

1. Counsel should interview the client immediately after appointment, hopefully building that sense of trust that is so important to a successful relationship with the client and disposition of the case. The trial team should spend the time necessary to show its sincere interest in the well being of the client, dealing with immediate issues that are troubling him and stressing to him the importance of *Skipper* evidence¹ and the danger of snitches.
2. Counsel or the mitigation specialist should take authorizations to the jail for the client to sign so that the specialist can begin interviewing significant people in the client's life and begin gathering records regarding the client's contact with schools, hospitals, doctors, military, etc.
3. The mitigation specialist should review these records as soon as they arrive so that references to other institutions with relevant records can be identified and contacted. Receiving the records is not the end nor should records be thrown into the corner of the office until a month before trial.
4. Counsel should determine what prior mental health diagnoses have been made. Counsel, along with the mitigation specialist, should

determine if prior diagnoses were valid in light of the client's actual history.

The trial team should look to see if there are less than obvious reasons to explain some conduct that at first glance appears to be harmful. For example, if the client ran away from home when young, was he or she trying to avoid an abusive, dysfunctional family or abusive family member? If the client was often truant, was it because the parent refused to take him to school? If your client showed aggression to people or animals, was he influenced by an older sibling or was this behavior merely a coping mechanism used to deal with other problems?

5. The team should regularly communicate with the mitigation specialist (also a team member) and review records and reports of her interviews with the client, family members and others.
6. Counsel should move for funding to hire a psychologist, neuropsychologist or qualified LCSW Social Worker as a consultant, not as a testifying expert, but as counsel's agent. This is someone who can assist at client interviews, make observations as to any disorders, assess the client's credibility and suggest theories of culpability and sentencing, areas of cross examination of the state's expert.

The consultant can provide insight on how to deal with the difficult client. She can offer advice as well as suggest strategy, tactics and other experts that are indicated.

7. Once the consultant has reviewed the biopsychosocial history and records received, interviewed the client and brainstormed the case with the rest of the team, work can begin on developing working theories of the guilt/innocence and sentencing phases, and identifying experts who can evaluate the working theories and testify in support of them.

Practice Note: Why should counsel develop a working theory of the case before retaining testifying experts to evaluate and testify in support of the theories? The writer has seen many cases in which mental health professionals have been asked to evaluate the client before the biopsychosocial history has been completed and a working theory identified. The professional, without guidance, will interview the client and conduct a battery of tests because he does not have sufficient information about the client. Following the evaluation he will review with counsel the results of his testing and interview of the client and all will discover: (1) some of the results will be relevant, (2) some will not be relevant and (3) some will be harmful. Counsel is then faced with the dilemma – do we put on the good evidence and try to neutralize the bad evidence or do we just not call this witness because the bad evidence outweighs the good? It is troubling for counsel to then realize that the professional did not focus on what was really needed because the trial team gave the professional no guidance – no working theory to evaluate. If the team identifies a working theory of the case, based upon the results of the biopsychosocial history investigation, it can then give guidance to the professional by way of the referral letter. Everything that the professional does during the evaluation will then be relevant to the working theory. Information that is bad or not relevant can usually be avoided. It is unlikely that an evaluation of the client will provide counsel something that is not at least suggested in the biopsychosocial history. Evaluate the theory and not the client. Please see Chapter 3, "Developing Mental Health Evidence," for samples of referral letters.

Counsel is now able to better direct what he wants the expert(s) to look for and what tests, if any, to perform. The consultant can refer counsel to additional experts and provide an affidavit, or oral testimony, in support of your motion for Chapter 31 funding of other experts. This incremental procedure permits counsel to show the court that he is not wildly spending money without thought. The same amount of money will likely be spent, but with different experts dividing the work.

¹ *Skipper v. S.C.*, 476 U.S. 1 (1986), evidence from jailers and regular jail visitors of good/reformed behavior of the defendant and that the defendant made a good adjustment to jail, is mitigation evidence a defendant has a right to present.

By carefully and incrementally developing the mental health evidence, counsel can avoid “burning” a witness who, because of what he has done or discovered during an unguided evaluation, is not able to testify without damaging the defense case. If a witness is “burned” in this way, counsel may be forced to go to trial without any expert testimony.

Limiting the Expert’s Duties

Counsel should make sure that the mental health professionals on the team do not wear more than one hat. A treating psychiatrist should not act as a consultant. Neither should a consultant, nor the mitigation specialist, testify at trial. A mental health professional can have different goals and biases depending on their role on the team. These should be recognized and strict boundaries should be drawn between the professionals depending on their goals.¹

Practice Note: Why should the consultant and the mitigation specialist not testify? Whenever either of these team members takes the stand, the privileges that protect their communications between the trial team and the client are waived. The consultant and mitigation specialist have seen everything, the good, the bad and the irrelevant. They have participated in brainstorming sessions where many confidential items were discussed. If you do not want to see the evidence on the front page of the local newspaper then don’t call to the stand a witness who can divulge it.

Which Experts Might Counsel Want to Consider?

It is important to remember that all experts are not alike. Just because a person has the necessary education and training to become a psychologist or psychiatrist does not mean that the particular background is right for the client’s case.

When counsel asks a mental health professional to “go shrink my client,” often counsel is not sure of the difference between a psychologist or psychiatrist. Even if counsel knows the difference, she does not know which one she needs that early in the representation. Only when the biopsychosocial history is reviewed and one or more working theories of the case are developed will counsel know if a psychiatrist, psychologist, neuropsychologist or other expert is needed.

It is important that all experts retained by the team maintain an intellectual curiosity about the mental health field in which they are to consult or testify. Counsel may consider asking each expert to provide a representative sample of the current literature in that field. In this way, counsel and experts will have the same understanding of the current state of the science.

The Consultant

Counsel may choose as a consultant a psychologist, neuropsychologist or a Licensed Clinical Social Worker. Among the many valuable services he can provide, the consultant can:

- interact with the client, client’s family and team members;
- brainstorm the case with other team members;
- help the team understand the significance of data that is collected via the biopsychosocial history investigation;
- suggest working theories of the case for both culpability and sentencing;
- identify experts who can evaluate the theories and testify in support of the theories chosen;
- testify (in person or by affidavit) in *ex parte* hearings to support a request for Chapter 31 funding;
- assist with the drafting of the referral letter to each testifying expert;
- assist with direct examination of defense mental health witnesses;

- assist with cross examination of prosecution witnesses.

Qualifications of a Consultant

In addition to a great intellectual curiosity, the consultant should have expertise in the following areas:

- an understanding of the process by which the biopsychosocial history is conducted;
- the detection of childhood trauma and a clinical understanding of how it effects persons later in life;
- reactive attachment disorder and the consequences of a child’s failure to establish a secure attachment during the first 36 months of life;
- an understanding of human behavior and the ability to see even violent behavior as a symptom of trauma or as a method to cope with stressors and crisis;
- an understanding of the science of neurobiology and its relationship to human behavior;
- an understanding of the physical signs of neurological impairment;
- an interdisciplinary background and an understanding of other mental health disciplines;
- an understanding of the differences between a clinical practice and forensic litigation;
- perhaps most critical: the ability to see the “client as a human being who is ultimately comprehensible and deserving of the best mental health assistance and advocacy possible.”²

Possible Testifying Experts

The trial team must decide at a minimum: (1) who to retain, (2) what issues should the expert evaluate, and (3) what do we want the expert to do when on the stand? The testifying expert will either (a) personally interview and evaluate the client and provide an opinion based upon the interview(s) and records review; (b) forego a personal interview and base her opinion upon a review of the records and interviews with third parties. This method has the advantage of perhaps making the opinion more credible, and less subject to challenge, as it is based upon records that others (often experts and lay experts) have generated in the past. It is not based upon the client’s own report that may be inaccurate, incomplete or biased. (c) The expert may serve as a “teaching witness” who explains to the jury the science behind an issue that has been raised by the defense. Certainly, a teaching component will hopefully be present with all expert testimony and all of the three will likely refer to interviews and records generated by the biopsychosocial history.

The expert can relate hearsay information if such information is generally relied upon in formulating an opinion. KRE 703.

Counsel might consider one or more of the following to act as a testifying witness. Do not begin to make your selection of a testifying expert until the data, developed by the biopsychosocial history investigation, has indicated the expertise that will be needed. When reviewing the *curriculum vitae* of any potential expert, pay close attention to the specialties or areas of interest in which the expert has obtained additional education, teaching experience, work history or has written peer reviewed literature.

All mental health experts should have the ability to assess the condition of the client’s mind and relate this to his behavior. The specific expert who will be best suited for the client’s case will be determined by the biopsychosocial history, the working theories of the case as developed by trial counsel and the particular qualifications of the expert that relate to the working theories.

¹ The ABA Criminal Justice Mental Health Standards has a good discussion of some of these issues in Standard 7-1.1. (page 12).

² Clark, J. and Monahan, E., *Decision-Rules for Integrating the Expert into the Case: An 8-Step Process*, DPA Mental Health & Experts Manual, 8th ed., (2005) at page 2.

Psychologist

These professionals can relate brain condition and activity to human behavior. They often base their opinions on interviews with the clients, examination of relevant records and perhaps standardized tests that they administer. There are batteries of tests that may be appropriate for the clinical practice, but not suitable for the forensic representation of one charged with a crime. Counsel should discuss any testing with the psychologist and decide which ones are desired and which ones are not. Some tests are likely not to be relevant to the referral question counsel has sent to the mental health professional. These are referred to as personality tests or inventories. These include the MMPI and the Millon Clinical Multiaxial Inventory. These tests are discussed in Chapter 3, "Developing Mental Health Evidence."

Psychiatrist

The psychiatrist should also be able to relate brain activity and condition to behavior. The psychiatrist is also a medical doctor who can evaluate situations where a medical condition is masquerading as (or complicating) a mental health problem. A psychiatrist should be able to testify about the basic types of mental illness such as schizophrenia, bio-polar condition, and depression. Psychiatrists can order additional hospital testing and prescribe medication. Hopefully the psychiatrist's medical training can alert her to abnormalities in the client's physical appearance that would indicate often overlooked problems, such as Fetal Alcohol Syndrome (FAS) or other neurological impairments. Because a psychiatrist can prescribe medication, counsel may want to consider a psychiatrist as a treating expert rather than one who will testify.

"[P]sychiatrists often talk in terms that are difficult for the lay person to understand, sometimes they are too focused on the diagnosis of psychopathology as found in The Diagnostic and Statistical Manual Fourth Edition (DSM-IV). The primary data of their opinion, the client interview, can be viewed as highly subjective and miss the larger picture of the impact of other systems on the client's life. However, of all mental health professionals, they continue to hold the greatest prestige in the criminal justice system—at least among the judiciary."¹

Neurologist

This professional is a medical doctor and should be skilled at detecting physical disease and damage to the central nervous system, especially the brain. She can also testify about the link between the brain and behavior. She can use brain imaging techniques, blood and spinal fluid analysis, and neurological examination to arrive at her conclusions.

Neuropsychologist

Neuropsychology is a specialty branch of psychology devoted to studying the relationship between the brain and behavior. The brain is an organ of behavior and damage to the organ can result in cognitive, intellectual, behavioral and emotional changes. This professional, just as other qualified mental health experts, can testify as to competency to stand trial, criminal responsibility, insanity and mitigating factors. He can determine the presence, location and severity of brain damage. He can also describe the impaired functions of the brain and both the short and long term practical consequences of the impairment. He can distinguish between psychiatric and neuropsychological problems.

Why a neuropsychologist and not a neurologist? Neurologists are mostly concerned with lower brain functions, such as reflexes, sensations and balance that are mediated by the brain stem, midbrain and cranial nerves. Medical tests are not good for determining the consequences of brain damage and have poor sensitivity and specificity for detecting mild brain damage. Neuropsychologists look at higher brain functions that are mediated by the cerebral cortex. Their tests have better sensitivity for detecting brain function.

Intellectual Curiosity of the Expert

¹ Clark, J. and Monahan, E., *id.* at page 3.

As with all of your mental health experts, it is critical that each have the intellectual curiosity such that they keep current with the state of the science and literature relevant to your theory. Too often, experts rely on what they have learned in the past and stop doing current research – like many lawyers - or will conduct the evaluation in the same way in which it was done in the past instead of incorporating new developments into their forensic evaluations. Ask the expert to provide you with several journal articles on the issue which he or she is to evaluate. Such a request will hopefully ensure that the trial team and the expert both understand the current state of the science.

Beginning the Relationship

Regardless of the experience and qualifications of the consultant, trial counsel should not assign the job of developing a theory of defense or mitigation to the consultant or other expert. Defense counsel is ultimately responsible for developing the mental health evidence and the theories for trial. The consultant should want this direction from counsel.

The expert is not told what conclusions to draw. In the referral letter, he will be advised of the working theory chosen by counsel and asked to evaluate for this theory. If the expert finds that the working theory proves itself to be valid and becomes the trial theory, the expert can testify in support of that theory. At trial, he will advocate for his opinion which is in support of the theory, he will not advocate for the client. See Chapter 3 "Developing Mental Health Evidence" for samples of referral letters.

Persuading the Evaluator/Testifying Expert

Counsel may be concerned about how much information to give the evaluator and how much effort should be devoted, if any, to influence the evaluation. It is the writer's belief that the evaluator should have all information that supports the choice of that portion of the working theory upon which the witness has been asked to evaluate. If the data was convincing to the trial team, it should be used to convince the evaluator that the theory is a good one. Send the expert the records that led the trial team to the chosen theory. Anything that is not relevant to that theory will likely waste the expert's time if she has to review it.

"The role of the expert witness is very much like that of the judge or jury. Specifically, the expert is going to examine various forms of evidence to reach a decision about your client. There is nothing untoward about employing one's skills as an advocate to reinforce for the expert the aspects of the case that are in the client's favor. Indeed, it is disingenuous at best for lawyers to sit on their hands when virtually every other party interviewed may have a strong, highly opinionated and potentially adverse perspective on their client's behaviors, intentions, and current mental health status."²

Trial lawyers are advocates and this is no time to stop being an advocate. Allow the expert to understand the tentative theory of the case and what material exists to support it. If counsel has chosen the wrong theory, the expert can explain why. Better to learn of an unsound theory early on than realize in the middle of the expert's testimony that his conclusions do not support the trial team's theory. If counsel's initial theory is valid, then all the material that has been accumulated in developing that theory and the themes that support it can be used by the evaluator in making a persuasive presentation to the jury. If the expert, after thoroughly evaluating the client's condition, arrives at a conclusion that does not support the theory, it is not too late to adjust the team's preparation.

Naturally, any testifying expert should also be provided with any material that the prosecution possesses. Neither counsel nor the expert want to be "blindsided" by documents that would alter their opinion had the information been known ahead of time.

² Eric Y. Drogin, *Evidence and Expert Mental Health Witnesses: A "Jurisprudential Therapy" Perspective*, Wiley Expert Witness Update, Section 8.07 at 307, 2000.

The Ex Parte Motion - Educate the Judge and Change the Picture

Counsel is familiar with the law and procedures for obtaining Chapter 31 funding for expert assistance. The hearing for funding is held *ex parte* because the legislature, in enacting Chapter 31.185(2), recognized that if an accused was not indigent, he would not have to go to a judge to get approval for funding nor would he have to alert the prosecutor to the retaining of any expert. Someone who is indigent should not be treated differently and prejudiced by his indigent status.

When drafting funding motions, use the opportunity to tell the judge about the client's life experiences, mental health problems, barriers to success in life and why the approval of funds will help counsel explain the client's behavior to a jury. This will be an early opportunity for counsel to change the picture that the judge may have of the client. This will also be an early opportunity for counsel to explain to the judge that the client is living a life chosen by all of those caretakers who made bad choices; bad choices made long before the client was able to make choices of his own..

Protecting the Motion

Ideally, counsel's funding motion and order should be kept confidential. Unfortunately, this is not always the case. Circuit clerks have been known to pass along the funding requests to law enforcement or the prosecution. In some instances, the title of the funding motion "Motion to Approve Funding for Mitigation Specialist" is entered onto the docket for all to see.

So as to avoid this problem, it is suggested that funding motions be numbered on the face page, with the actual title of the request on the second page. The face page would read something like "Mr. Client's Motion Number One for Funding." The second page could then be titled "Mr. Client's Motion Number One for Funding: Mitigation Specialist." The court's order could be titled: "Order Approving Mr. Client's Motion Number One: Should the clerk need to enter information onto the docket, all that should appear is the number assigned to the motion and order. There should be no reason for the clerk to enter anything except what is on the face page. The court's order should also include the following language:

THIS ORDER, AND THE DEFENDANT'S EX PARTE MOTION FOR FUNDING, SHALL BE SEALED IN THE RECORD AND SHALL BE SEEN BY AND DISTRIBUTED TO DEFENSE COUNSEL AND THIS COURT ONLY. THE CLERK'S DOCKET ENTRY SHALL NOT NAME THE EXPERT DESIGNATED. ANY COMPUTER ENTRY WILL ONLY SHOW THE ENTRY OF A MOTION AND ORDER FOR FUNDING AND ITS NUMBER.

Counsel should consider providing the clerk with a manila type envelope and type on the outside of the envelope **THE CONTENTS OF THIS ENVELOPE HAVE BEEN SEALED BY ORDER OF THE COURT DATED ___/___/___.** **THE CONTENTS ARE FOR THE EYES OF THE COURT AND DEFENSE COUNSEL ONLY.** Counsel might consider the need to explain cordially to the clerk or deputy what is being done and point out the language in the judge's order so that the pleadings are handled properly. Make sure that any docket entry does not include the expert's name.

The Culturally Competent Expert and Team

The culture of the client should be considered in every case by counsel and other members of the trial team. This is especially true in the serious criminal case where the client's mental health is in issue. The client's mental impairments can be expressed and interpreted differently in different cultures. "Simply put, lawyers must engage their clients in a culturally competent manner. Such engagement minimizes the likelihood that lawyers will misunderstand their clients' goals, behaviors and communications."¹

Counsel should consider the concept of culture in as broad a context as possible and not limit consideration of cultural differences to only those who don't speak our language. The culture in the African/American community will be different than the culture of those in white suburbia. The cultural influences on those living in poverty will be different from the influences on those living in an upper middle class neighborhood. Think outside the box!

Counsel must understand the client's culture might help to answer the following questions: (1) Why is he the way he is? (2) Why does he think the way he does? (3) Why does he react to stressors the way he does? (4) As to the alleged crime, why did he do what he did? (5) Why did he not do what the prosecution says he did? Does culture provide a less obvious answer?

The client's culture and English language abilities may affect the way counsel interacts with the client, the interviewing techniques used by the mitigation specialist, as well as any psychological tests administered by a mental health expert. Lead counsel must insist that all members of the trial team be culturally competent. This is certainly true in a capital case as cultural competence is mandated by the ABA's Supplemental Guidelines for the Mitigation Function, Guideline 5.1.

If counsel is appointed in a less-than-capital case to represent a client with different cultural influences where funding is not routinely ordered, the need for culturally competent assistance may serve as a special basis for funding. If counsel perceives a problem in the case like lack of funding, "re-perceive" the problem and make it the judge's problem. When in doubt, ask for the resources.

Juror Perceptions of Expert Testimony

Research by the Capital Jury Project reveals how people who served on capital juries view the process. Many jurors respond negatively to some defense experts.² It was noted that jurors often viewed defense experts, such as psychologists and psychiatrists, as "hired guns" and gave them little credibility.

Studies have shown that in complex cases, jurors may tend to evaluate the credibility of experts in large part on their personal characteristics rather than on the information they presented. Jurors may resolve the issue of conflicting expert testimonies by ignoring both of them.³

One of the most powerful witnesses is the lay expert. This is an individual who has personal knowledge and experience of the defendant or the defendant's circumstances outside of the present representation, and some basis on which to give an expert opinion concerning a mitigating factor. One such witness was the director of a rehabilitation center for recovering addicts. The witness was a former drug addict and a prostitute who happened to know the defendant's mother. This witness was both qualified to give an opinion on the effects of drug addiction and poverty on children and at the same time could speak from her personal experience and that of the client. Several jurors noted, in giving a life sentence to the defendant, that this witness was found to be very credible. It is difficult for a prosecutor to cross-examine an expert whose experience is personal and not limited to academics

Another example was a defendant's commanding officer in the marines. This witness testified about the client's ability to conform to a restrictive structured environment. The testimony was from personal experience and not based upon diagnostic criteria contained in a confusing psychiatric manual.

KRE 701 allows opinion testimony by a lay person as long as (1) the testimony is helpful to a clear understanding of the witness' testimony, (2) based upon the perception of the witness and (3) not based upon education, training or specialized knowledge within the scope of KRE 702.

¹ Perlin, M.L. & McClain, V., *Where souls are forgotten: Cultural competencies, forensic evaluations, and international human rights*, Psychology, Public Policy & Law 15, 257-277 (2009). See also, Holdman, S. and Seeds, C., *Cultural Competency in Capital Mitigation*, Hofstra Law Review, vol. 36, no. 3 (2008).

² Scott E. Sundby, *The Jury as Critic: An Empirical Look at How Capital Juries Perceive Expert and Lay Testimony*, 83 Va. L. Rev. 1109.

³ Ivkovic, S. and Hans, V., *"Jurors' Evaluations of Expert Testimony: Judging the Messenger and the Message"*, 28 Law and Soc. Inquiry 441 (2003).

Section 3 was added to KRE 701 to prevent lawyers from attempting to bypass the reliability standards of KRE 702 by offering opinions by lay people under KRE 701.

Practice Note: In the *Daubert* or 702/705 hearing, counsel may be inclined to “go in for the kill” on the state’s witness. The witness may be relatively unprepared and this lack of preparation and/or lack of sufficient relevant facts or data to support his opinion may be painfully obvious. The writer would suggest that unless counsel is reasonably certain that the judge will find that the witness is not an expert, “going in for the kill” is not recommended at this hearing. Should the judge allow the witness to testify, rationalizing that counsel can impeach on cross examination, any delay between the hearing and testimony may give the prosecution and witness just enough time to regroup and recover so that the weaknesses in his testimony are cured. Counsel should consider using the *Daubert* hearing for discovery and save the damaging impeachment cross examination for the jury.

KRE 702/703/705

In *Daubert v. Merrell Dow Pharmaceuticals*, 509 U.S. 579 (1993) the U.S. Supreme Court overruled the “generally accepted in the scientific community” Frye Test for admissibility of scientific evidence and replaced it with the Federal Rules of Evidence. Under the Federal Rules, the judge is to act as a gatekeeper utilizing a set of factors which have not been codified in Kentucky. The Kentucky Supreme Court adopted *Daubert* in *Mitchell v. Commonwealth*, 908 S.W. 2d 100 (Ky. 1995).

A *Daubert* hearing under KRE 702 can be very valuable to the defense for the following reasons: (1) the hearing can provide great discovery, particularly discovery of the facts or data which forms the basis for the expert’s opinion; (2) *Kumho Tire Co. Ltd. v. Carmichael*, 526 U.S. 137 (1999) (adopted by Kentucky in *Goodyear Tire and Rubber Co. v. Thompson*, 11 S.W.3d 575 (Ky. 2000)), has extended the reliability test to opinions based upon “specialized knowledge.” Accordingly, if a policeman offers an opinion that is based upon a specialized knowledge gained as a police officer, that opinion should be first heard outside the presence of the jury and satisfy the relevant *Daubert* reliability factors; (3) the defense can identify, prior to testimony before the jury, all opinions that the prosecution is to offer; and (4) either party can elicit hearsay (if deemed trustworthy) information that is relied upon by the witness in forming an opinion under KRE 703(b).

Practice Note: The Unintended Expert Witness. The prosecution will often call witnesses who have specialized training and knowledge, usually police officers who are more than happy to acknowledge their extensive training in multiple areas. Some of these are “scene witnesses,” police officers who have education and training in law enforcement generally and specialized training in other areas. While generally little thought is given to these “throw away” witnesses, defense counsel may be able to (very carefully) turn such a witness into an expert witness for the defense. For example, if a theme in mitigation will be the very rough neighborhood the client grew up in, one of the investigating officers may be familiar with the area and confirm the roughness of the neighborhood. An officer who had been engaged in a high speed chase with the client once testified that “We are trained in how to (1) drive in a high speed chase and (2) make the pursued driver wreck his car. He suddenly became an unintended expert. In a case in which the defense theory was that the client was not the leader but a follower, all defendants used military terms like “C.O.” and “X.O.” The first state’s witness was a “scene witness” who happened to be retired from the military. He became a teaching, lay expert witness on the meaning and significance of these terms as they relate to leadership positions. In order to use a prosecution witness in this way, counsel must (1) be well versed in the facts of the case and theories (culpability and sentencing) and supporting themes, (2) be alert to the possibility of converting a prosecution witness and, (3) be well versed in the “closed cross method” of cross examination so that the witness can effectively be lead in the direction that counsel desires.

What to Avoid in an Expert?

Defense counsel should be cautious about hiring the mental health expert who is too quick to label the client as one with an anti-social personality. This propensity will likely signal that the person is unable to humanize the client and is unwilling to look behind the client’s bad acts to see if there is another explanation for the behavior such as a mental illness, addiction, bad home or school conditions or coping skills which have influenced or caused the apparent bad behavior. Labeling a person as anti-social is easy and is made easier by the DSM manuals which provide the lazy expert with a convenient cookbook-type of checklist of bad behavior. (Please refer to the Chapter on Personality Disorders for a discussion of how to challenge a diagnosis of APD.) As this witness has already concluded that your client is anti-social, it will be very easy for him to agree with the prosecution’s main theory of the case – that your client is a bad person.

Defense counsel should also be concerned about the witness who insists on administering personality inventories such as the MMPI, Hare Psychopathy Checklist Revised or projective tests (ink blots) even when counsel has expressed concern beforehand. These tests may erroneously suggest that the client has a personality disorder or is a psychopath. Even if the test results are accurate, there is nothing mitigating in any of the disorders which may be suggested by the tests so there is “no reason to go there.” It is bad enough when the prosecution is saying it, even worse when the defense expert is agreeing.

Also be concerned when the psychologist insists on stating that she has identified a particular diagnosis when counsel’s theory is to focus not on a diagnosis (which the state will successfully contest), but instead focus on the client’s life experiences and conditions that explain his behavior. Counsel may not want to get into a battle over whether or not a particular diagnosis exists and the expert must understand this dynamic. These “red flags” all suggest that the expert will insist on following a clinical approach to the case rather than the forensic approach which the defense will follow.

Counsel should not abdicate the obligation to develop mental health evidence to be provided to the expert. Developing the mental health evidence is the obligation of lead counsel and the defense team and the expert must not insist on controlling this function.

Counsel should also avoid the expert who must talk over the heads of anyone who is listening – especially judges and juries. It is the writer’s experience that some professionals obtain great pleasure in using jargon and very long, incomprehensible words while testifying. “I must be smart because I can understand this and you can’t. If I can make 12 jurors understand then maybe the science is not so complicated (and I am not so smart) after all.” This witness is psychologically unable to suppress his ego enough to allow the listener to understand the science.

Investigating the Expert

Curriculum Vitae (CV)

Counsel should investigate the background and qualifications of both defense and prosecution witnesses. The backgrounds of witnesses that are to be considered by the defense should also be investigated. Counsel should review the following with regard to any witnesses:

the *curriculum vitae* (CV). Counsel should consider verifying education and employment history. Do the schools exist, are they legitimate, and did the professional actually graduate from the school with the claimed degree? Why did he leave employed positions? Is he a member of any “professional associations” where only an admission fee is required in order to be “certified”? If he is published, is his work peer reviewed? Was he paid by a company that just wanted a favorable article supporting their agenda? Is the cv up-to-date?

If it is possible to obtain a cv from different time periods, look for omissions, changes and even typographical errors (a favorite for prosecutors when a defense expert makes an error).

Professional Licensing and Board Certification

Verify that the professional's license is valid, current and dues paid timely. State agencies should have records of any ethics complaints made against someone it licenses. In Kentucky, contact www.psy.ky.gov for information on psychologists and www.kypsych.org for psychiatrists. An open records request will release the documents relevant to any complaint.

Social media

Google can be a good source of information and social media tools such as Facebook and Twitter can also be good sources of information. Viewers are constantly amazed at what supposedly intelligent people are willing to put out for public view!

Characteristics of a good testifying witness

A good forensic witness is one who:

- Is a scholar in a chosen field w/ good credentials;
- has no "skeletons in the closet";
- can humanize the client;
- can recognize a different explanation for behavior than the more obvious;
- is intellectually curious;
- understands applicable ethics rules. See www.apa.org/ethics/code/index;
- is confident without excessive ego;
- is experienced in treating "real people";
- has testified for both the prosecution and defense;
- can appreciate the difference between a clinical practice and a forensic practice;
- understands the obligation of lead counsel to direct development of evidence;
- has life experiences/activities that provide practical application to opinions;

- understands the concept of mitigation in the sentencing trial;
- understands the rules of confidentiality, privilege and work product protection;
- is inclined to humanize the client even when presented with facially bad facts;
- has experience on the witness stand;
- is willing to spend time preparing her testimony;
- can deal calmly with hostile cross examination;
- knows how much he can safely concede on cross examination without giving too much;
- has natural teaching instincts;
- will relate to jurors and neither talk over their heads nor talk down to them;
- charges reasonable fees;
- has an understanding of the indigent defense payment system.

Conclusion

When considering what experts to use and how to use them, allow the biopsychosocial history to guide counsel and the team. The information developed by this investigation will identify the relevant mental health issues in the case.

The thorough biopsychosocial history will allow defense counsel to develop the theories and themes of the case intelligently as well as the evidence in support of them. The role of the expert should be to explain the mental health evidence that has been presented, to tie all the sympathetic facts presented into a coherent presentation that will tell the client's story. Expert testimony is important, but it should not replace the lay testimony juries seem to find more credible.

For more discussion of Kentucky cases involving expert witnesses, see the DPA Trial Law Notebook and the DPA Evidence Manual.

Chapter 11: Appendix

"But Doctor, Isn't that Still Just Your Opinion?": Contributing to the Decision-Making Process of the Forensic Psychologist as Expert Witness

Eric Y. Drogin, J.D., Ph.D., ABPP

Curtis L. Barrett, Ph.D., ABPP

Almost 20 years ago, we were invited to provide an article for *The Advocate* that wound up being entitled "But Doctor, Isn't That Just Your Opinion?"¹ Requested to revisit this topic for the latest version of the *Mental Health Manual*, we're pleased to see that much of the material in that article is still germane to modern forensic mental health practice. In other words, this is "still" our opinion! We hope it will prove useful to you in fashioning your own.

In an earlier article for *The Advocate*, we asserted that:

The difference between the administration of a prescribed series of tests, and the ability to knit results from all sources of data into a responsive, compelling, persuasive, and ultimately convincing whole before the trier of fact, is the difference between the clinical psychologist who performs an *examination* and the forensic psychologist who conducts an *evaluation*.

The *evaluation*, however, is only the first of two steps in fulfilling the role of the forensic psychologist as expert mental health witness. The witness must first perform an evaluation, without bias, resulting in an *opinion*, and then must be prepared to *advocate* that opinion effectively within the overall context of the attorney's case presentation. As noted expert Dr. David Shapiro points out, "one should not consider oneself an advocate for the patient, for the defense, or for the government. One is an advocate only for one's own opinion."²

The process that leads to the construction of an expert opinion, and its advocacy in various contexts, can be viewed in the context of a series of "charges." Obviously, the defendant has been presented with "charges," or there would be no defendant. Ultimately, the attorney will be presented an itemized list of "charges" at the conclusion of the case, or quite likely there would be no expert.

What are often ignored are the "charges" with which the expert must be presented by the attorney at the inception of the expert's involvement in the proceedings. All too frequently, experts are merely asked to "perform an evaluation" of a defendant, with little if any additional guidance. Attorneys may focus exclusively on the contents of the forensic psychological report as a test of the adequacy of the expert's performance prior to testimony, without stopping to consider the need to influence the full scope of the expert's role in the construction and presentation of the attorney's overall theory of the case.

From Evaluation to Opinion to Advocacy

The flow of the expert's transition from forensic evaluation to effective advocacy of an expert opinion can be depicted in the following fashion:

The confluence of data from various sources such as examination, review, interview, research, and consultation (category



The *Ethical Principles of Psychologists and Code of Conduct*³ of the American Psychological Association (APA) contains many guidelines related to principles of psychological assessment, including the following:

subheadings provide merely a few examples) informs the scientific basis for an expert opinion. Advised of that opinion, the attorney must then determine if the opinion is sufficiently favorable and/or informative to continue to the advocacy phase, with the expression of that opinion via report, testimony, and/or deposition. Regardless of whether expression of the opinion will be persuasive to the trier of fact, the attorney may benefit from additional consultation by the expert regarding such issues as direct and cross-examination, witness interviewing, *et cetera*.

The scope of the evaluation, and the quality and persuasiveness of the opinion it serves to generate, depend upon the ability of the attorney to provide the expert with the appropriate data in as timely a fashion as possible.

Attorneys often want to know what are the "required" components of the data sources that contribute to the expert opinion. The answer to that question really depends upon the interaction of a variety of factors which may include, among others, the reliability and validity of the data which have been obtained, the nature of the forensic issue(s) to be addressed, the current status of the defendant, and the skill, training, and experience of the evaluator.

For example, a recently and severely brain damaged defendant, incapable of coherent speech or any understanding of verbal or written communication on the part of his attorney or anyone else, may be found incompetent to stand trial on the basis of thorough forensic clinical examinations, with a lesser degree of emphasis upon the contributory opinions of friends, family, and former teachers. Similarly, an opinion on the adequacy of an evaluation performed by another professional in the past may not require the testifying expert to perform an examination of that defendant some years later, as long as the conclusions provided are appropriately limited.

The adequacy and utility of the professional opinion is often most helpfully measured, not in binary terms of "adequate" versus "inadequate," or "competent" versus "incompetent," but rather in incremental terms regarding its potential for persuasiveness, and the degree to which it will withstand the rigors of cross-examination.

Sources of Guidance

While there is no solitary, bottom-line reference which definitively and comprehensively states the necessary components of a competent forensic psychological evaluation and/or report, there are numerous sources of guidance upon which attorneys and forensic psychologists can draw.

"Ethics codes" and "guidelines" are aspirational statements that seek to guide the behavior of any professional belonging to the associations that promulgate them. Failure to adhere to an ethical code or guideline may lead to expulsion from professional societies, and even to criminal sanctions when compliance is mandated by the psychologist's state licensing statute.

¹ Eric Y. Drogin & Curtis L. Barrett, "But Doctor, Isn't That Just Your Opinion?" Contributing to the Decision-Making Process of the Forensic Psychologist as Expert Witness, *THE ADVOCATE*, May 1996, at 14.

² Eric Y. Drogin & Curtis L. Barrett, *Forensic Mental Health Assessment: Moving from Examination to Evaluation*, *THE ADVOCATE*, Jan. 1996, at 14.

³ American Psychological Association, *Ethical Principles of Psychologists and Code of Conduct*, 57 AM. PSYCHOL. 1060 (2002). This document can be accessed online at www.apa.org/ethics/code/index.aspx.

9.01 Bases for Assessments

(a) Psychologists base the opinions contained in their recommendations, reports, and diagnostic or evaluative statements, including forensic testimony, on information and techniques sufficient to substantiate their findings.

(b) Except as noted in 9.01c, psychologists provide opinions of the psychological characteristics of individuals only after they have conducted an examination of the individuals adequate to support their statements or conclusions. When, despite reasonable efforts, such an examination is not practical, psychologists document the efforts they made and the result of those efforts, clarify the probable impact of their limited information on the reliability and validity of their opinions, and appropriately limit the nature and extent of their conclusions or recommendations.

(c) When psychologists conduct a record review or provide consultation or supervision and an individual examination is not warranted or necessary for the opinion, psychologists explain this and the sources of information on which they based their conclusions and recommendations.

9.02 Use of Assessments

(a) Psychologists administer, adapt, score, interpret, or use assessment techniques, interviews, tests, or instruments in a manner and for purposes that are appropriate in light of the research on or evidence of the usefulness and proper application of the techniques.

(b) Psychologists use assessment instruments whose validity and reliability have been established for use with members of the population tested. When such validity or reliability has not been established, psychologists describe the strengths and limitations of test results and interpretation.

(c) Psychologists use assessment methods that are appropriate to an individual's language preference and competence, unless the use of an alternative language is relevant to the assessment issues.

9.04 Release of Test Data

(a) The term *test data* refers to raw and scaled scores, client/patient responses to test questions or stimuli, and psychologists' notes and recordings concerning client/patient statements and behavior during an examination. Those portions of test materials that include client/patient responses are included in the definition of *test data*. Pursuant to a client/patient release, psychologists provide test data to the client/patient or other persons identified in the release. Psychologists may refrain from releasing test data misuse or misrepresentation of the data or the test, recognizing that in many instances release of confidential information under these circumstances is regulated by law.

(b) In the absence of a client/patient release, psychologists provide test data only as required by law or court order.

9.08 Obsolete Tests and Outdated Test Results

(a) Psychologists do not base their assessment or intervention decisions or recommendations on data or test results that are outdated for the current purpose.

(b) Psychologists do not base such decisions or recommendations on tests and measures that are obsolete and not useful for the current purpose.

9.11 Maintaining Test Security

The term *test materials* refers to manuals, instruments, protocols, and test questions or stimuli and does not include *test data* as defined in Standard 9.04, Release of Test Data. Psychologists make reasonable efforts to maintain the integrity and security of test materials and other assessment techniques consistent with law and contractual obligations, and in a manner that permits adherence to this Ethics Code.

The APA has also recently adopted updated *Specialty Guidelines for Forensic Psychologists*¹ that provide additional guidance regarding evaluation and report procedures, including the following:

2.04: Knowledge of the Legal System and the Legal Rights of Individuals

Forensic practitioners recognize the importance of obtaining a fundamental and reasonable level of knowledge and understanding of the legal and professional standards, laws, rules, and precedents that govern their participation in legal proceedings and that guide the impact of their services on service recipients. Forensic practitioners aspire to manage their professional conduct in a manner that does not threaten or impair the rights of affected individuals. They may consult with, and refer others to, legal counsel on matters of law. Although they do not provide formal legal advice or opinions, forensic practitioners may provide information about the legal process to others based on their knowledge and experience. They strive to distinguish this from legal opinions, however, and encourage consultation with attorneys as appropriate.

3.02: Responsiveness

Forensic practitioners seek to manage their workloads so that services can be provided thoroughly, competently, and promptly. They recognize that acting with reasonable promptness, however, does not require the forensic practitioner to acquiesce to service demands not reasonably anticipated at the time the service was requested, nor does it require the forensic practitioner to provide services if the client has not acted in a manner consistent with existing agreements, including payment of fees.

4.02: Therapeutic–Forensic Role Conflicts

Providing forensic and therapeutic psychological services to the same individual or closely related individuals involves multiple relationships that may impair objectivity and/or cause exploitation or other harm. Therefore, when requested or ordered to provide either concurrent or sequential forensic and therapeutic services, forensic practitioners are encouraged to disclose the potential risk and make reasonable efforts to refer the request to another qualified provider. If referral is not possible, the forensic practitioner is encouraged to consider the risks and benefits to all parties and to the legal system or entity likely to be impacted, the possibility of separating each service widely in time, seeking judicial review and direction, and consulting with knowledgeable colleagues. When providing both forensic and therapeutic services, forensic practitioners seek to minimize the potential negative effects of this circumstance.

8.02: Access to Information

If requested, forensic practitioners seek to provide the retaining party access to, and a meaningful explanation of, all information that is in their records for the matter at hand, consistent with the relevant law, applicable codes of ethics and professional standards, and institutional rules and regulations. Forensic examinees typically are not provided access to the forensic practitioner's records without the consent of the retaining party. Access to records by anyone other than the retaining party is governed by legal process, usually subpoena or court order, or by explicit consent of the retaining party. Forensic practitioners may charge a reasonable fee for the costs associated with the storage, reproduction, review, and provision of records.

9.03: Opinions Regarding Persons Not Examined

Forensic practitioners recognize their obligations to only provide written or oral evidence about the psychological characteristics of particular individuals when they have sufficient information or data to form an adequate foundation for those opinions or to substantiate their findings. Forensic practitioners seek to make reasonable efforts to obtain such information or data, and they document their efforts to obtain it. When

¹ American Psychological Association, *Specialty Guidelines for Forensic Psychology*, 68 AM. PSYCHOL. 7 (2013). This document can be accessed online at www.apa.org/practice/guidelines/forensic-psychology.aspx.

it is not possible or feasible to examine individuals about whom they are offering an opinion, forensic practitioners strive to make clear the impact of such limitations on the reliability and validity of their professional products, opinions, or testimony. When conducting a record review or providing consultation or supervision that does not warrant an individual examination, forensic practitioners seek to identify the sources of information on which they are basing their opinions and recommendations, including any substantial limitations to their opinions and recommendations.

The *ABA Criminal Justice and Mental Health Standards*¹ are the product of several multidisciplinary teams, including psychiatrists, psychologists, attorneys, and others, who worked pursuant to a MacArthur Foundation grant to inform the legal process about dealing with the defendants suffering from mental illness or mental retardation. The following is one representative standard, regarding assessment of competency to stand trial:

7-4.5 Report of the Evaluator

[a] The first matter to be addressed in the report should be the assessment of the defendant's competence to stand trial. If it is determined that the defendant is competent to stand trial, issues relating to treatment or habilitation should not be addressed. If it is determined that the defendant is incompetent to stand trial, or that the defendant is competent to stand trial but that continued competence is dependent upon maintenance of treatment or habilitation, the evaluator should then report on the treatment or habilitation necessary for the defendant to attain or maintain competence.

[b] If it is determined that treatment or habilitation is necessary for the defendant to attain or maintain competence, the report should address the following issues:

- (1) the condition causing the incompetence;
- (2) the treatment or habilitation required for the defendant to attain or maintain competence and an explanation of appropriate treatment alternatives in order of choice;
- (3) the availability of the various types of acceptable treatment or habilitation in the local geographical area. The evaluator should indicate the agencies or settings in which such treatment or habilitation might be obtained. Whenever the treatment or habilitation would be available in an outpatient setting, the evaluating expert should make such fact clear in the report;
- (4) the likelihood of the defendant's attaining competence under the treatment or habilitation and the probable duration of the treatment or habilitation.

[c] If the evaluating expert determines that the only appropriate treatment or habilitation would require that the defendant be taken into custody or involuntarily committed, then the report should include the following:

- (1) an analysis of whether the defendant, because of the condition causing mental incompetence, meets the criteria for involuntary civil commitment or placement set forth by law;
- (2) whether there is a substantial probability that the defendant will attain competence to stand trial within the reasonably foreseeable future;
- (3) the nature and probable duration of the treatment or habilitation required for the defendant to attain competence;
- (4) alternatives other than involuntary confinement which were considered by the evaluator and the reasons for the rejection of such alternatives.

¹ AMERICAN BAR ASSOCIATION CRIMINAL JUSTICE STANDARDS COMMITTEE, ABA CRIMINAL JUSTICE MENTAL HEALTH STANDARDS (1989). This document can be accessed online at www.americanbar.org/content/dam/aba/publications/criminal_justice_standards/mental_health_complete.authcheckdam.pdf.

These *Standards* also address, in more general fashion, requirements for the overall content of forensic psychological reports:

7-3.7: Preparation and Contents of Written Reports of Mental Evaluations

[b] Contents of the written report.

(1) The written evaluation should ordinarily:

- (A) identify the specific matters referred for evaluation;
- (B) describe the procedures, tests, and techniques used by the evaluator;
- (C) state the evaluator's clinical findings and opinions on each matter referred for evaluation and indicate specifically those questions, if any, that could not be answered;
- (D) identify the sources of information and present the factual basis for the evaluator's clinical findings and opinions; and
- (E) present the reasoning by which the evaluator utilized the information to reach the clinical findings and opinions. The evaluator should express an opinion on a specific legal criterion or standard only if the opinion is within the scope of the evaluator's specialized knowledge.

Statutory guidelines may be limited in scope, but mandate key requirements that are often ignored by attorneys and not disclosed to expert witnesses. For example, in Kentucky, KRS 504.100 ("*Appointment by court of psychologist or psychiatrist during proceedings*") provides that:

- (2) The report of the psychologist or psychiatrist shall state whether or not he finds the defendant incompetent to stand trial. If he finds the defendant is incompetent, the report shall state:
 - (a) Whether there is a substantial probability of his attaining competency in the foreseeable future; and
 - (b) What type treatment and what type treatment facility the examiner recommends.

We frequently review reports that provide a bottom-line opinion regarding competency, but that fail to adhere to these additional requirements.

Sometimes, the issue is not *what* constitutes an evaluation or report, but rather *who* is to perform or write it. According to KRS 504.060 ("Definitions for Chapter"), pertaining to competency to stand trial and criminal responsibility evaluations:

- (9) "Psychologist" means a person licensed at the doctoral level pursuant to KRS Chapter 319 who has been designated by the Kentucky Board of Examiners of Psychology as competent to perform examinations.

Both KRS 504.100 and KRS 504.070 ("*Evidence by defendant of mental illness or insanity; examination by psychologist or psychiatrist by court appointment; rebuttal by prosecution*") refer to the appointment of a "psychologist" to "examine, treat, and report on the defendant's mental condition." One frequently encounters criminal responsibility and trial competency evaluations where reports are signed by a psychologist at the doctoral level and also by a psychological associate or certified psychologist at the master's level, where it transpires that a substantial portion of the evaluation has been performed by the latter professional.

Conclusions

There are many different routes to a professional opinion. The route taken will determine the credibility, persuasiveness, and generalizability of that opinion, in conjunction with the reputation and skill of the expert witness providing it. A wealth of resources including ethical codes and guidelines, learned treatises, and statutes contributes to the constantly shifting parameters of what are acceptable and/or necessary components of the forensic psychological evaluation and report. Attorneys will greatly enhance the quality of the professional opinions of their experts, to the extent that they provide those experts with the fullest possible range of

data, and continue to discuss in a collegial fashion the evolving nature of forensic mental health sciences.

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Chapter 12: Cross-Examining the Prosecution's Mental Health Expert

By Kelly Gleason & Robert Harp¹

I. AVOIDING THE CROSS

Before the issues of cross-examining the prosecutor's mental health expert are addressed, consider the possibility of avoiding the necessity of a cross altogether.

A. Co-opting the state's expert

Depending upon who the expert is and the facts of your case, you may decide to assist the state's expert by providing information to the expert to insure an accurate, well-informed diagnosis and avoid a finding of competency or sanity. Before making this decision research the expert.

- Talk with attorneys who have dealt with the expert in the past and ask about their experiences and if they have heard anything about other cases. Talk with experts who are familiar with the state's expert.
- Does the expert have a reputation as a hired gun for prosecutors?
- Is the expert open to working with defense attorneys?
- In how many cases has the expert testified? What was the outcome?
- What is the expert's reputation among fellow psychologists or psychiatrists?
- Has the expert ever found anyone incompetent to stand trial or insane at the time of the offense?
- Has the expert worked with your prosecutor in the past?

This approach may be risky, but even if an incompetency or insanity determination does not ultimately result, there may be benefits to the defense. For instance, the state expert may validate information which is crucial to your case before the jury. The expert may be a tremendous help in the sentencing or penalty phase, despite an unfavorable competency/sanity finding, or even support an extreme emotional disturbance or intoxication defense. Think about the theory of the case before making this decision and about what you can realistically expect from the state's expert, given the information which you have obtained about the expert, the facts of the case, and your client's background and current mental state.

B. Precluding the state expert's testimony

There may be grounds for a motion to preclude the expert's testimony or part of the expert's testimony for several reasons. Some possible grounds follow:

1. **The expert is attempting to testify regarding a particular matter beyond the scope of his/her expertise.** Being an expert is not enough. One must be an expert as to the specific question to be answered. *Kemper v. Gordon*, 272 S.W.3d 146, 154 (Ky. 2008) citing *Berry v. City of Detroit*, 25 F.3d 1342, 1351 (6th Cir. 1994).
2. **The expert may lack sufficient foundation to testify.** KRE 703 & 705. "Expert testimony must be cross-examinable." *Sanborn v. Commonwealth*, 892 S.W.2d 542, 550 (Ky. 1994) (citing KRE 705). An adverse party may establish the underlying facts or data on which an expert's opinion is based during cross-examination if they are not brought out by the proponent during direct examination.
3. **The expert's testimony may be inadmissible due to a violation of the prosecutor's discovery obligations.** RCr 7.24(9) (including "results or reports of physical or mental examinations" and oral or written incriminating

statements). Discovery violations may also violate the accused's rights to due process, a fair trial, confrontation, and effective assistance of counsel.

4. **The expert's evaluation may be inadmissible as the result of a violation of the defendant's Fifth Amendment privilege against self-incrimination and/or the Sixth Amendment right to counsel (and Section 11 of the Ky. Constitution).** See, e.g., *Estelle v. Smith*, 451 U.S. 454 (1981). It is not clear that defense council can be present at the state examination of the defendant, but the law is clear that the defense expert may be present. KRS 504.080(5): "A psychologist or psychiatrist retained by the defendant shall be permitted to participate in any examination under this chapter."

II. INVESTIGATING THE STATE EXPERT

An effective cross-examination can only be accomplished after investigating the background of the state expert. Remember you practice in a state in which "experts" who have testified in death penalty cases include a fraud, a felon, and a fabricator of credentials. You will not know very important information about the expert unless you investigate.

The following is an outline by Robert Harp, Investigator with the Capital Trial Unit, of the main sources of information for an investigation of a mental health expert.

Background Investigation

Mental Health Expert

A. Personal Information

1. Obtain as much personal information as possible. This will provide you with other sources of information at a later date.
 - a. Full name
 - b. Address
 - c. Date of Birth
 - d. Social Security Number
 - e. School{s} attended
 - f. Reports, Books or Articles published

B. Professional License

1. Status
 - a. Current or Expired
 - b. How Obtained
 - i. Test
 - ii. Agreement from another state
 - c. Application information (May not provide this information)
2. Complaints
3. Number and type
4. Disciplinary Actions
5. License if noted in other states

C. Personal Background Check

1. NCIC (National Check)
2. Driving Record
 - a. Indication of Alcohol and Drug related offenses

¹ As revised and updated by Glenn McClister

3. Credit History
4. U. S. District Court, Bankruptcy Division

D. City Business License

1. Location of Practice
 - a. Indication of volume of practice

E. County Courthouse Records

1. Criminal Court Records
 - a. Local only, Misdemeanors
2. Civil Court Records
 - a. Civil Suits and Judgments

F. Professional Associations

1. American Medical Directory
 - a. American Medical Directory, Doctor by States and Cities
 - b. Name index of all Doctors (Members)
 - c. Year of Birth, Medical School, Year Graduation, Year Licensed, Residence and Office Address
2. Professional Publications
 - a. Papers
 - b. Published Articles
 - c. Published Book(s)
 - i. Name, Date and Subject Matter

G. Insurance Reporting Service

1. Type of insurance
 - a. Liability
 - b. Risk
2. Claims made against his insurance
 - a. Losses

H. Foreign Mental Health Professional of Doctor

1. Immigration and Naturalization Service
 - a. Immigration Identification Card
 - b. Alien Card
 - c. Aliens must report Address every year
 - d. Alien Visa File

I. Military Records

1. Military personnel and Civilian under contract

J. Testimony in Other Cases

1. Civil
2. Criminal

III. OTHER INVESTIGATION

It may be helpful in planning a motion practice and in preparing for trial or a pretrial hearing to develop a sense of the context in which the expert mental health testimony will be offered and the understanding of the various parties of this testimony.

A. The prosecutor

What experience has the prosecutor had with mental health experts? A more sophisticated prosecutor will present a different challenge than a

less experienced one and may have a repertoire of "dirty tricks" which you must anticipate and diffuse. Has the prosecutor authored any pleadings or other documents which would be useful to the defense? For example, an Assistant Attorney General obtained an additional expert in a Kentucky capital case by alleging that KCPC personnel were incompetent to perform the necessary evaluation. Is there a relationship between the prosecutor and the expert which would suggest bias?

B. The police/prosecution witnesses

Do the police or other prosecution witnesses have information which will contradict or undermine the testimony of the state expert? They may have helpful observations of the accused around the time of offense or in past contacts with the accused.

C. The judge

Has the judge had much experience with mental health testimony in criminal cases? Civil cases? As a judge or as an advocate? What is the experience in the local courts with expert mental health testimony in criminal or civil cases?

D. The jury

The nature of your jury may be very significant to the goals and methods of your cross-examination. Have any jurors been involved in the mental health professions? Have they or their family/friends experienced contact with mental health professionals? How much importance will they attach to mental health expert testimony? Investigate these areas in voir dire.

IV. DEFINE THE GOALS OF CROSS-EXAMINATION

Do you need to cross-examine this witness? If yes, then define what you hope to accomplish specifically and with the theory of the case in mind. Depending upon the facts of the case and your jury, these goals may vary widely. Some potential goals are discussed below.

Warning: In setting the goals for cross-examining the state expert keep in mind what the weaknesses/strengths of the defense expert are (if you have one). For example, you do not want to hammer on the little time spent with the accused by the state expert if your expert did not spend much time with the client either.

A. Destroy the expert

This is rather ambitious but the situation may lend itself to a scorched earth approach. If there is little or no good information offered by the state's expert in the report or at trial and there is sufficient basis for an attack on the expert's credentials, the quality of the exam, or improper motive/bias, then this may be the way to go.

B. Elicit positive opinions from the expert

The expert may have reached some conclusions which are helpful to the theory of defense. Bring these points out to the jury and lay the groundwork for an explanation as to why the expert was mistaken as to the harmful conclusions.

C. Elicit positive facts from the expert

The expert may have no positive opinions to offer for the defense but may be used to validate and reinforce facts which are helpful to the client. For example, the expert can verify that the defendant was diagnosed schizophrenic previously or that the defendant exhibited symptoms of severe depression around the time of the offense. Use the state expert to reinforce the lay and expert witnesses you will call later.

D. Demonstrate that the expert had insufficient basis, insufficient credentials, and/or insufficient experience to formulate a valid opinion

Unless you decided to attempt to co-opt the state expert, your expert is going to know a lot more about your client, will have spent more time with him/her, and will be more experienced and better-educated

(hopefully) than the state expert. You will be able to lay the foundation in cross for an argument that if the state expert had more experience, training, information, and time and had expended the effort to obtain this, then s/he would have reached the same proper conclusion as the defense expert.

V. AREAS OF CROSS-EXAMINATION

A. The expert -- qualifications and bias

1. Academic credentials
 - a. Psychologists -- Masters or Ph.D.?
 - b. Psychiatrists -- Specialization?
 - c. Board Certifications
 - d. Grades/Class Rank
 - e. Other
2. Experience
 - a. Forensic experience vs. counseling
 - b. Numbers of patients/setting
 - c. State/private
 - d. Previous experience w/ competency and/or insanity evaluation and testimony
 - e. Other
3. Compensation
 - a. This case
 - b. Future cases
4. Professional/philosophical bias
 - a. Hired gun for prosecutors
 - b. Views on crime and punishment
 - c. Treatment or punishment orientation
 - d. Publications/speeches/other writings
 - e. Work experience
 - f. Other
5. Personal bias
 - a. Victim of crime
 - b. Family/friends victim
 - c. Relationship w/ victim
 - d. Relationship w/ prosecutor
 - e. Race/cultural/gender/class bias
 - f. Other

B. The method

1. Tests (non-medical)
 - a. Objective vs. subjective
 - b. How administered
 - c. Testing atmosphere/effects
 - d. Examiner effects (various factors related to the examiner can effect the outcome, e.g., whether the examiner has a moustache, race, gender, cultural background, bias)
 - e. Examinee effects (race, age, gender, occupation, education, economic and marital status, drug or

alcohol use -- e.g., caffeine can have a substantial impact, depression, etc.)

- f. Inherent bias in tests (race, culture, gender, etc.)
- g. Reliability -- the degree to which the testing instrument consistently gives the same results
 - i. internal consistency
 - ii. test-retest consistency
 - iii. interjudge consistency
- h. Validity -- the degree to which the testing instrument measures what it purports to measure
 - i. descriptive validity -- accuracy of the score, diagnosis, or interpretation as a reflection of current behavior
 - ii. predictive validity -- accurate prediction of future behavior
- i. Research individual tests used (how test was developed, validity/ reliability studies, revisions of the test, critical publications, etc.)
- j. Raw data obtained by testing supports a variety of conclusions
- k. Errors in testing procedure or data
- l. Errors in interpreting the test results
- m. Other
2. Tests (medical)
 - a. General physical
 - b. Neurological -- EEG, CAT scan, PET, MRI, etc.
 - c. Lab work (chemical imbalances often are significant in diagnoses)
 - d. Expert qualified to interpret test?
 - e. Failure to perform indicated medical tests
3. The client interview
 - a. Time spent w/ client; number of interviews
 - b. Setting (jail, office, etc.)
 - c. Others present
 - d. Examiner effects (race, gender, cultural background, bias, demeanor, etc.)
 - e. Examinee effects (race, age, gender, occupation, education, economic and marital status, drug or alcohol use -- e.g., caffeine can have a substantial impact, depression, etc.)
 - f. Recording procedure (notes, audiotape, videotape, etc.)
 - g. Other
4. The Social History/Records
 - a. Client's self-report
 - b. Interviews w/ family, friends, employer, etc.
 - c. Interviews w/ prior doctors or counselors
 - d. Medical records, including birth records, prior psychological/ neurological evaluations, etc.
 - e. Criminal records, including juvenile and probation

- f. School records
- g. Military records
- h. Other
- 5. The crime
 - a. Client's report
 - b. Interviews w/ police; offense report
 - c. Interview w/ crime victim
 - d. Interviews w/ witnesses
- 6. The evaluation team
 - a. Staff assistance
 - b. Medical assistance
 - c. Consulting assistance
 - d. The team as a standard of practice (KCPC staffs each patient w/ a psychiatrist, psychologist, social worker, nurses, and a medical physician, and contracts w/ a neuropsychologist and neurologist when that testing is indicated)
 - e. Discovery of relevant documents and information which are not in the experts "report," e.g., medical evaluations, testing raw data, logs

C. The conclusion

- 1. The written report
 - a. Errors of fact
 - b. Errors in use of technical terms
 - c. Internal inconsistencies
 - d. Inconsistencies w/ other documents or testimony
 - e. Inconsistencies w/ expert's trial testimony
 - f. Other
- 2. Expert not qualified to reach the conclusion
 - a. Ignorance of the history of the profession
 - b. Ignorance of substantive principles
 - c. Lack of experience on specific topic
 - d. Lack of relevant degree, coursework, and/or clinical experience
 - e. Other
- 3. The evaluation process was flawed or incomplete
 - a. Better tests were available and not used
 - b. Testing was incomplete; further tests required
 - c. Errors in testing flawed the process
 - d. Interviews were flawed or incomplete
 - e. The process did not meet established standards
 - f. The process was inferior to that of defense expert
 - g. Other
- 4. Erroneous or incomplete data rendered a flawed conclusion
 - a. Failure to verify information
 - b. Reliance on hearsay information
 - c. Assumptions rather than personal observation

- d. Factual errors
- e. Failure to consider relevant data
- f. Additional information could alter conclusion
- g. Lack of diligence/effort
- h. Other
- 5. The jury should not agree with the expert's opinion
 - a. Inconsistent with common sense
 - b. Inconsistent with prosecutor's lay witnesses
 - c. Inconsistent with other experts' opinions (the defense expert, previous treating physicians, psychologists, etc.)
 - d. Other expert could reach a different opinion based on same data
 - e. Interpretive standards are so subjective, especially when the human mind is involved, that the opinion could be wrong -- not an exact science
 - f. Opinion is a possible, not probable
 - g. Controversy within the field of psychology or psychiatry
 - h. Expert has made inconsistent statements in the case
 - i. Expert has made prior inconsistent statements outside the case (testimony, publications, etc.)
 - j. Expert's statements, opinions, process, etc., are inconsistent w/ learned treatises and/or professional standards
 - k. Expert has a poor grasp of the facts
 - l. Other

VI. RESOURCES

These are a few helpful sources of information. Your mental health consultant can suggest others. Help is also available through local and national organizations.

J. Ziskin & D. Faust, *Coping with Psychiatric and Psychological Testimony*, 4th Ed. (Law and Psychology Press, 1988) (3 volumes)

The American Psychiatric Press Textbook of Psychiatry (American Psychiatric Press 1988)

American Psychiatric Association, *Desk Reference to the Diagnostic Criteria from DSM-V* (2013)

H. Kaplan & B. Sadock, *Comprehensive Textbook of Psychiatry* (5th Ed. 1989)

Imwinkelreid, *The Methods of Attacking Scientific Evidence*, (Michie 1982)

R. Clifford, *Qualifying and Attacking Expert Witnesses* (James Publishing 1988)

ABA Criminal Justice Mental Health Standards

C. Roberts & S. Golding, "The Social Construction of Criminal Responsibility and Insanity," *Law and Human Behavior*, Vol. 15, No. 4 (1991)

C. Slobogin, "Estelle v. Smith: The Constitutional Contours of the Forensic Evaluation," *Criminal Law Review*, 31 *Emory Law Journal* 71 (1982)

American Psychiatric Association, "Report of the Task Force on the Role of Psychiatry in the Sentencing Process," *Issues in Forensic Psychiatry* 202 (1984)

American Psychiatric Association, Principles of Medical Ethics (Psychiatry) (1981)	right to counsel at psychiatric examination
American Psychological Association, Ethical Principles of Psychologists, 36 American Psychologist 633 (1981)	23 ALR Fed 710 -- adequacy of psychiatric examination
17 ALR 4th 575 --	KELLY GLEASON
effective assistance and competency	ROBERT HARP
3 ALR 4th 910 --	

Chapter 13: DSM-V

Many papers relating to the DSM series of diagnostic and statistical manuals will painstakingly discuss the history of the manuals' development. In this chapter, such a review will not be undertaken as it is believed to be unnecessary to the practice of criminal defense.

"The publication of DSM-V brings innovations to the coding, classification and diagnosis of mental disorders that have far-reaching effects across many disciplines."¹ Here are some features of the DSM-V that will be of interest to the criminal defense practitioner.

Intellectual Developmental Disorder

1. Changes to "Mental Retardation"

- (a) The DSM-V no longer uses the term "mental retardation" noting that U.S. Public Law 111-256, Rosa's Law, replaces that term with "Intellectual Disability." The term "Intellectual Developmental Disorder" will become the official term in 2015 when adopted by the World Health Organization. An intellectual disability is now classified as a type of Neurodevelopmental Disorder.²
- (b) The diagnostic criteria continue to be three in number: (i) Deficits in intellectual function (followed by examples such as reasoning and judgment); (ii) Deficits in adaptive functioning that result in failure to meet developmental and sociocultural standards for personal independence and social responsibility; and (iii) Onset of intellectual and adaptive deficits during the developmental period.
- (c) Note these are the same three criteria used in Kentucky's definition of an "individual with an intellectual disability." KRS 504.060(7)
- (d) The DSM-V puts less emphasis on the I.Q. score in determining Intellectual Disability. More attention is being placed upon deficits in adaptive functioning. *In fact, a reference to an I.Q. of 70 or two standards below the norm no longer appear in the diagnostic criteria.* (emphasis added).

"By removing I.Q. test scores from the diagnostic criteria, but still including them in the text description of intellectual disability, DSM-V ensures that they are not overemphasized as the defining factor of a person's overall ability, without adequately considering functioning levels. This is especially important in forensics cases."³

(ed) The *severity* (mild, moderate, severe, profound) of the Intellectual Disability is determined by the level of adaptive functioning rather than an I.Q. score.

Practice Note: It remains to be seen how courts will react to these changes. The writer doubts that they will have any effect on jurors' inability to find a person convicted of a capital crime to be a person with Intellectual and Developmental Disabilities. However, counsel has additional tools to litigate the issue of intellectual disabilities (ID) on behalf of the client in cases where ID is a possible defense under KRS 504.020 and/or the Commonwealth is trying to kill your client in a capital case. The United States Supreme Court in *Hall v. Florida*, 572 U.S. ____ (2014) supplements the reduced emphasis on the single intelligence quotient (I.Q.) score by holding that if a defendant is claiming intellectual disability and offers an IQ score in the range of 70-75, he must be allowed to offer additional clinical evidence of intellectual disability and adaptive deficits.

In so holding, the Supreme Court (5 to 4 with Kennedy writing for majority and Alito for the minority) the court specifically:

- a. recognizes the potential inaccuracies of I.Q. testing;
 - b. approves the use of the standard error of measurement (+/- 5) if nothing in state statute prevents it. A statute that would prevent using the SEM would likely be unconstitutional under the majority's rationale.
 - c. acknowledges that one's I.Q. is more properly expressed in terms of a range rather than one number. "Intellectual disability is characterized by an I.Q. of approximately 70". *Atkins v. Virginia*, 536 U.S. 308, n.3 and slip at 20.
 - d. Adopts the term of "intellectual [and developmental] disability" in place of "mental retardation"
 - e. Approves the consideration of "accepted clinical standards" in deciding the issue. Does this implicitly approve the Flynn Effect?
 - f. References the DSM-5 emphasis on developmental disabilities (adaptive deficits) over a strict I.Q. score. "It is not sound to view a single factor as dispositive of a conjunctive and interrelated assessment", citing DSM-5 at 37, (slip at 21).
 - g. Uses consensus of states (slip 12) and consensus among professionals in the field (slip 20) in analysis.
2. Personality Disorder diagnostic criteria and "conduct disorder," necessary for a diagnosis of antisocial personality, are "largely unchanged." A plan is in place to fold the ten current personality disorders into five or six. One of the proposed new categories is "antisocial/psychopathic type." This is a plan that the defense bar should watch closely.
 3. Reactive Attachment Disorder has been reconfigured from one disorder with two subtypes into two distinctive disorders which will have no impact on the defense lawyer.
 4. The Fetal Alcohol Spectrum Disorders (plural) are now referred to as a "Neurodevelopmental Disorder associated with Prenatal Alcohol Exposure" (ND-PAE).⁴ The Axis Method (1-5) of categorizing mental illness, disabilities, conditions and disorders, etc., has been abandoned.

Criticism of the DSM

"The standardization of psychiatric diagnoses was the product of many factors including (1) professional politics within the mental health community, (2) increased government involvement in mental health research and policy making, (3) mounting pressure on psychiatrists from health insurers to demonstrate the effectiveness of their practices, and (4) the necessity of pharmaceutical companies to market their products to treat specific diseases."⁵

"Except for autism, all the DSM-V changes loosen diagnosis and threaten to turn our current diagnostic inflation into diagnostic hyperinflation. Painful experience with previous DSM's teaches that if anything in the diagnostic system can be misused and turned into a fad, it will be. Many millions of people with normal grief, gluttony, distractibility, worries, reactions to stress, the temper tantrums of childhood, the forgetting of old age, and 'behavioral addictions' will soon be mislabeled as psychiatrically sick and given inappropriate treatment."⁶

DSM-V and Criminal Defense

The DSM-V is surely important to the mental health professional who maintains a clinical practice. The importance of the manual diminishes when considered in the context of criminal defense. Viewing the few "items of interest" listed above is enough to cause one's eyes to glaze

¹ American Psychiatric Association, Desk Reference to the Diagnostic Criteria from DSM-V (2013).

² APA Desk Reference, *id.* at p. 17.

³ www.DSM5.org "Intellectual Disability", American Psychiatric Publishing, (2013).

⁴ DSM-V under the diagnostic category of "Specified Other Neurodevelopmental Disorder" (315.8).

⁵ Mayes, R. and Horwitz, R.V., *DSM-III and the Revolution in the Classification of Mental Illness*, J.Hist. Behavior.Sci., 41:249-267 (2005).

⁶ Frances, Allen, *DSM-V in Distress*, Psychology Today, December, (2012).

over, perhaps permanently, (Glazed-Over Eyes Disorder-Permanent Subtype).

The DSM-V may be helpful to the public defender in cases in which the client pleads insanity, is not competent to stand trial, disabled by Intellectual Disabilities and/or exposure to fetal alcohol. The manual will certainly be important if the Commonwealth is maintaining that the client has a particular diagnosis (usually a personality disorder). The defense will want to challenge the diagnostic criteria for the disorder. However, the more our expert talks about diagnostic criteria the less she is talking about the client's life experiences, her symptoms and how these both humanize her and explain her behavior. Should our expert get into a debate with a state's expert over whether or not a diagnosis exists, the defense will usually lose.¹ Counsel needs to tell the client's life story and paint the picture of the events in her life that help to explain her behavior. Which of the following descriptions would be most persuasive to a listener, especially a juror? Which would make for a better start to an opening statement in sentencing?

Description #1

DSM-V diagnostic criteria: The client was exposed to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:

1. she directly experienced the traumatic event(s);
2. she witnessed, in person, the event(s) as it (they) occurred to others.²

OR

Description #2

"And then he turned on her. She couldn't recall the words. Perhaps at the time there had been no words, or she hadn't heard them, there was only the crack of the smashed bottle, like a pistol shot, the stink of whisky, a moment of searing pain which passed almost as soon as she felt it and the warm blood flowing from her cheek, dripping on the seat of the chair, her mother's anguished cry, "Oh God, look what you've done, Rhoda. The blood! They'll never take it back now. (a

new chair-delivered in the wrong color- bought for the abusive father). They'll never change it."³

Rhoda is the victim and she retained the scar that marred her beautiful face until the day she died. But in the eyes of her mother, who enables and covers for the father's violent assault, it is all Rhoda's fault. The picture painted by the author P.D. James is powerful and without reference to any dull diagnostic criteria. The more we try to relate the client's experiences to some plastic element of the DSM, less will be the impact on the listener.

The DSM and the Prosecution

The DSM is often used as a cook book that best fits the theory of the prosecution. A prosecutor might say, "These are the diagnostic criteria listed in the DSM-V, a/k/a 'the bible.' The defendant does not meet any of these criteria. If he appears to meet any of them, it is because he is 'faking good' or 'faking bad', i.e., he is malingering. One can never trust a malingerer. The only diagnostic criteria which he truly possesses are those that tell you he is a sociopath. Be afraid! Be very afraid! You cannot trust the defense. Their witnesses are all professional liars, whores and 'hired guns.' Believe what we tell you because we represent you, the people." Jurors will generally do what the prosecution wants them to do.⁴

Conclusion

The defense should not care what the condition is called or what label is given to a collection of terrifying experiences or a lifetime of trauma. We can get unnecessarily bogged down in the losing debate of whether the client suffers from PTSD, Complex PTSD, Type III PTSD or DESNOS (Disorders of Extreme Stress Not Otherwise Specified). Counsel should, at every opportunity, humanize the client and direct the team's focus toward who she is, why she is the way she is, why she did what she did and a reasonable and compassionate resolution of the charge(s) against her. We should tell the story of Rhoda who suffered trauma and humiliation at the hands of her pathetic parent. No label will change the picture of her pain.

¹ Sundby, Scott, E., *The Jury as Critic: An Empirical Look at How Capital Juries Perceive Expert and Lay Testimony*, Virginia Law Review, Vol. 83, No. 6, (Sep. 1997), pages 1109-1188.

² Post Traumatic Stress Disorder, Desk reference to the Diagnostic Criteria from DSM-V, 309.81 (F43.10) at p. 143.

³ James, P.D. *The Private Patient*, Vintage Books (2009) at p. 7.

⁴ Sundby, Scott W., *id.*



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