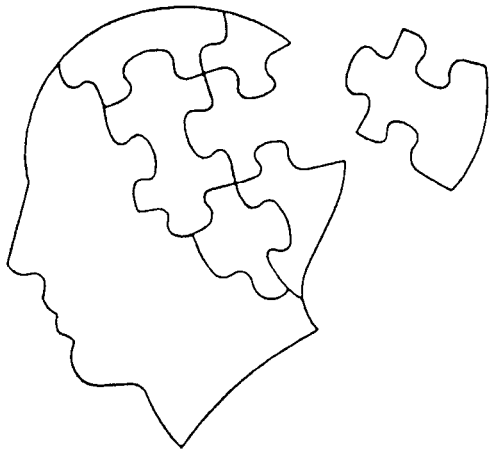
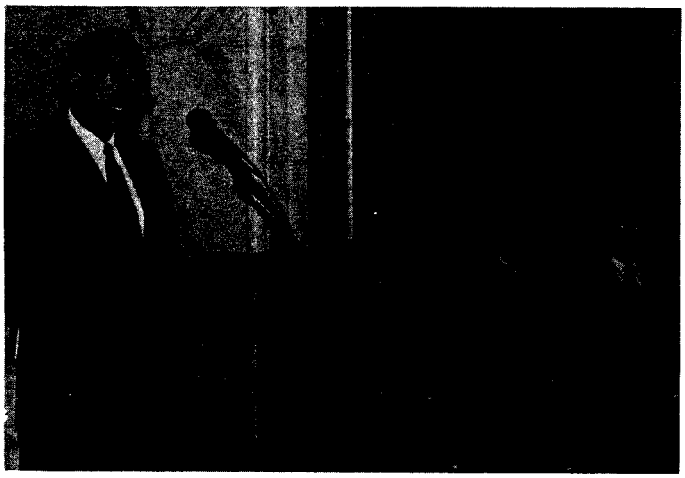
Kentucky Department of Public Advocacy

THE ADVOCATE

Journal of Criminal Justice Education & Research *Volume 18, No. 6, November 1996*

Social Histories Increase Reliability of Decisionmaking





Lewis Takes Over as Public Advocate

The Advocate

The Advocate provides education and research for persons serving indigent clients in order to improve client representation and insure fair process and reliable results for those whose life or liberty is at risk. *The Advocate* educates criminal justice professionals and the public on its work, its mission, and its values.

The Advocate is a bimonthly (January, March, May, July, September, November) publication of the Department of Public Advocacy, an independent agency within the Public Protection and Regulation Cabinet. Opinions expressed in articles are those of the authors and do not necessarily represent the views of DPA. *The Advocate* welcomes correspondence on subjects covered by it. If you have an article our readers will find of interest, type a short outline or general description and send it to the Editor.

Returning violence for violence multiples violence, adding deeper darkness to a night already devoid of stars. Darkness cannot drive out darkness; only light can do that. Hate cannot drive out hate; only love can do that.

- Martin Luther King, Jr.

FROM THE EDITOR

Mental Health Forum. Lexington's Robert Walker, MSW, LCSW presents a paridign shifting article on developing a social history of a client that revals comprehensive context for reliable decisionmaking. Increasingly, the standard of practice requires a thorough social history in the mental health evaluation process in the criminal justice system. Long ago John Blume observed as much in *The Advocate*. Experience verifies Blume's observations. Mr. Walker educates us on how to discover a client's context so decisionmakers have more confidence in their decision which involves a citizen's life or liberty. **EDITOR'S NOTE:** This article was commissioned by *The Advocate* to inform its readers of the standard of practice for social histories in capital cases where a defendant's life is at stake and where the constitutional focus is not only on the client's crime but also who the client is. It is likely that social histories of a lesser degree will increasingly be relevant in non-capital criminal cases where the mental state of the accused is informed by the context revealed by a social history. **Drs. Drogin and Barrett** look at the issues of using out-of-state experts.

Public Advocate Changes. As **Allison Connelly** concludes her 4 year term as leader of Kentucky's Indigent Defense System, **Ernie Lewis** begins to lead DPA. Thoughts from a variety of perspectives on our new Public Advocate are offered in this issue. We also briefly look at the Public Advocacy Commission, P & A, and Allison Connelly's accomplishments.

Criminal Rules Process. Supreme Court Justice **Joseph Lambert** describes the process the Court has set up to consider changes in the Kentucky Rules of Criminal Procedure.

Drugs. What are the side effects of taking drugs for treatment? **Helen Danser** from the Division of Mental Health tells us the side effects are often significant.

Funds for Statisticians. More and more criminal law cases evidence a need for the use of statisticians. While more common in the civil arena, there are criminal law areas that are informed by these experts. We look at how to obtain funds for them.

Edward C. Monahan, **Editor**

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Paid for by State Funds KRS 57.375 & donations.

IN THIS ISSUE

The absence of risk is a sure sign of mediocrity.

- Charles DeFoucauld

Chief Justice Administers Oath to Governor's Pick for Public Advocate

Erwin (Ernie) W. Lewis, 49, of Richmond took the oath of office October 14, 1996 in the Capitol Rotunda in Frankfort as the sixth Public Advocate for the Commonwealth of Kentucky.

Governor Paul Patton named Lewis to the post on September 17. Patton had stated that he wanted to find the best person for the job, and he was present and made remarks at the Rotunda ceremony.

The oath of office was administered by Chief Justice Robert F. Stephens in the Capitol Rotunda. Tony Wilhoit, Chief Justice of the Court of Appeals and first public defender in 1972, moderated the ceremony.

In the position of Public Advocate, Lewis will head the Department of Public Advocacy, (DPA), which is in charge of Kentucky's public defender efforts and also its protection and advocacy work on behalf of persons with developmental disabilities and the mentally ill. He serves a four-year term.

DPA, which is an independent agency within the Public Protection and Regulation Cabinet, headed by Secretary Laura M. Douglas, maintains law offices across the state. Douglas said of Lewis' appointment, "His mentoring to other attorneys and his career dedication to providing quality criminal defense to Kentucky's poor provides Lewis with the leadership and experience to serve in his new role."

DPA is responsible for delivery of public defender services in all of Kentucky's 120 counties, providing legal representation to over 100,000 persons annually.

Lewis is a 19-year veteran of Kentucky's public defender system, having worked as an appellate lawyer, regional trial manager, state-wide chief of trial services and, most currently, director of DPA's Richmond office which covers Madison, Clark, Jackson, and Rockcastle Counties. "We give you thanks this day for those whoever now seek to legislate for the common good and for those who seek to implement the law of the land without prejudice or partiality to the rich or to the poor or to the powerless or the powerful," prayed the Reverend Ron Renwick of Lexington's Second Presbyterian Church in opening the ceremony.

Ernie has practied for years before Judges Adams and Jennings. Circuit Judge William Jennings suported Lewis' appointment. "Those of you that are familiar with Ernie's background are not at all surprised today, I'm sure,

Chief Justice Robert F. Stephens swearing in Ernie Lewis for oath of office of Public Advocate with Ernie's wife, Christie, Ernie, and children, Benjamin and Rachel.

that he's here in this position. His deep sense of devotion to this cause, has keen intellect, as well as his work ethics has brought him here today," observed Jennings.

Circuit Judge Julia Hylton Adams told Governor Patton that he did great honor for the 25th Judicial Circuit in selecting our public advocate. "Ernie is recognized throughout the United States for his teaching skills and his willingess to share with young advocates the art and the passion for the law," noted Adams.

In reflecting on the remarks of Judges Adams and Jennings, Judge Tony Wilhoit told those present, one of the most significant things about this is the people who have taken Ernie's measure ever day, day in and day out, to say what they've said.

After the administration of the oath, Lewis remarked, "It's a great honor to receive the Governor's trust in this way. I've spent my life trying to achieve justice for all poor citizens accused of crimes and for all those facing legal problems because of disabilities or illness." He emphasized his vision of the right to counsel for Kentucky's poor. "The vision and the right to counsel is all too often unmet. But visions draw us away from the reality of what is to the reality of what could be. I will be drawn in the next four years by the vision of the right to counsel. I ask you to judge me by that vision. And hopefully within 4 years we will have moved just a little closer to justice rolling down like a mighty river, proclaimed.

Lewis is a 1969 graduate of Baylor University, who also holds a Master of Divinity degree in theology from Vanderbilt. He received his law degree in 1977 from Washington University in St. Louis.

Among the goals Lewis has projected for his tenure as Public Advocate is "educating the public on the proper and appropriate role of an independent public defender agency as an indispensable part of the criminal justice system."

Outgoing Public Advocate Allison Connelly observed, "Ernie Lewis has been a public defender for nearly 20 years. So, he has a firsthand knowledge of the many problems and challenges facing Kentucky's public defender system. Yet, he has no political agenda but to insure, in criminal cases, quality representation of all people who are too poor to hire a lawyer. His next four years will be difficult, but I have every faith he will succeed."

Louisville attorney Robert C. Ewald of *Wyatt, Tarrant & Combs* is chair of the Public Advocacy Commission, which oversees DPA, said of Lewis' appointment, "Ernie has earned great respect as a skilled criminal defense lawyer and proven administrator during his service with the Department. The Commission is confident he will be an outstanding Public Advocate."

Praise for the appointment has come from many other corners as well.

Addie Hailstorks, Director of the National Legal Aid and Defender Association's Defender Division, commented, "Ernie Lewis is a career public defender, who is recognized nationally for his dedication to achieving justice for a scorned population -- the criminally accused. His appointment to be Kentucky Public Advocate is a welcomed sign of no retreat in the delivery of high quality criminal defense services to the state's indigent accused and convicted."

KENTUCKY PUBLIC ADVOCATES

1) Anthony M. Wilhoit, 1972-1974
2) Jack E. Farley, March, 1975 - October 1, 1983
3) Paul F. Isaacs, October 1, 1983 - December 31, 1991
4) Judge Ray Corns, Acting, January 1, 1992 - June 16, 1992
5) Allison Connelly, July 2, 1992 - September 30, 1996
6) Erwin W. Lewis, October 1, 1996 -

According to Deryl Dantzler, Dean of the National Criminal Defense College in Macon, Georgia, said, "Ernie Lewis is an excellent lawyer, gifted teacher, and dedicated champion of justice. For 12 years, Dantzler has been dean of the college where Lewis has taught for the last decade.

Indianapolis attorney Rick Kammen, a longtime colleague of Lewis, observed, "He is one of the few lawyers who could adequately replace Allison Connelly as public advocate. He is a dedicated, thoughtful, and brilliant lawyer of national stature, and Kentuckians should be proud to have him as their public advocate."

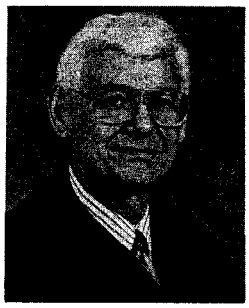
Jodie English of Richmond, Indiana, an NCDC faculty member who has taught with Ernie, said, "Three outstanding candidates were nominated, one of them the incumbent. The fact that the incumbent was not chosen will certainly not deter an attorney with the integrity of Ernie Lewis from the independence and zealous advocacy essential to do the job."

Norman Harned, President of the Kentucky Bar Association, observed, I know Ernie Lewis is dedicated to the principle of equal justice for all citizens and that he will continue the tradition of Allison Connelly and her predecesors. The public defender's office is in good hands and I'm confident that he will see the high standards that have been a tradition in the office continue.

DPA's general counsel, Vince Aprile, who has been with DPA for 23 years commented, "Ernie has the heart of a litigator and the soul of an advocate. He has dedicated his legal career to providing quality criminal defense representation to the poor, through his own stellar advocacy and through the leadership he has provided many other public defenders in the Department of Public Advocacy. He is will qualified and well prepared, by service and philosophy, to assume this new role."

Lewis is the sixth person to hold the position of Public Advocate. Others have been Anthony M. Wilhoit, Jack E. Farley, Paul F. Isaacs, Ray Corns, and Allison Connelly.

Kentucky Court of Appeals Judges Select Anthony Wilhoit of Versailles as New Chief



FRANKFORT - Anthony M. Wilhoit of Versailles is the new chief judge of the Kentucky Court of Appeals, replacing Charles Bruce Lester of Campbell County, who recently retired.

The chief judge is elected by other appellate judges and serves a four-year term. The judge is responsible for the appellate court's management and operation.

Wilhoit is a graduate of Thomas More College, the University of Kentucky College of Law and the University of Virginia School of Law. Before his appointment to the Court of Appeals in 1976, Wilhoit was the first state public defender and was deputy secretary for the state Department of Justice.

The Court of Appeals hears cases appealed from a lower court or an administrative agency. The record of the original trial is reviewed with attorneys presenting the legal issues to the court for a decision.

There are 14 judges on the Court of Appeals, two elected from each of the seven appellate districts in the state. The judges are divided into panels of three. They travel throughout the state to hear appeals. Their decisions may be appealed to the Kentucky Supreme Court.

Wilhoit represents the Fifth Appellate District, along with Judge Paul D. Gudgel of Lexington.

- Lexington *Herald-Leader*, July 4, 1996

Governor Patton's Remarks During Swearing In Ceremony of Public Advocate Lewis

Good afternoon - Chief Justice Stephens, Judges, Reverend Renwick, Ladies and Gentlemen.

It is a great pleasure to be here as we prepare to administer the oath of office to Ernie Lewis, Kentucky's 6th Public Advocate.

Our nation has long distinguished itself by its constitutional guarantee that each person will receive due due in criminal procedings.

The Kentucky Department of Public Advocacy has the responsibility to serve as legal counsel to poor Kentuckian's who are accused of or who have been convicted of a crime. Through this service, the Kentucky Department of Public Advocacy actualizes the due process guarantees of the Constitution.

Many judges, several of whom are here today, have fully supported Mr. Lewis' appointment. But for those of you who don't know Ernie Lewis - let me tell you a little bit about Kentucky's new Public Advocate.

Ernie Lewis is a twenty-year veteran of the defender system. He was the defense lawyer in several high-profile cases.

Ernie Lewis has first-hand knowledge of the many problems and challenges facing Kentucky's public defender system.

He is recognized nationally for his dedication to achieving justice for his clients.

Governor Patton during his remarks at the ceremony.

Ernie Lewis received high praise from his colleagues. He is described as *'an excellent lawyer, gifted teacher, and dedicated champion of justice'* by one. Another says of Lewis, *'Ernie has the heart of a litigator and the soul of an advocate'.*

Kentuckian's should be proud to have Ernie Lewis as their Public Advocate. He is an extremely capable litigator who is well qualified and well prepared, as displayed by his leadership and dedication, to assume his new role.

Today, I welcome Ernie Lewis as he takes the oath of office as Kentucky's 6th Public Advocate and I look forward to our working together.

SIXTH AMENDMENT, UNITED STATES CONSTITUTION (1791)

"In all criminal prosecutions, the accused shall enjoy the right...to have the assistance of counsel for his defense."

The Public Advocacy Commission

Robert C. Ewald, Commission Chair

The 12 person Commission consists of a representative from each of the law schools, and members recommended to the Governor by the Speaker of the House of Representatives, the President Pro Tem of the Senate, the KBA, and members appointed by the Kentucky Supreme Court and the Governor.

The Commission assists the Department in insuring its independence through public education about the purposes of the public advocacy system, and has budgetary and general supervision responsibilities.

Robert C. Ewald, *Wyatt, Tarrant & Combs*, is Commission Chair. Previous Commission chairs have been William R. Jones, Professor of Chase Law School and formerly its Dean; Anthony M. Wilhoit, Kentucky Court of Appeals Judge; Max Smith, Frankfort criminal defense attorney; and Paula M. Raines, Lexington attorney and psychologist.

Current members of the Commission are:

Robert W. Carran, Coxington, Kentucky
Susan Stokley-Clary, Frankfort, Kentucky
Robert C. Ewald, Louisville, Kentucky
Jean Gossick, Lexington, Kentucky
Margo Grubbs, Elsmere, Kentucky
Roberta M. Harding, Lexington, Kentucky
Donald K. Kazee, Highland Heights, KY
Barbara B. Lewis, Louisville, Kentucky
Currie Milliken, Bowling Green, Kentucky
Paul E. Porter, Louisville, Kentucky
Maria Ransdell, Lexington, Kentucky
John M. Rosenberg, Prestonsburg, Kentucky

DPA's Protection & Advocacy Division

In addition to public defender services, the Protection and Advocacy Division (P & A), an independent office which protects and advocates the rights of Kentuckians with developmental disabilities and mental illnesses, is located in the Department. The mission of Protection & Advocacy is:

The Protection and Advocacy Division protects and advocates the rights of Kentuckians with disabilities. P & A assists its clients in understanding options, expressing preferences, and ensuring these preferences are heard and acted upon. Through case direction from its clients, P & A represents its clients' expressed disability-related interest in community and institutional settings across the state.

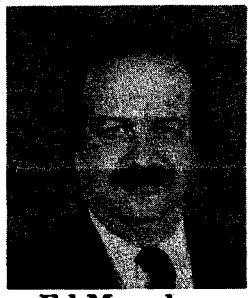
P & A's systems advocacy efforts are driven by the need to establish and expand rights and service options and to improve the quality and responsiveness of the existing system of services. Systems advocacy addresses policy issues which affect persons with disabilities within legislative and administrative forums. Issues identified in P & A client complaints form the basis for systems change initiatives. The P & A Advisory Board (DD) and P & A Mental Health Advisory Council provide guidance in identifying key systems change issues that will enhance independence, productivity, and integration into the community.

P & A aggressively opposes systems change efforts that could result in reduction of rights/ service options, discrimination, exploitation, or limit informed participation and consent of persons with disabilities in decision making forums.

P & A values Kentuckians with disabilities as full, equal citizens entitled to equal access to the same opportunities afforded to all Kentuckians. Kentuckians with disabilities are entitled to be free from abuse, neglect, exploitation, discrimination, isolation, and disenfranchisement and to be treated with respect and dignity.

P & A is completely independent of any agency or governmental entity providing treatment, services, or habilitation to persons with disabilities. P & A has federal and state standing to represent clients' disability-related complaints in and out of court. It is the policy of the agency to try to resolve complaints through informal and administrative means, using the courts as the last resort.

Monahan Named DPA Deputy



Ed Monahan

Ed Monahan, 45, of Lexington has been named by newly appointed Public Advocate Ernie Lewis as Deputy Public Advocate. In appointing Monahan, Public Advocate Lewis stated, "Ed Monahan has been for 19 years a trusted advisor, a valued colleague, and a wonderful friend. He is nationally recognized as one of the nation's best attorney trainers. His creativity is legendary. His advice is ethically based and honest. I look forward to having him serve in this capacity over the next four years."

In the position of Deputy Public Advocate, Monahan will be in charge of education and development, strategic planning, public information, editing of *The Advocate*, rules and legislation, and other special projects.

Monahan is a 20 year veteran of Kentucky's public defender system, having worked as an appellate lawyer, chief of trial services, and most currently, director of education and development. Since 1976 Monahan has represented 11 capital clients at trial and appeal.

Upon being named Deputy, Monahan said, "I have worked to serve indigent criminal defendants with a special focus on trying to improve representation across Kentucky through education, planning and bringing the best national public defender thinking to Kentucky. I am eager to work with Ernie to lead Kentucky's public defender system to insure fair and reliable results for the accused. It is a personal and professional privilege to work with Ernie who for 19 years has been bringing about the vision of the right to counsel for Kentucky's poor."

A native of Ludlow, Kentucky, Monahan is a 1973 graduate of Northern Kentucky's Thomas More College, and a 1976 graduate of The Columbus School of Law of Washington, D.C.'s Catholic University of America.

Monahan has been a part of educating public defender managers across the country though the National Legal Aid and Defender's (NLADA) Defender Management Training Conferences in Albuquerque, Philadelphia, Chicago, San Diego, New Orleans, Baltimore and at NLADA's Annual Conference in Pittsburgh, Toronto, Canada, San Francisco and Kansas City. He has also taught defender management for public defenders in Missouri, New Mexico and Tennessee.

Addie Hailstorks, Director of the National Legal Aid and Defender Association's Defender Division commented, "The Kentucky DPA could not have selected a better person for this critical position. Ed Monahan has been a stalwart promoter of quality education and development for public defenders nationwide. NLADA owes much to Mr. Monahan for his wisdom and guidance throughout the development of our national programs. The appointment of Mr. Monahan is commendable and reflects a strong and continuous commitment to quality legal representation for Kentucky's indigent population accused of crime."

Monahan will be working with Public Advocate Lewis in collaborating with DPA managers to improve the coaching, mentoring, and leading at DPA. "In these challenging times, our clients and employees deserve no less than the very best leadership," according to Monahan.

Monahan is the third person to hold the position of Deputy Public Advocate. David Murrell, now a Louisville attorney, and William C. Ayer, now an Assistant Commonwealth Attorney in Frankfort served during Public Advocate Jack Emory Farley's eight year tenure.

SUPREME COURT OF KENTUCKY

Back Row (left to right): Justice Joseph Lambert, Justice Nicholas N. King, Justice Walter A. Baker, Justice Donald C. Wintersheimer; *Front Row (left to right):* Justice J. William Graves, Chief Justice Robert F. Stephens, Justice Janet L. Stumbo

Connelly Ends Advocate Term

Allison Connelly

Public Advocate Allison Connelly's four year term ended September 30, 1996. Connelly continues her career defender service as Directing Attorney for DPA's Stanton Office, replacing Bill Spicer who transferred to DPA's Covington Office. As head of Stanton, Connelly will be directing the defender efforts in Powell, Wolfe, Estill, Owsley, Lee and Breathitt Counties.

During her four years as Kentucky's chief defender, Connelly brought about many advances, including increased funding for the contract and full-time systems, and taking DPA out of its deficit status. The new funding provided, among other things, 10 additional attorneys for the Jefferson County Public Defender program, and two additional attorneys for Fayette County Legal Aid Office. Connelly brought about substantially increased recoupment from clients.

One of the major undertakings during her tenure was the Governor's Task Force on the Delivery and Funding of Public Defender Services. Through the work of the Task Force, Connelly shepherded successful passage of legislation which created additional funding through two new fees, a $50 DUI fee and a $40 client administrative fee. These funds were critical since general fund allocations from the General Assembly remained flat. KRS 31.185 and 31.200 were amended to create an expert witness fund across Kentucky, a sorely needed permanent resource. Full-time offices were opened in Covington (trial) and Madisonville (trial & post-conviction), and a regional defender office was established in Elizabethtown. At the end of her term, public defender services were provided through contracts in 73 counties and through full-time defenders in 47 counties. Maximum bills for capital cases contracted out of DPA due to conflicts rose from $2,500 to $5,000 per attorney per case. DPA's capital trial unit increased in size to meet DPA's statewide capital trial needs.

Performance standards for contract appellate attorneys were instituted. To save money, DPA downsized its lean management under Connelly.

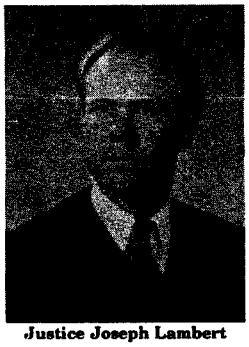
The screening process to determine eligibility for defender representation was improved due to the work of the Task Force and Connelly by requiring under KRS 31.120(2) the pretrial release officer to obtain an affidavit of indigency.

Connelly's overriding theme of her term was equal justice. She was the first woman to head Kentucky's statewide public defender program.

"There can be no equal justice where the kind of a trial a man gets depends on the amount of money he has."

- Hugo Black, Justice of the United States Supreme Court
Griffin v. Illinois, 351 U.S. 12, 19 (1956).

A Brief Overview of the Criminal Rules Committee Process



Justice Joseph Lambert

In Section 116 of the Constitution of Kentucky, the Supreme Court is granted "power to prescribe...rules of practice and procedure for the Court of Justice." To assure the orderly and thorough consideration of proposed amendments to the Rules of Criminal Procedure, the Supreme Court maintains a standing committee on criminal rules. Traditionally, membership consists of attorneys from the criminal defense bar and from the prosecution, from both rural and urban areas, and usually includes one or more judges. The Chief Justice appoints a Justice of the Supreme Court to serve as Chairperson for a term of two to four years. The Chairperson has broad discretion in appointing Committee members.

A rules cycle begins in the fall of each year and the Committee receives proposals until the end of January or perhaps a little thereafter. All proposals must be in the form of a rule with new material underlined and language to be stricken placed in brackets. The proposed rule should be accompanied by a letter explaining the reason for and benefit of the change. The proposal and accompanying material should be sent to the Chairperson who will then provide each member of the Committee with copies of all documents. After receiving the proposals, the Committee meets on one or more occasions and after thorough discussion, votes to recommend adoption, amendment or rejection. In this process, the Committee considers the impact of each proposal upon the practice of law and the administration of justice and furnishes its recommendations with arguments pro and con to the Supreme Court for its consideration. Prior to the *Bench and Bar* publication deadline, the Supreme Court reviews each proposal from the Committee so determine if any should be eliminated at that time In general, rules proposals which are favorably recommended by the Criminal Rules Committee are sent forward by the Court for further consideration which includes publication in the Spring issue of the *Bench and Bar* and consideration at the rules hearing held in conjunction with the annual KBA convention.

The rules hearing which is held immediately prior to the convention is presided over by the entire Supreme Court. Members of the Bar and laypersons are invited to orally address the Court in support of or opposition to any proposed rules amendment. The purpose of this hearing is to provide interested persons with an opportunity to orally inform the Court of their views and to give the Court an opportunity to ask questions and, in general, give thorough consideration to the views which may be expressed. After the rules hearing, written comments are solicited from those wishing to be heard funkier and such written comments as may be received are duplicated and furnished to each member of the Supreme Court prior to final consideration.

In the early fall, September or October, the Court votes finally as to adoption or rejection of rules proposals and thereafter the cycle begins again.

At present the Court is considering modification of the rules committee process into a two-year cycle In recent years, a number of rules proposals which are substantially the same are made each year and it has begun to appear that the time of Committee members and the Court is not being used wisely.

Currently serving members of the Criminal Rules Committee are Judge Bill Cunningham of the 56th Judicial Circuit, Eddyville; Karen Greene Blondell, Commonwealth's Attorney, Middlesboro; Ray Larson, Commonwealth's Attorney, Lexington; William E. Johnson, Frankfort; Frank W. Heft, Jr., Public Defender, Louisville; David A Sexton, Deputy Attorney General, Frankfort; Jerry J. Cox, Mt. Vernon; and Chairman Joseph E. Lambert, Justice, Supreme Court of Kentucky, P.O. Box 989, Mt. Vernon, Kentucky 40456.

Fundamentals of Biopsychosocial Evaluation in Forensic Cases©

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 preceed 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 mental 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. This comprehensive quality accounts for the increasing importance of these evaluations in criminal proceedings.

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. In fact, the objectives and methods of the treatment plan should arise directly from the findings of the biopsychosocial assessment. In clinical situations, the biopsychosocial is but a tool to support the treatment process; its only readers should be other clinicians and its contents should be understood solely in the context of treatment processes. Nonclinical uses of clinical information, however, appear to be on the increase. Disability claims and insurance claims call for the release of medical records and numerous other legal and quasi-legal proceedings drag clinical records into their processes. Furthermore, clinicians from all mental health disciplines find themselves drawn into courtroom proceedings to render opinions about their clients based on what has been learned during treatment episodes. What one learns in the context of treatment is likely to be very different from what is learned in forensic processes. The translation from therapist-helper to courtroom player creates considerable ethical quandary for the conscientious clinician. There is perhaps wisdom in keeping the two realms distinct rather than allowing them to be blended into one all-embracing role for the clinician.

The use of a clinical document for other than clinical purposes is generally a misuse of the information. Little can be done, however, to remedy the steady hemorrhaging of private information into public arenas. One of the more troubling areas where this is occurring is in criminal justice processes. A document that was written expressly to guide a clinician in a treatment approach becomes a segment of evidence - an "expert's" view of an individual. An expert's view is likely to have the aroma of "truth" about it, and perhaps this is why there is the desire to bring mental health experts to testify about defendants in criminal trials. With this in mind, the clinician (particularly those who have rendered treatment to the defendant) will need to exercise restraint in evaluative reports in order to avoid misrepresentation of defendant accounts and professional opinions *as facts*. Clinical records often do not make this distinction clear and client reports or professional inferences can appear as "facts." 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 mental 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. Nonmedical mental health professionals might feel intimidated by psychiatric presence in criminal proceedings. 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 will 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 Forensic Perspective

The term *forensic* is used throughout this paper as if it were a unitary notion. It is not; it covers a waterfront of legal and quasi-legal proceedings in criminal and civil areas and there are considerable differences in the form and content of forensic evaluations in these different environments. This discussion focuses on the criminal arena within which there are three distinctly different forensic perspectives that condition the nature and methods of the evaluation. This perspective arises out of the legal context of the assessment. The three contexts include: 1) defense, 2) prosecution and 3) friend of the court.

As the reader reviews the purposes of the forensic biopsychosocial below, attention should be paid to the particular stance of the evaluation and the degree to which the purpose is conditioned to meet the needs of the context. For example, the defense posture generally calls for more attention to the *individual and complicating* features - the mitigating and aggravating circumstances of the case. A prosecution perspective, on the other hand, will bundle the pathological descriptors that convey the degree to which the defendant is *different from others and is incapable of reform*. The friend of the court position most nearly approximates the clinical perspective in that it appears to be more "objective" (an illusion) by not taking an adversarial role as the others do although the "friend" is often drawn into the adversarial process upon rendering an opinion. The "default" perspective used throughout this paper is the defense role, but the reader should be alert to the different possibilities as each topic area is covered.

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. The professional understands the structure of the information and has little difficulty moving from one domain of information to another. There is a *conceptual order* to the clinical document that follows agreed upon formats for describing the client's 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*. The narrative context does not mean that the evaluation must be written in a strictly historical way, but that the fundamental narrative structure of the individual's life is represented at some point in the report. The narrative can be part of the summary of findings, where the clinician gives a meaningful view of the individual or it can be the introduction of the evaluation. The clinician who wishes to make a rhetorical point of the testimony will give the narrative both at the beginning of her or his testimony as well as later on. At a minimum, the clinician should use narrative to capture the presenting situation for the evaluation - namely, the events leading up to and including the crime.

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 and aggravating circumstances that can influence the court's understanding of the crime. From a prosecution perspective, the pathology will be stated in conclusive and absolute terms so as to portray the depth of disorder present in the defendant.

2) **Plausible Portrait:** The prosecution's presentation of facts in a criminal proceeding is designed to show the *differentness* of the defendant. 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 the approach is to convince the juror of the "otherness" of the criminal, the demonic quality; it is designed to destroy empathic feelings, for if one can *identify with the criminal*, then punishment becomes harder to decide. Prosecution wants to reduce the defendant to an abstraction or a "thing" that is distinctly different from the juror. 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. Juries have difficulty with portrayals that exaggerate the victimhood of the defendant. What is more compelling is a realistic portrait of the individual as someone with whom one can identify; it must be a *plausible* person - neither too demonic nor too helpless.

The applied behavioral sciences have tended to move away from the study of intentionality. Most clinical discussions of a client's behavior will focus on the various biochemical, social/ environmental and developmental influences that can account for the client's actions. Intentionality is generally not a concern except with those individuals who are seen as being personality disordered. In these cases, the clinicians attribute most of the origin of problems to the intentional set of the individual. Criminal justice, however, places a high degree of importance on intentionality since it is a formative ingredient in determining the criminality of the defendant's actions. 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. This is not an easy task, since the evaluator might not have a good feel for the substance of the individual's environment and culture. If the evaluation does not capture this quality of the individual, it will have missed a salient feature that is essential for the juror to understand. 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. The prosecution stance will lead the evaluation to portray the environment as either one that afforded as many positive as negative choices or it will feign concurrence with the defense and portray it as a hopeless mixture of two totally destructive forces - the self and its chosen world.

4) **Rehabilitation Potential:** The evaluation should describe the individual's strengths or redeeming features that point toward 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 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 a 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:** It is good to know for whom one works. Communication in the court system is at times sluggish, but it is generally awesomely "correct." The evaluator should be crystal clear about who is requesting the assessment and the exact uses that are envisioned for the report. Generally, it is a defense attorney requesting the evaluation, but in cases where the court is requesting it, the evaluator should make certain to get a court order. The evaluator should have a clear understanding with the

6 ELEMENTS OF THE EVALUATION PROCESS

1. Numerous Interviews of Client;
2. Collateral Interviews of Family, Significant Other Persons;
3. Review of Records;
4. Taking of Life and Health History, and Doing a Mental Status Exam;
5. Review of Reports of Other Professional Opinions of the Client;
6. Application of Research Data.

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 meretriciousness. The evaluator should assess the attorney's strategy to determine his or her degree of accord with it in ethical terms. 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 the 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 with all signatures witnessed.

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 disorder and any and all outpatient records. Criminal records, evidence of placement in group homes, fostercare 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. These collateral contacts also help in gaining information about the individual's current family and social relationships. When the case involves spousal homicide, the collateral interviews are essential as they can establish the vital context within which the crime was committed and can ramify the personal qualities of the defendant in ways that can be very helpful.

   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 fully in the balance of this paper.

   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 voguish "disorders" in popular books. Theory has sometimes been helpful in welding together the many disparate pieces of information about a defendant's mental or emotional condition, but in the harsh cross examination environment of today, empirical findings will be far more potent.

The Biopsychosocial Format and Content

I. 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.

> *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 1995, 3 December and 9 December 1995."

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. Has the individual been as completely forthcoming as she or he would be in the outpatient world? The answer can be both "yes" and "no." The desire to tell someone something that might lead to freedom is very powerful and can produce distortion. Likewise, the lack of authentic privacy can inhibit full disclosure of matters that the individual thinks might result in either other charges or complications to the case. It is often difficult to ensure even a boundaried 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 Lousville, 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 sentencing options. The presenting circumstance provides clear guidance for the kind of exploration that the clinician should undertake. The first of these focuses more on the individual's moral and cognitive capacities where the second focuses more on rehabilitation capacities. With the first of these presenting situations, the clinician might use two major components: 1) the defendant's view of the circumstances before and after the period of the crime, and 2) a summary of "objective" reports from the police or victims.

1. The clinician should elicit the individual's understanding of the circumstances of the referral and the reason for the evaluation. Secondly, the clinician should have the individual describe the circumstances of the crime as a way of gaining his or her understanding of the events and the "frame" that the individual is putting on the exper-

ience. 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. Reports of severe distortions of power and control are among the more meaningful elements that the clinician should pay heed to. The assessment of the individual's cognitive capacities must be integrated into the dimension of guilt ascertainment.

2. 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. This is a two-edged sword, however, and must be displayed with caution as the genetic influences can easily be characterized as "wired in" and can be used to rationalize either death or long terms of incarceration since the prospects for change are seen as small. Organically determined disorder has the advantage of being seen as outside the scope of individual intentionality and thus it offers substantial mitigative strength, but caution is advised in cases where there might be a tendency to view the individual as beyond rehabilitation.

The genogram offers the clinician a 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.

In order to construct the genogram in a convincing and competent manner, the clinician must have a thorough command of those disorders that show high comorbidity coefficients and a high degree of intergenerational transmission. The tracing of single disorders will catch but a small part of the genetic pattern while sensitivity to comorbidites will identify the full array of potential limitations with which the individual was struggling. The clinician must also be alert to comorbidities that do not share obvious genetic or biological commonalties such as the co-occurrence of schizophrenia and PTSD. Clinical wisdom tends to look down the most traveled pathways; but forensic process often calls for innovative examination of less frequented associations.

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 with Post-Traumatic Stress Disorder than to damage to the formation of self. The individual who was exposed to sexual abuse in childhood carries a hightened 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.

The high degree of acceptance of sexual abuse as a factor in psychopathology has perhaps led to too simplistic a use of it in understanding the evolution of self and symptom. Too often, one discovers a history that describes an individual as having been "sexually abused" with little or no specificity. The forensic evaluation that rests on this kind of simplification will probably be unconstructive. Physical and sexual abuse need to escape their labels. The biopsychosocial should define the specific actions that were perpetrated on the individual and might even avoid the *de rigueur* label since the overuse of the term might even prove counterproductive to the purposes of the evaluation.

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) that direct and retrieve memories. 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 combinatory 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 probable 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 child-

hood. 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. It is probable that the individual's account of these foster placements is distorted, but whether true or not, these accounts represent the individual's perspective on this period of life. The unsettled nature of fostercare can have untoward effects even when the foster parents have been helpful.

With all of these history events, it is critical that the evaluation read "the client reports a history of this event at age X" rather than "at age X, the client experienced this event". The first version records the phenomenological where the second suggests fact. With all history issues, the report should consistently make a distinction between what is known versus what is reported by the individual. This is critical to the science of the matter, the ethics of proper evaluation and the verification of the evaluator's objectivity.

As mentioned earlier in this article, the clinician should use great care in delineating the abuse history. A too morbid picture can easily lead to a juror's conclusion that the individual is hopelessly damaged and beyond rehabilitation. The attempt at portrayal of profound victimization can backfire into a depiction of pathology with which the juror cannot identify and toward which there is only a feeling of fear. Should the clinical portrait create a feeling of fear in the juror, then the aims of the defense will not be met while those of the prosecution will be.

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.

Example: "Could you describe for me what it was like in your family when you were in grade school? And what about before that? Do your brothers/sisters see it the same way? How do you think they would describe your family at that time? What was the hardest thing to deal with? What were the best things about your family? When you were a child, to whom did you feel closest? Why? How did you react to what was happening when X happened to you? How did your brothers/sisters react when these things happened? If I were interviewing your mother/father, what would they say about you at that time? How would they describe you?"

When seeking additional information about the sequence of events, ask, "And then what happened?" instead of more close-ended (but seemingly obvious) questions like "And did he do this to you many times or only the one time?" The more indeterminate the question, the greater the opportunity for the individual to give authentic responses. Obviously, there are times when the clinician must hone in and probe for specifics through more determinate questioning, but as a general rule, the less restricted mode is recommended. (Another exception to this lies in the use of presumptive questioning which is described below.)

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 of 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 fac-

tors (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. There is no certain relationship between the maternal use of these substances and impaired outcomes for the child, however, and clinical inferences from these data should be treated carefully. Again, as with abuse histories, a conclusive portrayal of severe neurocognitive harm caused by maternal drug use during pregnancy can lead to a juror's belief that the individual is incapable of change or rehabilitation.

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 its immaleability in adulthood. There should be inquiry into symptoms of early childhood disorders such as enuresis,

SOCIAL HISTORIES: CONTEXT AND EXPLANATIONS, NOT EXCUSES

It is important to emphasize that mitigating evidence -including what I will say about the structure of capital defendants' lives and the nature of their social histories - is *not* intended to excuse, justify, or diminish the significance of what they have done, but to help explain it, and explain it in a way that has some relevance to the decision capital jurors must make about sentencing. Thus, nothing that I will say in the following pages is intended to in any way diminish or otherwise lose sight of the significance and human tragedy of capital violence. Quite the contrary, I do not believe we pay fitting tribute to the victims of these crimes by continuing to ignore their causes. Only if we look honestly at the lives of those who commit capital crimes - and cease to be blinded by the fictionalized, demonized caricatures the media feeds us - can we learn the lessons by which future victims can be spared.

Social histories, in this context, then, are not excuses, they are explanations... But no jury can render justice in the absence of an explanation. In each case, the goal is to place the defendant's life in a larger social context and, in the final analysis, to reach conclusions about how someone who has had certain life experiences, been treated in particular ways, and experienced certain kinds of psychologically-important events has been shaped and influenced by them.

- Craig Haney, *The Social Context of Capital Murder: Social Histories and the Logic of Mitigation*, 35 Santa Clara Law Review 547, 560 (1995)

phobias, sleep problems, and communication 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, forms 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. These "nonpsychological" factors sometimes seem less appealing than the more dramatic events of a defendant's presentation, but they call for close attention, particularly when the clinician begins assessing for cognitive functioning. It is useful to note whether there were close attachments to any parent or adults during this period of development. 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 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 psychosocial 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 incapabilities, 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.

With adolescence, the pleasure centers of the brain begin to turn on and the individual is challenged to master these elemental drives. It is very informative to approach this period of development with attention to the individual's ability to inhibit the native impulses that are emerging. There are several factors that can assist the individual in doing this: cognitive processes (including internalized rules and mores), social constraints and parental supervision. Typically, among disturbed or antisocial populations, there are deficits in most of these three areas. They 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.

Procedural tips:

Presumptive questioning can be very useful when the clinician suspects denial or overendorsement of certain topic areas. The pre-

sumptive way of inquiring into drug taking behavior begins with questions like these: "What is the earliest time you remember using marijuana? Who first exposed you to marijuana [alcohol, etc.]? When you were first getting into drugs, which one seemed to have the greatest effect on you? What usually happened when you got high? Who were you usually with?"

This same style of questioning can be useful with aggression and sexual behaviors as well. For aggression, it follows this line of inquiry: "When you were really young - say, 5, 6 or 7, what kind of fights did you get into? Did anyone get hurt? How so? What was the earliest time that you can remember using a weapon in a fight? What happened? Who got hurt?" For sexual events, it follows this line: "What is the earliest time you can remember of any sexual contact? Who was with you? What happened? What about other times after this? For how long did this continue?"

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 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. This commonly held belief must be revised when working with forensic populations in general and domestic violence cases in particular. The argument for mutuality of partner choice might have validity in middle class and nondisturbed groups of people. Furthermore, it might have meaning with males, who still today remain the seekers of partners, but it has little validity with females - particularly in lower socioeconomic groups who largely *agree* to relationships rather than actively choosing them. This might be an offensive notion to those who have sought increased independence of women in the past three decades, but the sad reality is that men still dominate the partner selection processes - *particularly in lower socioeconomic sectors of society*. The significance of this idea cannot be underestimated when domestic violence is a feature of the relationship. 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 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. A recent graduate male MBA might earn more than an equal female MBA, but the difference is not likely to be as great as that between a minimum wage female and a male who is a skilled or semi-skilled laborer. The male wage is likely to be three to four times hers. Her mate selection is far from free in the sense that we usually like to think of it.

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 toward domination of partners. Why would it not influence mate selection?

With the whole notion of mate selection, the clinician is cautioned to exercise care with the use of assortive mating assumptions. The literature on assortive mating is lengthy, but still heavily imbued with theory that is inspecific about the selection variables that might lead to mate choices. Mate choices should be examined in light of real economic and cultural factors, not merely psychological or romantic ones.

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.

Procedural tips:
The ascertainment of power and control is at times difficult. Rather than pursuing direct frontal questioning about this, the clinician might make use of some simple devices that give data from which inferences can be made. For example, one might inquire about who writes checks, who reconciles accounts, who "manages" the cash. Inquire about how decisions are made when an appliance breaks down, who decides about repair versus replacement, who makes the choice about replacement equipment. Who is responsible for the details of daily living in the home - cooking, cleaning, dishes, child care and what division of labor exists here? Once the clinician has information about the handling of money and daily tasks, one has a relatively clear picture of the distribution of power and control. The response to concrete questions is generally more productive than the more abstract questions about roles in the relationship.

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 the individual appears engaged with his or her partner and 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.

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?"

The clinician will need to form an impression of the communication styles of the defendant and his or her partners. This is perhaps more art than science, but an effort should be made to get a picture of the ways in which the couple communicate about positive as well as negative matters.

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 dependency. 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) Lifestyle or creation: 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 or adults with disabilities. If there are caregiver duties, what financial support helps the individual with this? Are there social security benefits involved? Has the individual been a responsible custodian of the resources for the disabled person or is there evidence of diversion for the individual's own benefit? Are there incidents of abuse of the dependent person? If so, how were these resolved?

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. This is particularly true for alcohol where studies have shown that early use in males is correlated with paternal use and antisocial traits. These patterns require close assessment because the conclusions and opinions that result can be of such consequence to the individual.

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. When the individual gives evidence of IV drug use, the risk potential for HIV infection should be considered as very high. This item should also be addressed when the defendant's overall risk status is evaluated.

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 or 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 educational performance. While clinicians are often reluctant to explore the issue of low intellectual functioning because of the potential for damaging labeling, it is nonetheless, a critical issue in forensic evaluations and should be addressed directly. It relates to the cultural and familial issues in that severe neglect in early childhood can have disastrous results on the development of intellectual ability and, where formal intellectual assessment instruments have been used, inferences about environmental factors might be constructive when there is evidence that habilitative services might exact some degree of growth. Problem solving capability is a critical ingredient to rehabilitation potential and this function is directly related to intellectual ability.

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 educational 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 from the time of the commission of the crime to the present. 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. The clinician should evaluate the impact of the home and community on the emotional state of the residents. If the defendant is currently housed in a correctional facility, this should be noted along with the stressors that accompany such a setting.

CAPITAL BIOPSYCHOSOCIAL HISTORIES REQUIRE TIME AND EXPERTISE

Life history investigations [in capital cases] require between 200-500 hours of intensive work depending on the complexity of the case, accessibility of lay witnesses and records, and the extent of mental impairment of the client and lay witnesses. Some of the factors which come to bear on the length of time necessary to prepare a life history adequately include: the need to develop client and lay witness trust; the need to overcome the reticence of witnesses because of the sensitive nature of the information sought; the need to triangulate data to ensure reliability; the time required to locate and retrieve records and to locate and interview witnesses; the impairments of both clients and lay witnesses; the need to investigate at least three generations within the client's family; and the need to integrate massive amounts of data into a concise and understandable form.

- Lee Norton, Ph.D., *Capital Cases: Mitigation Investigation*, The Champion, Vol. 16, No. 4 (May 1992) at 45.

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. If the individual has credit cards, the clinician should inquire about the amount of debt on them. 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. In assessing expenses it is important to identify rent-to-own charges. Poor people frequently fall prey to these methods of purchase and can incur substantial 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 paravocational 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 had 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 toward 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.

The risk assessment should cover both the period proximate to the commission of the crime and the present as this can help in defining the total context of the signal event. Typically, even "high risk" individuals show marked fluctuation of risk status and it is useful to describe these features accurately.

The assessment of risk in forensic populations is a challenge since, almost by definition, these individuals are in the highest risk categories. The task of the clinician is to separate out the cultural, psychopathological (in the sense of true mental disorder), environmental, and personality factors. 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 indvidual. 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. To take seriously, however, does not mean that all threats or suicidal statements must lead to rescues and hospitalization. The burden placed on the clinician is to wade through the defendant's statements and arrive at reasonable safeguards that can diminish risk in the short run. *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 others 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.

There are three major components to the assessment of suicide: A) the predisposing factors, B) ideational patterns, and C) the actuality of the plan.

A. ***Predisposing factors:*** Suicidology literature identifies numerous disorders as being risk factors for suicide. Among these are: depression, alcoholism, drug dependence, personality disorder (particularly borderline and antisocial types), schizophrenia, familial history of suicide, impulsivity, chronic and disabling or terminal disease, history of severe childhood physical and/or sexual abuse, and recent severe personal losses (by divorce or death). The presence of any one or more of these disorders simply means that the individual's risk for suicide is increased. almost by definition, forensic cases will involve these disorders. As a general rule, the greater the degree of psychopathology, the greater the risk for suicidal lethality.

The history of abuse has complex associations with suicidality and should be assessed very carefully. With childhood sexual abuse self mutilation is a likely adult symptom and the individual might represent his or her acts as suicidal in nature. Close investigation will generally show that the mutilative act, however, has very different dynamics from suicidal gestures or attempts. The dissociative processes involved with mutilation are generally referred to as *parasuicidal* thoughts and behaviors. The clinician should take steps to evaluate whether the defendant shows a pattern of self mutilation or suicidality or both.

B. ***Suicidal ideation:*** There are distinct thought patterns associated with suicidality. These include both declarative statements of intent and automatic thought processes that form a template of negative beliefs in the individual. The clinician should examine both domains of thinking. The degree of lethality is associated with two factors: a) the degree of expressed intent and b) the degree of hopelessness. Research points particularly to the second of the two as being an important indicator of lethality. When the individual has a belief that under no circumstances can he or she be better off, then risk is high. The assessment of thinking can be guided by reviewing Beck's triad of thinking about self, world and future. The ideas associated with the future are the ones that cue the clinician about the degree of hopelessness. Expressed intent is also important and should be assessed by inquiring into the rationale and the individual's ideas of what he or she envisions happening after the act. Essentially, the clinician is looking for what the individual sees as the goal or outcome of the act. This can elicit the manipulative agenda that always needs assessing in the forensic suicidal situation.

C. ***Actuality of the plan:*** Expressed intent and rationale for the intent is important, but the clinician should also inquire about method of suicide. There are two ingredients to this: a) the degree of specificity and detail associated with the plan and b) the feasibility of the plan. The individual who has a high degree of detail in the plan, who knows, for instance how much Valium or Elavil is necessary to cause death, and who has the medicine, is at high risk. The individual who has but vague ideas about method and who has few means to obtain the methods for suicide is at lower risk.

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 assesses 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 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.

Nothing in the forensic evaluative situation obviates the duties to warn and protect intended victims of threatened harm. Likewise, should the clinician discover abuse, neglect or exploitation of a child or a dependent adult as defined by statute, there is nothing about the forensic situation that overrides a duty to report.

There are five dimensions of the assessment of violence or aggression: A) the biological and genetic influences, B) the early childhood exposure to violence either as a witness or victim, C) the developmental pattern of violence in the individual, D) the thought processes associated with violent behavior and E) the outcomes and consequences 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. This has also been demonstrated with a particular type of alcoholism that is associated with antisocial behavior. Where there is a family history of violence, alcoholism associated with antisocial traits, learning disability, ADHD, closed head injury or other trauma to the brain, and B cluster personality disorder, there is an increased likelihood of biogenetic predisposition toward aggressive styles of behavior. 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. The clinician might eschew much inquiry in this area because of dubious reliability of information and the lack of neurological expertise. While there are definite limits on the scope of this area of inquiry, the clinician should still take as detailed a history of potential head trauma as possible. This can be done by inquiring into bike accidents, automobile accidents, injuries from fights, drug overdoses re-

sulting in loss of consciousness, alcoholic blackouts, arrest related head injuries, falls, swimming or diving accidents, inhalant abuse, and childhood physical abuse by a parent or caregiver. Mental retardation in combination with any of the above predisposing factors becomes yet another multiplier in the equation. In the mental status examination, the clinician will assess cognitive functioning in more detail. This information should obviously be correlated with the history of head trauma to form a thorough risk assessment of the individual.

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. The victimization can increase the risk that an adult will be violent. Again, as a general rule, the degree of physical violence experienced by the child *either as a victim or as a witness* tends to correlate with the degree of violence expressed by the adult. Brutalization seems to be an inculcated trait. Clearly, the combination of genetic predisposition with childhood exposure to violence is an indicator of very high risk for adult violent 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:*** The clinician should, as mentioned above, use presumptive questioning to obtain a picture of early childhood violent acts committed by the individual. This history 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. Domestic violence victims, for instance, might find their own violent acts to be out of keeping with their view of themselves. This dissonance can be very important in forming an impression of lethality. In general, the degree to which violence is integrated into the view of self is correlated with the degree to which 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 the outcomes were. This refers to the actual harm done to others. Defendants can be forthcoming about fights they have had in the past, but generally need more probative questioning about the degree of harm or injury they have caused. Obviously, there is substantial difference between an individual who has been in several fights and who has bruised his victims, versus the one who has put three people in a hospital. 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.

Procedural tips:

Since the individual is likely to be defensive about harm caused to others, the clinician is advised to put questions in a more "objective" rather than personal frame. For example, one might ask, "When these fights occurred, who got hurt?" "What happened after the knife appeared?" "Where did the bullet go in?" "After the fight was over, what did you discover had happened?" These questions offer a slight deflection away from what might seem overly personal accusations and give the defendant a way to answer without seeming to agree with them.

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 ex-

perienced 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 unless they have made arrangements that protect their safety and security. When the defendant is a domestic violence victim who has then killed an abusive spouse, the individual's risk for harm from the husband's family should be assessed. As a general rule, the greater the history of abuse victimization, the greater the risk for future harm as well. This has been noted even with a history of sexual abuse. Rape victims, for instance, have a higher reported rate of previous sexual assault or abuse than do women who have not been raped. Survival patterns perhaps serve some important functions for victims, but they do not always safeguard against future abusive acts. The clinician should take the history of childhood victimization and evaluate the individual's current situation in context with that history.

Postscript on risk assessment: The assessment of risk in forensic populations inevitably points toward two disorders that have high risk for harm to self and others: the Borderline Personality Disorder (BPD) and the Antisocial Personality Disorder (ASPD). While it is easy to arrive at these diagnoses with forensic cases, it is also easy to merely indulge in dismissive labeling and to use the diagnoses to serve as a shorthand for explaining all of the defendant's behavior. The clinician is strongly encouraged to avoid this. It is bad science and it is questionably ethical practice. These two diagnoses are among the most pejorative of all and their use implies a lack of "real" mental disorder. There is no doubt but that a clini-

CLIENT'S HISTORY NEEDED FOR RELIABLE EVALUATIONS

Many forensic evaluations are unreliable because the history upon which they are based is erroneous, inadequate or incomplete. All too often, the medical and social history relied upon by mental health professionals is cursory at best and comes exclusively from the client or possibly from the client and discussions with one or two family members.

This can result in a fundamentally skewed view of the relevant history because often the client, and even their family members, are very poor historians and may fail to relate significant events which are critical to a proper determination of an individual's mental state at the time of the offense.

For example individuals who are physically, emotionally and/or sexually abused often minimize the severity and extent of the abuse. Their view of what is "normal" and thus what should be related to a clinician is frequently impaired. Similarly, individuals with mental retardation or other organic brain impairments generally are unable to recall significant events regarding their medical history which may be critical to a reliable diagnosis. It is also well established that many mental illnesses, *e.g.*, bipolar mood disorder and schizophrenia, run in families and thus it is important to know the family as well as the client's medical and psychiatric history.

- John Blume, *The Elements of A Competent & Reliable Mental Health Evaluation*, The Advocate, Vol. 17, No. 4 (August 1995) at 7

cian who sees a large number of individuals in forensic settings will find a significant number of antisocials and borderlines. The effective biopsychosocial, however, goes beyond the label to define the exact characteristics of the individual so that the reader can form a clear picture of the person rather than the cartoon that is the diagnosis.

It is further important to note that while traditional thinking about the suicidal disposition has defined it as distinctly different from a homicidal or aggressive disposition ("aggression turned inward"), there is now substantial evidence that the two are overlapping phenomena. In fact, all three dimensions of risk show overlap. An individual can be at risk of being victimized, be suicidal and homicidal as well. The astute clinician will explore all three domains of risk.

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. The volume and quality of vocabulary should also be noted. The individual might make use of a very impoverished vocabulary or one that is marked by neologisms, words that are made up by the individual. The clinician will use care in making inferences about the vocabulary since the individual's culture can be the primary contributor to this rather than mental disorder. 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.

a) The clinician will elicit the individual's concerns, worries and any obsessions or preoccupations if they are present. With

individuals who have a history of substance use disorder, gambling, sexual deviance or compulsion, the clinician will want to elicit the content of obsessional thinking around these subjects. Traumatic content might also emerge as a persistent and intrusive set of ideas or worries.

b) The clinician needs to explore whether the individual has perceptual disturbances such as hallucinations or misperceptions of real objects. This will also include distorted perceptions of circumstances and social situations. Individuals with severe personality disorder will typically give evidence of marked perceptual distortions of social events and contexts. It is important to assess perceptions, however, within the cultural context of the individual. This can not be over-emphasized in domestic violence cases where the influences of the "Stockholm" syndrome exert profound impact on the individual's perceptual field.

c) The individual's key beliefs and automatic thoughts should be assessed. Using traditional cognitive therapy approaches, the clinician can obtain the individual's most prominent automatic thoughts that guide emotion and behavior. The individual's basic beliefs about life, moral or religious beliefs, social custom and other features can be helpful in assessing either the individual's motivating principles or rationalizations. Strong biases or negative beliefs such as racist or sexist ideas should be noted if they are relevant to the criminal activity. It is also important to explore the individual's moral thinking. While this might seem ridiculous with antisocial personalities, it is, nonetheless, a useful area of inquiry. Many "antisocials" in the broader sense of the term have moral standards such as not "ratting" on fellow gang members or of not hurting children, etc.. Years ago these individuals were diagnosed with the label "dyssocial personality" and there is some value to the term. More importantly, however, it can be fruitful to learn whether the individual has moral values that direct some of his or her conduct. Kohlberg and Gilligan offer two sets of insights that can be very important to forensic evaluations of domestic violence cases. Kohlberg's traditional understanding of moral thinking describes male patterns as rule following behavior while Gilligan has shown that women's moral thinking is relationship contextual. While men rely on codes of conduct (look at gangs again), women are more likely to solve moral issues based upon the nature of their relationship to the other person.

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 the 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 a subtracting serial 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 memoral capacity for short term, intermediate term and long term functions. All memoral 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. Memoral disorder requires very careful assessment. Deficits can be either attributable to psychological (trauma) or neurological events (strokes, head injury, etc.) or psychiatric illness (schizophrenia). Forensic cases sometimes present the clinician with instances of selective memoral impairments where one set of events is remembered with clarity while others are not. The use of the term "selective" implies a deliberative act and should be avoided in all but the most egregious cases. Memory is a complex cognitive process and is influenced by many factors. *The safest clinical path is 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 clinician 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) *Executive functioning:* The clinician should assess the individual's ability to plan future actions and to inhibit impulses. This is essentially an evaluation of frontal lobe functioning in the individual. When the individual has a history suggestive of closed head injury, this issue needs particularly close attention. Closed head injury often affects the frontal and prefrontal lobes and this creates impairment of executive functions. The individual can be asked, "When you feel the urge to ___ [drink more, steal something, drive fast, etc.], what keeps you from doing it?" Or, "How do you plan out your time off from work?" "What is the furthest time in the future that you might plan something?" "How do you budget your money and how do you keep within your pay amounts?"

k) *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. After examining some of these more abstract questions, it can be useful to ask the individual to give some examples of actions he or she has taken that would be good examples of sound judgment. The individual's selection of items can be almost as informative as the content of the decision that he or she reports. As referenced above, the individual's moral thinking should be examined. It should be looked at descriptively and then should be evaluated for its degree of congruence with the individual's culture and society at large.

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. The biopsychosocial should show the ways in which social and psychological factors influence biological ones and the other way around. Juries might be more compassionate with organic impairments than psychological or social ones, because they can appreciate how a damaged brain can influence behavior but few understand the obverse. It is less known that social and interpersonal environments can influence the development of brains. This can and should be explained through the use of simple developmental models that are easy for lay persons to grasp. (For instance, ask the jury what it envisions would be the result if we took a child's injured leg and wrapped in a cast from age 9 to 26? What would the functioning capacity be of that one leg when the person has become an adult? This is not unlike what happens when we "wrap" a developing brain in simple, neglectful environments - it simply does not develop the structures that others have for thinking.)

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 behavior 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. In the assessment of domestic violence, the clinician should pursue questions about the history of injuries incurred in these acts and the treatments that might have been received. Some individuals will give evidence of lasting impairments from these injuries because of the severity of attack and a spousal prohibition of seeking medical care.

The individual's health history cannot be taken by simply asking whether the individual has any physical problems. The inquiry must be formal and go through all organ systems. A health history or screening form of some sort should be employed. This can include basic information about family diseases that have strong correlation with genetic transmission. If, for instance the clinician is evaluating an individual who gives evidence of memoral vagueness and poor cognitive complexity and it is discovered that he or she has an extensive family history of early-onset Alzheimer's Disease, then the relevance of clinical findings takes on new dimensions.

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. It must include the findings from the assessment of physical as well as mental health. Self care, shopping, tending to financial matters, securing medical and other treatment services, using transportation, keeping house, maintaining social contacts, all form a part of the functional assessment.

The clinician should also assess the individual's adaptive strengths that can be built upon in either treatment or rehabilitative care. The individual might have demonstrated capacities that have either been ignored in the psychiatric or psychological evaluations because they are not overtly clinical in nature. 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. What this assessment does is pull the elements together into a comprehensible whole that makes sense of all the comorbidities and problems from the history. This is the place in the evaluation where the themes mentioned at the beginning of this article become important. The integrative assessment should build a plausible portrait of the individual and place the individual's decisions in the context of real life stressors and real environmental factors. The salient must be delineated from the plethora of details and it must be rendered in plain and clear ways. Labels may be used - but with caution. They can have the opposite to the intended effect. Instead of summarizing, they can have the effect of overriding all of the complexities that the biopsychosocial has developed.

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 meaningful 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.

Additional Readings:

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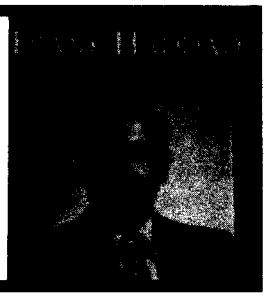
HOW EXTENSIVE ARE SOCIAL HISTORIES?

What constitutes an adequate social history? The amount of time and energy devoted to collecting collateral data generally depends on variables such as the nature of the offense, the charges, the presence or absence of a history of mental illness, and the possible punishment. Social histories in non-capital offenses require less time to complete but are nonetheless important.

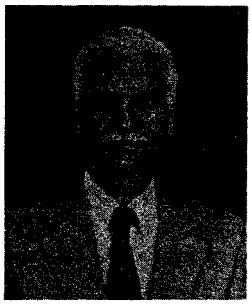
- Lee Norton, Ph.D., *Toward A Better Understanding of the Importance of Psychosocial Histories in Forensic Evaluations*, The Advocate, Vol. 18, No. 5 (September 1996) at 81.



New Director of DPA's Law Operations Division

Effective October 14, 1996, Dave Norat, 48, assumed leadership of the Law Operations Division of the Department of Public Advocacy. Any correspondence or questions regarding that Division should now be directed to Dave. Dave began with DPA in 1974.

A long time advocate for alternative sentences, Dave will still be available for consulting on sentencing and diversion plans. Dave will continue his work in bringing about systems change in the way that the criminal justice system deals with offenders with mental retardation or mental illness.



"Guess Who's Coming to Dinner?": Setting a Place for the Foreign Mental Health Expert

Honour a physician with the honor due unto him for the uses which ye may have of him... The skill of the physician shall lift up his head: and in the sight of great men he shall be in admiration.

- Apocrypha
Ecclesiasticus 38: 1-3

The more ignorant, reckless, and thoughtless a doctor is, the higher his reputation soars even amongst powerful princes.

- Desiderius Erasmus
Praise of Folly, 1509

Every doctor will allow a colleague to decimate a whole countryside sooner than violate the bond of professional etiquette by giving him away.

- George Bernard Shaw
The Doctor's Dilemma, 1911

I have noticed that doctors who fail in the practice of medicine have a tendency to seek one another's company... A doctor who cannot take out your appendix properly will recommend you to a doctor who will be unable to remove your tonsils with success.

- Ernest Hemingway
A Farewell to Arms, 1929

The use of foreign mental health experts [1] broadens the scope of scientific and technical assistance available to defendants. Fresh faces, fresh minds, and fresh ideas stimulate creative thinking, and inspire innovative new ways of approaching cases. In addition, these experts may lend an advocate the advantage of surprise, and their impressive-sounding and even novel credentials may favorably impress judges, juries, and opponents. They may also provide your only option for professional mental health assistance, as domestic experts may shun cases of local notoriety, or may be reluctant to be placed in a situation compelling unflattering and public reflection on a colleague's clinical judgment.

Utilization of foreign experts also serves to keep domestic experts on their toes.

There is nothing new about employing foreign mental health experts. These persons are routinely invited into the Commonwealth to consult with attorneys, examine defendants and/or witnesses, and testify regarding the results of their evaluations.

What many attorneys do not realize is that the performance of a mental health examination may constitute the unauthorized practice of the foreign expert's profession in this jurisdiction. For example, KRS 319.010 ("Definitions") provides, *inter alia*, the following:

> *[3] "Practice of psychology" means* ***rendering to individuals, groups, organizations, or the public any psychological service*** *involving the application of principles, methods, and procedures of* ***understanding, predicting, and influencing behavior****, such as the principles pertaining to learning, perception, motivation, thinking, emotions, and interpersonal relationships;* ***the methods and procedures of interviewing****, counseling, and psychotherapy; of constructing,* ***administering, and***

interpreting tests of mental abilities; aptitudes, interests, attitudes, personality characteristics, emotion, and motivation. *The application of said principles and methods includes, but is not restricted to: diagnosis, prevention, and amelioration of adjustment problems and emotional and mental nervous disorders of individuals and groups; educational and vocational counseling; the evaluation and planning for effective work and learning situations; and the resolution of interpersonal and social conflicts. [emphasis supplied]* [2]

According to KRS 319.005 ("Practice of psychology and use of title by persons not licensed or certified prohibited"):

> *No person shall engage in the practice of psychology...or hold himself [or herself] out by any title or description of services which incorporates the words "psychological," "psychologist," or "psychology," unless licensed or certified by the board. No person shall engage in the practice of psychology in a manner that implies or would reasonably be deemed to imply that [s]he is licensed or certified, unless [s]he holds a valid license or certificate issued by the board.*

It is clear from these statutory provisions that the performance of a clinical mental health examination, forensic or otherwise, would meet the basic criteria for the practice of psychology.

The potential consequences of unauthorized practice are described in KRS 319.990 ("Penalties"):

> *[1] Any person who violates any of the provisions of this chapter shall be guilty of a misdemeanor and, upon conviction, shall be punished by imprisonment for not more than six (6) months, or by a fine of not more than five hundred dollars ($500), or by both fine or imprisonment, and each violation shall be deemed a separate offense.*
>
> *[2] Either the Attorney General or the appropriate Commonwealth's or county attorney shall have the authority to prosecute violations [of KRS 310].*

The *Ethical Principles of Psychologists* and *Code of Conduct* [3] may be interpreted as compelling any domestic or foreign psychologist aware of unauthorized practice to intervene. Standard 8.05 ("Reporting Ethical Violations") provides that:

> *If an apparent ethical violation is not appropriate for informal resolution...or is not resolved properly in that fashion, psychologists take further action appropriate to the situation, unless such action conflicts with confidentiality rights in ways that cannot be resolved. Such action might include referral to state or national committees on professional ethics or to state licensing boards.*

It is not difficult to imagine the effect on a foreign mental health expert's credibility, and by extension, the client's legal situation, if an opponent were to discover or query the expert's "unauthorized" professional practice within the borders of the Commonwealth.

Does this mean that attorneys cannot or should not employ the foreign mental health expert? Of course not. They must, however, jump through the statutory hoops germane to the various professions. For psychologists, for example, KRS 319.015 ("Activities not included in the practice of psychology") makes it "legal" to employ the foreign mental health expert when he or she is:

> *[8] [A] nonresident temporarily employed in this state...rendering psychological services for not more than thirty (30) days every two (2) years, if [s]he holds a valid current license or certificate as a psychologist in his [or her] home state or country and registers with the board prior to commencing practice in the Commonwealth.*

This statutory scheme compels some additional investigation on the part of the attorney, aided by the foreign mental health expert. Does the expert's home jurisdiction specifically designate its professionals as "psychologists," or is some other term employed? Are the "license" and/or "certificate" utilized, or is some other credential conferred? [4]

Similar but distinct practice restrictions and exceptions apply to physicians [5] and social workers [6]. In addition to these technical qualifications for professional practice, hiring attorneys should bear some additional considerations in mind:

1) Sometimes attorneys hire foreign mental health experts when they are not licensed to practice in *any* jurisdiction. There is a difference between clinical practice and research which must be explored.

2) Developing new talent is always a priority; however, check with colleagues in other jurisdictions regarding the putative expert's track records, and confirm his or her eligibility and freedom from legal charges or ethical complaints with the appropriate state board.

3) Some *bona fide* experts are not active in so-called "professional" matters, and in fact may reject or even disdain them. This issue must be identified and remediated in advance.

4) In general, remember that knowledge is not always highly correlated with persuasiveness!

5) Ask new experts for *vitae*, work samples, and copies of relevant publications. Run this information and subsequent "sanitized" work product by a mental health consultant whom you trust, as the case progresses. The courtroom is no place to form a concrete impression as to whether your expert's assistance is competent and effective.

References

[1] In this article, the term "foreign" refers to those individuals licensed, certified, or otherwise residing or practicing primarily in a jurisdiction other than the Commonwealth of Kentucky.

[2] Additional definitions are supplied in 201 KAR 26:121 (4) ("Scope of practice"), which describes "clinical psychological services" as including:

[a] Psychological testing and the evaluation or assessment of personal characteristics such as:
1. Intelligence;
2. Personality;
3. Abilities;
4. Interests;
5. Aptitudes; and
6. Neuropsychological functioning;

[b] psychotherapy;
[c] counseling;
[d] psychoanalysis;
[e] hypnosis;
[f] biofeedback and behavioral analysis and therapy;
[g] diagnosis and treatment of mental and emotional disorder or disability;
[h] alcoholism and substance abuse disorders of habit or conduct;
[i] the psychological aspects of:
1. physical illness;
2. accident;
3. injury; or
4. disability;

[j] psychoeducational evaluation, therapy, remediation, and consultation;

[k] assessment directed toward diagnosing the nature and causes, and predicting the effects, of subjective distress) of personal, social and work dysfunction; and of the psychological and emotional factors involved in and consequent to, physical disease and disability. Procedures may include: interviewing, and administering and interpreting tests of intellectual abilities, attitudes, emotions, motivations, personality characteristics, psychoneurological status, and other aspects of human experience and behavior relevant to the disturbance;
[l] Intervention directed at identifying and correcting the emotional conflicts, personality disturbances and skill deficits underlying a person's distress or dysfunction. Interventions may reflect a variety of theoretical orientations, techniques, and modalities. These may include: psychotherapy, psychoanalysis, behavior therapy, marital and family therapy, group psychotherapy, hypnotherapy, social-learning approaches, biofeedback techniques, and environmental consultation and design;
[m] professional consultation in relation to assessment and intervention;
[n] program development services in the areas of assessment, intervention, and consultation; and
[o] supervision of clinical psychological services.

There are relevant distinctions between restriction of unauthorized practice on the one hand, and definition of the scope of practice of certain specialties on the other, but the latter is illustrative of those activities which the psychologist performs in the course of his or her professional practice.

[3] American Psychological Association (1992). *American Psychologist*, 47 [12], pp. 1597-1611.

[4] Note that the statute refers to a "nonresident." It is often the case that a psychologist will live in one jurisdiction and practice in another. If the "foreign" mental health is in fact a Kentucky resident only licensed or certified to practice in another jurisdiction, it may be advisable to clarify this status with the licensing board in advance, in order to avoid the (admittedly remote) possibility of an embarrassing challenge at a later date.

[5] KRS 311.560 ("Practice of medicine or osteopathy without license prohibited; exceptions") states, *inter alia*, that:

> [1] Except as provided in subsection [2] of this section, no person shall engage or attempt to engage in the practice of medicine or osteopathy within this state...unless [s]he holds a valid and effective license or permit issued by the board as hereinafter provided.
>
> [2] The provisions of subsection [1] of this section shall not apply to...
>
> [b] Persons who, being nonresidents of Kentucky and lawfully licensed to practice medicine or osteopathy in their states of actual residence, infrequently engage in the practice of medicine or osteopathy within this state, when called to see or attend particular patients in consultation and association with a physician licensed pursuant to this chapter.

There are less complicated (and potentially expensive) ways to make the foreign medical expert "legal" for forensic evaluation purposes. According to KRS 311.571 ("Qualifications for license; exception in extraordinary circumstances"):

> [5] An applicant seeking regular licensure in the Commonwealth who was originally licensed in another state may obtain licensure in the Commonwealth without further testing and training if the applicant:
>
> [a] Has been endorsed in writing by the applicant's original licensing state as being currently licensed in good standing in that state; and
> [b] Would have satisfied all the requirements for regular licensure described in the preceding subsections had the applicant sought original licensure in this state.

[6] For social workers, KRS 335.030 ("Practice without license prohibited; use of titles") provides, *inter alia*, that:

> *[N]o person shall engage in the practice of social work unless [s]he is licensed in accordance with the provisions of KRS 335.010 to 335.160 and 335.990, and no person shall hold himself out to the public by any title or description of services representing himself as a "Certified Social Worker," or "Social Worker," or any other title that includes such words except as such usage of title or description is authorized by KRS 335.010 to 335.160 and 335.990.*

The following option is afforded by KRS 335.120 ("Licensure without examination; reciprocal agreement between states"):

> *The board may grant the appropriate license without examination to any person who at the time of application holds a valid license from another state and who meets the current minimum requirements for licensure in Kentucky provided a reciprocal agreement exists between the states.*

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Boyce F. Martin, Jr. Inducted as Chief Judge of the United States Court of Appeals for the Sixth Circuit

Judge Boyce F. Martin, Jr. was inducted October 1, 1996 as Chief Judge of the United States Court of Appeals for the Sixth Circuit. Judge Martin succeeds former Chief Judge Gilbert S. Merritt whose term expired.

Judge Martin was originally appointed as a Circuit Judge of the United States Court of Appeals for the Sixth Circuit on September 26, 1979, and has served as Circuit Judge from that date until the present. Before his induction as Circuit Judge, Judge Martin was a member of the Kentucky Court of Appeals, serving as its chief judge from the creation of the court, in 1976, until he took oath as Circuit Judge, in 1979. From 1974 until 1976, Judge Martin served as a Jefferson Circuit Court Judge, both in the Common Pleas Branch and in the Chancery Branch. Prior to joining the judiciary in 1974, Judge Martin worked in the United States Attorney's Office for the Western District of Kentucky, and later practiced law privately in Louisville. He also served as a law clerk to Judge Shackelford Miller, Jr. on the United States Court of Appeals for the Sixth Circuit.

Judge Martin received his undergraduate degree from Davidson College in Davidson, North Carolina, graduating in 1957. Following military service, Judge Martin received his law degree from the University of Virginia School of Law in 1963. He has many civic interests both inside and outside the bar. He has recently completed an eight-year term of service as Chairman of the Board of Trustees of the I.W. Bernheim Foundation, which operates the Bernheim Arboretum in Clermont, Kentucky, near Louisville. In addition, he has served as Vice-Chairman of the Board of Trustees of Hanover College in Hanover, Indiana; he currently serves as a Trustee of Davidson College in Davidson, North Carolina. He has served, as well, on many committees within the American Bar Association and the Judicial Conference of the United States. The induction ceremony was presided over by Circuit Judge Nathaniel R. Jones. For further information, contact James A. Higgins, Circuit Executive, (513) 564-7200.

Effectively Seeking Funds for a Defense Statistical Expert: Factfinding in the Face of Uncertainty

It has been seen in courtrooms across the nation: The DNA expert tells jurors that the chance that the blood found at the crime scene belongs to someone other than the defendant is less than the chance for winning the lottery. Faced with such damning evidence, what is a defense attorney to do? Even an attorney with some background in science is not qualified to do the complicated statistical analysis involved. Consequently, that attorney's cross-examination of the expert leaves much to be desired. Too often, attorneys finds themselves grappling with the myriad of numbers used by the expert, searching for some way to communicate the limits of the findings, while the jurors become increasingly supportive of the expert's testimony.

Another situation too often seen in American courtrooms: the defendant, a black male, has been indicted by a predominantly white grand jury taken from a majority black community. Defense counsel knows that she can have the indictment dismissed if she can prove the discrimination. However, discrimination is an ostensibly random process and is almost impossible for the attorney to prove on her own. Even attorneys with some background in statistics are simply unable to do the complicated analysis needed to yield accurate - and believable - results.

In these situations, defense attorneys must seek the assistance of an expert in statistics. When the client is indigent, securing an expert means convincing a court to provide funds. This article to provides attorneys a framework to convince a judge that statistics can assist the reliability of the fact finding process, and that in the interests of ensuring that reliability, two statisticians are almost always better than one. Convincing the trial court of those basic facts will put an attorney well on her way to receiving the expert funding for a defense statistician her client needs to effectively present the case.

What is the field of statistics?

In the beginning, science was simple. You observed an event, and tried to explain it. End of story. Thus, Aristotle could tell the world with absolute conviction that there were only a finite number of elements, because those were the ones he could see. In other words, the scientific process consisted of two steps: empirical observation and hypothesis. *See* Bernard Dixon, *The Science of Science: Changing the Way We Think* 8-9 (1989); Isaac Asimov, *New Guide to Science* 6-10 (1984).

This method proved unsatisfactory. Our observations would differ from our hypotheses when the circumstances changed. So, a new element of the scientific process evolved: experimentation. Experimentation works on a basic principle of logic: in order to prove that a particular event or condition was caused by one factor, one has to exclude all the other possible factors. Thus, when conducting an experiment a scientist manipulates her environment to account for all possible factors. Only then will she be able to exclude those factors from consideration. *See* Dixon, *supra*, 12-15; Asimov, *supra*, 12-14.

When experiments were simple, this was easy to do. Galileo proved that gravity affected all things equally by dropping rocks from a tower. However, as experiments became more complicated, it became harder for scientists to manipulate their environment to the point that they could draw reliable conclusions from their data. Thus, the need for statistics.

Statistics tries to solve a number of problems. First, statisticians try to account for and correct error in the measurement of data. Measurement errors often arise in the context of surveys. For example, scientists studying the relationship between dietary cholesterol and cholesterol levels in the blood neglected to account for smoking when taking their data. As

a result, it was unclear whether the results of that data were attributable to dietary cholesterol, or to the fact that many people with bad diets also smoke. Statisticians were able to partially offset that error. Consequently, medical scientists were able to draw meaningful conclusions from what would have otherwise been hopelessly unreliable data.

Second, statistics tries to compensate for extrapolation error. Particularly when dealing with social science experiments, or other experiments on human conditions, it is impossible to gather a complete data set. Without statistics, it would be impossible to determine the extent to which the results of that data set could be used to predict results from subjects outside the data set. If you took a survey of 400 people, and all you knew was that, if the election were held today, 40% would vote for A, and 60% would vote for B, you could not use that to predict who the voters in that jurisdiction would actually vote for. It could be that all 400 of the participants were residents of a small republican enclave in rural Virginia. Or, they could be Hutu tribesmen in Rwanda, who are neither eligible to vote, nor familiar with the candidates. However, if you applied statistical standards, such as the likelihood that the participants would vote, or the geographic and demographic makeup of the sample, you can use that small sample to predict the result of an election in a nation of 250,000,000.

Statistics accomplishes this useful function because statisticians are willing to admit that error is part of the process. The reason this is useful is fairly evident. The standards for absolute scientific proof are almost impossible to meet. For something to be a scientific fact, it must always be true. However, statistics utilizes probability to allow scientists to draw meaningful, useful conclusions in circumstances where absolute truth is impossible. It redefines "proof" so scientists can utilize information that would previously be considered useless. Thus, scientists can treat certain conclusions as facts, without having to succumb to the standards of scientific proof which are impossible to meet in the real world. In short, statistics is a scientific process which permits scientists to make meaningful guesses and use them.

However, that statement does not cover one of the fundamental problems with statistics and the law. The fact that statisticians apply the scientific principles of probability to permit meaningful conjecture does nothing to explain the process of statistics. It merely explains why statistics is useful. The process, or art, of statistics uses scientific and logical principles to decide the relationship between relevant factors. Logically, it is easy to see why these relationships cannot be proven, since it is the uncertainty in these relationships which creates the need for statistics in the first place. Thus, the use of assumptions is implicit to statistics. These assumptions are "gap fillers" which fill in the missing facts which would, in the absence of statistics, prevent scientific conclusions. Statistics is therefore the rules for assumptions, *i.e.*, the use of scientific, mathematical and logical rules governing when, where, and how assumptions can be used.

Statistics is both the science of conjecture and the art of assumption.

Statistics is beneficial because it allows us to draw conclusions in situations where the standard scientific process is unavailing.

Statistics is imperfect because it requires statisticians to make difficult and often counter-intuitive choices, without a completely solid factual framework upon which those choices can be based.

Statistics is useful because it enables us to find answers where there are no hard and fast answers. At the same time, statistics is dangerous precisely because of the nature the problem it was developed to overcome, *i.e.*, the lack of hard answers - creates uncertainty and permits abuse.

The Science: How statistics can be used in the courtroom

In *United States v. Shonubi*, 895 F.Supp 460 (E.D.N.Y. 1995), the court, in a lengthy opinion, discussed the value of statistical evidence in factfinding. Statistical evidence presented to the sentencing judge in a heroin smuggling case as to the probability that the defendant carried between 1,000 and 3,000 grams of heroin was held to be admissible. The court strongly expressed the value of statistical evidence stating that:

> Courts which deny themselves the help of statistical tools increase the risks of incorrect conclusions.... Putting aside questions of cost and availability to both sides, there is no reason to deny fact-finders reliable information or analytic techniques... [T]he law [can] not afford to exclude highly probative statistical evidence and useful quantitative methods. Courts ignore whole categories of evidence only at their peril. *Id.* at 516, 518.

Statistics is a valuable tool which should not be ignored. The court also stressed that "statistical and non-statistical proof are intertwined." *Id.* at 523.

> By checking one mode of analysis against the other, triers improve the quality of their decisions. This implies that in evaluating non-statistical proof, courts should not lose sight of the potential utility of statistics. Similarly, in using statistics and other scientific techniques, courts must not ignore the fundamentals of inferential analysis, standard heuristic devices, and other techniques traditionally used by triers of fact in assessing the probative force of evidence. *Id.* at 523.

This is a fact that must be addressed by the attorney requesting funds for a defense statistician. A review of appellate cases affirming the denial of funds for a statistics expert reveals that courts require additional, traditional facts supporting the argument for which the expert is requested. The failure to make a substantial threshold showing explains the failure of appellate courts to afford funds for statistical experts. This article empowers attorneys to persuasively make the threshold showing. *See also* "Funds for Resources: Persuading and Preserving," *The Advocate*, Vol. 16, No. 6 (January 1995) at 82.

Case law teaches us these important lessons: 1) courts and jurors regularly use statistics to solve legal problems; 2) courts and jurors regularly listen to statisticians from both the prosecution and the defense to make reliable decisions; and 3) to obtain funds to employ a defense statistician, a substantial threshold showing is necessary.

Funds Granted for Defense Staticians

Funds have been granted in Kentucky cases at the trial and district court level for the employment of defense experts to do statistical analysis in a number of cases:

Commonwealth v. Paul Kordenbrock, Indictment No. 80-CR-1, Boone Circuit Court, for statistical analysis of the composition of the grand jury in the amount of $235. The expert was Stephen E. Edgell, Ph.D., University of Louisville.

Commonwealth v. William Stark, Jr., Indictment No. 90-CR-11, Shelby Circuit Court, for change of venue survey for Shelby and Franklin Counties in the amount of $3,400. The expert was Walter Abbott, Ph.D.

Commonwealth v. Mark Dunn, Indictment No. 95-CR-36, Garrard Circuit Court, for a change of venue survey for Franklin, Garrard and Jessamine counties in the amount of $2,500. The expert was Bruce J. Rose, Ph.D., Kentucky State University.

Kordenbrock v. Scroggy, Civil No. 86-186, federal district court, Covington, $1,463 for the statistical analysis of the underrepresentation of young persons in the grand and petit jury pools. John B. McConahay, Ph.D., Duke University was the expert.

Jury Discrimination

One of the most common uses of statistics is cases in which a party is alleging discrimination in the composition of the jury panel. The statistics are used to show that the probability of the particular jury panel's composition is so unlikely that discrimination may be present in the process.

Castaneda v. Partida, 430 U.S. 482 (1977) is the leading case on discrimination in the selection of a grand jury panel. The Supreme Court looked to statistical evidence to hold that the Texas "key man" system for selecting grand jurors was unconstitutional under the equal protection clause. A study of the representation of Mexican-Americans on the grand jury panel over eleven-years demonstrated that only 39%

of grand jury members had been Mexican-American despite the fact that Mexican-Americans represented 79% of the county population. The court noted the 40% disparity and a statistical analysis that the probability of such a disparity is less than one in 10 to the 140th power in finding that a prima facia case of discrimination had been established.

The Supreme Court looked to statistical evidence in *Duren v. Missouri*, 439 U.S. 357 (1979) to hold that women were under-represented on the jury venire in violation of the defendant's sixth amendment right to a jury trial. The state law in question exempted women from jury duty if the so requested. Despite the fact that women represented 54% of the adult population, they consisted of only 15% of weekly venires.

In both of the above Supreme Court cases, the defense presented specific statistical evidence which the government rebutted with broad attack on the assumptions underlying the statistical evidence. *Castaneda* at 489-93, *Duren* at 367-69.

When requesting funds for an expert to conduct a study, the defense must present a substantial threshold showing indicating the necessity for such investigation. In *McQueen v. Commonwealth*, 669 S.W.2d 519 (Ky., 1984), the Court held that it was not error to deny the defense funds to conduct a search to determine proper representation of a cross-section of the community on the jury panel because the defense attorney failed to make a sufficient threshold showing. The court noted that there was "not one shred of evidence...which indicated any irregularity or underrepresentation." *Id.* at 521.

Likewise, in *Ford v. Commonwealth*, 665 S.W.2d 304 (Ky. 1983), *aff'd*, 841 F.2d 677 (6th Cir. 1988), rejected the defense's request for funds for a second statistical investigation. In this case, the defense did receive funding for and conduct an initial study to show discrimination in the drawing of the petit jury. The Court rejected this study because the study used the county census rather than limiting the analysis to the "eligible population" - registered voters and property owners. The Court then rejected the defense's request for funds for a corrected study because the defense failed to convince the judge via a threshold showing.

> He presented us with no showing that the results reached by an additional

The Stages of Statistical Study and the Potential for Error

1) The Study Design. Entails identifying the issue to be studied, assessing the nature of the information required, determining how the data will be collected, creating instruments for collecting the data, and defining a sample. **Focus on whether the study documents what needs to be proven.**

2) The Sample. **Is the sample size adequate?**

3) Underlying Assumptions. **Are there any flaws in the design assumptions?**

4) Data Collection. **The expert must properly supervise and control the persons involved in the gathering of the data. Survey data must be collected in a non-biased fashion.**

5) Analysis. The selection of a statistical method for the purpose of analyzing the data.

6) Computerized Analysis. **Determine whether: The data were properly recorded on the forms used. The information was entered into the computer accurately. The computer program designed to manipulate the data was correctly written and implemented. The computer processed the information properly.**

7) The Results. Summary of the conclusions.

8) **The Limits of Statistics. While the results will reveal whether there is a relationship between the data, they will not indicate the reason for the relationship.**

How to Evaluate an Expert's Statistical Analysis, The Practical Lawyer, April 15, 1982, p. 69.

> expert would have differed, in any respect, with the results reached by the expert he did retain....
>
> Additionally, the statute (KRS 31.110) provided for assistance to needy persons charged with a crime states that such person are entitled to be provided with "necessary services...including investigation and other preparation." We do not conceive that employment of statisticians and mathematicians to examine the representation of recognizable groups on jury venires, especially in the absence of specific knowledge of irregularities, to be included in "necessary services." We know of no statute or principle which would authorize expenditures of public funds to conduct a witch hunt. *Id.* at 308-09.

These cases illustrate the need for defense counsel to provide judges specific threshold showings of the necessity of statistics in showing discrimination as used in the Supreme Court cases and the need to present some evidence of the possibility of discrimination as part of the request for funds.

Jury Selection

In a recent capital case, *Randy Haight v. Commonwealth*, No. 94-SC-288, tried in Louisville on a change of venue from Garrard County there were irregularities in the way jurors were selected. The case illustrates the benefit of statistical analysis by a defense expert.

In order to obtain 14 jurors (12 who would decide the case plus 2 alternates), the deputy circuit court clerk, on her own and not at the direction of the judge, drew 3 jurors from the 17 left after the exercise of peremptories by the parties, leaving 14 jurors. These 3 were women, 1 of whom was black. The defense objected to the failure to comply with the selection process of RCr 9.36. As a result, the court directed the clerk to draw the jurors out anew by picking 14 out of the 17, leaving 3 to be excused.

Against all odds, when the clerk redrew the 14 names from the 17, the statistically highly improbable occurred. The clerk explained it at a hearing which occurred 10 days later, *"it just so happened that the same three popped up."* The hearing further revealed that the clerk did not use balls or cards. She used 8-1/2 inch x 3 inch sheets of papers with the jurors' names on them. There was a marked physical difference between the two sets of juror sheets. The 3 drawn out were folded. The 14 were not folded "enough to make any difference." As the clerk stated, "every one of them ***except for the 14***, they were all folded and I straightened them all back out."

It is statistically highly improbable for the same 3 jurors to be *randomly* drawn out twice using different selection methods. Rather than a random process, the clerk drew the same jurors as she had done before as a result of failing to remix the cards, or due to using slips which had 3 folded and 14 not folded, or putting the 3 names on the bottom of the stack of names, or some other human defect. The physical conditions were not conducive to randomness, and made a random process extremely improbable. While the clerk recalled 10 days after the event that she shuffled the cards before the second draw, it is possible she did not do that in light of her drawing the same 3. The clerk's use of strips of paper of varying sizes, 3 of which were folded, was not a "...neutral selection mechanism to generate a jury...." *Holland v. Illinois*, 493 U.S. 474 (1990). A lottery conducted in this manner would not have sufficient public confidence to be viable.

Kentucky State University's Professor Bruce J. Rose, Ph.D. did an extensive analysis of the probabilities of the above two draws occurring by chance. His statistical analysis showed that there are only 15 chances out of 10,000 tries that the second draw of 14 from 17 would not have selected the 3 jurors. Stated conversely, there is a 99.85% chance that the 3 names would have been pulled on the redraw! This statistical analysis shows that failure to draw any of the 3 names on the redraw did not happen by chance or randomly. "The mind of justice, not merely its eyes, would have to be blind to attribute such an occurrence to mere fortuity." *Avery v. Georgia*, 345 U.S. 559 (1953) (Frankfurter, concurring).

In *Avery*, 60 names were drawn from a box containing names of prospective jurors. The white prospective jurors' names were printed on white tickets and the black prospective jurors names were printed on yellow tickets. Of

the 60 drawn, none were black. The judge who selected the names "testified that he did not, nor had he ever, practiced discrimination in any way...." *Id.* at 561. "Obviously that practice makes it easier for those to discriminate who are of a mind to discriminate." *Id.* at 562. *Avery* held that a prima facie case of discrimination was established and the state had the burden to disprove it. The "opportunity for working of a discriminatory system exists whenever the mechanism for jury selection has a component part, such as the slips here, that differentiates between white and colored; such a mechanism certainly cannot be countenanced when a discriminatory result is reached." *Id.* at 564. The slips in Haight's case were differentiated with 3 being folded, 14 unfolded, and the names of the 14 readable. The statistical analysis in this case placed a dramatically precise calculation on the improbability of eliminating the same 3 people in two draws.

Other Statistical Issues

Other areas to consider presenting statistical evidence include: jury selection, change of venue, identification (DNA, fingerprints, bloodtyping, etc...), community standards in obscenity cases, media contact, and sentencing.

Art: The Danger of Receiving Statistical Evidence without Effective Rebuttal

The use of statistics presents the danger that mindnumbing numbers will be erroneously produced and relied on by factfinders. In *Chumbler v. Commonwealth*, 905 S.W.2d 488 (Ky. 1995). The prosecutor attempted to link a cigarette butt found at the scene to the defendant. The butt was tested and found to be that of a type A secretor, the same type as the defendant. The brand of the cigarette was narrowed to twelve possible brands one of which the defendant smoked. In closing argument, the prosecutor multiplied the percentage of the population who are type A secretors by the percentage of Americans who smoke by the nationwide share of the type the defendant used to come to the odds 2 in 1000. He misexplained to the jurors, "And that's the odds that [the defendant] was standing there, 2 in 1000... would've flipped down a Newport cigarette." *Id.* at 495.

The Kentucky Supreme Court found these calculations "completely unfounded and in error" and despite the lack of objection found "palpable error affecting [the defendant's] substantial rights resulting in manifest injustice." *Id.* The Court compared the prosecutor's erroneous statistical calculations to the "polygraph in their unreliability and propensity to mislead and may have convinced jurors of modest analytical ability that no one but [the defendant] could have committed the crime." *Id.* Statistics can be unintentionally miscalculated and the mistake can be missed by defense counsel, the judge and the jurors. In cases with more complex calculations the potential for a mistake to pass through the court increases.

Cases in which only one party offers statistical evidence present the danger that the fact-finder will be awed by the incredible numbers and incomprehensible mathematics. This may lead to jurors taking the understandable shortcut of merely believing the conclusion made by the expert. *Dubose v. State*, 662 So.2d 1156 (Ala. Cr.App. 1993), *aff'd*, 662 So.2d 1189 (Ala. 1995), illustrates danger of misleading the fact-finder and the importance of providing the defense with expert assistance to counteract this effect. At trial, the prosecution presented statistical evidence on the possibility of the defendant having the a DNA "match" with samples taken from the victim. The state's expert first estimated that there is a 1 in 500 million probability that the defendant's DNA pattern would appear in the North American black population and a 1 in 22 million probability that that pattern would occur in the North American caucasian population. Then he stated that there are between 15 to 20 million African-American males in North America explaining that "what the statistics tell us here is you would only expect to find this pattern once and we have found it." *Id.* at 1164.

He concluded by stating that his calculations used three standard deviations, thus producing conservative or significantly underestimated frequencies of occurrence that favor the accused and that without the use of standard deviations, the frequency of occurrence (presumably in the black male population) would be approximately 1 in 500 *billion*. Later on cross-examination, the expert stated his calculations were based on a database of 1,300 people. *Id.* at 1164-65.

To most jurors, attorneys or judges this testimony appears to extremely convincing that the

sample found on the victim is a match with the DNA of the defendant. In this case, this was critical evidence which led to the jury finding the defendant guilty of murder during a kidnapping, murder during a rape, and murder during sodomy. The defendant was then sentenced to death.

Before reading further look again at the testimony by the state's expert in *Dubose*, *supra*, for errors, assumptions, and misleading conclusions made to the fact-finder.

Following is a short list of the problems with this expert's testimony:

1. **Assumption.** The expert compares the probability of finding this particular sample in the North American black population (presumably of both sexes) with the number of black males in North America. This is comparing apples to oranges. He is making the assumption that the probability for all blacks is the same as the probability for male blacks without any evidence that this is so.
2. **Study Design.** The expert limits his examination only to North American black males. What is the probability that this sample could be from another population? If the probability of this sample matching with an hispanic male is 1 in 400 million then the probability of the assailant being hispanic rather than the same race of the defendant is greater.
3. **Sample.** What is the evidence that this sample size is large enough for this analysis?
4. **Data Collection.** How was this sample chosen? How is a black person defined for this analysis? Is a person whose great-great grandfather is white considered black?
5. **Result.** What is the confidence interval? In other words, what is the percentage of error?
6. **Result.** The expert put the 1 in 500 billion number in front of the fact-finder without explaining importance of using standard de-

The following questions should be asked when dealing with statistical evidence:

1. What formula did the expert use to generate the final number?
2. Has the expert shown that the formula itself is valid?
3. What does each variable in the formula represent?
4. Does the proper use of the statistical technique, such as the binomial distribution, the normal distribution, and regression analysis that the assumptions are satisfied in the instant case?
5. What is the source for every number that the expert inserted in a variable in the formula? Is the source itself trustworthy? Is the source admissible?
6. Did the proponent misuse the final number during the trial? For example, did the proponent characterize a probability of the defendant's mere presence at the crime scene as the likelihood of guilt?
7. Is the statistical testimony so complex and the final number so impressive that the jury may be overwhelmed or confused?
8. Did the witness exceed his or her expertise by attempting to draw an inference on a question of law?

Scientific Evidence 2d, Paul C. Giannelli and Edward J. Imwinkelried, 1993, pp. 476-77.

viations to reach a reliable conclusion and why that number should not be used.

7. **Result.** The statement "What the statistics tell us here is you would expect to find this pattern once and we have found it." is extremely misleading to the lay person. When a statistician uses the word "expect" it is a term of art analogous to the word average. For example, if a six sided die is thrown six times one would expect that a particular side would appear one time. In the real world, we know that it is still possible that a particular side could appear more than once. When a statistician says he expects it to appear once in six rolls, what he means is that given an infinite number of rolls a particular side would appear on the average one out of six times. The statement of the expert in this case is as if he said "There is a one in six chance of this side appearing. We have rolled the die twice and one time the side appeared so we have found the side and it will not appear again in the next four rolls." To understand the weight to give the statement, the fact-finder should be informed what the probability is of the side or DNA pattern occurring more than once would be.

This list represents just a few areas in which it would be necessary for the defense to have access to its own expert for assistance in discovering these problems, effectively cross-examining the state's witness, explaining the importance of the assumptions and vocabulary used to the fact-finder and rebutting the state's evidence.

In *Dubose*, *supra*, the trial defense attorney was denied funds for his own expert. In an effort to render effective assistance, the attorney was forced to attempt to demonstrate the complexity of the issue and the possibility for error of the evidence presented by the state's experts through cross-examination without the aid of a defense expert. Counsel's uneducated questions prompted four or five of the jurors to tell the court that they understood the evidence even if the attorney did not, and the jurors asked that they not have to listen to any more questions. *Id.* at 1185.

The appellate court recognized the need for a defense expert:

> [T]o the jury, his questions sounded nit-picking, confusing, and ignorant and were not as interesting as the lesson in genetics they had just received. This cross-examination did not sufficiently counter the general and overly simplistic and consequently misleading explanations of an incredibly complex process.... Clearly, their comments to the trial court indicated that several jurors considered that they understood the technique as they had followed the state experts' explanations, but their clear signal that they unquestionably believed that they could see the matches themselves and did not fathom or effectively evaluate the complexity of the technique.... "[I]ll-equipped cross-examiners, the tendency of jurors to be awed by the cutting-edge technology and unimpressed by the nit-picking of the defense, and the possibility of improper presentation and the use of statistics increase the difficulty of a successful attack of the profiling technique." Janet C. Hoeffel, Note, *The Dark Side of DNA Profiling: Unreliable Scientific Evidence Meets the Criminal Defendant*, 42 Stan.L.Rev. 456, 517 (1990). *Id.* at 1186-87.

The jurors tend to accept the conclusion of the "expert" in the field and become frustrated with the lawyer who because of his lack of knowledge is unable to launch a focused cross-examination on the specific trouble areas in the expert's testimony. The practical effect of defense counsel not having access to its own expert is that rather than giving an effective and time-efficient cross-examination which enables the juror to fully understand the testimony being presented, counsel is forced to blindly flail about in search of the question which will serve to shed light on the complexity and uncertainty of the evidence.

Ultimately, after watching this direct and feeble cross of the expert the jurors may, without truly understanding the evidence, accept the expert's conclusion as the truth on the issue. This allows the prosecution's expert to supplant the juror's responsibility as the finder of fact. *See Mahan v. Farmers Union Cent. Exch., Inc.*, 768 P.2d 850, 857 (Mont. 1989) ("statisticians may testify that their statistical test show or do not show patterns...but may not

testify to the ultimate conclusion. The jury should be the final arbiter of that issue.").

This danger is at its greatest in a criminal case.

> Protection of defendants in criminal cases warrants special concern, but burdens of proof and existing rules of evidence, as well as constitutional and statutory protections rather than exclusions of highly probative evidence that happens to be in statistical form are the best means of avoiding justice. Rather than excluding statistics, courts should provide for defense and court-appointed experts to ensure that statistic, when available, are properly used. *U.S. v. Shonubi*, *supra*, at 518.

The benefits of statistics in decision making in most instances warrant their use, but the danger of misuse requires that both parties have access to experts to insure that the jury is viewing the evidence for what it truly means.

Conclusion

Admittedly, the appellate case law does not strongly support the need for funding for statisticians, but creative trial attorneys are requesting and receiving funds for these experts. Defense attorneys requesting funding for expert assistance in presenting statistical evidence as part of their evidence at trial during direct or in support of a motion prior to trial will find it effective to both explain the general value of statistics in fact finding and the specific need for statistics to support the traditional evidence in this particular case. In situations when an expert is requested for rebuttal of prosecution evidence emphasis should be placed on the role of assumptions in statistics and the complexity in interpreting results and discovering errors in conclusions.

FOOTNOTES

[1]The standard deviation is a method used by statisticians to predict the fluctuations from the expected value. *See Castaneda*, *supra*, at 1281 n.17.

[2]Basic probability and statistics texts describe what is necessary for random selection: "To be considered fair, one would want all cards or capsules or names to have the same chance of being chosen. That is, one would strive to emulate a mathematical or ideal selection in which the probabilities postulated for the possible outcomes are all equal. Thorough mixing or shuffling and blend selection are both essential." Bernard W. Lindgren, *Basic Ideas of Statistics* (1975) at 57.

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Acknowledgements

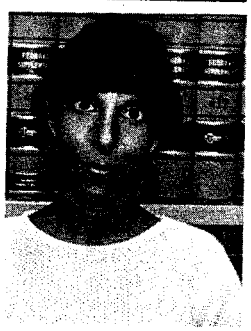
Prof. Lawrence A. Sherr, University of Kansas

Prof. Steven F. Arnold, Pennsylvania State University

Everything human is pathetic. The secret source of humor itself is not joy but sorrow.

- Mark Twain

West's Review



Julie Namkin

Brown v. Commonwealth, Ky.
___ S.W.2d ___ (9/26/96) 94-SC-804-MR

Bobby Brown was tried and found guilty but mentally ill (GMBI) of the murders of his father and brother, and guilty but mentally ill of the first-degree assaults of his mother and sister. He was sentenced to forty-eight years' imprisonment.

On appeal, Brown challenged the constitutionality of the statues authorizing a guilty but mentally ill verdict. To support his position, Brown argued "the promise of treatment lures the jury into returning a GBMI verdict over a not guilty by reason of insanity (NGRI) verdict, but...contrary to the expectations of proponents of the GMBI statute, such a verdict does not necessarily guarantee that a defendant will receive treatment in prison."

Although the Kentucky Supreme Court recommended that the General Assembly enact a GMBI statute, it stated "the time may have arrived for this Court to evaluate that statute." However, the Court did not believe Brown's case was the proper one for determining the constitutionality of the statute or the effectiveness of its provisions, since there was no evidence in the record on which to make such a determination. Although Brown had introduced newspaper articles to support his position, such evidence was not the type of "relevant and credible references, especially with regard to the issue of treatment" that the Court believed was necessary.

As to what type of evidence Brown could have introduced to support his argument, the Court cited to a 1996 Kentucky House Resolution (which was introduced on 1/17/96 - more than one and one half years after Brown's trial) indicating the Legislature's passage of the GBMI statutes set up a system "lacking in ade-

Brown v. Commonwealth, Ky.
___ S.W.2d ___ (9/26/96) 94-SC-804-MR

Commonwealth v. DeHaven, Ky.
___ S.W.2d ___ (9/26/96) 94-SC-69-DG

Peyton v. Commonwealth, Ky.
___ S.W.2d ___ (9/26/96) 95-SC-397-TG

Commonwealth v. Wirth, Ky.
___ S.W.2d ___ (9/26/96) 95-SC-402-CL

Thomas v. Commonwealth, Ky.
___ S.W.2d ___ (9/26/96) 95-SC-234-DG

Newkirk v. Commonwealth, Ky.
___ S.W.2d ___ (8/29/96) 95-SC-172-MR

Commonwealth v. Duncan, Ky.
___ S.W.2d ___ (8/29/96) 95-SC-00062-CL

Brown v. Commonwealth, Ky.
___ S.W.2d. ___ (8/29/86) 94-SC-1036-DG

Commonwealth v. Crider, Ky.
___ S.W.2d ___ (8/29/96) 95-SC-710-DG

McKinney v. Commonwealth, Ky.
___ S.W.2d ___ (8/29/96) 96-SC-207-MR

Commonwealth v. Burge, 92-SC-287-DG,
Herriford v. Commonwealth, 92-SC-873-TG,
& ***Commonwealth v. Effinger***, 92-SC-896-TG,
Ky., ___ S.W.2d ___ (8/29/96)

Commonwealth v. Collins, 95-SC-157-MR;
Collins v. Commonwealth, 95-SC-203-MR;
& ***Commonwealth v. Collins***, 95-SC-204-MR;
Ky., ___ S.W.2d ___ (8/29/96)

Snow v. Commonwealth, Ky.App.
___ S.W.2d ___ (8/9/96), 94-CA-002364-MR

Mullins v. Commonwealth, Ky.App.
___ S.W.2d ___ (8/23/96), 94-CA-002680-MR

Kentucky County Judge/Executive Association, Inc. v. Commonwealth, Ky.App.
___ S.W.2d --- (8/23/96) 95-CA-003062-MR

Edmonson v. Alig, Ky.App.
___ S.W.2d ___ (9/2/96), 95-CA-1138-MR

Commonwealth v. Hatfield, Ky.App.
___ S.W.2d ___ (9/20/96) 95-CA-2079-DG

quate funding, and it has taken no positive measures to correct this deficiency, thus falling clearly in contravention of its own mandate for treatment of individuals found to be GBMI." The Court stated it was "gravely troubled by a method of punishment which appears to be nothing more than a charade, cloaked in a verdict, GBMI, which amounts to nothing more than an oxymoronic term of art." However, the Court did not believe Brown's argument merited reversal.

Brown also argued the trial court committed reversible error when it failed to give Brown's tendered instruction on the disposition of a GBMI verdict and instead gave its own dispositional instruction. The Kentucky Supreme Court disagreed, although it stated that Brown's tendered instruction (which explained that Brown may or may not receive treatment while incarcerated depending on whether funds are available and whether the correctional mental health professional believes treatment is necessary) "appears more accurate" than the instruction given by the trial court (which stated Brown "shall" receive treatment while incarcerated until it is deemed no longer necessary). The Court pointed out that the constitutionality of the GBMI statute depends in part upon how the jury is instructed, but since the trial record was insufficient, reversal was not merited. The Court advised that its opinion "does not put to rest the issues of the constitutionality of the GMBI statute and the content of the instructions - especially with regard to treatment - to be given to the jury in a GBMI case."

Brown also argued he was entitled to a directed verdict of acquittal because the evidence of his insanity was overwhelming. Once again the Court disagreed stating the standard "is whether '[t]aking this evidence as a whole, it was not clearly unreasonable for any juror to find the defendant was not insane at the time of the incident,'" citing *Port v. Commonwealth*, Ky., 906 S.W.2d 327 (1995).

Brown argued it was error for the trial court to admit the evaluation offered by Dr. Meyer, the sole evidence that Brown was *not* insane, because Meyer never personally interviewed Brown. The Kentucky Supreme Court found no reversible error because "an 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 also argued it was error for the trial court to refuse to give his instruction defining the preponderance of the evidence standard that he was required to meet to prove his insanity. The Kentucky Supreme Court believed this argument was a "non-issue as counsel was free to argue the preponderance burden to the jury."

Brown further argued that it was error for the trial court to fail to instruct the jury that it must return a NGRI verdict of the evidence showed Brown was insane and it could not compromise by returned a GBMI verdict. The Kentucky Supreme Court disagreed and stated the jury was so instructed and Brown's argument was "merely one of semantics."

Brown argued he was denied a fair trial because during closing argument the prosecutor improperly accused defense counsel of unethical conduct. Without including the complained of comment in its opinion, the Court stated there was nothing in the comment which would warrant reversal and the trial court properly admonished the jury.

Brown also argued that the trial court erred when it allowed lay witnesses to express their opinion on the ultimate issue of Brown's sanity. The Kentucky Supreme Court disagreed noting that it has long allowed lay testimony in insanity cases.

Brown also argued it was error to admit photos of the crime scene and the deceased victim because they were irrelevant, especially since Brown admitted the killings. The Kentucky Supreme Court disagreed because "it is indispensable to the Commonwealth's case to establish that a crime has in fact been committed...." *Sanders v. Commonwealth*, Ky., 801 S.W.2d 665 (1991).

Lastly, Brown argued the indictment should have been dismissed with prejudice because his speedy trial rights were violated. Eight years elapsed between the crimes and the trial. The Kentucky Supreme Court disagreed. The first indictment was dismissed without prejudice because Brown was found incompetent to stand trial. After being involuntarily hospitalized for seven years, Brown was reindicted and it was

stipulated he was competent to stand trial. Since the time when a defendant is not under indictment is not counted for purposes of length of delay, and the time between the reindictment and the trial was ten months, and no specific incident of prejudice was alleged, no speedy trial violation occurred.

Brown's convictions were affirmed.

Commonwealth v. DeHaven, Ky. ___ S.W.2d ___ (9/26/96) 94-SC-69-DG

DeHaven was charged with murdering his estranged wife. He found her dead in her apartment on a Sunday, and the evidence revealed she had died the preceding Friday. DeHaven maintained he was not with the victim on Friday and evidence was presented that she had medical problems and died of natural causes.

The jury was instructed on murder and first degree manslaughter, although DeHaven objected to the manslaughter instruction. The jury found DeHaven guilty of first degree manslaughter.

The Kentucky Court of Appeals reversed DeHaven's conviction holding it was error to instruct the jury on first degree manslaughter because there was no evidence DeHaven was acting under extreme emotional disturbance. The Commonwealth sought discretionary review which was granted.

Although the Commonwealth argued in the Court of appeals that giving the first degree manslaughter instruction was proper, in the Kentucky Supreme Court the Commonwealth admitted error but argued the error was not prejudicial since DeHaven benefitted from the improper instruction by being convicted of an offense lesser than that with which he was charged.

The Supreme Court pointed out that a conviction "under an erroneous instruction for a crime that was not proven by the testimony is conclusive that the giving of the instruction was prejudicial." *Johnston v. Commonwealth*, 170 Ky. 766, 186 S.W. 655, 657 (1916). Since all parties agreed it was error to instruct on first degree manslaughter, and DeHaven was convicted under the erroneous instruction, the error was prejudicial.

In a four to three opinion, the Kentucky Supreme Court affirmed the opinion of the Court of Appeals reversing DeHaven's conviction.

Peyton v. Commonwealth, Ky. ___ S.W.2d ___ (9/26/96) 95-SC-397-TG

Peyton was convicted of two counts of trafficking in a schedule II controlled substance, second or subsequent offense; persistent felony offender first degree and possession of a handgun by a convicted felon. Her co-defendant, who was represented by the same trial counsel, was also charged with the same two trafficking counts.

On appeal, Peyton argued her due process rights were violated because the trial court failed to comply with RCr 8.30. There was no evidence in the record that Peyton and her co-defendant were given notice of the potential conflict of interest resulting from being represented by the same counsel, and there was no waiver of dual representation.

The Kentucky Supreme Court held "that non-compliance with the provisions of RCr 8.30 is presumptively prejudicial and warrants reversal in this matter." The Court set out a bright line rule that if the terms of RCr 8.30 are not followed, prejudice will be presumed.

Peyton also argued on appeal that it was error to sentence her as both a second and subsequent offense trafficker in controlled substances and a first degree felony offender. The Kentucky Supreme Court disagreed.

The facts revealed the two trafficking offenses occurred on two different dates. The PFO I conviction was based on one of these two trafficking charges in conjunction with a prior felony conviction of Peyton's. Peyton also had other prior felony convictions, many of which were trafficking charges. The trial court used a trifurcated procedure in which the jury was first instructed to find Peyton guilty on the two charged trafficking counts. The jury was not required to determine whether these offenses were other than first offenses. After finding Peyton guilty of both trafficking counts, the jury was instructed on the PFO I count and found Peyton guilty. The jury was then instructed as to the range of penalties and informed that a stipulation had been entered

that the trafficking offenses were subsequent offenses.

The Kentucky Supreme Court found no error with the procedure used by the trial court and pointed out that such a procedure had been previously approved by the Court in *Dedic v. Commonwealth*, Ky., 920 S.W.2d 878 (1996).

The Court did point out that it was error for the trial court to sentence Peyton on the underlying trafficking charge that was used for the PFO I charge as well as on the PFO I charge. The proper procedure is a single sentence on the PFO I charge.

Peyton's convictions were reversed and remanded for a new trial.

Commonwealth v. Wirth, Ky.
___ S.W.2d ___ (9/26/96) 95-SC-402-CL

This case involves a certification of the law on the proper construction of KRS 189A.010 and other statutes which deal with driving under the influence of alcohol.

The first issue the Kentucky Supreme Court addressed was whether in circumstances where a defendant may be guilty of violating two or more sections of the same statute, but subjected to only a single punishment, must the Commonwealth elect under which section of KRS 189A.010(1) it intends to proceed, or may it present proof of all statutory violations and permit a conviction on whatever basis is supported by the evidence.

The Court held the Commonwealth is not required to elect under which statutory subsection it intends to proceed. It may present evidence to prove one or more subsections of the statute and have the jury render a verdict upon the evidence presented. However, the Court pointed out that fundamental fairness and appropriate trial preparation require the Commonwealth to give notice as to which statutory subsections it will attempt to prove. A blanket notice covering all possible violations without regard to the actual evidence would defeat the purpose of giving notice and would not be acceptable.

The second issue addressed by the Court was whether the warning provided in KRS 189A.105 is sufficient or should be supplemented with additional warnings. Wirth argued a defendant should be informed of his right to counsel prior to deciding whether to take or refuse a breath or blood test. The Kentucky Supreme Court disagreed and held it was not going to extend the constitutional right to counsel to the pre-chemical test stage of the proceeding.

The third issue addressed by the Court concerned the foundational requirement for the admission of the breath test. The Court reaffirmed the foundational requirements set out in *Marcum v. Commonwealth*, Ky., 483 S.W.2d 122 (1972) and *Owens v. Commonwealth*, Ky., 487 S.W.2d 897 (1972). Additional requirements are set out in KRS 189A.103(3)(a), KRS 189A.103(4), and 500 KAR 8:020(2) which may be satisfied with business or public records showing compliance with the additional requirements. If the documentary evidence is properly admitted, it is unnecessary for the Commonwealth to produce the testimony of the technician who serviced and calibrated the breathalyzer machine.

The fourth issue addressed by the Court was whether the Commonwealth is required to present expert testimony by which the breath test result would be related back in time to the point of motor vehicle operation. Such evidence is called extrapolation evidence. Although other jurisdictions are divided as to whether extrapolation evidence is necessary, the Kentucky Supreme Court held extrapolation evidence is not required for the Commonwealth to make a prima facie case of a *per se* violation of the statute. KRS 189A.010(1)(a). The Court noted that based on KRS 189A.103(7), which allows a person who has been tested by the police to obtain an additional test by a person of his own choosing, a defendant could produce his own extrapolation expert based on the test taken by the police and any additional tests taken.

The law is now certified in accordance with this opinion.

Thomas v. Commonwealth, Ky.
___ S.W.2d ___ (9/26/96) 95-SC-234-DG

Thomas was tried and convicted of first degree robbery. His twenty year sentence was enhanced to life upon his conviction as a second degree persistent felony offender. His convic-

tions were affirmed on direct appeal and his subsequent RCr 11.42 motion was denied.

Years later Thomas filed a pro se CR 60.03 motion claiming the robbery indictment underlying his conviction was void under *Stark v. Commonwealth*, Ky., 828 S.W.2d 603 (1992), because it failed to specifically allege a person was robbed, but rather alleged a Convenient Food Mart was robbed. The trial court denied Thomas' CR 60.03 motion and the Court of Appeals affirmed the denial. The Kentucky Supreme Court granted discretionary review.

The Kentucky Supreme Court overruled that portion of *Stark, supra* that held a failure to include in the indictment an allegation that force was used or threatened against a person, rather than a business, constituted a failure to state a public offense.

The Kentucky Supreme Court stated that although "the indictment against Thomas was incomplete because it failed to state that Thomas used or threatened force against a person and failed to name that person, that defect does not mean the indictment failed to "charge an offense" or was insufficient to support a conviction. Failure to include the name of the person upon whom Thomas used or threatened to use physical force is the type of defect that can be easily cured at the trial level and must be raised by motion before trial in accordance with RCr 8.18."

Since Thomas had requested and received a bill of particulars, he was aware of the person upon whom he was alleged to have used force to accomplish the crime. He was on notice of the specific crime charged and the indictment was not misleading.

Because Thomas failed to bring any defect in the indictment to the attention of the trial court, he waived any defect in the indictment. Thus, the Court stated it did not have to decide whether RCr 60.03 was an appropriate avenue for relief in this case.

The Court affirmed the denial of Thomas' RCr 60.03 motion.

Newkirk v. Commonwealth, Ky. ___ S.W.2d ___ (8/29/96) 95-SC-172-MR

Wendell Newkirk was convicted in the Jefferson Circuit Court of one count of rape and one count of sodomy of his ten-year-old niece. He was sentenced to twenty years for each offense to run concurrently.

The charged offenses occurred while Newkirk was babysitting his niece. Upon the parents' return, the child's distress was discovered and she was taken for a medical exam during which she revealed what her uncle had done to her. Criminal charges were brought against Newkirk. Two days later, in an interview with the prosecutor, the child recanted her accusations.

Prior to trial, the trial court conducted a lengthy hearing on the Commonwealth's motion to introduce expert testimony regarding recantation. The Commonwealth presented the testimony of three experts that recantation is a common phenomenon among child sexual abuse victims and it is widely accepted in their respective fields. The defense presented no expert testimony. At the conclusion of the hearing, the court ruled the Commonwealth could introduce the expert testimony for the limited purpose of rebutting any attack on the child's credibility based on her recantation by explaining in general terms why an alleged victim might recant.

At trial the child testified Newkirk raped and sodomized her. On cross-examination, the defense elicited facts about the child's recantation. In rebuttal, pursuant to the trial court's pretrial ruling and over defense objection, a child psychiatrist testified in general terms about victim recantation of accusations of sexual abuse leveled at family members. The psychiatrist had never met the child-victim in this case.

In a four to three opinion, the Kentucky Supreme Court held the trial court erred when it allowed the Commonwealth to present expert testimony explaining that recantation was a common occurrence among sexually abused children.

The Kentucky Supreme Court explained the doctor's testimony was inadmissible for two reasons. First, it was irrelevant; and second, it invaded the province of the jury. The Court noted that "where the determination of credibility is synonymous with the ultimate fact of

guilt or innocence, expert opinion is inadmissible.... When...an expression of opinion as to credibility is the equivalent of an opinion as to guilt or innocence, it is of no consequence that the testimony was presented in a general manner rather than as specific to the case or on rebuttal rather than as evidence in chief."

Addressing the second issued raised by Newkirk on appeal, the Court held the trial court did not abuse its discretion when it allowed out-of-court statements by the child to the investigating police officers and the hospital examining doctor to be admitted, since the child could not recall specific details during her trial testimony.

The defendant's convictions were reversed and his case was remanded for a new trial.

Commonwealth v. Duncan, Ky. ___ S.W.2d ___ (8/29/96) 95-SC-00062-CL

This case involves a certification of the law on the question of whether a certified copy of the Transportation Cabinet's driving history is sufficient evidence of license suspension or revocation to sustain a conviction under KRS 186.620(2).

Ms. Duncan was charged with driving on a suspended license in violation of KRS 186.620 (2). After a bench trial, the district court found Ms. Duncan not guilty because the only evidence introduced by the Commonwealth was a certified copy of Ms. Duncan's driving history from the Kentucky Transportation Cabinet.

Since it is only necessary to prove the defendant was operating a motor vehicle while his or her license was suspended when prosecuting a suspended license charge, and it is not necessary to prove a prior conviction, the Kentucky Supreme Court concluded that a certified copy of the Transportation Cabinet's driver history is sufficient proof, by itself, to support a conviction under KRS 186.620(2).

This opinion overrules *Commonwealth v. Dean*, Ky., 732 S.W.2d 887 (1987).

Brown v. Commonwealth, Ky. ___ S.W.2d. ___ (8/29/86) 94-SC-1036-DG

James Brown was convicted of murder in the Mason Circuit Court and his conviction was affirmed on appeal in *Brown v. Commonwealth*, Ky., 639 S.W.2d 758 (1982).

At Brown's trial the Commonwealth's expert, Dr. Shaler, testified that blood found on Brown's boot could not have come from Brown. Eleven years later Dr. Shaler stated in an affidavit that he was mistaken when he testified the blood stain on Brown's boots could not have come from Brown. This affidavit was the basis for Brown's CR 60.02(f) motion to set aside his conviction. The trial court denied his motion without an evidentiary hearing, but assumed defense counsel's affidavit to be a true reflection of Dr. Shaler's thinking about his earlier testimony. The trial court believed the exclusion of Dr. Shaler's testimony "would in all probability not have affected the verdict of the jury...in view of the overwhelming evidence." Brown appealed to the Kentucky Court of Appeals which affirmed the denial of Brown's motion. The Court of Appeals pointed to this Court's prior opinion affirming Brown's conviction on direct appeal in which this Court noted that the evidence, even without Dr. Shaler's testimony, was sufficient to justify Brown's conviction. The Kentucky Supreme Court granted discretionary review.

In a four to three opinion, the Kentucky Supreme Court affirmed the opinion of the Court of Appeals.

According to the majority opinion, "relief should not be granted, pursuant to CR 60.02(f), unless the new evidence, if presented originally, would have, with reasonable certainty, changed the result." By contrast, the dissenting opinion states "the proper standard of review of the CR 60.02(f) motion includes a determination of whether there was a fundamental miscarriage of justice in the trial and the conviction" of the accused.

A majority of the Kentucky Supreme Court concluded that a review of the trial evidence failed to convince it that the outcome would have been different if all of Dr. Shaler's testimony had been excluded or if it had been admitted and Shaler's later misgivings had been available to the jury at trial. The Court also did not believe, contrary to Brown's assertion in his motion, that Dr. Shaler's testimony was a key piece or an important item of evidence against Brown. The Court based this conclusion on the fact that neither

trial counsel nor the prosecutor referred to Dr. Shaler's testimony in closing argument.[1] However, the dissenting opinion quotes portions of defense counsel's and the prosecutor's closing arguments where each refers to the blood found on Brown's boot, which was the basis of Dr. Shaler's testimony.

In upholding the trial court's denial of Brown's CR 60.02(f) motion, the Kentucky Supreme Court also noted that the trial judge who denied the motion was the same judge who presided over Brown's trial "and was thus in an excellent position to evaluate the import of Shaler's testimony."

Commonwealth v. Crider, Ky.
___ S.W.2d ___ (8/29/96) 95-SC-710-DG

The issue in this appeal is the constitutionality of KRS 224.99-010(9) to the extent it provides "concurrent jurisdiction and venue" in Franklin Circuit Court of criminal actions arising out of various environmental proceedings.

Carroll Crider and Crider and Rodgers, Inc., Caldwell County solid waste landfill operators, were indicted in Franklin County for violating KRS 224.40-100(2) and KRS 224.40-305, which prohibit operating an open drum without an approved compliance schedule and operating an open dump without first procuring the required permit. Each of the nineteen counts of the indictment alleged violations occurring in Caldwell County.

Prior to trial the defendants (Criders) argued that under § 11 of the Kentucky Constitution ("...the accused...shall have...a...trial by an impartial jury of the vicinage") they were entitled to venue in Caldwell Circuit Court. The Franklin Circuit Judge agreed with the Criders and concluded "the concurrent criminal jurisdiction provided by KRS 224.99-010(9), is violative of Section 11 in situations where there is no valid connection between the criminal activity and Franklin County."

The Court of Appeals upheld the trial court's ruling on appeal. The Kentucky Supreme Court granted the Commonwealth's motion for discretionary review.

The Kentucky Supreme Court agreed with both the trial court and the Court of Appeals that KRS 224.99-010(9) violates § 11 of the Kentucky Constitution "under these circumstances" and "that the lack of significant nexus to Franklin County is further reflected in the 19 counts alleging violations of environmental law all occurring 'in Caldwell County, Kentucky.'"

McKinney v. Commonwealth, Ky.
___ S.W.2d ___ (8/29/96) 96-SC-207-MR

Gary McKinney was charged with murdering his wife and two stepchildren. Blood stains were found on McKinney's clothing. The Commonwealth wanted to do DNA testing on these blood stains to see if they "matched" the victims' blood. Because the amount of blood was so small, the usual RFLP type DNA testing was not possible. The Commonwealth indicated it was going to send the blood samples to a lab in North Carolina (Genetic Designs) which would use PCR type DNA testing, a technique that can test samples much smaller than those required for RFLP testing. However, PCR type testing destroys the blood sample.

McKinney sought to prevent the Commonwealth from testing the blood samples until a hearing could be held to determine: 1) whether McKinney could depose chemists and lab technicians prior to testing; 2) the best available method of testing under the circumstances; and 3) whether the test results would be admissible at trial.

After a hearing, the trial court ruled that prior to any testing by the Commonwealth that would destroy the evidence or render it unsuitable for further testing, the Commonwealth shall give the defense at least two weeks notice of the testing date. Defense counsel, or any appropriate expert, shall be permitted to attend and observe the testing. The defense shall be granted funds under KRS Chapter 31 to employ an expert to observe the testing. The trial court further ruled it would conduct a hearing on the admissibility of the evidence after the Commonwealth indicated it would seek to offer the evidence at trial.

McKinney then sought a writ of prohibition or in the alternative a writ of mandamus in the Kentucky Court of Appeals to prevent the Commonwealth from testing the blood samples, which would result in the destruction of the samples and thus deny McKinney the opportunity to conduct his own testing. The Court of

Appeals denied McKinney's request for relief from the trial court's order. McKinney appealed to the Kentucky Supreme Court.

Affirming the opinion of the Court of Appeals, the Kentucky Supreme Court stated a defendant may not dictate the method of DNA testing chosen by the Commonwealth. The trial court is not required to determine the admissibility of scientific test results until after the testing is completed and the results are offered as evidence. If the trial court rules the evidence is admissible and the defendant is convicted, redress is through the process of appeal.

Commonwealth v. Burge,
92-SC-287-DG,
Herriford v. Commonwealth,
92-SC-873-TG,
& ***Commonwealth v. Effinger***,
92-SC-896-TG,
Ky., ___ S.W.2d ___ (8/29/96)

The issue in these three cases is whether a finding of criminal contempt for violation of a domestic violence order, issued pursuant to KRS 403.750, or for violation of a restraining order issued in a dissolution of marriage case, can bar a subsequent criminal prosecution on double jeopardy grounds.

In each case the defendant was convicted and sentenced on the criminal contempt charge prior to his indictment on the charges that resulted from the contemptuous conduct.

The Kentucky Supreme Court held a conviction and sentence for criminal contempt does not bar a subsequent prosecution on double jeopardy grounds because each statute requires proof of an additional fact which the other does not, citing *Blockburger v. U.S.*, 284 U.S. 299, 52 S.Ct. 180, 182, 76 L.Ed. 306 (1932). The Court clearly stated it was returning to the traditional *Blockburger* double jeopardy analysis which requires a determination whether the act or transaction complained of constitutes a violation of two distinct statutes and, if it does, if each statute requires proof of a fact the other does not. The Court overruled that portion of *Ingram v. Commonwealth*, Ky., 801 S.W.2d 321 (1990), which relied on a double jeopardy analysis based on the "single impulse" or "single act" test.

The Court of Appeals' opinion reversing the trial court's order denying Burge's motion to dismiss on double jeopardy grounds was reversed. The trial court's order denying Herriford's motion to dismiss on double jeopardy grounds was affirmed, and the trial court's order dismissing the indictment against Effinger was reversed.

Commonwealth v. Collins,
95-SC-157-MR;
Collins v. Commonwealth,
95-SC-203-MR;
& ***Commonwealth v. Collins***,
95-SC-204-MR;
Ky., ___ S.W.2d ___ (8/29/96)

Collins was tried and convicted of intentional murder and first degree criminal abuse of her twelve year old stepson. She was sentenced to twenty-one years on the murder charge and seven years on the first degree criminal abuse charge to run concurrently for a total of twenty-one years' imprisonment. These sentences were the subject of a separate appeal by the Commonwealth which is discussed below. Collins was free on bond bending appeal.

On appeal, Collins presented five issues for reversal of her convictions.

First, Collins argued the trial court erred when it ruled she could not introduce the remainder of the diary of a key Commonwealth witness, parts of which were introduced by the Commonwealth during the witness' direct testimony. This witness was originally charged along with Collins. The Kentucky Supreme Court felt that Collins' trial strategy was not hindered or jeopardized by the trial court's exclusion of the entire diary. Moreover, the Court pointed out that much of what Collins wanted to introduce through the diary was elicited from the witness on cross-examination. Thus, reversal was not required on this issue.

Second, Collins argued the trial court erred in not granting her motion for a directed verdict of acquittal since the evidence was insufficient to support a conviction on either the murder or the abuse charge. The Kentucky Supreme Court disagreed and noted that the standard of review in evaluating the sufficiency of the evidence is the same whether the evidence is direct or circumstantial. Thus, reversal was not required on this issue.

Third, Collins argued the trial court erred when it refused to sever the criminal abuse charge from the murder charge. The Kentucky Supreme Court disagreed because the evidence relating to the abuse charge would have been admissible in a trial on the murder charge, not as proof of criminal disposition, but as proof of a similar course of conduct or common scheme or plan. In addition, joinder of the offenses was proper because the crimes were closely related in character, circumstance and time. The two crimes occurred within a week of one another; both crimes took place at Collins' residence and there was a substantial degree of similarity between the way in which the child was abused and the way in which he was killed. Thus, reversal was not required on this issue.

Fourth, Collins argued that a separation of witnesses order was violated when the investigating officer, after the trial began, informed certain defense witnesses of the testimony of certain prosecution witnesses. Although a hearing was held on this matter, the evidence was conflicting as to what the officer actually told the witnesses. The Kentucky Supreme, while admitting there was a technical violation of the separation order, stated the facts do not reveal the objective of the separation of witnesses rule was circumvented by the officer, and there is no real proof to substantiate Collins' claim that defense witnesses changed their testimony after the officer spoke to them. The Court concluded the trial court did not abuse its discretion when it ruled, after the hearing, that no violation of the rule had occurred. Thus, reversal was not required on this issue.

Fifth, the trial court erred in allowing jurors to ask questions of the witnesses by approaching the bench and making a verbal inquiry, when KRE 614(c) requires questions by jurors to be submitted in writing to the judge. The Kentucky Supreme Court again found a technical violation of the rule, but deferred to the discretion of the trial court in determining that the jurors' questions were properly submitted. The Court concluded that any error was harmless because no prejudicial question was asked. Thus, reversal was not required on this issue.

Collins' convictions were affirmed.

The facts surrounding the Commonwealth's appeal of Collins' sentence are as follows. After the jury returned its guilty verdicts, but before the commencement of the sentencing phase of trial, the trial court offered Collins minimum sentences (twenty to twenty-five years on the murder charge and five to seven years on the criminal abuse charge, to be served concurrently) in exchange for her waiver of the sentencing phase. The Commonwealth objected, but the court overruled the objection and fixed Collins' sentence at twenty-one years on the murder charge and seven years on the criminal abuse charge to run concurrently. After final judgment was entered, the Commonwealth appealed to the Kentucky Supreme Court and its appeal was consolidated with Collins' appeal from her convictions.

The Kentucky Supreme Court, relying on its opinion in *Commonwealth v. Johnson*, Ky., 910 S.W.2d 229 (1995), held the trial court erred in accepting Collins' waiver of jury sentencing over objection by the Commonwealth. Accordingly, Collins' case was remanded to the Henry Circuit Court for jury resentencing.

Snow v. Commonwealth, Ky.App. ___ S.W.2d ___ (8/9/96), 94-CA-002364-MR

Pursuant to a guilty plea, Snow was convicted and sentenced to three years' imprisonment on each of two counts of theft, said sentences to be served concurrently. The sentences were then suspended and Snow was placed on probation. Less than five months later, Snow was convicted of several violations and misdemeanors and sentenced to ninety days in jail. The Commonwealth's motion to revoke Snow's probation was granted and Snow was remanded to custody. The ninety day sentence was ordered to run consecutive to the original three year sentence.

On appeal, relying on KRS 532.110(1), Snow argued the circuit court erred in ordering the ninety day misdemeanor sentence to be served consecutively to the three year felony sentence. The Court of Appeals disagreed.

Recognizing that concurrent sentencing is the general rule, the Court of Appeals concluded that KRS 533.040(3), which deals specifically with sentences of probation, controls in this situation and creates an exception for cases in which probation is revoked. Thus, the order of the circuit court was affirmed.

Mullins v. Commonwealth, Ky.App.
___ S.W.2d ___ (8/23/96), 94-CA-002680-MR

Mullins was charged with first degree sodomy, but was convicted of third degree sodomy of a fourteen year old girl. He was sentenced to four years. Mullins' wife allegedly caught her husband engaging in the charged offense and telephoned the police. She also testified at the grand jury.

At trial, Mullins and his wife both asserted the husband-wife privilege to prevent Mullins' wife from testifying against him. The trial court rejected this claim and Mullins' wife was compelled to testify against him.

Also at trial, the child's mother testified about the child's emotional reactions following the sexual abuse and the psychological treatment she received at a hospital and from a psychiatrist and a social worker. The social worker also testified she treated the child for nine months. Although Mullins objected to the mother's testimony as irrelevant, he failed to object to the social worker's testimony.

On appeal, the Court of Appeals held that pursuant to KRS 620.050 the husband-wife privilege of KRE 504(a) does not apply to evidence in a criminal proceeding regarding an abused child (notwithstanding that the child is not the child of either the husband or the wife and does not live in the household of either the husband or the wife).

The Court of Appeals also held that both the mother's testimony and the social worker's testimony about the child's emotional reaction to the charged offense and that she received counseling was irrelevant and inadmissible. However, the error was harmless "in view of the other evidence of guilt, most notably the eyewitness testimony" of Mullins' wife.

Mullins' conviction was affirmed.

Kentucky County Judge/Executive Association, Inc. v. Commonwealth,
Ky.App. ___ S.W.2d --- (8/23/96)
95-CA-003062-MR

The issue in this case is when is the Commonwealth obligated to reimburse counties for the detention of felony convicts.

The Court of Appeals held that the word "convict," as used in § 254 of the Kentucky Constitution, refers to a person who has been found guilty through a confession, plea or verdict of a felony crime proscribed by the state and has been sentenced to serve time in a state penal institution.

The Court of Appeals also held that KRS 431.215(2) is unconstitutional under §254 of the Kentucky Constitution insofar as it allows the Commonwealth to delay reimbursement to county jails for five days after the entry of judgment. As a result, the Commonwealth must reimburse the counties for their expenses for housing convicted felons in county jails pending their transfer to a state penitentiary.

Edmonson v. Alig, Ky.App.
___ S.W.2d ___ (9/2/96), 95-CA-1138-MR

This case stems from a request by attorney Jon Alig, made by letter, that the Kenton County Attorney, Gary Edmonson, provide him with certain records, pursuant to the Kentucky Open Records Act (KRS 61.870 *et seq.*).

One week later, having received no response to his request, Alig forwarded his request to the Attorney General's Office. Before the Attorney General responded, the County Attorney responded that the information Alig sought was exempt under KRS 61.878(1)(a)(k)(1).

The Attorney General's Office then issued an unpublished decision (94-ORD-154) that the County Attorney had 1) procedurally violated the Open Records Act by failing to respond within three business days, and 2) substantively violated the Open Records Act by failing to explain how the privacy exception of KRS 61.878(1)(a) was applicable to the requested records. The Attorney General's Office ordered the County Attorney to provide Alig with the records.

The County Attorney then filed a complaint in the Kenton Circuit Court seeking *de novo* review. The Kenton Circuit Court entered summary judgment for Alig. The County Attorney appealed to the Court of Appeals.

The Court of Appeals held that the County Attorney's original response to Alig's records' request was statutorily deficient. However, the Court of Appeals disagreed with the remedy of

disclosure of the records ordered by the Attorney General's Office and upheld by the Kenton Circuit Court. Since the issue of whether the records in question are statutorily exempt from disclosure has not been addressed, the Court of Appeals vacated the judgment of the Kenton Circuit Court and remanded the case to the Kenton Circuit Court for a determination of the status of the requested records.

Commonwealth v. Hatfield, Ky.App. ___ S.W.2d ___ (9/20/96) 95-CA-2079-DG

The issue in this case concerns a paternity action filed by the Commonwealth against Hatfield.

When Hatfield was sixteen years old he voluntarily engaged in sexual relations with Rush who was over the age of twenty-one. A child resulted from the parties' actions. Although Rush's actions may have constituted third degree rape, she was never charged with any crime.

After Hatfield turned eighteen years old, the Commonwealth filed a paternity action against him and an order of support. Blood tests confirmed Hatfield was the child's father. The Commonwealth moved for summary judgment, but the trial court denied the motion and dismissed the action because Rush may have committed third degree rape upon Hatfield. The Harlan Circuit Court affirmed the district court's order. The Kentucky Court of Appeals granted discretionary review.

The issue before the Court of appeals was whether, once Hatfield reached eighteen years old, he should be relieved of his civil obligation to support his putative child solely because, on the date of the child's conception, he was statutorily incapable of consenting to sexual relations regardless of his actual willingness to participate in such relations. The Court of Appeals concluded he should not be relieved of any such support obligation. The Court concluded that this state's strong public policy requiring fathers to support their out of wedlock children must take preference over any policy which may be embodied in the statutory rape legislation to protect victims of such crimes, especially since an innocent child rather than the perpetrator of the alleged crime would be the beneficiary of the support payments.

The rulings of the courts below were reversed and the case remanded for further proceedings.

Footnotes

[1]Appellate counsel should take note of this comment by the Court and when writing a brief should always try to use the prosecutor's comments in closing argument to support their arguments.

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DURHAM APPOINTED GENERAL COUNSEL FOR CORRECTIONS

In July 1996, Stephen P. Durham, was appointed General Counsel for the Department of Corrections. The legal division of the Department of Corrections represents Corrections officials, Parole Board members and employees in litigation in federal and state court and in administrative hearings. The division drafts the policies and procedures for the Department and provides training based on those policies.

Steve is a 1979 graduate of the University of Louisville and a 1983 graduate of U. of L. School of Law. From 1983-96, he was in private practice in Louisville, trying over 50 jury trial. From 1985-91, he was the public defender administrator for Shelby County. From 1992-96 he served as Master Commissioner in Shelby County. A guiding quote of Steve's in Chief Justice John Marshall's words, *To listen well is as powerful a means of communication and influence as to talk well.*

Treat Me, Release Me or Give Me A Jury Trial

"Hold the hooligans responsible and to hell with their rights!" You hear it in courtrooms, at legislative hearings, at Cabinet level meetings and in the media: the Juvenile Justice philosophy of the 1990s. Can we do both (hold juveniles responsible and ignore their rights) fairly and justly? Does the law allow it?

The Department of Public Advocacy has entered into a two year contract with the Cabinet for Families and Children and its successor(s) to represent children in the thirteen existing, residential treatment facilities in Kentucky. The effort to lift the veil from these residential treatment facilities has been challenging. Two of our staff have had their lives threatened. We have been told by juvenile court judges that persons under the age of eighteen have no right to their records if they intend to use them to sue the state. We have been told by staff for the Cabinet for Families and Children that they don't understand how a child can consent to allowing us to view their records or even represent them. This attitude towards our role exists within a juvenile justice system which has no trouble locking up kids, transferring them from one facility to another without any hearing, securing confessions using *Miranda* waiver forms styled for adults, and searching their rooms and property.

This article will be the first in an ongoing series over the next two years to educate the juvenile court practitioner on what we can learn from taking an inside look at the residential treatment facilities.

How can an examination of what is really happening to committed youth impact our juvenile clients' rights to more due process in juvenile court?

According to caselaw dating back to the late 1960's juveniles have no federal or state constitutional right to a trial by jury while their case is in juvenile court. It is generally believed that they are correctly denied this right because it is the state's role as *parens patria* to treat the juvenile offenders committed to its care. The Kentucky case on point is *Dryden v. Commonwealth*, 435 S.W.2d 457 (Ky. 1968). In pondering whether *In re Gault* required trial by jury for juveniles, our Court noted the following:

> Surely if the gravity of what may happen to a defendant in a juvenile proceeding is sufficient to invoke the other constitutional protections we have mentioned, by force of the same reasoning it would seem also to call for the right to a jury trial, which could hardly be classified as a less vital instrument of protection than the others. But that is mere logic and, as Holmes observed, in the course of jurisprudential navigation logic can be a deceptive compass indeed. *Dryden*, *supra* at 461.

The Court, in *Dryden*, then went on with jurisprudential logic and reasoned that since a child, found guilty of what would be a crime if s/he were an adult, would be treated the same as a child who has been dependent, neglected or abused, ("a world of 'white-washed walls, regimented routine and institutional laws'" *Dryden*, *supra* at 461) then neither child should be entitled to a trial by jury.

The interesting thing to note in 1996, is that children adjudicated "guilty" on public offenses *are* housed and treated differently, than children who are status offenders or dependent, neglected or abused. Theoretically, and usually in actuality, the Cabinet for Families and Children has a different placement plan and a different set of options for status offenders and dependent, neglect and abused children versus public offenders. Once the Department of Juve-

nile Justice is up and running, all public offenders will be committed to it and placed in facilities run by that department. What does this difference in treatment mean for a juvenile public offender who wants a jury trial?

The United States Supreme Court in *McKeiver v. Pennsylvania*, 91 S.Ct. 1976 (1971), concurred with the bottom line of *Dryden* that juveniles were not entitled to a jury trial. The Supreme Court was perhaps most concerned with maintaining the informality of juvenile court to protect the judicial economy of the system. The majority opinion in *McKeiver* emphasized that the juvenile court system contemplates "fairness", "concern", "sympathy" and "paternal attention," which apparently the Supreme Court thought were only possible with trial by the fatherly figure of a judge.

White's concurrence in *McKeiver* offered us a bit more as he noted that states are "free if they extend criminal court safeguards to juvenile court adjudications, frankly to embrace condemnation, punishment and deterrence as permissible and desirable attributes of the juvenile justice system." *McKeiver*, *supra* 91 S.Ct. at 1990. If there be jurisprudential logic for juveniles, the converse must also be true, where states embrace condemnation, punishment, and deterrence as permissible and desirable attributes of the juvenile justice system, they have an obligation to grant those juveniles the criminal court safeguard of what in Kentucky is the "sacred" right to a trial by jury.

To decide what Kentucky does embrace, it would seem important to evaluate not only our laws but our practices. How are juveniles actually treated once committed to the state following a trial before the juvenile court judge and adjudication as a public offender?

For the first time in Kentucky's history, there are six lawyers and four full or part-time paralegals making weekly attorney-client visits to juveniles in the state's thirteen residential treatment facilities. A quick tour through what the legal staff representing children in the facilities has uncovered could easily cause juvenile litigators to consider revisiting *Dryden* and *McKeiver* on behalf of their clients.

The most surprising fact we have learned concerns the amount of time juveniles are confined. Most juveniles are not released in the expected four to seven months required to move from the first to the fourth level in the facilities behavioral modification program. Instead, the residents in these facilities are often transported from one facility to another without notice or an opportunity to be heard. At the new facility they, must begin again at the orientation phase and move often laboriously from one level to the next. Candy in the mouth or a hairbrush left on a bed can drop a juvenile down one level and mean at least an extra month of "white washed walls and institutional rules." Juveniles, in some facilities are forced to work without pay for up to five hours a day. Isolation, under a number of guises, is used regularly in lieu of treatment and as a means of breaking down the will of resistant adolescents. One juvenile client had spent three months restricted to his bedroom, permitted no activities and kept on a bland, reduced diet. It is no wonder that many juveniles feel they would be better off in prison where they might see the light of day and have a gym in which to exercise. The educational programs for these youth are woefully inadequate and fail to comply with federal and state law. Are the juveniles perceiving this as punishment? Undoubtedly. Are they receiving treatment? Sometimes, but usually at a very minimal level.

Will the newly formed Department of Juvenile Justice make the environment in the juvenile facilities more or less punitive?

In forming the Department of Juvenile Justice, is the state giving up treatment as a primary objective? The answer must be no. Every juvenile brought into the justice system by KRS Chapter 600-645 still has a statutory and constitutional right to treatment based upon our Juvenile Code and prior caselaw. Furthermore, House Bill 117 which among other things, sets forth the mission of the new Department of Juvenile Justice seems to recognize that treatment must be a primary objective of the new department. With House Bill 117, a new section of KRS Chapter 15A mandates that the Department of Juvenile Justice shall prevent juvenile crime; identify juveniles at risk; provide services to law enforcement, victims, *defense attorneys*, and the public relating to juvenile crime, its prevention, detection, trial, punishment, and rehabilitation of youth; conduct research and comparative experiments to prevent delinquent behavior; identify juveniles

at risk; assess the needs of the juveniles and provide an effective and efficient program to treat and correct such youth.

The new commissioner of the Department, Ralph Kelly spoke of his commitment to meaningful treatment in a recent *Courier Journal* article (Sunday, October 13, 1996, p. A1, A18.) He does not appear to endorse a simplistic corrections' approach towards youth who will be in his Department's custody. In the years ahead, we hope that Commissioner Kelly will be successful in cleaning up the problems that exist and establishing an effective treatment model.

Until those changes are in place, every juvenile facing a real possibility of commitment and placement ought to consider demanding a right to trial by jury.

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Juvenile Post-Dispositional Unit

Rebecca Ballard DiLoreto assumed leadership of DPA's Juvenile Unit and the Juvenile Post-Dispositional Program. She started with DPA in September 1984 and has worked over the years in DPA's Richmond trial office, appeals and as DPA's recruiter.

Lisa Clare tranferred to the Juvenile Post-Dispositional Program on June 1, 1996 as Assistant Director. She was formerly an attorney with the Protection & Advocacy Division from April 1994 to June 1996. She has extensive experience with education law and civil rights work.

Tim Arnold has been a law clerk with DPA. He is a 1996 law school graduate of U.K. He will be working in the Juvenile Post-Dispositional Program as of October as an Assistant Public Advocate.

Jeff Sherr has been a law clerk with DPA. He is a 1996 law school graduate of U.K. He will be working in the Juvenile Post-Dispositional Program as of October as an Assistant Public Advocate.

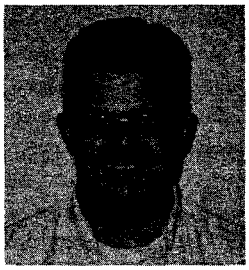
Claudia Smith has been an intern with the Fayette County Commonwealth Attorney's office from September 1995 - May 1996. She is a 1995 law school gradate of U.K. She will be working in the Juvenile Post-Dispositional Program as of October as an Assistant Public Advocate.

Amy Beaton is an Assistant Public Advocate as of July 16, 1996 working with the Juvenile Post-Dispositional Program in Western Kentucky. She received her J.D. from Northeastern University School of Law in 1994. She was previously an Assistant Federal Public Defender in San Antonio since 1994.

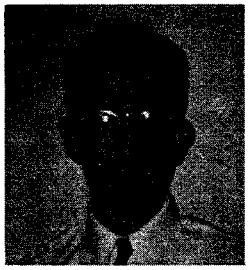
Kimberly Crone is an Assistant Public Advocate at DPA's Morehead Office as of July 16, 1996 working with the Juvenile Post-Dispositional Program. She received her J.D. from Chase Law School in 1995. She was formerly with the Children's Law Center in Covington.

Donna Southard is a Paralegal as of July 16, 1996 working with the Juvenile Post-Dispositional Program in Western Kentucky. She received her A.A. in Paralegal Studies at Western Kentucky University.

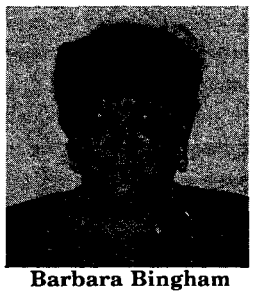
Barbara Bingham is a secretary/paralegal for the Juvenile Post-Dispositional Program, working in Frankfort. She interned in the Richmond field office has a 1996 A.A. degree from Eastern Kentucky University.



Tim Arnold

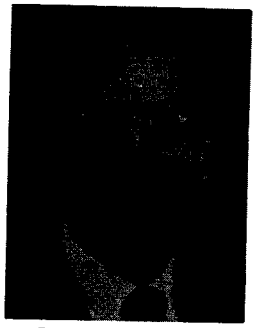


Jeff Sherr



Barbara Bingham

Plain View



Ernie Lewis

Pennyslvania v. Labron
116 S.Ct. 2485, 135 L.Ed.2d 1031 (1996)

The United States Supreme Court issued one of the few search and seizure opinions this term on July 1, 1996. This per curiam reversed two Pennsylvania Supreme Court cases in a manner implicating more issues of federalism than search and seizure law.

In *Labron*, the police arrested suspects and thereafter searched the trunks of their cars. In *Kilgore*, the police arrested the Kilgores and searched a farmhouse with consent and Randy Kilgore's truck after seeing the Kilgores walking to and from the truck. Drugs were found in both. In both cases, the Court of Appeals of Pennsylvania found no Fourth Amendment violation. In both, the Pennsylvania Supreme Court reversed the Court of Appeals and held that while probable cause existed in both, that exigent circumstances was also needed to conduct a warrantless search.

The United States Supreme Court reversed the Pennsylvania Supreme Court and held that under traditional Fourth Amendment law, "[i]f a car is readily mobile and probable cause exists to believe it contains contraband, the Fourth Amendment thus permits police to search the vehicle without more." The Court further found that the "ready mobility" of a vehicle provides the exigency and that no further exigencies are required.

Labron and Kilgore had argued that there was an adequate and independent state ground, and thus that the Court had no federal jurisdiction of these cases. However, the Court held under *Michigan v. Long*, 463 U.S. 1032 (1983) that the state cases were "'interwoven with the federal law, and...the adequacy and independence of any possible state law ground is not clear from the face of the opinion.'"

Justice Stevens issued a dissenting opinion, joined by Justice Ginsburg. Both believed that *Labron* was decided based upon adequate and independent state grounds, and that *Kilgore* would be decided similarly upon remand. Of the state court they said, "that court concluded that citizens of Pennsylvania are protected from warrantless searches and seizures of their automobiles absent exigent circumstances." The dissenters believe that "the decision to summarily reverse state decisions resting tenuously at best on federal grounds is imprudent and entirely inconsistent 'with the sound administration of this Court's discretionary docket.'"

The dissenters also note how little was accomplished in this per curiam decision. "To reinvigorate the privacy protections extended to Pennsylvania citizens under *Labron*, *Kilgore*, and *White*, the Pennsylvania Supreme Court need only set forth the appropriate talismanic language and state, even more clearly than it already has, that the 'Comonwealth's jurisprudence of the automobile exception [requires] both the existence of probable cause and the presence of exigent circumstances to justify a warrantless search...While the result will be identical, resources and respect will have been unnecessarily lost."

Commonwealth v. Wilson
1996 WL 517102 (Ky.App.)

The police in Hopkinsville at 5:00 a.m. saw a car behind a building that had recently been burglarized. The car sped off at 50 miles per hour in a 25 mile per hour zone. The car was stopped, and the driver arrested for DUI. The passenger, Mrs. Wilson, was asked to get out of the car to perform a field sobriety test. When she failed, the police offered to find someone to take her home. Thereafter, a search of the car revealed a purse with a heavy object in it, which was found to be cocaine and paraphernalia. Mrs. Wilson admitted that the cocaine was hers.

The trial court suppressed the evidence. In its order, the court found that the time and location of the car did not provide probable cause to pull over the car, and thus the resulting search was illegal. The Commonwealth appealed.

The Court of Appeals remanded to the trial court for additional findings of fact. In an opinion by Judge Gardner and joined by Judges Combs and Howerton, the Court agreed with the trial court that a car being in a place at a particular time does not justify the pulling over of the car when it leaves."[T]ime and location taken alone do not constitute the specific and articulable facts necessary to establish reasonable suspicion. Articulable facts indicating possible criminal activity are required."

The Court then remanded the case to decide the Commonwealth's separate claim that the driver's speed established probable cause. The Court did use *Whren v. United States*, 116 S. Ct. 1769, 135 L. Ed. 2d 89 (1996) to state that if the driver were speeding then probable cause to pull him over was established, even if the speed was a pretext to search for other evidence. "If it is determined by the trial judge that Turner had a reasonable belief that the vehicle was speeding, then the stop of the vehicle must be found to be proper even if the alleged traffic violation was a mere pretext for the stop."

United States v. Jenkins
92 F.3d 430

In this case, the Sixth Circuit Court of Appeals explores the issue of the standing of an absentee owner of a vehicle to challenge the search of that vehicle.

Here, Jenkins owned a trucking company, and as part of the business, began to smuggle marijuana from Texas to Tennessee. An agent of the TBI discovered that a shipment of marijuana was going to be made in a secret compartment of one of Jenkins' trucks, and eventually a truck was pulled over in Texas. The driver signed the consent to search the truck, while at the same time saying that he did not own "the stuff."

The Sixth Circuit,in a decision written by Judge Boggs and joined by Judges Milburn and Borman, affirmed the opinion of the district judge overruling the motion to suppress.

The Court reviewed *United States v. Blanco*, 844 F. 2d 344 (6th Cir. 1988), which had held that the renter of a car had no standing to challenge a search of the car when he had given the car to another to drive. The Court held that the district court had erred by failing to examine whether the defendant had exhibited a subjective expectation of privacy in his trucks. The Court further held that an "owner's expectation of privacy in the trailer of a tractor-trailer rig is of a type that society would recognize as legitimate."

That was the good news for Jenkins. The bad news was that the Court affirmed on the alternative ground that the driver of the vehicle had given consent to the search. "[W]e hold that a request to the driver of a rig to search the rig's trailer is firmly within the third of the three categories outlined above. That means that an officer is justified in thinking that the driver has authority to consent unless the officer knows (or is told) other information indicating that the usual assumption is incorrect."

Short View

1. ***In re D.D. v. State***, 59 Cr. 1360 (Ind. Ct. App., 7/8/96). The Indiana Court of Appeals has held that an officer's testimony that something "felt like contraband" during a patdown is not sufficient to meet the plain feel exception of *Minnesota v. Dickerson*, 508 U.S. 366 (1993). In *Dickerson*, the United States Supreme Court had held that under *Terry*, where an officer had probable cause to believe that an object touched during a lawful patdown was contraband, that object could be seized. "'Contraband' is a broad categorical and convenient term that does not connote a specific object. Accordingly, use of the term 'contraband' is legally insufficient to satisfy the plain feel doctrine, as contraband can include any number of distinct and dissimilar objects with differing contours and masses...We will not condone the use of a *Terry* protective search for weapons as a mere pretext to search for evidence."

2. In the August 30, 1996 *Lexington Herald Leader*, former Pike District Judge Keith

Hall was reported to have been reprimanded by the Judicial Retirement and Removal Commission for issuing a search warrant without naming the suspect, a place to search, or the items to be seized. Mr. Hall is now Pike County Attorney. Hall was quoted as saying, "I bent the rules for the police every chance I got on the war on drugs...I got in a hurry and I made a mistake...If I'm accused of cheating against drug dealers, I'm happy...I knew that this reprimand would mean nothing. I knew the public wouldn't care." Recall that the basic rationale for the good faith exception to the exclusionary rule was that it was needed to deter the police but not the judiciary.

3. ***United States v. Ramirez***, 59 Cr.L. 1483 (9th Cir. 8/2/96). The police obtained a warrant to arrest Shelby in Ramirez's house. Forty-five officers arrived, one of whom proceeded to knock out a window and stick a gun through the window. The homeowner, Ramirez, fired a gun into the ceiling, fearing the police were burglars. The officers fired back and shouted, "police." Ramirez then put his gun down and laid on the floor. Ramirez was then prosecuted for being a felon in possession of a handgun. The 9th Circuit held that this violated 18USC 3109, the knock and announce law. Shelby's previous actions as a fugitive did not create exigencies sufficient to abandon the requirements of the law. Thus, the district court was correct in suppressing the evidence of the guns. "Police must have some leeway in balancing the demands of the knock-and-announce requirement against other safety considerations. Nevertheless, the courts must ultimately determine whether the police struck that balance properly. We think it clear that the police did not do so in this case."

4. ***United States v. Duguay***, 59 Cr.L. 1505 (7th Cir. 8/15/96). The impoundment of a car after the arrest of a passenger violates the Fourth Amendment, according to the Seventh Circuit. Here, the driver did not want to turn over the keys to the car, there was no probable cause that contraband was in the car, and the driver was able to drive the car to a safe place. "The decision to impound an automobile, unless it is supported by probable cause of criminal activity, is only valid if the arrestee is otherwise unable to provide for the speedy and efficient removal of the car from public thoroughfares or parking lots."

5. ***State v. Colvin***, 59 Cr.L. 1508 (Conn. App. Ct. 8/13/96). The defendant was sitting on the stoop when he was seized by the police illegally. He was taken to his car, where drugs could be clearly seen through the window. The Connecticutt Court of Appeals held that seizing those drugs was a fruit of the illegal arrest, and ordered suppression of the evidence. "'The arrest, both in design and in execution, was investigatory.'" "Regardless of whether the police could have legally obtained the evidence, its discovery was not sufficiently attenuated from the misconduct. In addition, admission of this evidence would undermine the purpose of the exclusionary rule, deterring police misconduct."

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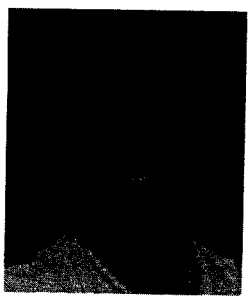

Debbie Garrison moved from the Department of Public Advocacy Office in Richmond where she worked as a legal secretary to Frankfort where she will be the Executive Secretary to the Public Advocate. A native of Lincoln County, Debbie has worked for DPA since 1984. Previously she was employed by the Department of Criminal Justice Training in Richmond from 1978-84. She is married to Gary Garrison who worked for CGH Transport. They have a 7-year old daughter, Sara Morgan. Debbie is looking forward to her new role. "I'm excited about continuing to work for Ernie and about the opportunity to work at this level of the statewide public defender system."

Medications Used to Treat the Symptoms of Mental Illness and Their Side Effects

This article will present a very brief review of the history of the medications used in the treatment of psychiatric disorders, it will review the therapeutic effects of those medications including the antipsychotics, a antidepressants, and mood stabilizers. Included in the review will be the more prominent side effects of these medications, and their potential drug interactions.

Storage conditions can adversely effect a medications usefulness. Therefore, a brief review of storage conditions is included at the end of the article.

Definitions:

***Positive symptoms** of mental illness, hallucinations; delusions, disorganized thinking; paranoia.*

***Negative symptoms** of mental illness, apathy; withdrawal; flat affect.*

I. Antipsychotics

The first medication used in the treatment of a mental illness was developed in Europe in the late 1940's as an adjunct to anesthesia, or as an antihistamine, depending on the literature under review. After some months use Chlorpromazine (Thorazine) was discovered to have beneficial effects in the treatment of the symptoms of schizophrenia. In the early 1950's Chlorpromazine was introduced in the United States, and shortly thereafter research and development of other agents with similar activity was begun. For a number of years the medications used to treat symptoms of mental illness were called "tranquilizers" because they blocked or stopped the agitation, disorganized thinking, hallucinations, and delusions that may occur in many people experiencing a psychosis. If the medications worked, the person became much more "tranquil" and better able to interact with others. During the decades of the sixties, seventies and part of the eighties, this group of medications were frequently referred to as "Major Tranquilizers" to differentiate them from the "minor tranquilizers" which were used to treat the symptoms of anxiety. During the latter part of the nineteen eighties medications used to treated the symptoms of psychosis began to be called "antipsychotics" and, medications used to treat the symptoms of anxiety were called "antianxiety agents". These terms are much more descriptive of the actions of the drugs when taken by people experiencing these conditions. The antipsychotics should stop the symptoms of psychosis, and the antianxiety agents should stop the symptoms of anxiety.

A. Type of Antipsychotic

- Phenothiazines which refers to the drugs chemical structure, which is related to Chlorpromazine and includes: promazine (Sparine); triflupromazine (Vesprin); thioridazine (Mellaril); mesoridazine besylate (Serentil); acetophenazine (Tindal); fluphenazine (Prolixin); perphenazine

Trilafon); prochlorperazine (Compazine); and trifluoperazine (Stelazine).

- Thioxanthines which refers to the chemical structure, and includes: chlorprothixene (Taractan) and thiothixene (Navane).

- Butyrophenones, a different chemical structure, and includes only haloperidol (Haldol) in this country.

All of the antipsychotics mentioned have characteristics similar to those of chlorpromazine. The deciding factors in determining which medication will be prescribed include: the degree of the side effects caused by a particular medication in this group; the dose needed to achieve desired results; the past experiences of the person to a particular medication; and known responses that family members may have had to one of the medications in this group.

B. Low Potency and High Potency Antipsychotics

Low potency antipsychotics require a large quantity of active medication to achieve a desired therapeutic response. Chlorpromazine is a low potency medication; its therapeutic dose is 100 milligrams.

High potency antipsychotics require a relatively small quantity of active medication to achieve a desired therapeutic response. The therapeutic dose of haloperidol, a high potency antipsychotic, is between two and five milligrams.

As a general rule the lower potency antipsychotics such as chlorpromazine and thioridazine will cause more drowsiness, sleepiness, and postural hypotension while the higher potency antipsychotics will cause more movement disorders. However, one should keep in mind that all the medications in these groups can and often do cause the full range of side effects.

Antipsychotics not chemically related to the phenothiazines, but with similar therapeutic and side effect activity include molindone (Moban) and loxapine (Loxitane).

C. Symptom Control

All the antipsychotics listed above can be expected to at least partially control the positive symptoms of psychosis for about sixty-five per cent of persons taking the medications. Symptoms that can be expected to be controlled by these medications include: hallucinations; delusions; disorganized thinking; and paranoia. The negative symptoms of psychosis such as withdrawal, and flat affect will not be helped by the antipsychotics mentioned above.

D. Side Effects

Some of the more prominent side effects that can be expected with the traditional antipsychotics include: dry mouth; dry eyes; dry throat; constipation; lowered blood pressure when standing or moving rapidly; photosensitivity (reaction between the medication and the UV rays of the sun and/or heat lamps or tanning beds to cause severe sunburn); photophobia (photosensitive reaction of the eyes) [especially with thioridazine]; drowsiness; sleepiness; difficulty in concentration; increased sensitivity to environmental heat and humidity; weight gain; and movement disorders.

The movement disorders include akathisia (sensation of the muscles quivering, the person may be unable to sit, or stand still and feels an urge to continue in motion); dystonia (the muscles do not work smoothly together and spasm); pseudoparkinsonism (mask like face, drooling, tremors, pill like rolling of the thumb and fore finger of both hands, cogwheel rigidity, and shuffling gait). Tardive dyskinesia (rhythmical involuntary movements characterized by puffing the cheeks; puckering the mouth; protruding the tongue and chewing motions. It is possible for tardive dyskinesia to include involuntary movements of the arms and legs). At the present time there is no known treatment for the symptoms of tardive dyskinesia except to withdraw all antipsychotic medication. Withdrawal of medication can cause a return, or a worsening of the persons symptoms, and may or may not reduce or eliminate the symptoms of the tardive dyskinesia.

The antipsychotics can cause body temperature dysregulation. With this particular side effect the brain cannot determine the external temperature. When this side effect occurs at

the same time that the body looses its ability to sweat the person is at risk for overheating or over cooling the internal organs, depending on the season of the year. This side effect is particularly problematic when the external temperature exceeds 80 degrees and the humidity is 40 percent or higher.

Neuroleptic Malignant Syndrome (NMS) sometimes occurs when an antipsychotic is started, or the dose is adjusted. This side effect seems to occur more often when the external temperature is above 80 degrees and the humidity above 40 percent, however, these conditions are not necessary for its occurrence. Symptoms of NMS include increased body temperature, muscle rigidity, and coma. Persons experiencing these symptoms need immediate medical treatment.

E. Coping with Side Effects of the Antipsychotics

Body temperature precautions should be exercised by all persons taking antipsychotic medications, especially if they must also take medication to control movement disorders caused by the antipsychotics. If the external temperature is above 80 degrees and the humidity is above 40% the person should remain in an air conditioned building if possible. Otherwise, (the building is not air conditioned, the person has an outside job, or must walk to run errands etc.) it is necessary that the person move slowly, stay in the shade as much as possible, take frequent rest breaks, drink plenty of cool non-alcoholic, non-caffeinated beverages. Any exposed skin should be protected by a high factor (at least 15%) sun blocking agent, light weight, light colored clothing should be worn, the head should be protected by a broad brimmed hat or cap, and the eyes should be protected with sunglasses. During cold weather, especially when the temperature is below 40 degrees and the humidity is above 40%, persons taking antipsychotics should be sure to wear enough protective clothing to prevent hypothermia and frost bite or freezing.

Dry mouth and constipation can also be potentially problematic for the person taking antipsychotics. These can be partially relieved by sipping cooling drinks (non-alcoholic, non-caffeinated), sucking on ice chips or hard, sugarless candy, or using artificial saliva (which can be purchased over the counter) for dry mouth; drinking plenty of fluids, eating a high fiber diet and exercising for control of constipation. Should these measures not adequately control constipation it may be necessary to use a stool softener, which may need to be ordered by the prescribing physician.

F. Clozaril (clozapine)

The antipsychotic clozapine (Clozaril) is chemically unlike the medications previously discussed and has a different mechanism of action and different side effect patterns. When clozapine provides a therapeutic effect it will control the negative symptoms of withdrawal and flat affect as well as the positive symptoms of psychosis. The major side effect of clozapine is agranulocytosis, a potentially lethal condition in which the granulocytes in the white blood cells, and the white blood cells themselves are reduced to a level that causes the body to be unable to activate the first line of defense in the immune system. Agranulocytosis can be expected to occur in two percent of those persons taking the medication. This side effect necessitates a complete blood count to be done weekly on all persons taking clozapine to prevent untoward consequences with the white blood cell count.

A second very serious side effect is the possibility of generalized seizures occurring in persons receiving 800 or more milligrams per day of clozapine. Should seizures occur due to the use of clozapine (or for any other reason) it is important that an anticonvulsant that spares the white blood cells and granulocytes be chosen to control the seizures. Valproic acid is often suggested (by the manufacturer of clozapine) as the anticonvulsant to be used. The manufacturer of clozapine suggests that carbamazepine not be used when clozapine is being taken because the carbamazepine can cause agranulocytosis, and suppress the manufacture of blood cells by the bone marrow. The effects of the carbamazepine can be additive with the effects of the clozapine.

There may be some degree of dyskinesia (defined earlier) with the use of clozapine, but the movement disorders that generally occur with the traditional antipsychotics do not appear to occur with clozapine. There are indications that some persons gain weight while taking this medication and some persons have difficulty with dry mouth while others have trouble with

excessive production of saliva. If clozapine must be discontinued it should be done gradually to reduce the possibility of the recurrence of symptoms. Should medical conditions dictate the immediate withdrawal of clozapine the consumer should be monitored very carefuly for the emergence symptoms.

G. Risperdal (risperidone)

The newest antipsychotic risperidone (Risperdal) at doses of less than six milligrams per day can be expected to act more like a serotonin reuptake inhibitor than a dopaminergic inhibitor. This means that at low doses one would expect to see a range of therapeutic effects closely related to those of clozapine.

H. Side Effects for Risperdal

One would not expect to see any of the movement disorders that can occur with the traditional antipsychotics at the lower dosage ranges of rieperidone. However, when doses reach six milligrams per day the activity of the medication tends to become more dopaminergic in nature. At eight milligrams per day and above the medication can produce effects similar to haloperidol. One should keep in mind that even though the medication is not expected to produce certain side effects (such as the movement disorders) at a particular dosage level nothing is too prevent such side effects. Therefore, one should be open to the possibility that untoward side effects may occur in certain individuals at any dosage range, and that certain individuals will not develop side effects that might be expected at a particular dosage range. This caveat is true of all medications, and is not confined to risperidone.

II. Antidepressants

The antidepressants (medications that are used to treat the symptoms of depression) share a history similar to that of the antipsychotics. The antitubercular Isoniazid (INH) was found to have antidepressant properties in the late 1940s. This observation led to research and development of mono-amine-oxidase inhibiting (MAOI) medications that were more specific for the control of the symptoms of depression than was the INH.

A. Mono-Amine-Oxidase Inhibiting Antidepressants

The only mono-amine-oxidase inhibiting antidepressants available in this country today are: isocarboxazid (Marplan), phenelzine (Nardil), tranylcypramine (Parnate). These medications work very well in controlling or relieving the symptoms of severe depression. However, they have a number of significant drug interactions that make their use a concern when persons also experience high blood pressure and must take antihypertensive medication. The mono-amine-oxidase inhibiting medications also interact with a variety of foods containing tyramine to cause a rise in blood pressure that can be problematic and in some instances fatal. Foods that have proven to create blood pressure problems when taken with the MAOI's include, but may not be limited to the following: beef or chicken livers; any meats prepared with a tenderizing agent; fermented sausages (including bologna, pepperoni, summer sausage); dried or pickled fish; game meats; cheeses (American processed, blue, natural brick, cheddar, Romano, sour cream, yogurt); nondistilled, fermented beverages; avocados; bananas; canned over ripe figs; raisins; sauerkraut; soy sauce; fava beans; caffeine; and chocolate.

B. Tricyclic Antidepressants

The mainstay in antidepressant medication in this country for the past ten years or more has been the tricyclic antidepressants. These medications are characterized and receive their name from the fact that they contain three rings in their chemical structure. The tricyclic antidepressants include: doxepin (Adapin, Sinequan); nortriptyline (Aventyl); amitriptyline (Elavil); desipramine (Norpramine, Pertofrane); imipramine (Tofranil); trimipramine (Surmontil); and protriptyline (Vivactil). These medication will relieve the symptoms of depression for many persons. However, they have some very prominent side effects.

C. Side Effects

Some of the more significant side effects include: dry mouth; dry throat and eyes; constipation; urinary retention; (especially in the presence of bladder dysfunction or prostatic dysfunction); weight gain; and photosensitivity. In addition, these medications exert a very pronounced effect on the cardiac muscle.

In therapeutic doses these medications can, in susceptible individuals, cause erratic cardiac rhythm. In overdose quantities these medications can cause fatal cardiac arrhythmias.

The antidepressant amoxapine is derived from the antipsychotic loxapine. Therefore, the side effect pattern for this medication will more closely resemble side effects of the antipsychotics than the antidepressants. When this antidepressant is being prescribed the individual should be monitored for all side effects listed with the antipsychotics.

D. Atypical Antidepressants

Bupropion (Wellbutrin) is a second generation antidepressant. It weakly inhibits serotonin, norepinephrine and dopamine reuptake. It may also be active in other parts of the brain such as the locus cerulesus. To date the major side effects that appear to occur when bupropion is taken include: dry mouth; blurred vision; dizziness; light headedness; faintness; drowsiness; diarrhea; tinnitus; photosensitivity; changes in appetite and weight; tremor; excess sweating; sedation; excess salivation and seizures. It is reported that the incidence of seizures with bupropion is four times the rate of seizures with the other antidepressants. Seizures appear to be dose related, and appear to occur most often in persons who have had a previous seizure, have had head injury, or have some other factor that can make them at risk for occurrance of seizures. Doses of bupropion for persons at risk for seizures should not exceed 450 mgm per day given in three divided doses. A single dose should not exceed 150 mgm. Bupropion should be given very cautiously to persons who are predisposed to seizures (discussed above), and especially when other antipsychotic medications must be take. Since bupropion can cause upset stomach, the drug can be taken with food to reduce the gastric irritation.

E. Selective Serotonin Reuptake Inhibitors (SSRI)

The newest antidepressants are the selective serotonin reuptake inhibitors (SSRI's). This group of medications include: fluoxetine (Prozac); paraxetine (Paxil); sertraline (Zoloft); venlafaxine (effexor); and nefazodone (Serzone). Fluvoxamine (luvox) has been approved for use in the treatment of Obessive Compulsive Disorder (OCD), while the other SSRI's have been approved for use in treating depression. All of the SSRI's are effective in treating the symptoms of depression and obsessive compulsive disorder. The doses needed to treat OCD are higher than for the treatment of depression.

Major side effects seen when the SSRI's are used include: agitation; trouble sleeping; feeling tired, draggy, and sleepy; dizziness; headaches; tremors; loss of appetite; nausea; diarrhea; photosensitivity; vaginal irritation; high blood pressure; urinary disorders; upper respiratory disorders; sinusitis; and changes in sexual desires and functioning. Sexual dysfunction is more prominent with the SSRI's than with the other antidepressants and has caused some persons to stop taking these medications. The SSRI's can also cause withdrawal effects in persons when they are stopped suddenly. These medications should be stopped gradually over several days time. Specific reductions should be tailored to the individual person.

III. Mood Stabilizers

A. Lithium

Lithium is used to treat the symptoms of Bi-Polar disorder. Bi-Polar disorder may exhibit both the manic and the depressive features in an individual situation, or it may present only the manic phase, or only the depressive phase. Until recently Lithium was the only major medication available to treat this disorder.

Major side effects seen with Lithium include: nausea; fine hand tremor; increased urination; increased thirst; diarrhea; and urinary urgency. Lithium can have a negative effect on the thyroid, liver and kidney. Persons taking Lithium should be monitored carefully for proper functioning of these vital systems. The following side effects need immediate medical attention: diarrhea; excessive sweating; loss of appetite; muscle weakness; high fever; drowsiness; trembling; slurred speech; and vomiting.

Since the therapeutic dose of Lithium is relatively close to the toxic dose, the person taking the medication should have periodic serum Lithium levels done to assure that toxicity is not occurring, or impending. The suggested time interval for serum Lithium levels for stabilized maintenance treatment is every three months.

It is important that persons taking Lithium not change the intake of salt and/or caffeine significantly since both these products can alter the serum level of the Lithium.

B. Tegretol

Carbamazepine (Tegretol) has been used for the last few years to treat the symptoms of Bi-Polar disorder. It is used alone or in conjunction with Lithium.

Primary side effects seen with carbamazepine include: nausea; vomiting (the medication can be taken with food to reduce the severity of this side effect); slow irregular heartbeat; slurred speech; tinnitus; aching joints; dry mouth; photosensitivity; depression; reduced calcium level; the possibility of reduced leucocytes in the white blood cells; and the possibility of bone marrow suppression.

C. Depakote

Valproate (Depakote/Depakene) has recently been approved by the Food and Drug Administration for the treatment of the symptoms of Bi-Polar disorder. Major side effects seen with this medication include: skin rashes; nausea/vomiting (taking with food can reduce this side effect); menstrual changes; constipation; dizziness; depression; lack of coordination; confusion; headache; and irritability.

IV. Drug Interactions

All of the medications listed above (antipsychotics, antidepressants, mood stabalizers) have the capability of interacting with a large variety of other medications. The list of potential interactions is too extensive for a report of this dimension.[1] The reader should note that all the medications mentioned will interact in a negative way with all alcoholic beverages, and all medications that have a depressant quality, or can enhance the depressant quality of other medications. This will include, but not necessarily be limited to: the antipsychotics; the antidepressants; the anticonvulsants; many of the cardiovascular medications; the antianxiety medications; and the sedatives and hypnotics. Of particular concern, since many persons do not think that they are potent enough to cause concern, are the over the counter medications. One should particularly note over the counter medications for cough or cold or sinus that contain alcohol, caffeine, phenylpropanolamine or other antihistaminic medications. These ingredients can be found on the label of the product. Other over the counter medications that can be potentially problematic are the products sold for sleep, weight control, or to stay awake. Aspirin and Tylenol may be a problem when taken with some medications. The primary concern that the reader should note is that persons taking any of the antipsychotics, antidepressants or mood stabilizers should not take any other medication, prescribed or over the counter without a thorough review by the prescriber.

V. Medication Storage

Medications can lose potency, or undergo physical-chemical changes if not stored properly. All the medications that have been reviewed in this article should be stored in such a manner that they are protected from light, heat and moisture. In this instance correct temperature is between 35 degrees and 86 degrees F. Light protection means generally that the medication should be stored in either an amber, or green container to reduce exposure to ultraviolet rays. Temporary storage of medications in dispensing sleeves, or other day minder containers to assist persons in remembering to take medications should pose no particular storage problem. These devices are generally designed to contain a one weeks supply of medications. However, persons living and working in Kentucky will want to note carefully the information contained in the following paragraph.

Another issue of vital concern to Kentucky consumers is the mandate in KRS 218A that controlled substances be kept in the original container they were in when received from the pharmacist or physician. The consumer should be aware that although this mandate is found in the Controlled Substance regulations the law enforcement community throughout the state applies the mandate across the board to all prescribed medications.

Footnotes

[1]Additional information about drug-drug interactions, drug-food interactions, and drug-lab interactions can be found in the references listed at the end of the article. These references are updated monthly. The reader should be able to access one or both references at any

community or hospital pharmacy. Other references include the American Hospital Formulary Service which should be available through any hospital pharmacy. The author particularly likes Goodman and Gilman's *The Pharmacological Basis of Therapeutics* as a reference for information on the pharmacology of all medications. The reader can also access additional information about medications through the Drug Information Center at the University of Kentucky, numerous journals devoted to the topic of medications and their effects. These can most easily be accessed through the University of Louisville, and the University of Kentucky medical libraries, and the University of Kentucky College of Pharmacy. Information is now available on the Internet for much of this material. Access to this information would be referenced through a provider in the field. Readers working outside the state of Kentucky will wish to check with the State Board of Pharmacy in your state concerning any special conditions applicable to drug storage, or drug handling procedures imposed by that board, or legislative body.

Bibliography

[1] *Facts and Comparisons Drug Information*, Monthly Update. Facts and Comparisons, Inc., St. Louis, Missouri; 1996

[2] Heller, William M., Ph.D., et al; *Drug Information for the Health Care Professional*; USPDI, current edition. The, United States Pharmacopeial Convention, Inc., Rockville, Maryland

[3] Package Inserts, Manufacturers medication information shipped with the medication.

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DIRECTOR OF PROTECTION & ADVOCACY RETIRES

Gayla Peach, longtime director of the Protection and Advocacy (P & A) Division, retired on September 15, 1996. Gayla worked with the division for 19 years and served as director for 16 years. During that time, P & A evolved from an agency with two employees into a formidable voice for persons with disabilities. Despite ongoing involvement with controversial issues, such as involuntary civil commitment, institutional conditions, deinstitutionalization, and educational services for children with emotional disabilities, Gayla managed to maintain P & A's independence. With typical modesty, Gayla requested that no ceremony be held to honor her accomplishments. P & A staff and advisory bodies had a brief surprise party for her to show their appreciation. Thousands of Kentuckians with disabilities and their families have benefitted from Protection & Advocacy services. Much of the credit for that level of impact goes to Gayla. We wish her continued improvement in her health. She will be missed.

Appalachians as A Cultural Group: Part Three

Cris Brown

The Importance of Documentation/ Uninterested Reporters

Recently, I went to Breathitt County with my son. My mother was determined to give him a history of the Brown family at her knee. As I sat and listened, I heard fantastic stories of my father's family: a relative carrying a man's head in a bag, a great-uncle's shoot-out with a Sheriff, etc.

I decided I needed to check up on some of the family stories I'd heard recounted. I talked to a reliable source, a paternal aunt, who was a teen during my childhood. She hadn't heard the story regarding the relative with the head in a bag. She explained about the shoot-out: a newly-deputized man had set out to kill my uncle on sight, and shot at him first, before they simultaneously fired and killed each other.

My aunt also told me that my Grandfather was in U.K. pre-med, when he was called home to take care of the family farm, not Medical School. This came as a shock as my grand-father was called upon to suture up cuts, one on my head, with carbolic acid and a curved needle, and thread, had a set of medical encyclopedias, and when he died, my family divided up his medical supplies - such as a leather medical bag, scalpels, eye cups, etc.

Yet my Aunt said that she had taken my eldest brother to the funeral of my great-grandfather. Baring a mistake on the tombstone, my great-grandfather died 10 years before my brother was born.

This is all by way of saying that anyone doing this work cannot take matters revealed to them by family members at face-value. People relate matters, perhaps unintentionally, wrong, or embellished. In these instances, non-family members may be more reliable reporters of events than family members.

Certainly documents, family Bible records, newspaper accounts, death certificates, etc. are a solid foundation for mitigation evidence, and are necessary to corroborate family member's stories, although they may contain mistakes as well- for instance, my brother's tombstone was carved with the wrong date of death.

While witnesses swear to and testify to the best of their belief, with a little effort, the State could make a shambles of your mitigation case, if you haven't done your homework by gathering documentation and checking out the stories told by family members. Don't accept matters at face-value.

It helps to always remember that the "fantastic" family stories are easier for the family to reveal, as they are "proud" of them, but these matters may have the least evidentiary value. The more fantastic the story, such as your client's father faced down and beat "Rocky" Marciano, the more documentation must be done to verify the story.

Look for the family "secrets" of which they are ashamed. These secrets are the hardest to discover, and bring to light.

Discussion of fantastic family stories may be the sincere attempt of a family member to be helpful and it takes a great deal of skill for a mitigation investigation to be able to winnow "wheat from chaff," and steer the person to more pertinent information. Being able to assess the evidentiary value of certain types of information, and explore in depth those matters while skimming over other matters is the hallmark of the experienced mitigation specialist.

More often recounting family stories is an attempt of the person to steer the conversation away from "sticky" topics and get the interviewer side-tracked. A skilled interviewer knows when to listen to establish rapport and when to re-direct the conversation to a more "meaty," topic.

Triangulating the information, having the client and family members as a source, uninterested parties as a source, and hard records as a source of evidence, and having an expert verify that this information is significant, reassures one that the mitigation evidence is solid, and unshakable. A healthy dose of skepticism can't hurt, as well.

Continuation of the Screening device:

J. PETS: Did the client ever hurt any pets: cats, dogs, hamsters, rats, or domesticated farm animals: pigs, chickens, ducks, lambs. [HUNTING DOES NOT QUALIFY.] Shot birds, killed non-poisonous snakes, hung animals, dissected, set afire animals, cut animals, crippled or paralyzed an animal.

Were animals kept in the house? What kind, was there urine and feces, odor in the house. How many?

Unusual pets the client may have had: pet squirrel, hawk, owl, raccoon, etc.

Felthous, Alan R. *et.al., Psychological Aspects of Selecting Animal Species for Physical Abuse*, 32 #6 Journal of Forensic Science, Nov. 1987 p.1713. [torturers/abusers of animals, may later abuse people.]

Repeat the question regarding someone taking away something that was important to the client, as a parent may have gotten rid of a pet.

One way of phrasing this is to find out if the client is "tender natured."

K. TREATMENT OF SIBLINGS: Again looking at how the client treated weak and helpless things: How did the defendant treat the younger children; Was the client a "little parent," inappropriately bossy. Was the client cruel or abusive to siblings? Was the client given control of the children, did he or she ever step over the line?

L. NEIGHBORHOOD CHARACTERISTICS - Were they treated any differently from other kids in the area?; Was their home worse or better than others, did they attend the same school as other children, ride the same bus, walk to the school, Were there any neighborhood cliques? Impacts of any moves, languages spoken at home.

M. GOVERNMENT AGENCIES: Were any government agencies involved with the family, AFDC, private agencies, such as Catholic charities, *etc.*; special school programs such as free lunches, Upward Bound, etc. Church groups donate food etc.

N. MOVES: Did the family live anywhere other than Kentucky? How many times has the family moved - what are the addresses, did it require the defendant to change schools? Did the client have to leave any significant support resources, family members, friends, activities?

O. WHY LEFT HOME: Years defendant was at home, when left home and why;

P. CONTACT WITH LAW: Any other family members even extended family, been in trouble with the law [If not obtained in parents/siblings section]. How common was it for people where you grew up to go to jail or prison?

How many people you grew up with died of suicide, overdoses, or during criminal activities in your neighborhood?

Q. EDUCATION: How many of the family finished high school. [If not obtained in the parents/siblings section]. Was an education valued in your family or was something else more valuable.

R. CLOSEKNIT: Is yours a closeknit family? Why or why not? Who can you depend on to help you out? When did the change occur, has it always been that way? How often does the family group get together? Whose house do they meet for holidays?

S. GUNS: What guns were kept at your house? At what age did you get your own gun? At what age did you go hunting? Did you ever bowhunt? Kill an animal by knife? Gut and clean your kill?

AFFECTION/LOVE - Were the parents physically demonstrative to the client and if not, were they affectionate with any of the other kids?

Did the parents tell the client that they were proud of them. Examples of ways that they showed them they were proud of them.

Particular look for attendance at school functions, praise for school awards, etc.

FAMILY MEMBER'S ILLNESS:

a. Was there was a time when either parent was away from the home for any significant amount of time, either with the defendant or with another child in the family that caused the family to be separated from a parent; Initial and later emotional responses and actions of parents and significant other family members to physician (justified complaints; exaggerated expectations; hostile projections) to spouse (guilt; blame) to child (guilt; feeling sorry; over-protection; attachment; resentment; rejection; neglect; abuse); psychiatric disorder or depression

b. Is there any history of "nerves" [mental illness or mental retardation in the family]; [Must be a blood relative].

Any suicide attempts in the family, suicides, hospitalization in a mental ward or facility, if family member receives medication for problem.

Eccentricities of family members such as mood sings, fractiousness, depression, crying spells, times they "go off." Any family member been in Eastern State or other mental facility, psychiatric ward of the hospital?

c. Any of the family on daily medication or has been under the treatment of a doctor for psychiatric problems, or if they felt that a family member needed counseling.

Client's Illness

I must credit my brother, David for the more innovative ideas of the following section. Aside from being a geologist, he also is a health enthusiast. He pointed out that in addition to environmental dangers in the soil, food stuff, water and air, persons from Appalachia have poor diets, exercise infrequently, and have health, mental health, and congenital problems that may affect the quality of their life, and certainly their longevity.

Statistics from CHR looking at the 1994 Kentucky population which sets out in districts that I could very easily isolate into the Eastern Kentucky counties, list the top 20 leading causes of death in Eastern Kentucky [and the State at large] in 1994 totalling 36, 919 persons as 1) Heart disease, 12,101 persons; 2) malignant neoplasm, 8,902 persons; 3) Cerebrovascular disease, 2,513 persons; 4) accidents, 1,585; 5) influenza/pneumonia 1,510 persons; 6) diabetes mellitus, 908 persons; 7) suicide 526 persons; 8) nephritis & nephrosis 473 persons; 9) arteries, arterioles, and capillaries, 468 persons; 10) septicemia, 423 persons; 11) cirrhosis of liver, 301 persons; 12) hernia & intestinal obstruction 262 persons; 13) emphysema, 258 persons; 14) homicide, 243 persons; 15) arteriosclerosis, 196; 16) symptoms & ill-defined conditions, 193 persons; 17) congenital abnormalities, 185; 18) certain causes in early infancy, 165 persons; 19) hypertension, 161 persons; 20) benign neoplasm, 98 persons; 21) all other causes 5,448 persons.

Eastern Kentucky accidents accounted for 23% of persons who died statewide of accidents. The counties with the highest accidents incidents were Floyd, 30 deaths, Pike 37 deaths, Perry 26 deaths, 21% of the persons who died from diabetes mellitus died in Eastern Kentucky. Highest numbers of diabetes deaths were in Harlan County, Pike County, and Boyd Counties. Emphysema accounted for 21% of the deaths from emphysema. These statistics bear out that diseases that have immediate impact on the flow of blood and thus oxygen to the brain and other vital organs place persons in Eastern Kentucky in a risk group.

In genetically carried illnesses, such as diabetes, it is important to learn not, only if the client has this illness, but also the names of other family members who have the illness.

You might have to break this screening down to common language such as "sugar" for diabetes for the person to know what you're talking about. It is best to ask about things in the vernacular, such as, "Have you ever had a problem peeing?"

Ask about the client's illness, find out if s/he had the normal childhood diseases: History of diabetes |"sugar", scars; dental |teeth| problems; age began smoking, amnesia |forget things/memory|, hepatitis or "yellow jaundice", heart problems |"bad heart| such as rheumatic fever, murmurs, hereditary problems or congenital birth defects, high blood pressure, stroke/heart attack, severe poisoning, seizures/epilepsy |"fits"|, fainting spells, chronic pulmonary |"breathing"| problems- allergies, asthma, any severe restriction or loss of oxygen, screen for fire extinguisher accidents |Red-Ball fire extinguishers| near-drowning |fall in the creek as a child, swimming/boating accidents|, broken bones, ulcers, goiters |swollen throat| from a lack of iodine in the diet, bedwetting, disfigurements, allergies, lead poisoning (ate lead-based paint), venereal disease. Any hearing loss, vision problems?

Tuberculosis/|"consumption/tb"|: exposure is greatly increased in Eastern KY due to expectoration, or spitting of phlegm on the sidewalk due to chewing tobacco or custom of clearing throat and spitting.

Farm accidents: injuries from farm machinery, such as plows, discs, cultivators, cornpickers, exposure to medicines for animals/ingestion of, being kicked by animals, near-fatal shooting incidents, hunting accidents, falls off cliffs, snake bites, animal bites, particularly rabid animals, brush fires, or fires where homes burned, sickness from eating bad food such canned goods that have spoiled, apple seeds which contain arsenic.

Exposure to airborne poisons such as winddrift from crop spraying with pesticides, fertilizers, accidental poisoning exposure through skin. Chemical burns from poisons. Screen for exposure to poisons such as strychnine, carbon tetrachloride, rat poison.

Loss of eye sight either permanent or temporary due to drinking bad moonshine, burns from welding.

Home remedies: Painting of a sore throat with merthiolate or mecurichrome |both of which are a mercury compound, not for internal ingestion|; kerosene or other petroleum products, mineral oil or castor oil, whiskey as a medicinal treatment, epsom salts, treatments for lice or worms, plants used for heart problems or kidney or other organ problems. Turpentine used for snake bites.

There's a variety of old fashioned remedies that are given to a baby and cause problems, such as a kerosene "tit" for teething problems. Look for any medications or ingestions of matters by a mother, which would have been transmitted to a nursing baby.

Screen for worm infestation and lice/"crabs," impetigo, hepatitis, pink eye, etc. where people and contact with soil.

Screen for infestation of the house by bats, mice, cockroaches, snakes, bugs.

Screen for use of chlorine bleach as a purifier for well water at too high doses.

Near fatal injuries of client and family members.

Did the client grow up near a river, tributary or stream, need to gain reports on raw sewage, garbage dumped into the water. It may be important to explore the aluminum content of that water.

Screen for any exposure to run-off from mining such as exposure to sulfur and water |which forms acid|, excessive silt in water, as mining affects the entire biosphere- water, air, soil. Oil from the mining roads to keep the dust down contaminates the water table and streams.

High levels of leaded paint were used until fairly recently, screen for the exposure to, and ingestion of paint.

Smoking of jimpson weed, rabbit tobacco.

List of hospitals and dates. Any emergency room visits? Who was the family doctor?

Ever had dizziness or trouble walking (not due to alcohol)?

Does the client get sick easier than most people?

Times when the family did not have enough money to go to the doctor and bones were set by a family member, wounds were treated by a family member, poultice, or herbal or home remedies were used to treat a medical problem.

Dental problems: Teeth were pulled out by wire pliers or other tools.

Diet: what kind of foods were served, fat fried, processed foods, high salt and sugar and fat foods. Was the client breast-fed or bottle-fed? At what age did the family receive help for the purchase of food by AFDC or WIC programs?

TIP: *There's a lot of personal information that's being asked for here, all of it could potentially have relevance to brain damage or systems which carry blood or oxygen to the brain. As with much of this instrument, you are merely collecting information.*

There are ways to motivate the person being interviewed. I once saw a transcript of an interview conducted by an attorney, where he said, "I don't know why I need to know this, but... and then asked the question. This is not the way to ask the question. If you feel that the questions are useless, you can't motivate the person to answer them.

HEAD TRAUMA: |See for further indepth questions: ***The Nature of Head Injury***, Kay Thomas with Muriel Lezak, Evaluating Persons with Traumatic Brain Injury.| Find out if he had any head injuries or an injury that would have taken him out of school or caused blackouts/dizziness, licks to the head, falls, crumbling porches or floors or steps that led to a fall, falls from a cliff or high rock, accidents during swimming, farm accidents migraine headaches, any fighting (nose broken?) or any sports injury, occupational injury, injuries while in military? Car accidents would be important to get in here.

Any time fainted during prayer or a religious experience.

If you find out he's been hospitalized, you need the names of those hospitals, who the doctor was, what the circumstances were, what the length of stay was. Specific dates/ years, if possible.

[*Use only for severe head trauma information / ask family members as well*]

Checklist of Behavioral and Personality Changes Following Severe Head Trauma

Changes in Sexual Behavior
- ☐ lack of sexual interest and curiosity
- ☐ absence of sexual dreams and fantasies
- ☐ loss of libido
- ☐ inability to experience orgasm
- ☐ less frequent intercourse or masturbation
- ☐ impotence
- ☐ sexual preference conflict
- ☐ sexual deviations: transvestism, transsexualism, voyeurism, exhibitionism, fetishism (paraphilia), sadism, masochism, heterosexual and homosexual pederasty, genital selfmutilation, frottage.

Anger, Irritability, Aggression
- ☐ intensified feelings of anger or irritability
- ☐ humorlessness
- ☐ moralistic sense of right and wrong
- ☐ sanctimonious or self-righteous behavior
- ☐ may be clear motive for act of aggression
- ☐ objectively minor provocative
- ☐ usually no amnesia for the incident
- ☐ may recall actions with much regret

Deepened Emotions
- ☐ emotional lability
- ☐ mood states (depression, elation, euphoria)
- ☐ fear-related experiences (anxiety, panic attacks, phobias, paranoia)

Intellectual
- ☐ newly-developed philosophical interests
- ☐ humorless, sobriety
- ☐ sense or increased significance of the internal or external world
- ☐ interpersonal viscosity or clinging (inability to bring conversation to appropriate end, insensitivity to temporal and spatial cues regulating social interactions)
- ☐ circumstances (style of speaking or writing characterized by the incorporation of multiple, often peripheral details and containing excessive clarifications, qualifications and circumstances).
- ☐ religiosity
- ☐ hypergraphia (a tendency to excessive and compulsive writing)

Memory Deficits
- ☐ look especially for word-finding difficulty (person will describe the frustrating feeling or being unable to articulate the word he/she is looking, leading to lots of you know and ummm expressions)
- ☐ presence of apathy, lack of goal-directedness
- ☐ poor judgment
- ☐ uninhibited and inappropriate social behavior
- ☐ whether anger subsides quickly or slowly
- ☐ difficulty in shifting thinking or reasoning from one pattern to another despite environmental signals to do so
- ☐ decrease in verbal fluency
- ☐ impaired ability to order things in proper time sequence
- ☐ easily distracted by irrelevant stimuli
- ☐ sexual disinhibition

RELIGION: Ask if the defendant was reared to go to church, to any particular church, what different denominations did he attend, why?, find out names of ministers or pastors, church members, that may have known him, find out his beliefs. If that is a common religion for that area? Screen for mystical experiences, faith healing, speaking in tongues, taken over by a spirit.

If faith seems key to understanding this client, screen extensively using the following:

Relationship with God:
- ☐ What will happen if you don't obey?
- ☐ What will happen if you backslide?
- ☐ What things will god forgive you of?
- ☐ What can't God forgive you of?

How does God make himself known - how does God speak to you?
- ☐ Dreams
- ☐ Fire
- ☐ During prayer
- ☐ Other people
- ☐ Signs
- ☐ Fasting
- ☐ Through fellowship
- ☐ Visions
- ☐ Hear his voice

Has God ever appeared to you - have you ever had a profound religious experience?

How does God punish you?

How does God correct you?

Have you ever been possessed by demons? Did you get a vision of the demons that possessed you?

Have you received the spirit or holy ghost?

- ☐ Have you spoken in tongues?
- ☐ Prayed or received faith healing?
- ☐ Handled serpent's or done other tests of faith?

Who do you turn to for spiritual guidance?

Whose teachings do you follow?

Do you rely on the old of new testament?

Do you believe in baptism and what happens if you are not baptized?

How do you worship - what are your church services like - when are then held?
- ☐ Wednesday
- ☐ Saturday
- ☐ Sunday

How important is tithing?

What has God asked you to give up to serve him?
- ☐ Smoking
- ☐ Drinking
- ☐ Dancing
- ☐ Liquor
- ☐ Sex or sex acts

What acts of man are unclean?

What foods are forbidden by god?

Have you ever fasted? For how long? What did you eat and drink?

Have you ever had a profound religious experience?

How could you tell you were saved? What about your live changed?

What is your role in church services?

What religious teachings/rituals occurred at home?

Did your parents base any punishments in religious teachings?

What role do women play in the church? What role do women have in a husband's life?

Is there any sin for which a person cannot be forgiven?

How does one purify or sanctify one's self?

What does your church teach about intercourse between a husband and wife?

SCHOOL: Wanting uniformity, good citizens, good core skills for the labor force, and an ability to fill out simple government forms, the public school system evolved. But public school did not entirely eradicate matters unique to the geographical culture of Appalachia.

Find out the names of the schools attended; what age s/he started school and what grade he completed; did he ever repeat a grade; was he in a vocational educational class, remedial reading class, or special education; if there were truancy problems; if expelled (why?); ask who his favorite teacher was, get names; find out if he ever had any bad experiences in school; grades he received; if he was punished for bad grades. How?

Find out if there was any thing about school that the client particularly liked; if there were any great problems with school.

If he quit school at an early age, find out why, and how the parents felt about school and his quitting; age and grade at the time he/she quit; what level of education his parents/siblings attained.

If the client was the smallest in the class; unpopular; class clown; class bully; perceived self as different from other kids. Names of school friends and their address and how long he'd known them. Who were the close friends of the client? names, ages, sex, types of interactions (clients with impaired peer relationships may give a list of close friends" with whom they have little contact. Did the friends come over and *vice versa*? Were these visits limited by anyone? Determine the overall style of peer interactions: withdrawal, isolation from peers, loner (may include much day dreaming) or preferential association with adults (may include premature adaption of adult mannerisms); regression to younger age group; (boys:) association with girls rather than boys; adoption of the role of mascot, class clown; aggressiveness; winning friends by making presents; use of humor; age-appropriate interaction.

EMPLOYMENT - Get a complete employment history: this includes person h/she did odd jobs such as laundry or ironing, farm work, mowing, etc. for; names of the employers, where worked, who worked under, coworkers that might know him, when he worked, how long he worked there, why he left, reason for any terminations; how much he was getting paid at the time, unions. If he was able to stay on the job for any length of time, find out if he was a hard worker, if punctual, if there was anything going on in his life that affected his ability to work well, any special training he received to work there.

PRIOR CONVICTIONS: Talk about juvenile record/times in Court: Camps, taken out of home as Incorrigible, put in group home.

Any stealing/firesetting as a juvenile? Anything that he did for which he was never charged.

Get a listing of prior convictions, what charged with, find out about the facts behind the charges, who represented them, what kind of time they did, what the circumstances were for that, place incarcerated, judge they went before, sentence received, served out, paroled or shocked.

Find out about family members that have a history of conviction, who represented them, and what time they served, who they appeared in front of. Particularly look for murders that they were suspected of, but never charged.

Has there been any civil litigation: car accidents, accidents on the job, business related, chronic illness, injury or pain, evictions, feuds with the neighbors, contested wills, etc.

It is very important to get a sense of the client's and others belief about the local court system and government system. Many believe that politicians are crooked, those with money get preferential treatment, you buy your way out of trouble with money, who you are or are related to counts when you're in trouble, they may have personal experience with vote-buying, or have heard of it, had the police fail to respond to domestic problems, had doctors fail to treat them and their family member dies, may believe the system is corrupt and be fatalistic about their chances of fair treatment. May have negotiated with judges to drop cases/ suits for a certain amount of money. may not trust lawyers and particularly public defenders. May have had a relative receive what they feel is unfair treatment by the system. May have been illegally beaten or arrested etc. in the past by law enforcement officers, both local and state.

Emotions/Feelings/Mental Health/Stress

[**NOTE:** *FOR SCREENING PURPOSES ONLY - a qualified mental health expert must be retained to do actual interview and testing.*]

For further reading: ***Mental Health Issues in Criminal Cases,*** John Blume, *The Advocate*, August, 1990, at 42. [updated article ***Mental Health Issues in Criminal Cases: The Elements of a Competent and Reliable Mental Health Examination***, *The Advocate*, Vol. 17, No. 4 (Aug. 1995)]. ***Antisocial Personality Disorder As Mitigating Evidence***, Brock Mehler, *The Champion*, June, 1990. ***Adult Antisocial Behavior and Criminality,*** Dorothy Otnow Lewis, Chapter 28, p. 1400. [For an in depth neurological/emotional assessment diagnostic tool, West Palm Beach, Mental Health Issues Instrument.] Kaplan, Howard B. et. al., *Antecedents of Psychological Distress in Young Adults: Self-Rejection, Deprivation of Social Support, and Life Events*, 24, Journal of Health and Social Behavior, 230-44, Sept. 1983.

Have you ever been bothered by having certain unpleasant thoughts all the time. An example would be the persistent idea that your hands are dirty or have germs on them, no matter how much you wash them. Or a persistent thought that relatives who are away have been hurt or killed.

Have you ever had any kind of thought like that? Was this only for a short time or was it over a period of at least 2 weeks?

Could you give me an example of this kind of thoughts that bothered you? Did these *thoughts* keep coming back into your mind again and again no matter how hard you tried to get rid of them?

Another example of an unpleasant thought would be the persistent idea that you might harm or cause the death of someone you loved, even though you really didn't want to. Or that you had accidently done something that harmed or endangered someone. Or you might have had thoughts you were ashamed of, but couldn't keep out of your mind. Have you ever been bothered by these or any other unpleasant and persistent thoughts? Was this only for a short time, or did these thoughts keep coming into your mind over a period of at least two weeks? Could you give me an example of the kinds of thoughts that bothered you?

Did these thoughts often bother you for more than an hour at a time? Did thinking about these ideas interfere with your life or work, or cause you difficulty with your relatives or friends, or upset you a great deal? When was the (first/last) time you were unable to put a thought like that out of your mind?

Some people have the feeling that they *have to do something over and over* again even though they know it is really foolish - but they can't resist doing it - things like washing their hands again and again, or going back several times to be sure they've locked a door or turned off the stove. Have you ever had to do something like that over and over? Could you give me an example? Was there a time when you felt you had to *do something in* a certain *order*, like getting dressed perhaps, and had to start all over again if you did it in the wrong order? Could you give me an example? Has there ever been a period when you felt you had to *count something*, like the squares in a tile floor, or always touch a particular thing, and couldn't resist doing it even when you tried to? Could you give me an example? Did you have to do any of these things several times over a period of at least two weeks? When you did any of these things, did they often take you more than an hour a day? Did any of these things interfere with your life or work, or cause you difficulty with your relatives or friends, or upset you a great deal? When was the (first/last) time you had to do something like that even though you thought it was really foolish or unnecessary?

Have you ever *believed people were spying on you*? How did you know that was happening? Was there ever a time when you *believed people were following you*? How did you know people were following you? Have you ever *believed that you were being secretly tested or experimented on?* How did you know you were being tested? Have you ever *believed that someone was* plotting against you or *trying to hurt you* or poison you? How did you know this was happening? Have you ever *believed that someone was reading your mind*? Did they actually know what you thought or were they just guessing from the look on your face or from knowing you for a long time?

Have you ever *believed you could* actually *hear what another person was thinking*, even though he was not speaking? How was it possible for you to hear what a person thought if that person didn't say anything?

Have you ever *believed that others could hear your thoughts*? How did they do that?

Did you ever feel that you were *under the control of some* person, power or *force*, so that your actions and thoughts were not your own? Who or what controlled you? Have you ever *felt* that *strange thoughts* or thoughts that were not your own *were being put* directly *into your mind*? Could you tell me about a time when that happened?

Have you ever *felt* that *someone* or something *could* take or *steal your thoughts* out of your mind? How did they do that?

Have you ever *believed that you were being sent special messages* through the television or radio, or that a program had been arranged just for your alone? Could you tell me about a time when that happened?

Have you ever *felt strange forces working on you*, as if you were being hypnotized or magic was being performed on you, or you were being hit by x-rays or laser beams? What kind of force was it? Have you ever had the experience of seeing something or someone that others who were present could not see - that is, *had a vision when you were completely awake*? Have you more than once had the experience of *hearing things or voices other people couldn't hear*?

A. What did you hear?
B. Did you ever hear that for more than a few minutes?
C. Did you ever hear voices others could not hear?
D. Did you ever *hear voices that other people couldn't hear commenting on what you were doing or thinking*?
E. Did you ever *hear* two or more *voices that other people couldn't hear talking to each other*?
F. Did you ever *carry on a* two-way *conversation with the voices* just as though someone was there with you?
G. How do you explain hearing things other people couldn't hear?

Have you ever been *bothered by strange smells* around you *that nobody else seemed* to be able *to smell*, perhaps even odors coming from your own body? What did you smell? Have you ever had *unusual feelings* inside or *on your body*

- like being touched when nothing was there or feeling something moving inside your body? What did you feel?

Have you ever had a period when *your interest in sex* was [At that time was your interest in sex] so much stronger *than is typical for you* that you wanted to have sex a lot more frequently than is normal for you or with other people you normally wouldn't be interested in? Has there ever been a period when you *talked* [Did you talk] *so fast* that *people* said they *couldn't understand you* or you had to keep talking all of the time? Have you ever had a period when *thoughts raced* [Did thoughts race] through your head so fast that you couldn't keep track of them? Have you ever had a period when you felt [Did you feel] that *you had a special gift or special powers* to do things others couldn't do or that you were a specially important person? Has there ever been a period when you *hardly slept* [Did you hardly sleep] at all but still didn't feel tired or sleepy? Has there ever been a period when you were [Were you] *easily distracted*, so that any little interruption could get you off the track?

A few people have terrible experiences that most people never go through - things like being attacked (IF FEMALE: or raped), being in a fire or flood or bad traffic accident, being threatened with a weapon, or seeing someone being badly injured or killed. Did something like this ever happen to you? Did you ever suffer a great shock because something like that happened to someone close to you? What was the worst thing like this that you experienced? How old were you when this happened? Bad experiences can cause changes in the way some people feel. You might or might not have experienced any of these changes.

(Now let's talk about [Event].) Did you *keep remembering* (EVENT) when you didn't want to? - Did you keep having *dreams or nightmares* about (EVENT) afterwards? - Did you ever suddenly act or *feel* as though (EVENT) *was happening again*, even though it wasn't? - After (EVENT), did you ever experience something that was similar or that reminded you of it? Did that upset you very much? Did you sweat or did your heart beat fast or did you tremble? - Did you go out of your way to *avoid* activities or *situations that might have reminded you of (EVENT)*? - After (EVENT), did you *try* hard *not to think about it?* - Do you remember (EVENT) well or is your *memory blank for* all or part of *it*? - Were you injured during the (EVENT)? Did you suffer a head injury as a result of (EVENT)? Were you unconscious for more than 10 minutes? - After (EVENT), did you *lose interest* in doing things that used to be important to you? - After (EVENT), did you find you *no longer had loving or warm feelings* toward others? - After (EVENT), did you *feel* isolated or *distant from other people*? - After (EVENT), did you begin to feel that there was *no point in thinking about the future* anymore? - After (EVENT), did you have more *trouble sleeping* than is usual for you - either trouble falling asleep, or staying asleep? - After (EVENT), did you *act unusually irritable* or lose your temper a lot? - After (EVENT), did you have more *trouble concentrating* than is usual for you? - After (EVENT), did you become *overly concerned* about danger or overly careful and watchful? - After (EVENT), did you *become jumpy or easily startled* so that ordinary noises or movements would make you jump or put you on guard?

a. Have they ever felt unlike themselves or out of control, felt they needed help or they'd explode? During the past year, did you feel you could easily cope with any serious problem or major change in your life? Do you bite your fingernails? What are the factors in your personal and work life that cause the most stress?
b. Find out how they respond to being angry; little anger/very angry; Are you easily frustrated? Have you gotten angry and broken anything within the past year?
c. Any emotions they currently might be feeling. Do you ever feel that you might go to pieces? Have you had any reason to wonder if you are losing control over the way you act, talk, think, feel or to your memory?
d. If they have any recurrent dreams; describe theme; nightmares; insomnia; sleepwalking/talking; fear of the dark. Are you bothered by bad dreams; do you sleep more than most people? Trouble getting to sleep or staying asleep? Do your dreams leave you with an aftermath of fear, sexual arousal, anxiety, a feeling of flying free?
e. If they have any ideas that won't seem to go away;
f. If there's anything they feel really badly about; [remorse for crime];
g. If there's anything that makes them cry a lot; last time they cried;
h. Do you anticipate the day with a feeling of excitement, or dread?
i. **SUICIDE**: Ask if they've ever considered committing suicide, find out the numbers of times, the circumstances, how they tried it, who was there that could confirm that, if they were hospitalized, if they saw a psychiatrist, if they were on medication;

   Suicidal gestures - things that weren't conscious attempts to die, but upon reflection could have caused death; suicidal threats; age of first suicidal ideation;

   Ever wished you were dead? Made actual plans to take your own life, have a timetable, have a way, revise a will, or give away possessions, write suicide notes, how did you feel when your plans were averted, what did you do after the attempt?
j. Referral to a Comp Care Center or doctor for depression, suicide, mental disorder treatment, nerves;
k. Any nervous tics;
l. Seen things growing larger/smaller;
m. Seizures.
n. Ever had daydreaming/fantasy of violence/killing someone?
o. Would you describe yourself as a trusting person?
p. How client deals with problems, *i.e.* confronts, reacts violently, ignores, obsesses.
q. Do you have trouble sitting still? Have trouble concentrating?
r. Have you ever had a *spell or attack* when all of a sudden you felt frightened, anxious or very uneasy in situations when most people would not be afraid or anxious - that is, when you were not in danger, or the center of attention or anything like that? IF YES, ASK BEFORE PROBING. Could you tell me about one spell or attack like that? During one of your worst spells of suddenly feeling frightened or anxious or uneasy, did you ever notice that you had any of the following problems? During this spell... A. Were you *short of breath* - having trouble catching your breath? B. Did your *heart pound*? C. Were you *dizzy or light-headed*? D. Did you have *tightness or pain in your chest*? E. Did your *fingers or feet tingle*? F. Did you feel like you were *choking*? G. Did you feel *faint*? H. Did you *swear*? I. Did you *tremble* or shake? J. Did you have *hot flashes*

or *chills*? K. Did you or *things* around you *seem unreal*? L. Were you *afraid* that *you might die*? M. Were you *afraid* that *you might act* in a *crazy* way? N. Did you have *nausea*? O. Did you have *belly pain*? P. Did you feel like you were *smothering*?

s. [Adapted Monroe Scale]: [ANSWERS: Never, Rarely, Sometimes, Often. Never answer assuming that drugs or alcohol were a factor.]

1. I have felt confused even in a familiar place.
2. I have come to without knowing where I was or how I got there.
3. I have been told I acted in a strange way, that I was not aware of.
4. I have had blackouts not related to the taking of drugs or alcohol.
5. I have had the experience where things looked suddenly smaller, bigger, distant or distorted.
6. Things have suddenly dropped from my hands, as if I had no control.
7. My speech has been slurred without any reason.
8. I have become wild and uncontrollable after one or two drinks.
9. I have become confused or delirious after taking drugs prescribed by a doctor.
10. I have had sudden severe headaches out of the blue.
11. I have had sudden excessive sweating or heart palpations without any reason.
12. I have had strange sensations that come and go away.
13. I have had momentary changes in my mood, without any reason.
14. Things have looked strange even in a familiar place.
15. Things have looked familiar in a strange place.

PART II.

1. I have tried to kill myself.
2. I have physically attacked and hurt another person.
3. I have been angry enough to kill somebody.
4. I do not feel totally responsible for what I do.
5. I have lost control of myself and hurt other people.
6. I have had the impulse to kill myself.
7. I have frightened others with my temper.
8. I have become so angry that I smashed things.
9. I have become so emotional that I ran away.
10. I have become so emotional that I screamed in rage.
11. I have acted on whim or impulse
12. I have lost control of myself, even though I did not want to.
13. I have been surprised by my actions.
14. I have been so tense I would have liked to scream.
15. I have experienced uncontrollable emotions.

SENTENCE COMPLETION: [Please Note: *Optional* - You may skip this section if the client seems to be in contact with reality. Ca be fun with younger clients to get to know them. Helpful with depressed clients.]

1. I want to see _____.
2. I dream of _____.
3. If I could only _____.
4. I hate _____.
5. Oh, how I wish _____.
6. What makes me sad _____.
7. Someday _____.
8. Girls _____.
9. I want to go _____.
10. When I'm alone _____.
11. If I were bigger _____.
12. I'd like to be _____.
13. If I were smarter _____.
14. I love _____.
15. My friends think _____.
16. I like best of all _____.
17. I want to know _____.
18. When I get older I'm _____.
19. My mother and father _____.
20. I feel like _____.
21. School _____.
22. Sometimes I think _____.
23. I would like _____.
24. My mother doesn't _____.
25. When I wake up at night _____.
26. Boys _____.
27. I am afraid of _____.
28. What makes me mad _____.
29. Other boys and girls _____.
30. My father is _____.
31. I am jealous of _____.
32. Reading _____.
33. I think most about _____.
34. I am proud of _____.
35. Other people think I'm _____.
36. I try to _____.
37. My brother _____.
38. I get fun out of _____.
39. I feel unhappy sometimes because ____.
40. I worry most about _____.
41. If another person hits me _____.
42. When people come to visit us _____.
43. I am sorry _____.
44. I am scared to _____.
45. Teacher _____.
46. I like to be _____.
47. When I play games _____.
48. My sister _____.
49. If I don't get what I want _____.
50. When I get hurt _____.

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History teaches that grave threats to liberty often come in times of urgency, when constitutional rights seems too extravagant to endure.

- Justice Marshall

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