MENTAL ILLNESS, YOUR CLIENT AND THE CRIMINAL LAW

A Handbook for Attorneys Representing Criminal Defendants in Connecticut

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TEN THINGS TO KEEP IN MIND AS YOU REPRESENT A CLIENT WHO MAY HAVE A MENTAL ILLNESS

1. **MENTAL ILLNESS AND MENTAL RETARDATION ARE NOT THE SAME:** Mental retardation is a permanent condition characterized by significantly below average intelligence accompanied by significant limitations in certain skill areas. Mental illness, on the other hand, usually involves disturbances in thought processes and emotions and may be temporary, cyclical, or episodic. Most people with a mental illness do not have intellectual deficits; some, in fact, have high intelligence. It is possible for a person with mental retardation to also have a mental illness. Some of the Connecticut statutes that address mental illness also address mental retardation, and you should look carefully at those statutes for the differences in how the two are addressed. This handbook does not address mental retardation.

2. **YOU OWE YOUR CLIENT A ZEALOUS REPRESENTATION:** You have the ethical obligation to represent your client zealously, which may include exploring your client's case for mental health issues. It may also include bringing appropriate motions if your client's mental illness has affected his or her case in any of the ways discussed in Section 1 of this handbook. A zealous representation may also include an awareness of the client's medical and medicinal needs during their incarceration. A lack of access to necessary or appropriate medical care and medications can affect the client's health and demeanor at the early stages of a criminal proceeding. Many mental illnesses require ongoing medical treatment, and an interruption or cessation of that treatment can affect a client and their behavior profoundly.

3. **IF YOUR CLIENT IS INCOMPETENT, STOP AND ORDER AN EVALUATION:** If your client is incompetent, he or she may not be able to make informed decisions about fundamental issues, such as whether to enter into a plea bargain agreement or, instead, proceed to trial. Do not allow your client to accept a plea bargain, or make any other decisions regarding the case, when you have grounds to believe that he or she is incompetent. Instead, immediately request a competence evaluation.

4. **MENTAL ILLNESS AND INCOMPETENCE ARE NOT SYNONYMOUS. YOU SHOULD BE CONCERNED ABOUT BOTH:** Keep in mind that competence to stand trial is distinct from mental illness, so that some clients who are fit to proceed to trial may still have serious mental illness. Even if your client does not have a competence issue, there may still be significant mental health issues in the case that you should explore. Remember, however, that if your client is competent to stand trial, he or she makes the final decision about how to proceed with the case, whether to explore and raise mental health issues, and whether treatment should be part of a disposition.

5. **AN INSANITY DEFENSE MAY BE APPROPRIATE:** By taking the time to properly inquire about your client's mental illness and explore various legal and medical options, you may obtain information that will help you decide if you should explore an insanity or "extreme emotional disturbance" defense. If your client receives a not guilty by reason of insanity verdict, he or she will avoid receiving an unjust conviction. However, as discussed further in Sections 7 and 8 of this handbook, there may be disadvantages to pursuing these defenses and you should discuss all of the pros and cons with your client.

6. **MITIGATE, MITIGATE, MITIGATE:** Mental conditions that inspire compassion, without justifying or excusing the crime, can be powerful mitigation evidence. Part of your job as an attorney may be to present the judge or jury with evidence that reveals your client as someone with significant impairments and disabilities that limit his or her reasoning or judgment. Mitigation evidence can be used to argue for a shorter term of incarceration or for probation instead of incarceration. In capital cases, mental illness and mental health testimony may mean the difference between life and death.

7. **INEFFECTIVE ASSISTANCE OF COUNSEL AND REVERSIBLE ERROR:** An attorney's failure to request the appointment or otherwise obtain the assistance of qualified mental health or mental rehabilitation professionals when indicated can be a violation of a defendant's Sixth Amendment right to effective assistance of counsel and your professional responsibilities. This applies to capital cases as well as other homicide cases and any alleged offense that suggests mental aberration. A defendant's prior history of mental impairment may indicate that you need the assistance of a professional evaluation. *Ake v. Oklahoma,* 470 U.S. 68 (1985). *Ake* also asserts the claim of indigent, convicted defendants to the assistance of mental health professionals at sentencing proceedings. An appellate judge may find reversible error if a client's incompetence or mental health issues are not raised in court.

8. **OVERCOME YOUR OWN POSSIBLE PREJUDICES BEFORE YOU HURT YOUR CLIENT AND HIS OR HER CASE:** A popular assumption is that mental-state defenses are attempts by bad persons to "get off" or deny responsibility for their behavior. Many people

believe that persons with mental illness, by contrast to those with mental retardation, have the ability to fully appreciate the nature of their acts and control them. This common attitude toward psychiatric disability can deeply influence judges' and juries' receptivity of expert witnesses and mental health defenses. Part of your job, if you are representing a person with a mental illness, is to overcome cynicism toward mental health issues in criminal cases. Mental illnesses are neurobiological brain diseases. A mental illness is a medical illness, not "hocus pocus," and the people who experience it suffer profoundly. Mental illness can be diagnosed, treated, and sometimes even cured. You do your client a disservice by presenting it any other way.

9. **INCARCERATION IS PARTICULARLY HARMFUL TO PEOPLE WITH MENTAL ILLNESS:** Jails can be very damaging to the stability, mental health, and physical health of people with mental illness. Numerous studies show that placing mentally ill people in single cells, isolation, or "lock down" can worsen their schizophrenia, depression, and anxiety. Mentally ill and mentally retarded adults are also more likely than others to be victimized by other inmates or jail staff. They are at high risk for suicide. They generally get inadequate, if any, medication and treatment while in jail. As set out in Section 5 of this handbook, you should seek to get your client's case dismissed quickly and, if appropriate, try to get your client released on bond, though this may be difficult to accomplish.

10. **DO NOT LET YOUR CLIENT GET CAUGHT IN THE "REVOLVING DOOR":** Many adults with mental illness are arrested for minor offenses that directly relate to their illness, their poverty, or their disturbed behavior. They cycle repeatedly through the courts and jails, charged with

the same petty offenses. This "revolving door" is not only a burden to the courts and the criminal justice system, but it is costly to society, to these individuals, and to their families. By quickly pleading your client to "time served" without exploring his or her mental illness, you may lose the opportunity to help your client get better so that he or she does not re-offend. Attorneys should do their best to link mentally ill defendants to appropriate treatment or services that will help them keep out of trouble. While it is important to get your client out of jail as soon as possible, it is equally important to keep him or her from returning to jail. Releasing persons with mental illness back into the community with no plan for treatment or aftercare is a recipe for revocation and recidivism. Don't set up your client to fail.

SECTION 1
WHAT IS MENTAL ILLNESS AND WHY SHOULD YOU CARE

WHAT IS MENTAL ILLNESS?

Connecticut statutes generally use the term "psychiatric disability" rather than "mental illness." Section 17a-495 of the Connecticut General Statutes defines a "person with psychiatric disabilities" as "any person who has a mental or emotional condition which has substantial adverse effects on his or her ability to function and who requires care and treatment." CONN. GEN. STAT. § 17a-495 (2006). The definition expressly excludes individuals dependent on illegal drugs or alcohol.

However, it is important to note that in Connecticut, there is no one legal definition of "mental illness" or "psychiatric disability." Rather, the definition of "mental illness" or

"psychiatric disability" largely depends on the purpose and context of the statute or regulation at hand. When reviewing a statute that uses such terms, you should always check whether there is a "definitions" provision that governs the statute. In some cases, statutes are silent on the definition and courts depend instead on administrative regulations or legislative history.

PREVALENCE AND SIGNIFICANCE OF MENTAL ILLNESSES

Mental disorders are quite common. In fact, one in five Americans has some type of mental disorder in any given year. About 15% of all people with mental illness will have an accompanying substance abuse disorder, although the percentage in the criminal justice system is much higher. About 16-20 percent of the jail and prison population has a significant mental illness (schizophrenia, bipolar disorder, or major depression) at any given time; this far exceeds the rate for these disorders in the general population. It is a common misperception that people with severe mental illness are significantly more violent than other people. Research shows this is generally not true. In fact, the vast majority of people with mental illness in jail are arrested for nonviolent offenses. Often, it is when people with mental illness are undiagnosed, untreated or stop taking their medication that they get in trouble with the law.

SERIOUS MENTAL ILLNESSES

There are a variety of mental illnesses and their severity ranges from mild to life-threatening. Many serious mental illnesses, such as those listed below, are chronic in nature, but can be managed or ameliorated with the proper medication and treatment.

Schizophrenia is a mental disorder that impairs a person's ability to think, make judgments, respond emotionally, remember, communicate, interpret reality, and/or behave appropriately so as to grossly interfere with the person's capacity to meet the ordinary demands of life. Symptoms may include poor reasoning, disconnected and confusing language, hallucinations, delusions, and deterioration of appearance and personal hygiene.

Bipolar disorder or manic-depressive illness is characterized by a person's moods, alternating between two extremes of depression and mania (exaggerated excitement). The manic phase of bipolar disorder is often accompanied by delusions, irritability, rapid speech, and increased activity.

Major depression is much more severe than the depression that most of us feel on occasion. People suffering from major depression may completely lose their interest in daily activities, feel unable to go about daily tasks, have difficulty sleeping, be unable to concentrate, have feelings of worthlessness, guilt, and hopelessness, and may have suicidal thoughts.

Other mental disorders or mental illnesses are defined in the glossary at the end of this handbook. While less severe than the disorders mentioned above, many of these disorders are also disabling and can profoundly affect the way a person thinks, behaves, and relates to other people. As an attorney, you can help ensure the fair, efficient, and humane administration of justice by paying special attention to those defendants who have a mental illness.

WHAT DIFFERENCE DOES IT MAKE IF YOUR CLIENT HAS A MENTAL ILLNESS?

Your client's mental illness may affect various aspects of his or her case, such as:

- the voluntariness of your client's statements. Statements that are the product of mental illness or mental retardation will not be excluded from evidence in the absence of impermissible coercive official conduct. However, conduct that is not coercive when used with nondisabled persons may impair the context, content, reliability and voluntariness of the statements of persons who are mentally ill.

- your client's ability to understand and explicitly receive the rights explained to him or her, including *Miranda* rights;

- your client's mental illness may affect memory, ability to make decisions, reasoning, judgment, volition, and comprehension;

- your client's ability to understand cause and consequence or learn from prior mistakes;

- the ability of your client to waive rights in a knowing, intelligent, and voluntary manner, including the right to counsel, right to be present, right to trial and appeal, and right to testify; and

- Choices and option concerning the disposition of his or her case.

SECTION 2
CONNECTICUT PUBLIC DEFENDER SERVICES

HOW DO CONNECTICUT'S PUBLIC DEFENDER SERVICES AFFECT YOU?

Section 51-296 of the Connecticut General Statutes provides for the appointment of counsel to represent indigent defendants. CONN. GEN. STAT. § 51-296 (2006). Indigent defendants are defined as individuals "formally charged with the commission of a crime punishable by imprisonment" who are not financially able to secure competent legal representation. CONN. GEN. STAT. § 51-297 (2006).

Counsel may not be appointed in misdemeanor cases where the defendant may not be subject to immediate incarceration or may be eligible for a suspended sentence of incarceration with a period of probation. However, where it later appears that the indigent defendant may, in fact, be subject to immediate incarceration or a suspended sentence of incarceration with a period of probation, then the court must appoint counsel. CONN. GEN. STAT. § 51-296 (2006).

The Guidelines on Indigent Defense published by the Connecticut Public Defender Services Commission contains several guidelines dealing specifically with clients who may have mental illnesses. To paraphrase:

- In general, counsel should "make accommodations where necessary" when representing a client with a physical or mental disability, in order to effectively protect and promote the client's rights and interests, and to establish an effective relationship with the client.

- At the initial client interview, counsel should try to ascertain both the client's competence to stand trial and/or the client's mental state at the time of the offense.

- Counsel should advise the client of the right to assert the insanity defense.

- When considering conditions of pretrial release, counsel should obtain information from the client regarding the client's physical and mental health. Counsel should additionally obtain from the client names or other sources that counsel could contact to verify the information. If pretrial release is not obtained, counsel should inform the court and the incarceration facility about any medical or psychiatric needs of the client.

- In investigating the charges, counsel should consult experts and other professionals regarding evaluations of the client.

- Counsel should consider seeking discovery of "all results or reports of underlying data regarding relevant physical or mental examinations, scientific tests, experiments and comparisons."

See CONNECTICUT PUBLIC DEFENDER SERVICES COMMISSION, GUIDELINES ON INDIGENT DEFENSE 1.1(b)(7); 3.1(e); 3.4(c)(5); 3.5(b); 5.1(b), (f); 6.2(b); 6.3(b)(6); 8.4(e) (2002).

HOW ELSE DO CONNECTICUT'S PUBLIC DEFENDER SERVICES HELP MENTALLY ILL DEFENDANTS?

The Office of Chief Public Defender contains a specialized unit, the Psychiatric Defense Unit, which is responsible for the representation of indigent defendants found not guilty by reason of mental disease or mental defect before the Psychiatric Security Review Board. The Psychiatric Security Review Board is a Connecticut state agency that reviews the status of all insanity acquittees through administrative hearings and determines the level of supervision and treatment necessary for them. The Board may recommend discharge, order conditional release, order confinement in a hospital for individuals with psychiatric disabilities, order placement with the Commissioner of Mental Retardation for "custody, care and treatment," or recommend confinement under conditions of maximum security. *See* CONN. GEN. STAT. §§ 17a-584, 17a-599 (2006). The Public Defender's office also offers a very supportive network of social workers who can often be of service, especially with jail diversion.

As set out earlier, jail can be especially threatening to mentally ill defendants. Therefore, it is particularly important that counsel is attune to the issues related to the defendant's mental illness in order to ensure that the defendant is accorded the appropriate treatment by the relevant authority, the court or the Psychiatric Security Review Board.

SECTION 3
THE INITIAL INTERVIEW

HOW CAN YOU TELL IF YOUR CLIENT MAY HAVE A MENTAL ILLNESS?

Here are some signs of a possible mental illness:

Certain types of offenses. Offenses such as criminal mischief, criminal trespass, prostitution, failure to identify, and public intoxication may signal an underlying mental illness. Many defendants with mental illness are also brought in on charges of "assault of a public servant" because they fight with police while they are psychotic. These offenses are frequently related to the client's poverty, homelessness, substance abuse, or transient lifestyle, but if they are part of your client's offense history or if your client has been arrested several times for the same offense, he or she may have a mental illness.

Behavioral or physiological clues. Your client may exhibit rapid eye blinking, vacant stares, tics or tremors, or unusual facial expressions. The symptoms of a mental illness and the medications your client may be taking may make him or her appear slow, flighty, inattentive, or sluggish. Your client may exhibit psychomotor retardation (slow reactions in movements or in answering questions) or clumsiness. Your client may be excessively uncooperative or argumentative. On the other hand, your client may appear very agitated, tense, or hypervigilant.

Circular nature of your client's conversation. While talking with your client, you may note the lack of a logical train of thought. In other words, your client may be unable to get from point A to point B.

Use of mental health terms. If your client has been in treatment, he or she may talk about his or her counselor or case-worker, about various medications, or about being treated in a hospital. He or she may use terms such as some of those listed in the glossary.

Paranoid statements. Your client may make paranoid statements or accusations. Or, he or she may exhibit phobias or irrational fears, such as a fear of leaving the jail cell.

Reality confusion. Your client may exhibit hallucinations. He or she may hear voices, see things, or misperceive a harmless image or situation as threatening or a meaningless coincidence as meaningful. Your client may be disoriented and seem confused about people and surroundings. He or she may have delusions (consistent false beliefs), such as lawyers who are out to get him or her, guards in love with him or her, or your client may believe that his or her food has been poisoned.

Speech and language problems. Your client may exhibit language difficulties, including incoherence, nonsensical speech, the use of made-up language, and non sequiturs. Your client may change the subject in mid-sentence, speak tangentially, or persistently repeat himself or herself. Or, instead, he or she may exhibit rapid, racing speech, or give monosyllabic or lengthy, empty answers. Your client may be easily distracted or may substitute inappropriate words for other words.

Memory and attention issues. Your client may exhibit a limited attention span, selective inattention on emotionally charged issues, or amnesia. These may also be signs that your client has had a head injury.

Inappropriate emotional tone. Your client may exhibit emotions such as anxiety, suspicion, hostility, irritability, and/or excitement; or he or she may appear downcast and depressed. On the other hand, your client may express little emotion at all or appear to have a flat affect. Your client may exhibit emotional instability. If your client has a bipolar disorder (manic depression), he or she may talk in a very rapid manner, seem excited, laugh at inappropriate times, make grandiose statements, or act very irritable.

Personal insight and problem-solving difficulties. Your client may exhibit self-esteem that seems either too high or too low. He or she may get easily frustrated or deny that he or she has mental problems. It may be difficult for your client to make plans and change plans when necessary. Perhaps most important, your client may also have an impaired ability to learn from his or her mistakes.

Unusual social interactions. Your client may have problems relating to others, including isolation, estrangement, difficulty perceiving social cues, suggestibility, emotional withdrawal, a lack of inhibition, and strained relations with family members and friends.

Medical symptoms and complaints. You should always be alert for physical symptoms, including hypochondria, self-mutilation, accident-proneness, insomnia, hypersomnia, blurred vision, hearing problems, headaches, dizziness, nausea, and loss of control of bodily functions. Some of these problems can develop as a result of incarceration, but many point to other more serious or long-standing mental health problems.

WHAT DO YOU DO IF YOU SUSPECT YOUR CLIENT HAS A MENTAL ILLNESS?

If you have grounds to believe that your client may be incompetent and/or mentally ill, you should explore further. Many people want to hide their mental illness. In fact, many defendants may go to great lengths to hide any indications that they are mentally ill, especially if they are in a jail setting. They may fear being committed to a mental hospital or being forced to take medication. They may not want to admit that they have not been compliant with their treatment, or they just may not want to appear different or dependent for fear of being victimized by others in jail. Just as a person who cannot read will often mask that inability, so too a person with mental illness can learn to hide his or her illness.

Other clients, particularly if they have never been formally diagnosed or treated, may not understand that they are mentally ill. The stress of the jail environment has been known to bring on symptoms of a person's illness and contribute to his or her deterioration, sometimes to the point of rendering him or her incompetent.

If your client is willing to talk about his or her mental health history and treatment, ask questions such as:

- Have you ever been treated for a mental or emotional problem?
- Have you ever been treated for substance abuse?
- Are you currently receiving treatment? If so, with whom?

- Do you know your diagnosis?

- What types of medication are you taking? Have you taken medications in the past? What were those medications?

- Have you ever been hospitalized for a mental health problem? If so, when and where? Did a court or judge order that you be hospitalized?

- Are there doctors, friends, or family members I can talk with who are familiar with your condition or treatment?

Be familiar with the names of public mental health clinics, such as local mental health authorities or psychiatric hospitals, and state mental hospitals in your area. It may be helpful to use the name of the facility when asking whether a client has been a patient.

Be delicate, tactful, and resourceful in your questioning when you sense that your client may not be forthcoming with you.

Mental illness still carries a powerful stigma, especially among males and among people of certain cultures. Blunt questions like "do you have a mental illness?" may not work. Here are some questions you might ask your client instead:

- Are you on any medications and, if so, what are they?

- Have you had any previous medical treatment and, if so, what was it?

- Do you have a juvenile record and, if so, for what types of offenses?

- Were you in any special classes in school and, if so, do you know why?

- Do you receive disability or Supplemental Security Income (551) benefits?

- Have you ever felt depressed?

- Have you ever been a patient at the Veterans' Administration (VA)?

- Have you ever been hospitalized?

- Have you ever had any dealings with a local mental health authority? (You may want to tailor this question using the name of the local mental health authority for your city or region).

- Are there doctors, friends, or family members I can talk with about your case?

Remember to speak simply and be prepared to repeat some of what you are saying. Ask simple, open-ended questions. Use eye contact to keep control of the dialogue and to keep your client focused. Do not impose on your client's "personal space." Tell your client when you do not understand and need more information. Paraphrase your client's responses to let him or her know that you understand. Remember that your client's delusions are real to him or her. Do not minimize or try to explain away hallucinations or delusions. You will likely elicit more information with a response such as, "That's

interesting— tell me more," than to argue the logic of statements that may appear bizarre or unusual to you.

Be patient. If your client has a mental illness, he or she may be irritated, belligerent, or see you as a threat. If your client is out of control, he or she may have a mental disorder. Some of your client's actions, reactions, and mannerisms may be irritating and/or offensive. Do not take this conduct personally; your client's mental illness may be influencing his or her personality. Find out if your client has stopped taking medication. If your client restarts taking his or her medication again, and it is appropriate for him or her to do so, then it will likely make your experience with him or her more pleasant.

Encourage your client to be honest and forthcoming with you. Tell your client that hiding important medical or mental health information may hurt his or her case and may hinder your ability to represent him or her well.

Do not speak about mental illness in a disparaging or derogatory manner. Do not add to your client's feelings of help-lessness, embarrassment, or shame about his or her mental illness. If you believe your client is incompetent, you should still address him or her as if he or she is competent. Many clients who get better after treatment remember how you treated them and what you said to them before treatment. If your client feels that you have treated him or her with respect, you are more likely to forge a trusting relationship with your client, which will help you represent him or her better.

Do not worry about malingering. It is the mental health evaluator's role, not yours, to determine who might be faking

mental illness. While it is true that some defendants try to fake mental illness in order to avoid prosecution or to get a reduced sentence, defendants who actually have a mental illness often try to hide their condition.

SECTION 4
WAYS TO OBTAIN INFORMATION

If after the initial interview with your client you have grounds to believe that your client may be mentally ill and/or incompetent, it is good practice to explore the issue further.

WHERE DO YOU LOOK FOR MORE MENTAL HEALTH INFORMATION?

Listed below are some steps you can take to gather relevant information if you suspect your client has a mental illness or is incompetent. Of course, it is always good to speak to your client first about the matter and to get him or her to sign a medical records release form where applicable.

- **Call your client's family.** The family is often the best, most current source of information about mental health treatment and history. Family members can also connect you with treatment professionals.

- **If your client is currently housed in an incarceration or detention facility, have your client submit a Release of Information form to his or her Unit Administrator.** This will allow you to access your client's master file at the facility, which contains his or her medical and psychiatric information, including the health and mental health assessment performed on your client upon intake. You can find

out more about the type of information available on your client by visiting the Department of Corrections website at http://www.ct.gov/doc/site/default.asp.

- **Upon written request, you have a right to inspect or copy any reports or results of physical or mental examinations made in connection with the charged offense from the state if such reports are "material to the preparation of the defense" or if the state intends to use them as evidence in chief at trial.** CONNECTICUT PRACTICE BOOK § 40-11(a)(4) (2007). You may be able to use such examinations to help get the charges against your client reduced or dismissed, or to help get your client diverted to a mental health facility.

- **Talk informally with jail staff.** Do they report bizarre behavior or complaints from other inmates or staff about your client?

- **Find out where your client is housed in the jail facility.** Many jails have special mental health or observation cells. These may be designated on your client's file or on a county computer screen.

- **Look at the police report for any indication of mental illness or bizarre behavior** by your client at the time of arrest.

- **If your client is being charged with a probation violation,** ask your client's probation officer if your client has a history of mental illness or is currently on a specialized probation caseload.

- **If your client has been in court before,** look to see if prior competence proceedings were conducted.

- **Look at information about your client collected by the pretrial release program.** These programs may have collected some information on your client's mental health status in the course of determining his or her eligibility for pretrial bond.

WHAT RECORDS WOULD BE HELPFUL?

If it appears that your client has or has had significant mental disorders or received treatment and that his or her mental health history will likely play a role at some point in the proceedings, you may want to obtain the following records:

- **Medical records from physicians or clinics.** Section 20-7c of the Connecticut General Statutes states that, upon written request, you may review a copy of your client's health record, including bills, x-rays, and copies of laboratory reports. CONN. GEN. STAT. § 207c (2006). Significantly, this provision does not obligate a doctor or clinic to provide access to information related to your client's "psychiatric or psychological problems or conditions." CONN. GEN. STAT. ANN. § 20-7c(e). However, the statute does not appear to bar you from at least requesting such information.

- **Medical records from hospitals and mental health facilities.** You are entitled to examine your client's health record at hospitals and mental health facilities. Depending on the type of facility, written consent may be required from either the patient, the patient's

attorney or the patients authorized representative to obtain the documents. CONN. GEN. STAT. §§ 4-104; 17a-548(b); 19a-490(b) (2006). You should check these records to see, for example, whether your client has been hospitalized multiple times, or has a history of voluntary or involuntary civil commitments. It is also worth checking the length of your client's typical hospital stays. You should also get the release forms from the hospitals where the person has stayed, as those forms tend to vary.

- **Pharmacy records.** Checking the extent to which your client has had prescriptions for psychiatric medications filled and refilled may account for erraticism in your client's behavior. In Connecticut, your client must indicate his or her oral or written consent to the pharmacy in order to obtain pharmacy records. CONN. GEN. STAT. § 20-626 (2006).

- **Family records.** Your client's family may have records of prior evaluations, prior treatment, prior applications for services, school records, or juvenile records.

- **School records.** Your client may have been enrolled in special education classes or may have been in special programs while in school. Look for the designation of an emotional disturbance on these special education records. General school records may provide an indication of behavioral illnesses or learning disabilities.

- **Employment records.** In Connecticut, your client must provide written consent in order for the employer

to permit inspection of his or her personnel files or any medical records retained by the employer. *See* CONN. GEN. STAT. §§ 31-128a-c (2006). Mental illness may have interfered with your client's ability to hold down long-term, stable employment. Therefore, evaluate your client's employment history. Has he or she had trouble keeping jobs? Has your client participated in the Vocational Rehabilitation program through the Connecticut Bureau of Rehabilitation Services or any other job training program?

- **SSI or Social Security Disability Insurance (SSDI) benefit checks from the Social Security office.** This may be your client's only source of income if he or she has a serious mental illness. You can ask your client to see applications and paperwork pertaining to these benefit programs.

- **VA records.**

- **Military records.**

- **Child Protective Services records.**

If your client cannot sign a medical records release form because he or she is incompetent or his or her competency is in question, you may be able to sign the release form as an authorized representative. You should read the statute governing the type of information you are seeking in order to determine if this is an option.

Additionally, some types of records may be available by subpoena. *See, e.g.,* CONN. GEN. STAT. §§ 10-15b(b)

(educational records); 17a-548(b) (certain hospital records); 31-128(f) (medical information contained within employment records). Be sure to note whether the statute applicable to the type of information you are looking to acquire allows the institution any options or imposes any conditions on the way the institution may respond to a subpoena.

Finally, you may want to consider hiring a mitigation specialist who can gather the information discussed in this section for you. A mitigation specialist can also develop a bio-psycho-social history of your client. Once you have this information, see where it takes you. Retaining a mitigation specialist is also relevant to effective assistance of counsel issues.

SECTION 5
PRETRIAL OPTIONS

TRY TO GET THE CASE DISMISSED

You should be seeking ways to get your client's case dismissed. What may seem like a minor misdemeanor conviction could come back to haunt your client down the road. For example, a family violence assault conviction can enhance a second family violence assault charge to a third degree felony and two convictions for prostitution or shoplifting can enhance the third charge of either of these two offenses to a state jail felony. Also, a criminal conviction may make your client ineligible for public housing. You can attempt to get a dismissal in various ways, but if you have never represented a person with mental illness before, get help from someone who has before embarking on any of the courses of action set out below.

TALK WITH THE PROSECUTOR

If you have an indication that your client's mental illness may have played a role in the charged offense, you may want to talk to the prosecutor about dismissing your client's case. The prosecutor may be more inclined to share your conviction that your client suffers from a mental illness and that the mental illness affected your client's judgment at the time of the alleged offense if you clearly document your client's mental illness and then provide that documentation to the prosecutor. However, if you are new to practice or otherwise unfamiliar with the prosecutor, you should talk to other attorneys in the community about the prosecutor's sensitivity, or lack of it, regarding mental health issues. If the prosecutor has a reputation for being less than sensitive about mental health issues, you may want to seek out another prosecutor or speak to the prosecutor's supervisor.

TALK WITH THE COMPLAINING WITNESS

The option of an outright dismissal may be more appealing to the prosecutor in a case where there is no alleged victim. If there is an alleged victim and the prosecutor does not seem inclined to dismiss your client's case, you may want to directly contact the alleged victim and, with your client's permission, present evidence of your client's mental illness to the alleged victim. The alleged victim might then go to the prosecutor and ask the prosecutor to drop or reduce the charges against your client. This approach, however, can backfire. You may end up only aggravating the alleged victim; so, be sure to discuss the pros and cons of this option carefully with your client before you proceed.

TALK WITH THE ARRESTING OFFICER

You may want to approach the arresting officer to see if he or she would be willing to ask the prosecutor to dismiss the charges, especially if your client is charged with a nonviolent offense or if the alleged offense is against the arresting officer. You may be able to get the officer to work with you if you bring him or her evidence of your client's mental illness.

RELEASE ON A BOND

If a quick dismissal is not an option and your client is competent to stand trial, you should speak to your client about whether to seek his or her release on bond. The court might condition your client's bond on outpatient treatment and your client may decide to forego release on bond to avoid this or other conditions that the court may impose. You and your client may also decide not to pursue a release on bond if your client is homeless or does not have a safe or stable place to live. If your client is in danger of picking up additional charges while on bond or failing to report to court in violation of his or her bond, it may significantly impair your chances of getting a favorable outcome to your client's case.

If you are further along in the pretrial process and your client has been determined to be incompetent, the court can release your client on bail if the court determines that he or she can be adequately treated (in order to regain competence) on an outpatient basis.

JAIL DIVERSION

The Connecticut Department of Mental Health and Addictions Services ("DMHAS") places clinicians in Connecticut's Superior Courts to be available to assist in screening eligible detainees for the presence of mental disorders at or prior to arraignment, evaluate their mental health, and participate in negotiating with the prosecution, defense, and the court to develop community-based mental health dispositions. DMHAS clinicians are available on-site in nearly all of the Connecticut Superior Courts and propose and subsequently monitor compliance with a court-ordered treatment plan.[1] The diversion teams consist of one to three clinicians who spend from one to five days a week in court, focusing on the arraignment of individuals with mental disorders. Since DMHAS clinicians are employees of the mental health center, and not the court, it is important to remember that they can only represent the client with his or her consent, and must be provided with written permission prior to discussing the case with the court. The clinicians locate potential clients by checking arraignment lists for repeat offenders and through notice by the judge, the sheriff, the public defender, the bail commissioner or the state's attorney. The clinicians evaluate the client and present to the court a proposed treatment plan, which may include diverting the client into the mental health system. In deciding whether to recommend diversion, the clinicians consider the seriousness of the charge, the treatment plan individuated for the client, the risk posed by the client and the extent to which the offense was related to the mental disorder.

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1. *See* www.dmhas.state.ct.us/jaildiversion.htm (last checked Feb. 20, 2007); www.dmhas.state.ct.us/documents/jaildiversion.pdf (last checked Feb. 20, 2007).

The court is not required to abide by the clinician's recommendation. If the treatment plan is accepted, the judge typically releases the defendant on a written Promise to Appear with the condition that the client participate in the proposed treatment plan and orders another pre-trial hearing, where the case may be continued or the charges dropped.

If you suspect that your client has a mental illness, or if your client has a documented history of mental illness, you should be sure to involve the court DMHAS clinician, if one has not already been assigned to your client.

VOLUNTARY HOSPITALIZATION OR COMMITMENT

There may be rare situations in which you want to explore this option with your client if your client meets the civil commitment criteria. *See* CONN. GEN. STAT. § 17a-502 (2006). For example, you may be able to broker a deal by which the prosecutor agrees to dismiss your client's case conditioned on your client's mental health commitment through the civil commitment process. *See* CONN. GEN. STAT. § 17a-498 (2006).

SECTION 6
COMPETENCE EVALUATIONS AND HEARINGS

THE BASICS

The question of competence to stand trial relates to a criminal defendant's mental state at the time of trial — not at the time of the alleged offense. In other words, determinations regarding your client's competence are not determinations on the merits of your client's case, and a determination of incompetence will not excuse the offense against your client.

THE INCOMPETENCE STANDARD

Section 54-56d(a) of the Connecticut General Statutes provides that:

A defendant shall not be tried, convicted or sentenced while he is not competent. For the purposes of this section, a defendant is not competent if he is unable to understand the proceedings against him or to assist in his own defense.

CONN. GEN. STAT. § 54-56d(a) (2006). Procedurally, "[a] defendant is *presumed* to be competent." § 54-56d(b) (emphasis added).[2] The burden of proof, and of going forward with the evidence, rests on the party intending to prove incompetence; that party must so prove by a preponderance of the evidence. *See id.* However, "[t]he burden of going forward with the evidence shall be on the *state* if the court raises the issue" and "the court may call its own witnesses and conduct its own inquiry." *Id.* (emphasis added).

Under Connecticut case law, the "test for competence to stand trial is whether [the defendant] has sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding — and whether he has a rational as well as factual understanding of the proceedings against him." *State v. George B.,* 785 A.2d 573, 579 (Conn. 2001) (quoting

2. It should be noted that this presumption of sanity extends beyond the realm of competence to stand trial into the trial phase of the adjudication. *See State v. Rossier,* 175 Conn. 204, 209 (Conn. 1977) (noting "the state has a right, in the first instance, to rely on the presumption that the defendant was sane at the time of the offenses . . ." (citations omitted)). However, once the defendant has put sanity at issue, any mention of this presumption should not be included in jury instructions regarding the insanity defense. *Id.* at 210.

Dusky v. United States, 362 U.S. 402, 80 S. Ct. 788, 4 L. Ed. 2d 824 (1960)). Moreover, evidence of a defendant's mental illness is not determinative of competence; a defendant may suffer from a mental illness and still understand the proceedings against him.

Ultimately, your client's competence involves more than his or her ability to correctly identify the different actors in the court process (e.g., the prosecutor, judge, defense attorney, or bailiff). You may want to consider the following questions in determining whether it is appropriate to request a competence examination for your client:

- Can your client explain the charges against him or her?
- Can your client explain or understand the legal issues/ procedures in his or her case?
- Can your client relate pertinent facts about the alleged offense?
- Does your client understand the available legal defenses?
- Does your client understand the dispositions, pleas, and penalties possible?
- Can your client appraise his or her role and the roles of defense counsel, prosecutor, judge, jury, and witnesses in his or her case?
- Can your client identify and locate witnesses?

- Does your client comprehend and follow your instructions and advice?

- Can your client follow his or her own testimony and the testimony of others for contradictions or errors?

- Can your client testify about relevant information and be cross-examined if necessary?

- Can your client tolerate the stress of the pre-trial and trial process?

- Can your client refrain from irrational and unmanageable behavior in court?

WHEN IS IT APPROPRIATE TO REQUEST A COMPETENCE EXAMINATION?

Generally, issues relating to your client's competence to stand trial should be resolved before the trial on the merits. However, you can request a competence examination at any point during the proceedings at which you believe your client is not competent to stand trial — even if you are in the middle of trying your client's case on the merits. *See* CONN. GEN. STAT. § 54-56d(c). (Note that the American Bar Association (ABA) considers it is improper to use competence procedures for purposes unrelated to the determination of competence, such as obtaining mitigation information, obtaining favorable plea negotiations, or delaying proceedings. STANDARDS RELATING TO COMPETENCE TO STAND TRIAL § 7-4.2(e) (1989)).

Many attorneys find themselves in an ethical bind when their client objects to having the competence issue raised. Some clients facing misdemeanor charges just want to plead to the

charges, spend a short time in jail, and then get out. Often, getting a psychiatric examination means that the client may spend more time in jail pending the examination, plus a lengthy time at a state hospital if he or she is found incompetent. The ABA stresses a lawyer's professional responsibility toward the court and the fair administration of justice as the paramount obligations in such an instance, and expects an attorney to advance the issue even over a client's objection whenever a good faith doubt arises about a defendant's competence to stand trial. STANDARDS RELATING TO COMPETENCE TO STAND TRIAL § 7-4.2(c) (1989). Of course, if your client is competent to stand trial, he or she makes the final decision about how to dispose of his or her case regardless of whether you agree with this decision.

If you believe your client is incompetent to stand trial, you should file a motion suggesting that the defendant may be incompetent. You should also seek to get your client's case dismissed as discussed in Section 5, but if the case is not dismissed you should know that competence examinations and hearings can be conducted even if your client is on bond or otherwise out of jail.

THE COMPETENCE EXAMINATION

Even though defense counsel usually files the incompetency motion, the court itself or the prosecutor may raise the issue of incompetency to stand trial. *See* CONN. GEN. STAT. § 54-56d(c) (2006). When the information known to the trial court at the time of the trial or plea bargain is sufficient to raise a legitimate doubt regarding the defendant's competence, the trial court must conduct a competency hearing.

Once the court orders a competency examination, the court may do any of the following:

- Appoint one or more physicians specializing in psychiatry to examine the defendant.
- Order the Commissioner of Mental Health and Addiction Services to conduct the examination by appointing either a clinical team of psychiatric specialists (consisting of a psychiatrist, a clinical psychologist, and either a licensed clinical social worker or a psychiatric nurse with a masters degree in Nursing), or one or more physicians specializing in psychiatry.

See Conn. Gen. Stat. § 54-56d(d)(2006). **PREPARE**

FOR THE EXAMINATION

You need to prepare your client and other supporting evidence for the competence examination. Encourage cooperation. Explain the following to your client:

- o the purpose and nature of the examination;
- o the potential uses of any disclosures made during the examination;
- o the conditions under which the prosecutor will have access to reports and other information obtained for the examination and the reports prepared by the evaluator; and
- o the conditions under which the examiner may be called to testify during sentencing.

- You may want to tell the evaluator why you think your client is unable to assist you or participate in his or her defense, being mindful of attorney/client confidences and attorney work product issues.

- Be aware that the attorney is authorized to observe the evaluation if he or she elects to do so.

- You should also obtain and submit to the examiner any record or information that the examiner regards as necessary for conducting a thorough evaluation on the matters referred.

- Make sure that the examination is conducted promptly after you have made the suggestion that the defendant may be incompetent to stand trial, so that your client does not languish in jail.

- Be aware of whether or not communications and records are privileged.[3]

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3. Connecticut has a broad psychiatrist-patient privilege that protects the disclosure without the patient's consent of confidential communications or records of a patient seeking diagnosis and treatment. The patient's consent is not required prior to the disclosure of records or communications that are made in connection with a court-ordered psychiatric examination, provided that (i) the patient is informed prior to the examination that any communications will not be protected by the privilege; and (ii) the communications are admitted only on issues relating to the patient's mental condition. § 52-146f (4); *State v. Jenkins,* 856 A.2d 383, 393 (Conn. 2004). Counsel's participation in the evaluation may raise questions of attorney-client privilege or attorney work product privilege. Additionally, participation by family, clergy and others may raise other privilege questions.

EVALUATE THE COMPETENCE REPORT

You should make sure that the doctor's report or evaluation is thorough and complete. If it is not, you should call the examining doctor and ask for a revised report. If you believe the revised report is still inadequate or inaccurate, you should ask for a second opinion. Inquire within the legal and mental health communities about other doctors who may be able to testify at the competence hearing on behalf of your client.

The competence report should **not** contain information or opinions concerning either your client's mental condition at the time of the alleged crime or any statements made by your client regarding the alleged crime or any other crime. You should seek to ensure that the competence report does not include any offense-related information or express the opinion of the examiner on any questions requiring a conclusion of law or a moral or social value judgment properly reserved to the trier of fact.

THE COMPETENCE HEARING

A thorough review of Section 54-56D of the Connecticut General Statutes, governing the competency hearing, examination, and commitment proceedings, is necessary to ensure an adequate familiarity with the full range of requirements and detailed procedures that the process involves.

The hearing must be held by the court no later than 10 days after it receives the written report. Evidence regarding the defendant's competency, including the written report, may be introduced by either the defendant or the state. One of the examiners must be present to testify to the written report

unless waived by both parties. Note that defense counsel can waive the hearing only if the report determines without qualification that the defendant is competent. *See* CONN. GEN. STAT. § 54-56(d)(e) (2006).

If the court finds your client competent, it shall continue with the criminal proceedings; if the court finds that your client is not competent, it shall make a determination of whether there is a substantial probability that your client, if provided treatment, will regain competency. If the court determines that your client will not regain competency, your client may be released or placed in a mental health facility. The court may also find that the defendant will regain competency, and order treatment. *See* CONN. GEN. STAT. § 54-56(f)-(g) (2006).

CAN YOUR CLIENT "REGAIN" COMPETENCE?

Whatever the particular diagnosis or disorder, your client's condition may be restored, though perhaps not cured, through hospitalization, other treatment, and/or psychotropic medication. Your client's history of response to treatment is the best indicator of whether your client is restorable, and in what time frame, and under what circumastances, you can expect such restoration.

Many criminal court judges may be unaware that dismissed cases are handled differently from cases that have not been dismissed. You may be able to use this distinction to your client's advantage, depending on the court you are in and the seriousness of the alleged offense. For example, a judge who handles misdemeanors may have never conducted a civil commitment proceeding — and may not want to start now. If you can impress upon the judge that a dismissal of your client's case will transfer the responsibility of the civil commitment proceeding to another court, the judge might urge the prosecutor to agree to dismiss the case.

SECTION 7
THE "INSANITY" DEFENSE

THE BASICS

Under Connecticut law, a defendant charged with a crime may assert an affirmative defense predicated on his lack of mental capacity *at the time of the crime's commission.* CONN. GEN. STAT. § 53a-13 (2006). In Connecticut, the term "mental capacity" refers to the Insanity Defense judged at the time of the allegedly wrongful acts or omissions to act, and should not be confused with competence or capacity to stand trial, which is a distinct legal formulation relating to the client's mental state at the time of the pre-trial and trial proceedings, as outlined in Section 6 of this Handbook.

The Connecticut General Statutes states:

> In any prosecution for an offense, it shall be an affirmative defense that the defendant, at the time he committed the proscribed act or acts, lacked substantial capacity, as result of mental disease or defect, either to appreciate the wrongfulness of his conduct or to control his conduct within the requirements of the law.

CONN. GEN. STAT. § 53a-13(a) (2006). As indicated above, the statute lists two instances where a defendant's culpability may be vitiated: (i) when a defendant cannot appreciate the wrongfulness of his conduct; or (ii) when a defendant is unable to control his conduct within the requirements of the law. It is important to note that while the state must prove beyond reasonable doubt that the defendant is guilty of the accused crime, the defendant must prove the affirmative defense of insanity by only a preponderance of the evidence. *State v. Steiger,* 590 A.2d 408, 425 (Conn. 1991).

"Wrongfulness," above, is interpreted according to both society's moral standards and to the defendant's perception of those standards in relation to his own conduct. A defendant may satisfy the first prong of the insanity defense if, because of a mental disease or defect, he did not have substantial capacity to appreciate that his actions or omissions to act were contrary to social morality—even though he might have known that his conduct violated the criminal code. Emphasis is on the defendant's cognitive state at the time of the alleged crime's commission.

Showing that a defendant was "unable to control his conduct" is a difficult standard to quantify, and will be based heavily on the facts supporting the defendant's impaired mental condition, as well as the facts surrounding the alleged crime's commission.

PREPARE YOUR CASE EARLY

If you are contemplating asserting the Insanity Defense, be sure to make the necessary preparations:

- Find a reputable doctor (psychologist or psychiatrist) as quickly as you can and have that individual immediately interview your client. Have the interview videotaped if you can, especially if your client exhibits signs of psychosis. Once your client has been given medication that alleviates the symptoms of his or her mental illness, the demeanor evidence of his or her mental state may be diminished or lost. The symptoms of your client's mental illness need to be preserved as evidence for the jury before this medication takes effect.

- If you and your client intend to rely upon the Insanity Defense, the defendant must notify the prosecuting authority in writing of such intention and file a copy of such notice with the clerk no later than 45 days after the first pretrial conference. CONNECTICUT PRACTICE BOOK § 40-17 (2007). Also, "[i]f there is a failure to comply with the requirements of this rule, such affirmative defenses may not be raised." *Id*.

- In addition, if you are planning on using expert testimony to support the affirmative defense of mental disease or defect or extreme emotional disturbance, you must file notice with both the prosecuting attorney and the clerk no later than 45 days after the first pretrial conference. CONNECTICUT PRACTICE BOOK § 40-18 (2007). You must also provide the prosecuting attorney with copies of reports of physical and mental examinations of the defendant prepared by any expert the defense intends to call as a witness within five days of receiving the report. *Id*.

EMPHASIZE LEGAL STANDARDS TO DISPEL MYTHS

There is a popular myth that a person who is found not guilty by reason of insanity ("NGRI") just "walks away". It is true that, like a simple not-guilty verdict, an NGRI verdict is considered a full acquittal of all charges. However, if you try your client's case to the judge, the judge might be reluctant to find your client not guilty by reason of insanity if he or she is operating under the myth that your client will automatically go free upon such a verdict — especially if your client is charged with a violent crime.

However, in reality, unlike a simple not guilty verdict, when a defendant is found NGRI, the court retains jurisdiction over the person and orders the person to be detained in a mental health facility. Custody is handed over to the Commissioner of Mental Health and Addiction Services where your client will be confined, or to the Commissioner of Mental Retardation, where your client will undergo an examination to determine his mental condition. *See* CONN. GEN. STAT. § 17a-582(a). Upon completion of the evaluation, the facility sends a report of your client's present mental condition to the trial judge, the prosecutor and you, the defense attorney, addressing whether the acquittee should be discharged. § 17a-582(b). Your client is entitled to a separate examination. CONN. GEN. STAT. § 17a-582(c) (2006). The court must then hold a hearing to determine whether your client will be confined or discharged. CONN. GEN. STAT. § 17a582(d)-(e) (2006).

Unfortunately, the foregoing myth is not just shared by the public at large, but by many judges, defense lawyers, and prosecutors. You will have a large advantage if you emphasize the legal standards and procedures and demonstrate considerable familiarity with both. The judge may feel that a guilty verdict, coupled with probation, will allow your client to get treatment while allowing the court to retain some degree of control over your client. By advising the judge that the court can likely both reach a verdict of not guilty by reason of insanity and maintain jurisdiction over your client, you can go a long way toward giving your client a zealous defense. At the present time, the psychiatric security review boards and psychiatric hospitals have been conservative in the release of individuals who have been found to be not guilty by reason of insanity. The defendant may therefore spend much longer in a hospital than if he/she pleads guilty, so you need to both weigh options very carefully and make sure the client is aware of the potential for long term confinement.

SECTION 8
"EXTREME EMOTIONAL DISTURBANCE" – AN AFFIRMATIVE DEFENSE TO A MURDER CHARGE

Connecticut law allows for an affirmative defense to murder where "the defendant committed the proscribed act or acts under the influence of extreme emotional disturbance for which there was a reasonable explanation or excuse, the reasonableness of which is to be determined from the viewpoint of a person in the defendant's situation under the circumstances as the defendant believed them to be."[4] CONN. GEN. STAT. § 53a-54a(a) (2006). Such 'extreme emotional disturbance' "constitutes a mitigating circumstance reducing murder to manslaughter in the first degree . . . ." CONN. GEN. STAT. § 53a-55(b) (2006).

This affirmative defense can be differentiated from an insanity defense in that the insanity defense "require[s] proof of a mental disease or defect" while the extreme emotional disturbance defense "require[s] proof only that the defendant acted under the influence of an extreme emotional disturbance." *State v. Hodge,* 726 A.2d 531, 562 (Conn., 1998).

As with all affirmative defenses under Connecticut law, the burden to prove extreme emotional disturbance lies with the defendant,[5] who must prove to the jury by a "fair preponderance

4. Additionally, Connecticut law allows evidence that the defendant suffered from a mental disease, defect or abnormality to be used to argue that the he or she did not possess the requisite intent to cause the death of another. CONN. GEN. STAT. § 53a-54a(b) (2006).

5. Under Connecticut statue, when a defense declared to be an affirmative defense is raised at a trial, the defendant has the burden of establishing the defense by a preponderance of the evidence. CONN. GEN. STAT. § 53a-12(b) (2006).

of the evidence" that, "(a) the emotional disturbance is not a mental disease or defect that rises to the level of insanity as defined by the Penal Code; (b) the defendant was exposed to an extremely unusual and overwhelming state, that is not mere annoyance or unhappiness; and (c) the defendant had an extreme emotional reaction to it, as a result of which there was a loss of self-control, and reason was overborne by extreme intense feelings, such as passion, anger, distress, grief, excessive agitation or similar emotions." *State v. Elliot,* 411 A.2d 3, 12-13 (Conn. 2006), *See also, State v. Aviles,* 891 A.2d 935, 953 (Conn. 2006); *State v. Zdanis,* 438 A.2d 696,698 (Conn. 1980). The reasonableness of the defendant's act is determined from the "viewpoint of a person in the defendant's situation under the circumstances as the defendant believed them to be." *Elliot,* 411 A.2d at 13.

SECTION 9
USE OF EXPERT MENTAL HEALTH WITNESSES, MITIGATION, AND SENTENCING STRATEGIES

EXPERT MENTAL HEALTH WITNESSES

HOW THEY CAN HELP YOU

Information obtained from mental health experts can help you make informed decisions about:

- the manner in which you work with your client;
- your client's competence to proceed;
- your client's mental state at the time of the offense;
- plea negotiations;

- jury selection;
- whether your client should testify;
- medical treatment or other services for your client while the case is pending;
- what types of assessments or evaluations are needed; and
- the selection of witnesses for the trial, including the penalty phase.

HOW YOU CAN GET THEM

The incremental approach set out below may not always be practical. Some judges may determine that a misdemeanor case does not warrant the use of an expert witness or that one expert is all you get. This may even be true in some felony cases. Consult with attorneys in your community about how to get experts appointed in your case. Ask the court clerk to learn if the court has developed standard form applications or motions you should use. It should be noted that the Connecticut statues related to the Public Defender Services provides for reimbursement of reasonable expenses related to "witnesses summoned" by attorneys representing indigent defendants. *See, e.g.,* CONN. GEN. STAT. § 51-292 (2006). The attorney needs to get prior approval for funds related to experts. Be sure to make a record if you cannot get the experts or resources you need.

THE INCREMENTAL APPROACH—START WITH A MITIGATION SPECIALIST

When deciding on your mental health expert(s), you may want to consider first consulting a mitigation specialist, who will often be a licensed social worker. The mitigation specialist will:

- conduct a thorough bio-psycho-social history investigation of your client;
- interview your client;
- conduct collateral interviews;
- gather your client's medical records; and
- determine what cultural, environmental, and genetic circumstances might have factored into your client's case.

Mitigation specialists are superior in many cases to traditional law-enforcement type investigators in developing mitigating evidence because they have training in the human sciences and an appreciation for the variety of factors that may have affected your client's development and behavior. At any rate, the person conducting the investigation should have training, knowledge, and skill to detect the presence of factors such as:

- mental disorders;
- neurological impairments;

- cognitive disabilities;
- physical, sexual, or psychological abuse;
- substance abuse; and
- other influences on the development of your client's personality and behavior.

Mitigation investigations should be thorough and extensive, especially in capital cases where the whole of the defendant's life needs to be judged in order to determine whether to spare her or him from execution. Moreover, the U.S. Supreme Court has held that failure to investigate such matters in a capital case can constitute ineffective assistance of counsel. *See Wiggins v. Smith,* 539 U.S. 510 (2003). On the other hand, if your client is charged with a misdemeanor, it may be enough to use the social worker mitigation expert, or another qualified investigator, as your only expert in the case.

THEN, YOU MAY WANT TO MOVE ON TO A CONSULTING PSYCHOLOGIST

The mitigation expert may then confer with a consulting psychologist, who will review the records and be able to determine the kinds of expert witness(es) you may need and the role they can play. In some cases, you need a professional with specialized expertise in testing intellectual functioning. Other times, you will want a person with specialization in personality testing, or you may want someone trained in the area of sexual trauma to interview your client. The consulting psychologist can refer specific aspects of your client's case to the testifying experts, who will interview your client in preparation for courtroom testimony.

NEXT, FOCUS ON YOUR TESTIFYING EXPERTS

You need to pay attention to the testifying expert's qualifications and select someone who will be credible and persuasive to the court and jury. It is important for testifying experts to be forensically trained since they will have a better understanding of the legal questions that need to be answered. You should thoroughly investigate the expert's background and prior testimony. It is good to have someone who has testified before and knows how to handle cross-examination. If your client's primary language is not English, you should consider hiring an expert who is fluent in your client's primary language. Testifying expert witnesses fall into several categories, and you should pick one who can best meet your needs:

- For testimony related to diagnosis, treatment, and medication for mental disorders and medical issues, you should obtain a psychiatrist as your testifying expert witness, preferably one with a forensic specialization.

- For testimony related to personality or behavioral disorders, intellectual or cognitive functioning, or administering and interpreting tests, you should obtain a psychologist as your testifying expert witness.

- You often need both a psychologist and a psychiatrist to enhance credibility.

- If your client has a brain injury or has problems with memory, language, or orientation functions, you may want to obtain a neuropsychiatrist or a neuropsychologist.

- You may also want to use a pharmacologist, or a specialist in addiction medicine or in sexual trauma if appropriate.

Local mental health professionals may not have the expertise you need. Also, some experts may feel beholden to local authorities for future income. If any circumstances arise that cause you to question the objectivity of the local health professional in question, you should seek expert assistance elsewhere.

This incremental approach to developing mental health evidence is considered by some to be superior to the "complete psychological evaluation" that attorneys often request, particularly in capital cases. This suggested approach may be more cost efficient, more likely to produce information that will advance your theory of the case, and less likely to generate information that will be of no use or, worse, will harm your theory and your client. Ideally, the same professional should not fill more than one role (evaluator, consultant, or treatment provider). ABA STANDARDS RELATING TO GENERAL OBLIGATIONS TO DEFENDANTS WITH MENTAL ILLNESS § 7-1.1 (1989).

MITIGATION

WHY IS MITIGATION IMPORTANT?

Mitigation is not a defense to prosecution. It is not an excuse for committing the crime. It is not a reason the client should "get away with it." Instead, it is evidence of a disability or condition that invites compassion. Mitigation is the explanation of the influences that may have converged in the years, days, hours, minutes, and seconds leading up to

the crime, the way information was processed in a damaged brain, and the behavior that resulted.

Human beings can react punitively toward a person whom they regard as defective, foreign, deviant, or fundamentally different from themselves. A client's bizarre behavior or symptoms may be misunderstood by jurors or may engender such fear that this behavior becomes an excuse to punish the defendant rather than a basis for mercy. Good mental health experts can provide testimony at the punishment phase to help the judge and jury understand who your client is, how he or she experiences the world, and why your client behaves as he or she does. They help you humanize your client so that the judge and jury see him or her as a person who deserves empathy and compassion. Many lives are spared in capital sentencing proceedings when jurors come to understand empathetically the disabilities, brain damage, and tormented psyche that may have led to a client's behavior. When presenting mitigation evidence, you must show the relationship between the disability and the conduct. It is not the "What?" It is the "So what?" If you cannot answer the "So what" question that each juror will be asking, the evidence of disability will look like an excuse, not an explanation.

SENTENCING STRATEGIES

When thinking about sentencing with your mentally ill client, there are a number of things you should consider and weigh.

MENTAL HEALTH INFORMATION AS MITIGATION CAN SOMETIMES HURT YOU.

You need to consider carefully the decision to present your client's mental illness to the jury. Some jurors do not believe in mental illness. Some jurors will not want your client to be out in the community on probation. Your client's mental illness may become fair game for argument; the state may try to use it against you. The prosecutor might say, "What's to keep this person from going off his medications again?" Or the prosecutor might imply that "We have to keep mentally ill people locked up for our own safety." On the other hand, you must remember that failing to raise the issue of your client's mental illness may result in a probated sentence that your client cannot comply with or in a period of incarceration that will further damage your client's mental health.

IF YOU DECIDE TO RAISE YOUR CLIENT'S MENTAL ILLNESS AT THE PUNISHMENT PHASE, BE SURE YOU HAVE SUFFICIENT EVIDENCE AND EXPERT HELP.

You need to be able to say more than that your client is depressed. You need to talk about the extent of the depression. Was your client depressed for a short period or was it more serious? Unless it is a very serious case that can be substantiated, jurors may think, "We've all been depressed" or "Everyone's depressed while they're in jail." Remember, the scope of inquiry at the punishment phase is much broader than at the guilt/innocence phase. There are different types of mental health experts, diagnoses, and resources that may be helpful. Simply interviewing your client or submitting him or her for a single mental health exam will almost always result in an incomplete picture.

YOU MAY BE BETTER OFF ADVISING YOUR CLIENT TO WAIVE A JURY AND TAKING THE MENTAL HEALTH EVIDENCE DIRECTLY BEFORE THE JUDGE.

The decision to go to the jury or the judge for sentencing depends on several things, including the charges involved, the judge, and how much the prosecutor is willing to work with you. If your client decides to go to the judge for sentencing and you are seeking probation, you should have a plan for the judge to consider — a stable place for your client to live, a doctor to go to, and a program to provide supervision to help your client stay out of trouble. Be an advocate for your client. Bring in witnesses who know your client, such as his or her psychiatrist, caseworker, and family members. If your client is on probation and the state has filed a motion to revoke or a motion to adjudicate guilt, you should seek the above-mentioned sources to keep the judge from revoking your client's probation or entering a conviction on the record against your client and sending him or her to jail. You can also have the probation officer handling your client's case testify about whether your client is on a specialized caseload.

MAKE SURE YOUR CLIENT RECEIVES AN ACCURATE AND COMPLETE MENTAL HEALTH EVALUATION.

If you are going to bring your client's mental illness before the judge or jury for sentencing purposes, make sure that the experts you use do more than conduct a mental status examination and offer a diagnosis. You should work with the expert to ensure that he or she conducts a wider-ranging inquiry into your client's mental health history and its

implications. For example, your client may have incurred a head injury at an early age, causing brain damage. Or there may be a familial history of mental illness or a generational pattern of violence and abuse in the home. It is important to interview outside sources such as family members, former teachers, physicians, etc., as well as to request all available records, and to consider the testimony and evidence they can provide. A comprehensive mental health examination should include:

- a thorough physical and neurological examination;
- a complete psychiatric and mental status examination;
- diagnostic studies, including personality assessment;
- neuropsychological testing;
- appropriate brain scans; and
- a blood test or other genetic studies.

In capital defense litigation, it is especially important to make sure your client has thorough and comprehensive mental examinations that evaluate each area of concern as indicated by the client's bio-psycho-social history.

MANY MENTALLY ILL OFFENDERS CAN HAVE CO-OCCURRING SUBSTANCE ABUSE PROBLEMS.

Many persons with mental illness have addictions to drugs and/or alcohol; others "self-medicate" the symptoms of their mental illness with drugs or alcohol. Under either scenario, it is likely that this type of client will have problems staying

clean and/or being successful on probation. Both substance abuse and mental illness are chronic, relapsing illnesses that need treatment. If your client has a substance abuse problem and also a serious mental illness, you should look into the availability of dual diagnosis treatment programs in your community. Some clients would rather accept a plea bargain agreement for jail time than wait to get into substance abuse or dual diagnosis treatment. Your client makes the ultimate decision about whether to get treatment, but you should talk candidly with your client about it. Try saying something like, "Look, you have this problem and you're probably not going to make it on probation. You're going to end up in the penitentiary—but we can get you some treatment to help you avoid that." Talk to your client about doing what is best for him or her over the long term rather than the short term.

YOUR CLIENT'S MENTAL ILLNESS SHOULD BE FACTORED INTO DECISIONS ABOUT PROBATION.

Your client may need special attention if he or she is seeking probation: Remember that your client may not be able to hold down full time employment, pay probation fees, keep track of appointments, navigate public transportation, perform community service, or complete schooling the way that other clients can. Special arrangements may need to be made and extra help may need to be provided if these tasks are part of the successful completion of your client's sentence. If your client is taking probation, you should work to assure that your client gets probation with treatment or gets conditions placed on his or her probation that will help him or her successfully complete the probation. If your client is facing revocation of his or her probation, you should educate the court about your client's mental illness and the treatment options that could be made part of the conditions of his or her probation.

The judge's ability to condition probation on treatment: The Connecticut General Statutes authorizes judges to require certain offenders suffering from mental illness to undergo medical or psychiatric treatment and remain in a specified institution as a condition of community supervision stemming from probated or suspended sentences. CONN. GEN. STAT. § 53a-30(a)(2) (2006). Judges may also require defendants to live in a residential community center or halfway house. § 53a-30(a)(9) (2006).

The judge can amend the conditions of probation: Under the Connecticut General Statutes, judges may modify or enlarge the conditions for probation at any time during the probationary period. § 53a-30(c) (2006). In order to amend the conditions, the court must hold a hearing, and there must be "good cause shown" for such modification. *Id.* There is a great deal of flexibility to tailor the appropriate conditions of treatment for offenders suffering from mental illness. Although mental health treatment may include medication, attorneys and judges are generally not in the best position to make judgments about specific medication options. However, you should advocate for the best available treatment for your client.

YOUR CLIENT MAY NOT WANT TREATMENT.

You cannot force your client to get treatment if he or she does not want it, even though you know it may be in his or her long-term interest. You may be limited in what you can do for your client. If your client's charges are minor and he or she has a supportive family, has a safe place to live, is usually relatively stable, and is competent, it may be better for your client to plead to jail time if you can negotiate a good deal rather than pursuing the insanity defense, even if

applicable, or accepting a probated sentence. However, you have an obligation to set out all the pros and cons of any plea bargain agreement for your client. If your client is considering straight jail time, you should tell him or her the possible benefits of taking probation with conditions that require treatment. Tell your client what you believe the chances are of him or her staying out of trouble if he or she does not get treatment, and what penalties might await your client if he or she re-offends.

GO THE EXTRA MILE FOR YOUR CLIENT.

Persons with mental illness who are not linked with appropriate services at sentencing are likely to re-offend, perhaps with more serious consequences and penalties attached to the second or third arrest. Try to set up your client with ongoing treatment and services to enhance the likelihood that he or she can stay out of trouble. If your client is going to the penitentiary, you can recommend that he or she be sent to a specialized mental health unit. If your client is being released on probation, stable housing is especially important. Talk with the probation department about the resources it uses. Call the local Mental Health Association, the local chapter of the National Alliance for the Mentally Ill (NAMI), or the local mental health authority for recommendations about services.

SECTION 10
RECENT DEVELOPMENTS

In this section, we call your attention to recent cases that attorneys need to be aware of when representing criminal defen-dants with mental illness.

Atkins v. Virginia

In *Atkins v. Virginia,* 536 U.S. 304 (2002), the United States Supreme Court held that the execution of mentally retarded persons constitutes cruel and unusual punishment in violation of the Eighth Amendment to the United States Constitution. Writing for the Court's majority, Justice Stevens stated: "Those mentally retarded persons who meet the law's requirements for criminal responsibility should be tried and punished when they commit crimes." But then he pointed out that "[b]ecause of their disabilities in areas of reasoning, judgment, and control of their impulses ... they do not act with the level of moral culpability that characterizes the most serious adult criminal conduct," and in addition, "their impairments can jeopardize the reliability and fairness of capital proceedings against mentally retarded defendants." *Id.* at 306-07.

Attorneys representing defendants with serious mental illness in capital cases may want to consider filing motions and making arguments to the effect that, as a logical extension of *Atkins,* the execution of persons with serious mental illness is also unconstitutional.

Sell v. United States

In *Sell v. United States,* 539 U.S. 166 (2003), the United States Supreme Court held that in cases of "serious criminal charges," the Government may involuntarily administer anti-psychotic drugs to a criminal defendant solely to render him competent to stand trial, at least in those cases meeting the criteria set out by the Court. In deciding whether the involuntary medication is appropriate, the court must balance the following factors: (1) whether there is a substantial state interest in having a criminal trial, taking into account any civil confinement for the mental condition; (2) whether the medication is substantially likely to render the defendant competent without offsetting side effects; (3) whether the medication is necessary or whether a less intrusive alternative procedure would produce substantially the same result; and (4) whether the drugs are medically appropriate.

Since the inception of the *Sell* factors, other federal courts have made the point that these factors are difficult to apply due to their amorphous and vague nature. Many cases have attempted to clarify the application of the factors. In *United States v. Gomes,* the Second Circuit noted that the Supreme Court had failed to provide a standard of proof by which to analyze the factors, and held that in order to involuntarily administer psychiatric drugs to render a defendant competent to stand trial, the *Sell* factors must be established "by clear and convincing evidence." 387 F.3d 157, 160 (2nd Cir. 2004). *United States v. Ghane,* clarified the second *Sell* factor, stating that a mere five to ten percent chance that the psychiatric medication would render defendant competent to stand trail did not meet the "substantially likely" requirement meted out by the Supreme Court. 392 F.3d 317, 320 (8th Cir. 2004). In *United States v. Evans,* the Western District of West

Virginia noted that the Supreme Court failed to provide guidance regarding what constituted "serious criminal charges." 293 F. Supp. 2d 668, 673 (W.D. Va. 2003). The court in *Evans* went on to note that, in examinations of the Sixth Amendment right to trial by jury (which only extends to those persons charged with "serious" offenses), the Supreme Court defined "serious" offenses as those for which "a term of imprisonment exceeding six months may be imposed." *Id.* Therefore, the *Evans* court concluded that for the purposes of applying the *Sell* factors, the definition of a 'serious criminal offense' would be determined by the crime's potential penalty.

Singleton v. Norris

The United States Supreme Court declined to review the Eighth Circuit of Appeals case of *Singleton v. Norris,* 319 F.3d 1018 (8th Cir.), *cert. denied,* 540 U.S. 832 (2003), which held that it is neither cruel and unusual punishment nor a violation of due process to execute an inmate who had regained competency through forced medication for legitimate reasons of prison security or medical need, even if the effect was also to render him competent to be executed. The Eighth Circuit majority avoided the question whether the Supreme Court's prohibition on executing the insane in *Ford v Wainwright,* 477 U.S. 399, 106 S.Ct. 2595, 91 L.Ed.2d 335 (1986), applied to the situation where the State's sole purpose in forcefully medicating an inmate is to render him competent for execution, something which the State conceded in its *Singleton* brief it could not do and which two state supreme courts have found unconstitutional under their state constitutions.

Wiggins v. Smith

Criminal defense lawyers need to be aware of *Wiggins v Smith,* 539 U.S.510 (2003), in which the United States Supreme Court determined that a capital defendant was denied his Sixth Amendment right to effective assistance of counsel by his lawyer's failure to investigate the troubled background which would have revealed evidence that could have mitigated the punishment. Thus, any evidence such as mental illness or mental retardation that might mitigate the defendant's crime or punishment should not be overlooked by the defense lawyer who wants to avoid a claim of ineffective assistance of counsel.

Bell v. Thompson

When reviewing a habeas corpus petition for a convicted first-degree murderer sentenced to death, the Supreme Court found that, where defense counsel made a strategic decision not to present mental health evidence as a mitigating factor at sentencing, after making a "reasonable investigation" the defendants background, a claim of ineffective assistance of counsel did not meet the "miscarriage of justice" standard as applied in *Sawyer v. Whitley,* 505 U.S. **333, 345-47 (1992). *Bell v. Thompson, 545* U.S. 1158 (2006).**

Clark v. Arizona

The Supreme Court upheld a conviction under Arizona's insanity test, which, as an abbreviation of the *M'Naghton* rule, is expressed solely in terms of whether or not the defendant had the capacity to determine if the act charged as a crime was right or wrong. The court stated that such a test did not violate due process. The Court also held that due

process was not violated by Arizona's ruling in *State v. Mott* (187 Ariz. 536, 931 P. 2d 1046 (en banc), cert. denied, 520 U. S. 1234 (1997)), which held that defense evidence of mental illness or defect could not be considered when determining whether or not the defendant had the requisite mens rea for any charged offense. *Clark v. Arizona,* 126 S. Ct. 2709 (2006).

Panetti v. Quarterman

Scheduled to be argued in April of 2007, this case raises the question of whether the 8th Amendment permits the execution of an inmate factually aware of the reason for his execution, but who, due to the severity of his mental illness, has a delusional belief as to why the state is executing him, and as such, does not appreciate that his execution is intended to seek retribution for his capital offense. *Panetti v. Quarterman,* 127 S. Ct. 852 (2007).

GLOSSARY OF COMMON MENTAL HEALTH TERMS

ADD — see attention deficit/hyperactivity disorder. **ADHD —** see attention deficit/hyperactivity disorder.

Affect — a person's immediate emotional state or mood that can be recognized by others.

Affective disorder — a mental disorder characterized by disturbances of mood. Depression, mania, "manic-depression," and bipolar disorders in which the individual experiences both extremes of mood are examples. Also called mood disorder.

Antisocial personality — a type of personality disorder marked by impulsivity, inability to abide by the customs and laws of society, and lack of anxiety, remorse, or guilt regarding behavior.

Anxiety — a state of apprehension, tension, and worry about future danger or misfortune. A feeling of fear and foreboding. It can result from a tension caused by conflicting ideas or motivations. Anxiety manifests through symptoms such as palpitations, dizziness, hyperventilation, and faintness.

Anxiety disorders — a group of mental disorders characterized by intense anxiety or by maladaptive behavior designed to relieve anxiety. Includes generalized anxiety and panic disorders, phobic and obsessive-compulsive disorders, social anxi-ety, and post-traumatic stress disorder.

Antidepressants — medications used to elevate the mood of depressed individuals and also to relieve symptoms of anxiety conditions.

Antipsychotic medications — medications that reduce psychotic symptoms; used frequently in the treatment of schizophrenia.

Attention Deficit/Hyperactivity Disorder (ADHD) — a disorder, usually of children but also present in adults, characterized by a persistent pattern of inattention and/or hyperactivity and impulsivity that is more frequent and severe than is typically found in individuals of a comparable level of development. Symptoms might include impatience, fidgetiness, excessive talking, inability to focus or pay attention, and distractibility.

Atypical antipsychotics — a new group of medications used primarily to treat schizophrenia with broader effectiveness and few side effects. Also called new generation antipsychotics.

Auditory hallucinations — voices or noises that are experienced by an individual that are not experienced by others.

Autism — a mental disorder, first evident during early childhood, in which the child shows significant deficits in communication, social interaction, and bonding and play activities, and engages in repetitive behaviors and self-damaging acts.

Behavior therapy — a method of therapy based on learning principles. It uses techniques such as reinforcement and shaping to modify behavior.

Behavioral health — a term used to refer to both mental illness and substance abuse.

Benzodiazepines — a class of anti-anxiety medications that have addiction potential in some people.

Bipolar disorder — a mood disorder in which people experience episodes of depression and mania (exaggerated excitement) or of mania alone. Typically the individual alternates between the two extremes, often with periods of normal mood in between. Also called manic-depression.

Borderline personality disorder — a mental disorder in which the individual has manifested unstable moods, relationships with others, and self-perceptions chronically since adolescence or childhood. Self-injury is frequent.

Clinical psychologist — a psychologist, usually with a Ph.D. or Psy.D. degree, trained in the diagnosis and treatment of emotional or behavioral problems and mental disorders.

Cognitive behavior therapy — a therapy approach that emphasizes the influence of a person's beliefs, thoughts, and self-statements on behavior. It combines behavior therapy methods with techniques designed to change the way the individual thinks about self and events.

Cognitive impairment — a diminution of a person's ability to reason, think, concentrate, remember, focus attention, and perform complex behaviors.

Compulsion — the behavioral component of an obsession. A repetitive action that a person feels driven to perform and is unable to resist; ritualistic behavior.

Conduct disorder — a childhood disorder characterized by a repetitive and persistent pattern of behavior that disregards the basic rights of others and major societal norms or rules.

DSM-IVR — the fourth edition of the Diagnostic and Statistical Manual of the American Psychiatric Association, revised. This is a nationally accepted book that classifies mental disorders. It presents a psychiatric nomenclature designed for diagnosing different categories of specific psychiatric disorders.

Decompensation — a gradual or sudden decline in a person's ability to function accompanied by the re-emergence of psychiatric symptoms.

Delusion — false beliefs characteristic of some forms of psychotic disorder. They often take the form of delusions of grandeur or delusions of persecution.

Dementia — a chronic organic mental illness which produces a global deterioration in cognitive abilities and which usually runs a deteriorating course.

Depression — an affective or mood disorder characterized by a profound and persistent sadness, dejection, decreased motivation and interest in life, negative thoughts (for example, feelings of helplessness, inadequacy, and low self-esteem) and such physical symptoms as sleep disturbances, loss of appetite, and fatigue and irritability.

Disruptive behavior disorder — a class of childhood disorders including conduct disorder, oppositional defiant behavior, and attention deficit/hyperactivity disorder.

Dissociative identity disorder — see multiple personality disorder.

Electroconvulsive therapy — a treatment for severe depression in which a mild electric current is applied to the brain, producing a seizure similar to an epileptic convulsion. Also known as electroshock therapy. It is most often used to treat severe, persistent depression.

Electroshock therapy — see electroconvulsive therapy.

Family therapy — psychotherapy with the family members as a group rather than treatment of the patient alone aimed at addressing family dysfunction and leading to improved family function.

Fetal alcohol syndrome — abnormal development of the fetus and infant caused by maternal alcohol consumption during pregnancy. Features of the syndrome include retarded growth, small head circumference, a flat nasal bridge, a small midface, shortened eyelids, and mental retardation.

Generalized anxiety disorder — an anxiety disorder characterized by persistent tension and apprehension. May be accompanied by such physical symptoms as rapid heart rate, fatigue, disturbed sleep, and dizziness.

Group therapy — a group discussion or other group activity with a therapeutic purpose participated in by more than one client or patient at a time.

Hallucination — a sensory experience in the absence of appropriate external stimuli that is not shared by others; a misinterpretation of imaginary experiences as actual perceptions.

Hypomania — an affective disorder characterized by elation, overactivity, and insomnia.

Illusion — a misperception or misinterpretation of a real external stimulus so that what is perceived does not correspond to physical reality.

Impulse control disorders — a category of disorders characterized by a failure to resist an impulse, drive, or temptation to perform an act that is harmful to the person or to others. A number of specific disorders, including substance abuse disorders, schizophrenia, attention deficit/hyperactivity disorder, and conduct disorder have impulse control features.

Learning disorders — learning problems that significantly interfere with academic achievement or activities of daily living involving reading, math, or writing. They are typically diagnosed from achievement on standardized tests.

Lithium carbonate — a compound based on the element lithium that has been successful in treating bipolar disorders.

MRI (magnetic resonance imaging) — a computer-based scanning procedure that generates a picture of a cross-section of the brain or body.

Malingering — feigning or significantly exaggerating symptoms for a conscious gain or purpose such as to get a change in conditions of confinement.

Mania — an affective disorder characterized by intense euphoria or irritability, exaggerated excitement, and loss of insight.

Manic-depressive disorder — a mood disorder in which people experience episodes of depression and mania (exaggerated excitement) or of mania alone. Typically the individual alternates between the two extremes, often with periods of normal mood in between. Also called bipolar disorder.

Mental illness — a generic term used to refer to a variety of mental disorders, including mood disorders, thought disorders, eating disorders, anxiety disorders, sleep disorders, psychotic disorders, substance abuse disorders, personality disorders, behavioral disorders, and others.

Mental retardation — a permanent condition usually developing before 18 years of age that is characterized by significantly subaverage intellectual function accompanied by significant limitations in adaptive functioning in other areas such as communication, self-care, home living, self-direction, social/interpersonal skills, work, leisure, and health.

Mood disorder — a mental disorder characterized by disturbances of mood. Depression, mania, and bipolar disorders, in which the individual experiences both extremes of mood, are examples. Also called affective disorder.

Multiple personality disorder — the existence of two or more distinct identities or personalities within the same individual. Each identity has its own set of memories and characteristic behaviors. The identities are believed to develop as a way of protecting the individual from the effects of severe abuse or trauma. Also called dissociative identity disorder.

Neuroimaging — newly developed computerized techniques that can create visual images of a brain in action and indicate which regions of the brain show the most activity during a particular task. Two common neuroimaging techniques are positron emission tomography (PET) and magnetic resonance imaging (MRI).

Neurosis (pl. neuroses) — a mental disorder in which the individual is unable to cope with anxieties and conflicts and develops symptoms that he or she finds distressing, such as obsessions, compulsions, phobias, or anxiety attacks. This is no longer a diagnostic category of DSM-IVR.

Nervous breakdown — a non-technical term used by the lay public, usually referring to an episode of psychosis.

Neuroleptic drugs — a category of older medications used to treat psychoses. Many have been linked to neurological side effects.

New generation antipsychotics — see atypical antipsychotics.

Obsession —An unpleasant or nonsensical thought that intrudes into a person's mind, despite a degree of resistance by the person. Obsessions may be accompanied by compulsive behaviors. A persistent, unwelcome, intrusive thought.

Obsessive-compulsive disorder — an anxiety disorder involving recurrent unwelcome thoughts, irresistible urges to repeat stereotyped or ritualistic acts, or a combination of both of these.

Oppositional defiant disorder — a childhood disorder characterized by a recurrent pattern of negativistic, defiant, disobedient, and hostile behavior toward authority figures that persists over time.

Panic attack — a sudden onset of intense apprehension, fearfulness, or terror often associated with feelings of impending doom, imminent heart attack, or other fears which often drive someone to seek medical care.

Panic disorder — an anxiety disorder in which the individual has sudden and inexplicable episodes of terror and feelings of impending doom accompanied by physiological symptoms of fear (such as heart palpitations, shortness of breath, muscle tremors, faintness).

Paranoia — a pervasive distrust and suspiciousness of others; suspiciousness or the belief that one is being harassed, persecuted, or unfairly treated.

Paranoid schizophrenia — a schizophrenic reaction in which the patient has delusions of persecution.

Personality disorder — an enduring pattern of perceiving, relating to, and thinking about the environment and oneself that begins by early adulthood, is exhibited in a wide range of personal and social contexts, and leads to impairment or distress; it is a constellation of traits that tend to be socially maladaptive.

Phobia — excessive fear of a specific object, activity, or situation that results in a compelling desire to avoid it.

Phobic disorder — an anxiety disorder in which phobias are severe or pervasive enough to interfere seriously with the individual's daily life.

Positron emission tomography (PET scan) — a newly developed technique that can create visual images of a brain in action and indicate which regions of the brain show the most activity during a particular task.

Post-traumatic stress disorder — an anxiety disorder in which a stressful event that is outside the range of usual human experience, such as military combat or a natural disaster, induces symptoms such as a re-experiencing of the trauma and avoidance of stimuli associated with it, a feeling of estrangement, a tendency to be easily startled, nightmares, recurrent dreams, and disturbed sleep.

Psychiatrist — a medical doctor specializing in the treatment and prevention of mental disorders both mild and severe.

Psychoactive drugs — drugs that affect a person's behavior and thought processes, including non-prescription or "street" drugs.

Psychotropic drugs — prescribed medications that affect a person's behavior and thought processes.

Psychoanalysis — a method of intensive and in-depth treatment for mental disorders emphasizing the role of unconscious processes in personality development and unconscious beliefs, fears, and desires in motivation.

Psychologist — a person with a Masters degree, Ph.D., Ed.D., or Psy.D., and a license in psychology, the study of

mental processes and behavior. Psychologists can specialize in counseling and clinical work with children and/or adults who have emotional and behavioral problems, testing, evaluation, and consultation to schools or industry, but cannot prescribe medications.

Psychopathic personality — a behavior pattern that is characterized by disregard for, and violation of, the rights of others and a failure to conform to social norms with respect to lawful behavior.

Psychosis (pl. psychoses) — a severe mental disorder in which thinking and emotion are so impaired that the person is seriously out of contact with reality.

Psychosomatic disorder — physical illness that has psychological causes.

Psychotherapy — treatment of personality maladjustment or mental disorders by interpersonal psychological means.

Psychotic behavior — behavior indicating gross impairment in reality contact as evidenced by delusions and/or hallucinations. It may result from damage to the brain or from a mental disorder such as schizophrenia or a bipolar disorder, or a metabolic disorder.

Repression — a defense mechanism in which an impulse or memory that is distressing or might provoke feelings of guilt is excluded from conscious awareness.

Schizoaffective Disorder — a mental disorder in which a mood disturbance and the active symptoms of schizophrenia occur together.

Schizophrenia — a group of mental disorders characterized by major disturbances in thought, perception, emotion, and behavior. Thinking is illogical and usually includes delusional beliefs; distorted perceptions may take the form of hallucinations; emotions are flat or inappropriate. The individual withdraws from other people and from reality.

Shock therapy — see electroconvulsive therapy.

Social phobia — extreme insecurity in social situations accompanied by an exaggerated fear of embarrassing oneself.

Sociopathic personality — a behavior pattern that is characterized by disregard for, and violation of, the rights of others and a failure to conform to social norms with respect to lawful behavior.

Stress — a state of arousal that occurs when people encounter events that they perceive as endangering their physical or psychological well-being.

Stress reaction or stress response — reactions to events an individual perceives as endangering his or her well-being. These may include bodily changes as well as psychological reactions such as anxiety, anger and aggression, and apathy and depression.

Stressors — events that an individual perceives as endangering his or her physical or psychological well-being.

Tangential — a word used to describe thoughts or words that are only marginally related to the issue at hand.

Tardive dyskinesia — an involuntary movement disorder or muscular activity that sometimes develops as the result of taking strong antipsychotic medication over a period of time.

Thought disorder — a disorder where associations between ideas are lost or loosened but are not perceived as such by the person.

Tic disorders — childhood disorders characterized by sudden, rapid, recurrent, involuntary motor movements or vocalizations. An example is Tourette's syndrome.

Tourette's syndrome — a childhood disorder characterized by multiple motor tics and one or more vocal tics that causes marked distress or significant impairment in social, academic, or other important areas of function.

COMMONLY PRESCRIBED PSYCHOTROPIC MEDICATIONS

The medications glossary is intended to help you better understand information you may see in your client's records or medical reports. Lawyers should always consult with medical professionals for a more complete understanding of these medications and their effects and for information about new medications not listed on these pages.

ANTIDEPRESSANTS

Medications used to treat symptoms of depression. Many of these medications are also now considered the medications of choice for anxiety disorders.

Generic Name	Brand Name	Other Uses/Notes
amitriptyline	Elavil, Endep	
amoxapine	Asendin	
bupropion	Wellbutrin	also used to treat ADHD in children
bupropion	Zyban	also used to decrease cigarette smoking in adults
citalopram	Celexa	
clomipramine	Anafranil	also used to treat obsessive-compulsive disorder
desipramine	Norpramin, Pertofrane	also used to treat ADHD and Tic disorders in children
doxepin	Adapin, Sinequan	sometimes used to encourage sleep
escitalopram	Lexapro	

Generic Name	Brand Name	Other Uses/Notes
fluoxetine	Prozac	approved for use with children; higher doses used for obsessive-compulsive disorder.
fluvoxamine	Luvox	also used for obsessive-compulsive disorder
imipramine	Janimine, Tofranil	also used to treat bed-wetting in children
isocarboxazid	Marplan	
maprotiline	Ludiomil	
mirtazipine	Remeron	
nefazodone	Serzone	
nortriptyline	Aventyl, Pamelor	also used to treat anxiety disorders in children
paroxetine	Paxil	
phenelzine	Nardil	
protriptyline	Triptil, Vivactil	
reboxetine	Edronax	
selegiline	Deprenyl	also used with children to treat ADHD in Tourettes syndrome
sertraline	Zoloft	also used to treat anxiety disorders and obsessivecompulsive disorders in children
tranylcypromine	Parnate	also used to treat ADHD and anxiety disorders in children
trazodone	Desyrel	also used to treat insomnia

trimipramine	Rhotrimine, Surmontil
venlafaxine	Effexor

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5 ANTIANXIETY OR ANTIPANIC

Medications used to treat anxiety, tension, excitation. Many of these medications are classified as benzodiazepines. Many of the antidepressants are also considered to be the medications of choice for anxiety disorders.

Generic Name

alprazolam

buspirone

chlordiazepoxide

clonazepam

clorazepate

diazepam

flurazepam

halazepam

hydroxyzine lorazepam oxazepam

prazepam temazepam

Brand Name	pam	Atarax,
Other Uses/Notes	Vistaril	
Xanax	Ativan	
Buspar	Serax	
Libritabs, Librium	Centrex	
Klonopin	Restoril	
Azene, Tranxene		
T-Quil, Valium		
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ANTIPSYCHOTIC

Medications used to manage the symptoms of psychotic disorders such as schizophrenia and manic-depressive disorder. Many are used as chemical restraints for aggressive, agitated, and self-abusive behaviors in children and adults. The new generation (atypical) medications tend to have fewer side effects.

Generic Name	Brand Name	Other Uses/Notes
aripiprazole	Abilify	
chlorpromazine	Largactil, Thorazine	
chlorprothixene	Taractan	
clozapine	Clozaril	new generation (atypical) medication; requires weekly blood tests
fluphenazine	Prolixin, Modecate, Permitil	comes in longer-acting injectable form
haloperidol	Haldol	comes in longer-acting injectable form
loxapine	Loxapac, Loxitane, Daxolin	
mesoridazine	Serentil	
molindone	Lidone, Moban	
olanzapine	Zyprexa	new generation (atypical) medication
perphenazine	Trilafon, Etrafon	
pimozide	Orap	also used to treat burette's disorder in children

Generic Name	Brand Name	Other Uses/Notes
quetiapine	Seroquel	new generation (atypical) medication
risperidone	Risperdal	new generation (atypical) medication
thioridazine	Mellaril	rarely used any longer
thiothixene	Navane	
trifluoperazine	Stelazine	
triflupromazine	Vesprin	
ziprasidone	Geodon	new generation (atypical) medication

MOOD STABILIZER

Medications used to treat acute manic episodes and to prevent relapse of manic-depressive symptoms. Most of the following except lithium and olanzapine are also anti-seizure medications.

Generic Name	Brand Name	Other Uses/Notes
carbamazepine	Epitol, Tegretol	also used with children
divalproex Sodium	Depakote, Epival	also used with children
gabapentin	Neurontin	
lamotrigine	Lamictal	not for use with children
lithium carbonate (lithium)	Carbolith, Duralith, Eskalith,Lithane, Lithizine, Lithobid, Lithonate, Lithotabs	

Generic Name	Brand Name	Other Uses/Notes
lithium citrate	Cibalith-S	also used to treat hyper-aggressive behavior in children
olanzapine	Zyprexa	new generation (atypical) medication
oxcarbazepine	Trileptal	
tiagabine	Gabitril	
topiramente	Topamax	
valproate (valproic acid)	Depakene, Valrelease	also used with children

ANTIOBSESSIONAL

Medications used to treat symptoms of obsessive-compulsive disorder. They are also used as anti-depressant and anti-anxiety agents.

Generic Name	Brand Name	Other Uses/Notes
clomipramine	Anafranil	
fluoxetine	Prozac	high doses
fluvoxamine	Luvox	

MEDICATIONS USED TO TREAT ADHD (Attention Deficit/Hyperactivity Disorder) IN CHILDREN

Generic Name	Brand Name	Other Uses/Notes
clonidine	Catapres	also used to treat burette's disorder, ADHD, aggression, self-abuse, and severe agitation in children
dextroamphetamine	Dexedrine	
dextroamphetamine	Adderall	
guantacine	Tenex	also used to treat Tourette's disorder
methylphenidate	Ritalin	
propranolol	Inderal	also used to treat Tourette's disorder, aggression/self abuse, intermittent explosive disorder, and severe agitation in children

ANTI-SIDE EFFECT MEDICATIONS

Medications usually used to treat the neurological side effects of many, especially older, anti-psychotic medications. Side effects, also called extrapyramidal symptoms, include tremors and rigidity. Also see ANTI-SEIZURE MEDICATIONS below.

Generic Name	Brand Name	Other Uses/Notes
amantadine	Symmetrel	
benztropine	Cogentin	
propranolol	Inderal	also used to treat some behavior disorders
triexyphenidyl	Artane	

ANTI-SEIZURE MEDICATIONS

Medications used to treat side-effects such as seizures. Many are also used to treat bipolar or manic-depressive disorder. Benzodiazepines are often prescribed as anti-seizure medications as well.

Generic Name	Brand Name	Other Uses/Notes
carbamazepine	Epitol, Tegretol	
clonazepam	Klonopin, Rivotril	also used to treat anxiety disorders, psychosis, mania, severe agitation, severe insomnia and Tourette's disorder in children
divalproex sodium	Depakote, Epival	also used to treat bi-polar disorder
ethosuximide	Zarontin	
lamotrigine	topiramate	
phenytoin	valproate (valproic acid)	
primidone		

Lamictal o
also used to treat bi-polar disorder
pamax

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i Depakene, also used with children
Valrelease

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MEDICATIONS USED TO TREAT ALCOHOLISM

Medications used to help people resist drinking.

Generic Name	Brand Name	Other Uses/Notes
calcium carbimide	Temposil	
disulfiram	Antabuse	
naltrexone	ReVia	also used to block the effects of opioides

MEDICATIONS USED TO TREAT INSOMNIA

Medication used to help people sleep better. Some of the benzodiazepines (tranquilizers) are also used to treat insomnia.

Generic Name	Brand Name	Other Uses/Notes
chloral hydrate	Noctec, Somnos, Felsules	
diphenhydramine	Benadryl	also used with children
flurazepam	Dalmane	
oxazepam	Serax	
temazepam	Restoril	
trazodone	Desyrel	also used with children
triazolam zaleplon	Halcion	
zolpidem	Sonata	
	Ambien	

RESOURCES FOR HELP