

Kentucky Department of Public Advocacy

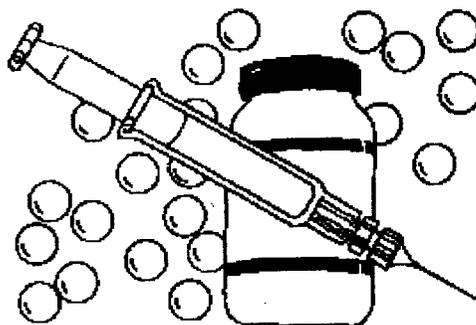
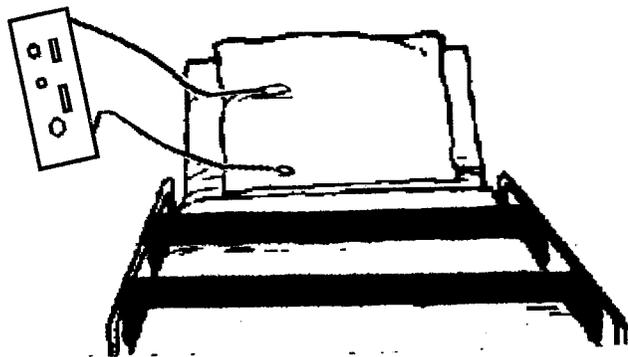
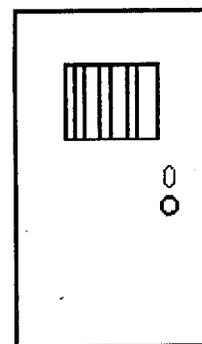
# THE ADVOCATE



*Journal of Criminal Justice Education & Research*

*Volume 18, No. 5, September 1996*

## 202A



### **Involuntary Civil Commitment in the 90s**

**Intensive Case Management of the Mentally Ill**

**Kentucky's Parole Statistics**

**Intensive Litigation Institute being held October 6-11, 1996**

## The Advocate

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

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Discrimination: "As long as you keep a person down some part of you has to be down there to hold him down, so it means you cannot soar as your otherwise might."

- Marian Anderson

### FROM THE EDITOR:

#### The KRS Chapter 202A

**Triage.** Too often, public defenders with way too many cases engage in the survival strategy of triage. The result is that cases viewed as the least significant often are not afforded the time necessary for fully competent representation. Juvenile cases often face this fate. So do involuntary commitment cases. In an attempt to call us all individually and as a system to see involuntary commitment cases as very significant, this issue of *The Advocate* focuses on those cases, the law, the perspective of clients, and alternatives to incarceration (intensive case management) which are creative, effective and working in jurisdictions in this country. Next issue we will bring you an article on the side effects of drugs administered to these clients.

**Parole.** Bob Hubbard tells us about parole in Kentucky. Unfortunately, there's not nearly as much parole data available today compared to several years ago. Competent advice to clients by criminal defense attorneys is all the more difficult without this data.

**Race.** Does race play an inappropriate factor in the way people are treated when incarcerated? **Bill Stewart** addresses the role of race in the way civilly committed persons have been treated in Kentucky and what's been done about it.

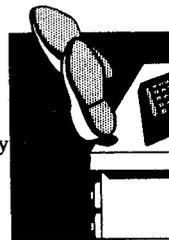
**Mental Health Forum.** Our lively dialogue continues to reveal significant perspectives on the **Dr. Smith** commentary on **John Blume's** article on what competent mental health evaluations consist of. **Dr. Tony Semone** and **Dr. Lee Norton** Tell us the critical role psychosocial histories and neuropsychological testing play in competent evaluation.

*Edward C. Monahan, Editor*



### Triage

1a: "the process of grading marketable produce. b: the lowest grade of coffee berries consisting of broken material. 2: the sorting of and allocation of treatment to patients esp. battle and disaster victims according to a system of priorities designed to maximize the number of survivors." *Webster's Third New International Dictionary* (1986).



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### MENTAL HEALTH FORUM:

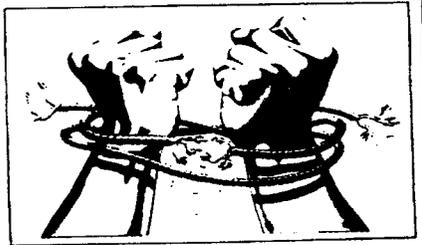
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# Involuntary Civil Commitment in the 90s: A Constitutional Perspective

1. Policy Positions That Move Civil Commitment
2. Public Concerns About Safety and Security
3. Basic Types of Civil Commitment
4. Extended Civil Commitment Standards
5. Constitutional Parameters
6. Recommendations

Generally, our society has not provided the money, resources, and sustained attention necessary to make their care, treatment, and housing a compelling financial and programmatic priority. This is true whether a person with a mental illness is in an institution, in a community program, in a family home, or on the streets.

## Introduction

As a society we are challenged by the theoretical and pragmatic morass we call civil commitment, which for all the change and progress occurring in the 60s, 70s, and 80s remains more of an enigma than a rational and organized system of involuntary intervention. Yet the overriding reason a substantial gap continues to exist between humane and decent care for persons with mental illnesses and the care they often receive is easily identifiable: Generally, our society has not provided the money, resources, and sustained attention necessary to make their care, treatment, and housing a compelling financial and programmatic priority. This is true whether a person with a mental illness is in an institution, in a community program, in a family home, or on the streets.

Despite efforts to improve the lives of persons subjected to civil involuntary interventions - and some advances certainly have been made - the superstructure necessary to fulfill the promises and potential for change nationwide has never been put into place. Moreover, given significant constraints on federal, state, and local expenditures, sustained efforts to redo the national health care system, and differences of opinion about what should be done to change involuntary interventions, widespread systemic improvements in the civil commitment process are highly unlikely to come soon. If our system of involuntary civil commitment for persons with mental illnesses does undergo improvement, in all likelihood the changes will involve incremental adjustments to the existing system rather than what is really needed: a fundamental reworking of the theories and practices that guide involuntary civil commitment nationwide.

This article describes the social forces that tend to dominate policy discussions about civil commitment, reviews the basic types of civil commitment, identifies the statutory standards that govern extended civil commitment, and presents the constitutional framework within which involuntary civil commitment should operate. The article also recommends making systemic adjust-

ments and implementing existing constitutional principles as a way to improve involuntary civil commitment. These suggestions are offered in lieu of wholesale changes - such as eliminating involuntary commitment altogether - that likely would be ignored. The conclusion presents common elements that civil commitment systems using the proposed constitutional principles and recommendations would share.

### **1. Policy Positions That Move Civil Commitment**

A major problem in effectively addressing involuntary interventions, including civil commitment, is the fragile nature of the social consensus upon which these interventions are founded. Numerous "policy positions" - many of which are described briefly below - contribute, more or less, to the policy mix that has produced the current commitment schemes.

#### **A. The Advocates' Perspective**

Three often interrelated policy positions represent the core values of those who represent persons with mental illnesses in various legal, administrative, and legislative forums.

1. **Civil liberties.** The best result is the one that maximizes individual liberty.
2. **Least restrictive alternative.** The best result is the one that least intrudes on an individual's liberty. Conceptually, this view is closely tied to the civil liberties perspective.
3. **Deinstitutionalization.** Large institutions - and by implication involuntary inpatient commitments - are inherently harmful and should be replaced with voluntary placements in smaller, less restrictive community programs.

#### **B. Medical Model**

The best result is the one that most relies on physicians and medical institutions to make decisions about an individual's care and treatment.

#### **C. The Family Model**

The best result is the one that most relies on family members to make decisions about a relative's care and treatment.

#### **D. The Consumer Model**

The best result is the one that most relies on former patients to make decisions about what types of care and treatment should be made available to current patients.

#### **E. Fiscal Conservatism**

In this economy, powerful fiscal limits govern what our society can do to help persons with mental illnesses.

*Recent corollary regarding national health insurance.* For Americans to have something even approaching universal health care coverage, the costs for mental health care must be strictly limited or even eliminated under that coverage.

#### **F. Nihilism**

Society should eliminate all systems for providing care and treatment to persons with mental illnesses because only a few of them get the help they need and far too many are subjected to physical, mental, and sexual abuse.

*Common corollary to nihilism.* The psychiatrists who control most involuntary interventions act more like employees of authoritarian regimes in the way they dispense mindaltering remedies than like humane care givers.

#### **G. Help the Helpless**

Two policy positions are advocated by persons seeking involuntary interventions for those who cannot help themselves.

1. **Help the homeless.** Because most homeless persons are former mental patients who have been deinstitutionalized, reinstitutionalizing and performing other involuntary interventions for former mental patients is needed to solve much of the homelessness problem.
2. **Provide needed treatment.** Because, as a result of their conditions, many mental patients do not know what is best for themselves, society has a moral obligation to provide care and treatment to these persons, doing so coercively if necessary.

## 2. Public Concerns About Safety and Security

The public's concerns about safety and security as they affect civil commitment fall into three subtexts.

1. **The streets are not safe.** Far too many persons who should be receiving involuntary inpatient care are at large in the community committing crimes and other acts of violence, destruction, and nuisance that lower the quality of life for the rest of society.
2. **Predictions of violence and identification of dangerousness.** Although in the past social scientists and psychiatrists have consistently overestimated their abilities to predict violence and to identify dangerousness, our knowledge may have progressed to the point that we can now accurately predict violence and identify dangerousness in specific circumstances.
3. **Criminalization of mental illness.** Society has an obligation to protect citizens by using the criminal justice system to keep violent persons with mental disabilities off the streets and by using the mental health system to prevent dangerous prisoners whose sentences have expired from being released into the community.

### A. Fill the Beds

Hospitals must fill their psychiatric beds or else they will fall short of their revenue needs and psychiatric patients will suffer as a result.

### B. Jobs

Society should not close psychiatric institutions and hospitals to provide care for persons with mental illnesses in decentralized settings because this would cause working people (*i.e.*, members of unions) to lose their jobs and/or face reductions in pay.

The overriding concerns of the groups promoting the above positions often go beyond or ignore the issue of which civil commitment system is best for society. Yet each of these positions contributes in its own way to the commitment system we have now and probably to any that is fashioned in the future.

When viewed in the best light, each of these social positions reflects powerful feelings or beliefs having some utilitarian aspect that garners recognition. Some of the positions represent fundamental social values or are promoted by valued or distinguished groups in society.

In a more critical light, however, these competing positions may cause many problems for effectively restructuring the civil commitment system. Some of the positions are overly broad in their applications or too absolute in their conceptualization to be implemented fully. Others may be based on good intentions but are misguided. In certain instances, the viewpoints represent thinly veiled positions of selfinterest that may not serve the best interests of persons with mental illnesses or of society. Some of the viewpoints merely perpetuate myths, stereotypes, or deceptions that undermine efforts to reform civil commitment.

Whatever one may think about the various viewpoints described, a consensus must be forged among the persons and organizations representing these positions if systemic improvements in civil commitments are to occur. Given the wide differences in these opinions, any basis for consensus must have a strong legal and moral mandate. Constitutional principles can provide a strong foundation for achieving such a consensus.

## 3. Basic Types of Civil Commitment

Many different ways of categorizing civil commitment into "types" are available. The method presented here is drawn primarily from two works, *The Mental and Physical Disability Law Reporter* and the book entitled *The Mentally Disabled and the Law*.<sup>1</sup> Not surprisingly, the eight primary types of commitment and various subtypes described below reflect a decidedly legal perspective.

### A. Informal Commitment

Competent individuals can admit themselves to a facility for voluntary treatment and discharge themselves on short notice without fear of being involuntarily committed. Several states use this type of commitment.<sup>2</sup>

### B. Voluntary Commitment

A facility can admit a competent individual for voluntary treatment, but demands that certain

bureaucratic requirements be satisfied before the individual can be discharged and/or retains the right to institute involuntary commitment proceedings instead of discharging the patient.

### C. Third-Party Commitment

A person other than the proposed patient who has authority by virtue of an established legal relationship with that person (e.g., a guardian) can effectuate the proposed patient's voluntary or involuntary civil commitment. (Note that according to the definitions used here, if the law requires a due process hearing in addition to the guardian's consent, the procedure is not actually a third-party commitment.) Laws governing third-party commitment vary somewhat depending on whether the proposed patient is an adult or a minor.

*Adults.* A legal guardian or a parent with guardianship powers can consent to have the ward/adult child civilly committed. Depending on the jurisdiction and circumstances, the commitment may either be "voluntary," whereby the guardian can withdraw consent and initiate a process leading to discharge unless involuntary commitment proceedings are instituted, or "involuntary," whereby if consent is withdrawn a proceeding - either administrative or judicial - must be held before discharge will be granted.

*Minors.* A parent or legal guardian can consent, subject to administrative review as established in *Parham* case (discussed further below), to have a child civilly committed. Like the commitment of an adult, the commitment of a minor can either be "voluntary" in that the parent's withdrawal of consent will lead to discharge or "involuntary" in that discharge depends on an administrative or legal proceeding.

### D. Short-Term Commitment

This type of involuntary commitment is characterized by the relatively short duration between a patient's being taken into custody and his or her being released or held over for extended commitment. Depending on the jurisdiction, short-term commitments may be limited statutorily to periods ranging from twenty-four hours (Illinois)<sup>3</sup> to six months (West Virginia),<sup>4</sup> although they typically last from three to thirty days.<sup>5</sup> Short-term commitments also may be divided into three different subtypes based on their substantive purposes.

*Emergency commitment* applies when a person's mental condition poses an immediate danger to self or others.

*Commitment for observation or evaluation* is used to observe, examine, or evaluate a respondent pursuant to extended commitment proceedings.

*Temporary commitment* is a stop-gap or interim measure used before extended proceedings can be held.

### E. Extended Commitment

Under this procedure, patients are subject to long-term or in some cases indefinite involuntary commitment to inpatient facilities, but only after the most rigorous substantive and procedural due process requirements are met. In many respects, extended commitment is the commitment type around which all commitments revolve.

### F. Outpatient Commitment

This process is used to involuntarily commit a patient to an outpatient facility. Depending on the statutory scheme and circumstances involved, the process may be similar to preventive detention or be a less restrictive alternative to inpatient hospitalization.

### G. Criminal Commitment

A person who remains in the control of the criminal justice system may be subject to involuntary inpatient or out-patient treatment. Depending on the circumstances, treatment may occur in facilities run by either the mental health or the criminal justice authorities. Generally, four subtypes of criminal commitment exist.

*Pretrial detention* occurs when a defendant who has been accused of a crime but has not been adjudicated incompetent to stand trial is treated involuntarily.

*Commitment of persons found incompetent to stand trial* occurs when persons who are found incompetent to stand trial are committed for treatment until they regain their competency or they cannot be held any longer without violating due process.

*Insanity acquittal* occurs when defendants who are found not guilty by reason of insanity are

committed to treatment facilities until they are no longer mentally disabled and dangerous.

*Post-trial commitment* occurs when defendants are committed involuntarily to treatment facilities while serving their sentences.

## H. Recommitment

This is the procedure for renewing involuntary extended commitments in either the civil or the criminal systems. Generally, the same standards used for the original commitment apply, although - particularly in a criminal context - the burden of proof may shift to the patient/ inmate.

Of all the civil commitment types discussed here, only one type - informal commitment - is really voluntary in the sense of allowing the patient self-determination. All the other types involve some level of coercion and/or the substituted consent of another person. Thus, for most purposes, civil commitment should be viewed as a series of interventions involving different degrees and types of involuntariness.

### 4. Extended Civil Commitment Standards<sup>6</sup>

Although many have written about new developments in the statutory standards for extended involuntary civil commitment during the past ten years, in fact not much has actually changed. An overwhelming majority of jurisdictions still base their commitment standards on dangerousness to self or others and/or on grave disability.<sup>7</sup>

Today almost every jurisdiction's civil commitment scheme has at least two major parts: a definition describing the types of mental conditions covered under the statute<sup>8</sup> and the commitment criteria or standards that link mental conditions to specific justifications for requiring involuntary commitment.<sup>9</sup>

In all but six jurisdictions, mental conditions are referred to as mental illnesses.<sup>10</sup> These illnesses (sometimes called disorders) typically, but not always, are described as significant, severe, substantial, or gross impairments.<sup>11</sup> In many jurisdictions, the statutes limit their coverage of mental illnesses or disorders by excluding certain specific types of conditions altogether or in most situations unless the respondent otherwise meets the commitment criteria.<sup>12</sup> The most frequently listed conditions excluded from definitions of mental illnesses or mental disorders are mental

retardation, epilepsy, developmental disabilities, drug addiction, and alcoholism.<sup>13</sup>

With respect to criteria for civil commitment, every jurisdiction has at least one major standard based on dangerousness to self and others or on something close to that.<sup>14</sup> Indeed, most jurisdictions base all of their standards either on dangerousness to others and/or to one self or on something that closely resembles dangerousness to self,<sup>15</sup> such as grave disability,<sup>16</sup> inability to provide for one's basic human needs,<sup>17</sup> or treatment that is essential to one's welfare.<sup>18</sup>

Only five jurisdictions have established criteria that diverge from the dangerousness standard in substantial ways,<sup>19</sup> as the American Psychiatric Association recommended in the early 1980s.<sup>20</sup> Three states have added criteria that target severe mental illness: Arizona commits respondents who are persistently and acutely disabled, Hawaii commits respondents who are obviously ill, and Oklahoma commits respondents who need inpatient treatment as indicated by a previous diagnosis of a history of mental illness or by a need to prevent progressive debilitation caused by a mental impairment. Delaware commits respondents who cannot make responsible decisions about hospitalization. Iowa, in a statute that raises serious constitutional questions, commits respondents considered likely to inflict serious emotional injury on members of their families or on others who lack reasonable opportunities to avoid contact with the respondents.

Apart from basic commitment standards, the most common criteria involve alternatives to inpatient hospitalization. Of the thirty-two jurisdictions with such criteria, twenty-three require that commitment be the least restrictive alternative or employ a similar formulation.<sup>21</sup> Other jurisdictions mandate the least restrictive alternative disposition through their case decisions.<sup>22</sup>

Thus, a typical jurisdiction today limits involuntary civil commitment to persons with (1) severe, significant, gross, or substantial mental illnesses who because of their mental illnesses (2) pose a danger to self or others, or are gravely disabled, and for whom (3) inpatient hospitalization is the least restrictive viable alternative.

Human kind cannot bear very much reality.  
- T.S. Eliot, "Burnt Norton,"  
*Four Quartets* (1935).

## 5. Constitutional Parameters

The United States Constitution is the one set of principles that is legally - and, I would argue, morally - binding on all Americans. Thus, constitutional principles should provide the foundation upon which any civil commitment system is built and implemented. Moreover, the Constitution's requirements provide the minimum standards necessary to satisfy substantive and procedural due process.

One must recognize, however, that the Constitution's requirements are not absolute, as much of what could be defined has not even been considered by the Supreme Court, and that which has been considered may be subject to differing interpretations. Thus, in reviewing the constitutional dimensions of civil commitment, one should focus on what is now settled or at least accepted by a broad consensus of legal opinion.

The key areas affecting civil commitment that the Supreme Court has written about are

- ◆ the right to treatment,
- ◆ dangerousness,
- ◆ criminal commitment,
- ◆ the least restrictive alternative,
- ◆ the commitment of minors,
- ◆ informed consent,
- ◆ procedural due process, and
- ◆ equal protection.

### A. Right to Treatment

Although the Supreme Court has never fully embraced a right to treatment for persons with mental disabilities, it has made rulings that create a limited right to treatment for those who are involuntarily committed.

In its 1975 decision in *O'Connor v. Donaldson*,<sup>23</sup> the Court did not accept the Fifth Circuit's holding<sup>24</sup> that for all nondangerous persons subject to civil commitment the Constitution demands that minimum treatment standards be established and enforced. Instead, the justices unanimously agreed that

a State cannot constitutionally confine without more a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends.<sup>25</sup>

Moreover, wrote the Court, a "finding of 'mental illness' alone cannot justify a State's locking a person up against his will and keeping him indefinitely in simple custodial confinement."<sup>26</sup>

This landmark opinion left unresolved whether a constitutional right to treatment exists,<sup>27</sup> what "more" must be provided to nondangerous persons who are civilly committed, and what besides a mental disability justifies involuntary commitment.

Seven years later, while considering the liberty interests of a person confined because of mental retardation, the Court found in *Youngberg v. Romeo*<sup>28</sup> a right to adequate training and treatment related to institutional residents' need to enhance or further their abilities to exercise their constitutional rights.<sup>29</sup> Although the justices disagreed as to whether residents had a "constitutional right to training, or 'habilitation,' per se,"<sup>30</sup> when viewed together *Donaldson* and *Youngberg* certainly establish the rights to not be civilly committed without strong justification and to obtain treatment minimally necessary to prevent or reduce commitment.

In addition, the case law and legal literature provides strong support for the proposition that the Constitution mandates that residents who have the potential to live outside an institution either with or without the assistance of friends and relatives must receive the minimal community resources they need to be deinstitutionalized, including treatment and habilitation.<sup>31</sup>

### B. Dangerousness

Although determining who is or is not "dangerous" is a complex and controversial issue unlikely to be settled soon, dangerousness plays a crucial role in the present civil commitment system and undoubtedly will continue to do so in any future system. Moreover, a vast majority of state involuntary commitment statutes already include a dangerousness standard, and substantial reason exists to conclude that dangerousness has a constitutional dimension as well.

The first Supreme Court decision to address dangerousness was *O'Connor v. Donaldson*,<sup>32</sup> which introduced the notion that dangerousness is a major justification for civil commitment. Later, in *Zinerman v. Burch*,<sup>33</sup> a majority of the justices agreed that dangerousness is a constitutional requirement for civil commitment.<sup>34</sup>

The involuntary placement process serves to guard against the confinement of a person who, though mentally ill, is harmless and can live safely outside an institution. Confinement of such a person...is unconstitutional."<sup>35</sup>

If dangerousness is not an absolute requirement for involuntary civil commitment, it is very nearly so, for under the *Zinermon* formulation persons cannot be civilly committed unless they are dangerous or cannot live safely in the community. At most, only a small difference exists between being dangerous to oneself and being unable to live safely in the community.

### C. Criminal Commitment

The U.S. Supreme Court concluded in *Baxstrom v. Herold*<sup>36</sup> that a prisoner cannot be civilly committed to a mental hospital after completing his or her sentence without being afforded the same due process protections as anyone else facing civil commitment.<sup>37</sup> Similarly, in *Jackson v. Indiana*<sup>38</sup> the Court held that unless formal civil commitment proceedings are instituted, defendants found incompetent to stand trial cannot be held longer than necessary to restore their competency or to determine that their competency cannot be restored in the foreseeable future.<sup>39</sup> *Vitek v. Jones*<sup>40</sup> reinforced the difference between civil commitment and imprisonment by establishing that prison inmates must receive certain minimum due process protections before they are transferred to mental health facilities.<sup>41</sup>

To date, however, the most important Supreme Court decision in terms of criminal commitment is that for *Jones v. United States*,<sup>42</sup> which diverged from the prior line of decisions. A narrow 5-4 majority affirmed the continued commitment of an insanity acquittee who had been hospitalized for a period that exceeded the prison sentence he would have received if convicted of the misdemeanor he had been charged with.<sup>43</sup> The Court upheld applying the preponderance of the evidence standard to the indefinite commitment of persons acquitted by reason of insanity because of differences between insanity acquittees and other respondents facing civil commitment. The majority noted that acquittees were found, based on proof beyond a reasonable doubt, to have committed acts that would have been crimes had they been sane. Under the Constitution, punishment would be inappropriate for insanity acquittees; therefore, the length of a

criminal sentence associated with an act was deemed irrelevant to the duration of commitment, which instead depends on the inmate's recovery.<sup>44</sup>

Taken together, the Supreme Court's criminal commitment decisions indicate that the Constitution recognizes substantial differences between the commitment of respondents in general and the commitment of persons charged with or serving sentences for crimes, including defendants in prehearing detention, defendants found incompetent to stand trial, defendants found guilty by reason of insanity, and defendants still serving their sentences after being convicted. Civil commitment standards and procedures need only be applied to prisoners who have completed their sentences and to criminal defendants found incompetent to stand trial who have no reasonable prospects of having their competency restored.

### D. The Least Restrictive Alternative

In *Shelton v. Tucker*,<sup>45</sup> the U.S. Supreme Court established the constitutional principle that even legitimate governmental purposes may not be pursued in ways that intrude on fundamental personal liberties when the same purposes can be achieved using less intrusive means.<sup>46</sup> At first glance, one might logically assume that a person could not be civilly confined in an institution or facility if less intrusive kinds of care and treatment were available.<sup>47</sup> Yet the Supreme Court has resisted concluding that patients in inpatient facilities have a broad right to community mental health care.<sup>48</sup> Moreover, with respect to civil commitment and equal protection, the Court recently observed that as long as a Kentucky statute had a rational basis, whether less restrictive means were available for achieving the same ends was irrelevant.<sup>49</sup> Most states, though - either in their statutes or in their case law - recognize a right to treatment in the least restrictive setting.<sup>50</sup>

Although the concept of the right to treatment in the least restrictive setting enjoys broad support, its implementation has been disrupted by certain practical realities. In some instances, the concept has been diluted by the notion that if resources are unavailable or if the proposed alternative is unfeasible, then the least restrictive alternative is not required.<sup>51</sup>

More fundamentally, however, the concept suffers from confusion about how courts should measure relative restrictiveness. Should restrictiveness only be a measure of liberty, meaning that more liberty is always the correct result? Or is restrictiveness more appropriately a measure of self-determination and substituted judgment, meaning that whatever individuals would choose for themselves is what is required?<sup>62</sup> Or does the proper measure reflect a combination of these fundamental values?

### E. The Commitment of Minors

The only U.S. Supreme Court decision specifically discussing the rights of children in the commitment process is the *Parham* case, which produced two sharply divided opinions, one involving children with mental illnesses<sup>53</sup> and the other children with mental retardation.<sup>54</sup> Most of the justices rejected the view that a full due process hearing is required before parents or guardians can consent to have children in their custody civilly committed. Instead, only an administrative action is needed in which some neutral fact finder, who may be the admitting physician or facility administrator, reviews the parents' or guardians' decision.<sup>55</sup> The Court did rule that for commitment decisions made by non-parental guardians, such as state agencies, more due process protections may be required, but never noted what those protections might be.<sup>56</sup> Based on a subsequent Supreme Court decision involving incompetent adults,<sup>57</sup> however, which is discussed further below, one may reasonably assume that to avoid liability a facility or hospital must ensure that the parents or guardians seeking to have their child/ward committed give their informed consent and that the commitment be reasonable in terms of the child's medical interests.

### F. Informed Consent

A 5-4 majority of the U.S. Supreme Court in *Zimmerman v. Burch*<sup>58</sup> held that a man who could not give informed consent because of his mental condition had stated a civil rights cause of action against state officials responsible for his being committed "voluntarily" to a state hospital.<sup>59</sup> That is, state officials could be liable if they clearly saw - or should have seen - that a respondent was incompetent to make an admission decision.<sup>60</sup> In the absence of informed consent, the state and its officials must ensure that the respondent is given the full due process required

under the state's involuntary commitment proceedings.<sup>61</sup> The majority noted that state officials had not exercised reasonable professional judgment in failing to question the competency of a person being admitted to a mental facility.<sup>62</sup>

Consequently, states and their employees are on notice that to avoid liability they must exercise reasonable professional judgment in making commitment decisions and either must obtain actual informed consent or use involuntary commitment procedures.

### G. Procedural Due Process

As a result of the U.S. Supreme Court's unanimous decision in *Addington v. Texas*,<sup>63</sup> the state must prove by clear and convincing evidence the basic elements of civil commitment.<sup>64</sup> The preponderance-of-the-evidence standard does not meet minimal due process requirements, whereas proof beyond a reasonable doubt is not constitutionally required.

In this opinion, the Court not only established a clear dichotomy between civil and criminal proceedings and the due process required for each, but recognized that when fundamental civil liberties are at stake a need exists for heightened due process, including a hearing. The Court has never decided, however, whether the right to counsel also is constitutionally required for commitment proceedings. Caselaw and state statutes, however, firmly establish this right because of the important liberty interest at stake.<sup>65</sup>

### H. Equal Protection

For years, many scholars, commentators, and observers assumed that U.S. Supreme Court decisions involving persons with certain mental disabilities could be applied to persons with other mental disabilities in similar situations. Thus, for example, if a person with a mental illness had a particular due process right, a similarly situated person with mental retardation would have a corresponding right. The Court's decision in 1993 for *Heller v. Doe*<sup>66</sup> challenges this assumption in the context of civil commitment.

A divided Court upheld a Kentucky statute allowing adults with mental retardation to be committed under standards below those required to commit adults with mental illnesses. This law requires proof beyond a reasonable doubt when the respondent has a mental illness, but only

clear and convincing evidence - the minimum constitutional requirement - when the respondent has mental retardation.<sup>67</sup> Moreover, the state law provides standing for parents of adults with mental retardation to support a commitment petition, but no similar standing for parents of adults with mental illness.<sup>68</sup>

The justification for affirming the Kentucky commitment statute centered on differences between the two types of mental disabilities concerning their onset and their duration. In addition, the Court's language emphasized that the majority was ready to conclude, but did not have to, that persons with mental disabilities are not members of a suspect classification entitled to strict scrutiny for equal protection purposes.<sup>69</sup> This means that in reviewing statutory classifications involving persons with mental disabilities, courts need only find a rational relationship between the law and its stated purpose instead of a compelling justification.

## **I. The Americans with Disabilities Act**

Although the Americans with Disabilities Act (ADA) does not directly address involuntary interventions, including civil commitment, it does establish certain equal protection principles that might affect how involuntary interventions should be implemented.

The ADA is the major civil rights legislation affecting persons with mental and physical disabilities that addresses discrimination in the distribution of public services and programs.<sup>70</sup> Under Title II, any state government or agent of state government is prohibited from making decisions about the care and treatment of persons with mental disabilities based solely on a person's disability. Instead, decisions must be based on a person's failure to meet the necessary qualifications of the treatment or program being provided.<sup>71</sup>

Although how this basic principle is implemented depends on a case-by-case interpretation, disability-based discrimination is undoubtedly inherently suspect under the ADA, and the agency or agent making a treatment decision has the burden of showing that any discrimination is justified by the nature of the program or service being provided, or by its benefits to the person with disabilities.<sup>72</sup> This principle applies to situations in which persons with one type of disability are treated differently than those with

other types of disability, or in which persons with disabilities are treated differently than persons without disabilities.

## **6. Recommendations**

Although one certainly could argue that the entire civil commitment system needs to be re-evaluated and redesigned, such a broadbased result is unlikely in this political and economic climate. Thus, I present specific recommendations that I consider both desirable and achievable in today's policy environment. What unites these recommendations is each one's being predicated on the preceding constitutional and statutory analysis. They are intended to provide the foundation upon which a new civil commitment system should be built, not to serve as an exclusive list of recommendations. The recommendations also assume that involuntary civil commitment should exist, which, of course, may be a threshold issue in any discussion about revising civil commitment systems.

### **A. A Constitutional Foundation**

To reflect the broadest social consensus and to minimize litigation, any civil commitment system should be constitutionally sound both in theory and in practice. Thus, steps should be taken to incorporate constitutional principles in statutes, regulations, and policy directives affecting civil commitment and to ensure that minimum constitutional requirements are understood and achieved consistently while implementing laws. Everyone involved in the civil commitment process should understand what the Constitution requires and be encouraged to initiate action when those requirements are violated. The gap between the law and actual practice is well documented. Narrowing that gap, particularly with respect to fundamental constitutional principles, should be a major objective of any civil commitment system.<sup>73</sup>

### **B. Seven Constitutional Principles**

From discussions of constitutional principles, seven emerge as fundamental to a sound civil commitment system.

1. Civil commitment should not be used to involuntarily confine non-dangerous persons who, either on their own or with the assistance of others and the government, can reside in the community safely.

2. Governments should provide treatment, habilitation, rehabilitation, training, and support services in the community to prevent involuntary commitment or to allow those involuntarily committed to be released afterward.
3. Involuntary civil commitment should not be used punitively to confine the following: persons who can no longer be held by the criminal justice system, including prisoners whose sentences have expired; defendants charged with crimes who can no longer be confined as incompetent to stand trial; insanity acquittees, unless they are mentally ill and dangerous; and persons no longer incompetent to stand trial who have not yet been tried. Conversely, defendants should not be imprisoned if they would not have been charged, tried, or convicted of a crime except for their mental conditions.
4. Voluntary commitment should only be initiated by the respondent, the respondent's legal guardian, or the parent of a minor; be based on informed consent; and be accompanied by administrative safeguards, including an independent administrative inquiry into whether commitment is in the respondent's best medical interests and reflects reasonable professional judgment.
5. Minimum due process for anyone facing involuntary civil commitment should include a formal hearing at which the respondent has legal counsel and should require the state or person to bear the burden of proving by clear and convincing evidence that each basic element of the commitment standard is satisfied.
6. Despite any sound policy reasons for having different civil commitment standards and requirements for different categories of respondents, such distinctions should not result in laws, policies, or practices that fail to meet previously established minimum constitutional requirements. Moreover, any such distinctions should be based on sufficient legislative justifications to avoid challenges based on equal protection or the ADA.
7. Any standards or practices that support involuntary civil commitment and thus interfere with respondents' constitutional interests must be established and implemented in ways that least intrude upon those constitutional interests.

### **C. The Least Restrictive Alternative Redefined**

The least restrictive alternative, as applied to civil commitment, should be redefined carefully to incorporate the full range of values and concerns that would motivate a competent individual to make care and treatment choices. Liberty is one such value or concern, but clearly is not the only one. Thus, similar to the modified substituted judgment standard for substitute decision making,<sup>74</sup> the first priority should be to offer the least restrictive alternative favored by the respondent or by the respondent's legal guardian based on the respondent's values and preferences. Otherwise, the least restrictive alternative should be based on the respondent's best interests, taking into account all available information indicating what the respondent would prefer.

If the definition of least restrictive alternative is to incorporate any notion of feasibility, its language must employ strict limits, as governments are always going to be strongly influenced by fiscal concerns.

### **D. Dangerousness to Self**

The definition of living safely in the community should be defined carefully and with consideration to any similarities and differences this concept has to dangerousness to self. In all likelihood, comparing the two notions will show that the differences between them are not major.

### **E. Competency and Informed Consent**

A determination of competency to make treatment decisions should closely follow any decision to involuntarily commit a respondent, unless the respondent already has been adjudicated incompetent. If an incompetent respondent does not already have a guardian, a guardian should be appointed. Keep in mind that involuntarily committing a respondent is not in itself a determination that the respondent is incompetent to make treatment decisions. Nor is a determination of some other type of incompetency the same as incompetency to make treatment decisions.

For a voluntary commitment, an independent administrative body or agent within the hospital should determine whether the respondent can give informed consent to the commitment.

For a third-party voluntary commitment, the court or administrative body authorizing the commitment should determine whether the respondent has been adjudicated incompetent and whether the party making the commitment decision is duly authorized to do so. If the answer to either inquiry is "no," voluntary commitment is inappropriate and should not take place.

## F. Training

Everyone associated with a jurisdiction's commitment process should be trained to understand the laws, regulations, and policy directives associated with that process and to speak out whenever the law is not being followed.

## 7. Conclusion

Any jurisdictions that incorporate the constitutional principles and recommendations presented in this article would share certain statutory provisions. Each provision is already embraced by some states, but is not part of a set of provisions applicable in every state. The provisions are set out together below.

1. The basic criteria for extended commitment would be clear and convincing evidence that
  - (a) a respondent is mentally ill and either a danger to self or others, or unable to live in the community safely with the help of friends, family, and governmental assistance;
  - (b) the respondent can benefit from the proposed commitment;
  - (c) no viable alternative exists that the respondent or the respondent's guardian or counsel would prefer to inpatient commitment;
  - (d) reasonable governmental efforts have been made to provide the respondent with any funding or resources that would eliminate the need for commitment;
  - (e) either the respondent or a guardian can provide informed consent to care and treatment decisions once commitment commences.
2. Due process safeguards for extended involuntary commitment would include the right to

counsel, the right to a judicial hearing, and the use of the clear-and-convincing standard of proof in which the burden of proof fell on the state or whoever was seeking the commitment.

3. A clear differentiation would have to occur between persons subject to civil commitment and persons subject to the authority of the criminal justice system. Only discrete classes of persons entering the criminal justice system could be subjected to civil commitment, and all of those - except for insanity acquittees - would be subject to the same commitment procedures as civil respondents.
4. Respondents' competency would be reviewed administratively or judicially before commitments began. If a respondent was thought incompetent to make treatment decisions, a judicial determination of this would be made. If the court found the respondent incompetent, a guardian would be appointed.

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## FOOTNOTES

<sup>1</sup>S.J. Brakel, J. Parry, B. Weiner, (3d ed. 1985).

<sup>2</sup>J. Brakel, "Voluntary Admission," in J. Brakel, J. Parry, B. Weiner, *The Mentally Disabled and the Law* (3d ed. 1985) at 180-181.

<sup>3</sup>Ill. Ann. Stat. ch 91 1/2, § 3-607 (Smith-Hurd 1987).

<sup>4</sup>W. Va. Code §27-5-4(k)(1)(1986).

<sup>5</sup>J. Parry, "Mental Health Law," in M.G. MacDonald, R.M. Kaufman, A.M. Capron, I.M. Birnbaum, eds., *Treatise on Health Law* (1993) at 20-52 to 20-64.

<sup>6</sup>All the information in this section is taken from the table of involuntary civil commitment standards that appears at the end of this article.

<sup>7</sup>See table, cell (4).

<sup>8</sup>See table, cells (1) through (5).

<sup>9</sup>[Chart supra note 5 cells (6)-(11)] [See chart, cells (6) to (11), in J. Parry, "Mental Health Law," in M.G. MacDonald, R.M. Kaufman, A.M. Capron, I.M. Birnbaum, eds., *Treatise on Health Law* (1993) at 20-52 to 20-64.

- <sup>10</sup>*Ibid.*, cell (1).
- <sup>11</sup>*Ibid.*, cell (2).
- <sup>12</sup>*Ibid.*, cell (5).
- <sup>13</sup>*Ibid.*, cell (5).
- <sup>14</sup>*Ibid.*, cell (6).
- <sup>15</sup>*Ibid.*, cell (6).
- <sup>16</sup>*Ibid.*, cell (6), see Alaska, California, Colorado, Connecticut, Idaho, Indiana, Louisiana, and Washington.
- <sup>17</sup>*Ibid.*, cell (6), see Illinois, Mississippi, Nebraska, Oregon, Utah, and Virginia.
- <sup>18</sup>*Ibid.*, cell (6), see New York and Texas.
- <sup>19</sup>*Ibid.*, cell (6), see Arizona, Delaware, Hawaii, Iowa, and Oklahoma.
- <sup>20</sup>APA's New Model Law Rejects Dangerousness as Only Valid Criterion for Civil Commitment," 34 *Hosp. & Comm. Psych.* (Oct. 1983) at 975, 979.
- <sup>21</sup>*Ibid.*, cell (8).
- <sup>22</sup>For example, Illinois, North Dakota and Colorado do not specify that the least restrictive alternative must be used, but the requirement is imposed in the case law of those states. See, *In re Devine*, 572 N.E.2d 1238 (Ill. App. Ct. 1991), 15 MPDLR 455; *In re R.N.*, 453 N.W.2d 819 (N.D. Sup. Ct. 1990), 14 MPDLR 300; *Colorado v. Stevens*, 761 P.2d 768 (Colo. Sup. Ct. 1988), 13 MPDLR 15
- <sup>23</sup>422 U.S. 563 (1975).
- <sup>24</sup>*Donaldson v. O'Connor*, 493 F.2d 507 (5th Cir. 1974).
- <sup>25</sup>*O'Connor v. Donaldson*, 422 U.S. 563 (1975) at 576.
- <sup>26</sup>*Ibid.* at 575.
- <sup>27</sup>*Ibid.* at 578-89 (Burger, C.J. concurring).
- <sup>28</sup>457 U.S. 307 (1982), 6 MDLR 223.
- <sup>29</sup>*Ibid.*
- <sup>30</sup>*Ibid.* at 329 (Burger, C.J., concurring).
- <sup>31</sup>*Scott v. Plante*, 691 F.2d 634 (3d Cir. 1982), 7 MDLR 74; *Woe v. Cuomo*, 729 F.2d 96 (2d Cir. 1984), 8 MPDLR 280.
- <sup>32</sup>422 U.S. 563 (1975).
- <sup>33</sup>110 S.Ct. 975 (1990), 14 MPDLR 116.
- <sup>34</sup>*Ibid.*
- <sup>35</sup>*Ibid.* at 987.
- <sup>36</sup>383 U.S. 107 (1966).
- <sup>37</sup>*Ibid.*
- <sup>38</sup>406 U.S. 715 (1972).
- <sup>39</sup>*Ibid.*
- <sup>40</sup>445 U.S. 480 (1980), 4 MDLR 92.
- <sup>41</sup>*Ibid.*
- <sup>42</sup>463 U.S. 354 (1983), 7 MDLR 299
- <sup>43</sup>*Ibid.*
- <sup>44</sup>*Ibid.*
- <sup>45</sup>364 U.S. 479 (1960).
- <sup>46</sup>*Ibid.*
- <sup>47</sup>*Lake v. Cameron*, 364 F.2d 657 (D.C. Cir. 1966). See also McGraw and Keilitz, "The Least Restrictive Alternative Doctrine in Los Angeles Civil Commitment," 6 *Whittier L. Rev.* 35, 37 (1984).
- <sup>48</sup>*O'Connor v. Donaldson*, 422 U.S. 563 (1975); *Youngberg v. Romeo*, 457 U.S. 307 (1982), 6 MDLR 223.
- <sup>49</sup>*Heller v. Doe*, 113 S.Ct. 2637 (1993), 17 MPDLR 338.
- <sup>50</sup>J. Parry, "Mental Health Law" in M.G. MacDonald, R.M. Kaufman, A.M. Capron, I.M. Birnbaum, *Treatise on Health Care Law*, (1993) at 20-46.
- <sup>51</sup>J. Parry, "Summary, Analysis and Commentary: Least Restrictive Alternative," 9 MPDLR 314 (1985).
- <sup>52</sup>J. Parry, "Least Restrictive Alternative," 9 MPDLR 314-316 (1985).
- <sup>53</sup>*Parham v. J.R.*, 442 U.S. 584 (1979), 3 MDLR 231.
- <sup>54</sup>*Secretary of Pub. Welfare v. Institutionalized Juveniles*, 442 U.S. 640 (1979), 3 MDLR 231.
- <sup>55</sup>*Parham v. J.R.*, 442 U.S. 584 (1979).
- <sup>56</sup>*Ibid.*
- <sup>57</sup>*Zinerman v. Burch*, 110 S.Ct. 975 (1990), 14 MPDLR 116.
- <sup>58</sup>110 S. Ct. 975 (1990), 14 MPDLR 116.
- <sup>59</sup>*Ibid.*
- <sup>60</sup>*Ibid.*
- <sup>61</sup>*Ibid.*
- <sup>62</sup>*Ibid.*
- <sup>63</sup>441 U.S. 418 (1979), 3 MDLR 164.
- <sup>64</sup>*Ibid.*
- <sup>65</sup>Note 5 supra at 20-104-106.
- <sup>66</sup>113 S.Ct. 2637 (1993), 17 MPDLR 338.
- <sup>67</sup>*Ibid.*

<sup>68</sup>*Ibid.*

<sup>73</sup>"National Center for State Courts' Guidelines for Involuntary Civil Commitment," 10 MPDLR 409, 415-420.

<sup>69</sup>*Ibid.*

<sup>74</sup>J. Parry, "A Unified Theory of Substitute Consent: Incompetent Patients' Right to Individualized Health Care Decisionmaking," 11 MPDLR 378 (1987).

<sup>70</sup>42 U.S.C. §12132 (Supp. 1992).

<sup>71</sup>42 U.S.C. §12131(2); 28 C.F.R. § 35.104.

<sup>72</sup>28 C.F.R. §135.139(c). See *Williams v. Secretary, Executive Office of Human Servs.*, 609 N.E.2d 447 (Mass. Sup. Jud. Ct. 1993), 17 MPDLR 273; *Easley v. Snider*, No. 93-0221 (E.D. Pa. Dec. 20, 1993), 18 MPDLR \_\_\_\_.

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### **ABA Publishes New Edition of Mental Disability Law Primer**

The American Bar Association's Commission on Mental and Physical Disability Law announces the publication of the fifth edition of *Mental Disability Law: A Primer*. The latest version of this popular handbook adds extensive coverage of the Americans with Disabilities Act (ADA), important legal developments that have occurred since the 1992 edition, and a new format and appearance.

The *Primer* is primarily intended for lawyers new to the mental disability law field, lawyers whose primary practice is in other fields of law, mental disability professionals, non-lawyer advocates, and graduate students - particularly individuals enrolled in mental health law, psychiatry and the law, disability law, or clinical law programs. The *Primer* also serves as a handy reference for lawyers and other professionals who specialize in mental disability law issues.

The *Primer*, which runs 144 pages and has 18 chapters, two appendices, and a detailed table of contents, is divided into five parts. Part I covers key mental disability terms and definitions, incentives - including attorneys' fee awards - for lawyers who represent clients with mental disabilities, and effective representation of those clients. Part II focuses on major community issues such as employment, housing, education, and insurance. This section places particular emphasis on ADA-related developments.

Part III examines the field from an institution's perspective - civil commitment, institutional rights, liability concerns, and criminal justice mental health issues such as the insanity defense and competency to stand trial. Part IV reviews self-determination concerns including competency, guardianship, decision-making rights, and confidentiality. The appendices of Part V provide a complete table of cases and brief descriptions of the ABA Commission's activities and services.

The *Primer* costs \$15.00 plus \$5.00 shipping and handling. To order this publication or to obtain a catalog of other disability law products and services, please contact the ABA Commission on Mental and Physical Disability Law at its new address, 740 15th Street, N.W., Washington, D.C. 20005-1009, or call (202) 662-1570, TDD: (202) 662-1012; Fax: (202) 662-1032.

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# Tales from the Inside

*These two articles were written by consumers of mental health services. They are typical of the stories of many persons in Kentucky who have been in mental health facilities.*

## **If You Think They Are Out to Get You - Read This**

I became aware of involuntary hospitalization almost twenty years ago when I was admitted to a psychiatric hospital for the first time. I came there voluntarily and while being evaluated the physician informed me now that I had a psychiatric label that any time I angered my spouse or family they could easily have me admitted whether I wanted it or not. The real tragedy in this happened not to be the telling but the believing of this by me. I guess I should have considered his credibility when he told me that the food at this facility tasted great when it became blatantly obvious that it didn't.

I can only say that for a long time I felt uneasy about this process. The most important thing I can remember about fear is that it is not the things that frighten me that harm me. My failure to call those things what they are which gives them power over me. Going into any unfamiliar legal procedure for the first time can be overwhelming for the most stable persons. Workshops such as those done by the Department of Mental Health and Protection and Advocacy take some of the mystery out of it and these organizations are to be commended and encouraged to continue.

My first experience with involuntary hospitalization happened in 1980. I felt great and people were telling me I suffered from an illness. All the other illnesses I had before I didn't like how I felt so what they said made absolutely no sense at all. They had the audacity to call me mentally ill. I have spent most of my life trying to control my feelings. I know now to do so invites them to overwhelm me. Today I just acknowledge them and they pass. I came to Louisville to visit my sister and spent most of the night pacing the floor and laughing horrendously. That behavior greatly concerned her. I also went to visit a drug

rehabilitation center where I had recently been a resident. My mood fluctuated almost moment by moment. The staff contacted that sister and she swore out the warrant. The police picked me up at the center and took me to a station where a woman did an evaluation.

I really did not understand her role in all of this. I just enjoyed all the attention I received. The decision ended with my being taken to a psychiatric hospital with a seventy-two hour hold. While there a patient told me when I went to the hearing I could sign myself in as a voluntary patient and the process stopped. Sheriffs' deputies picked me up at the hospital and took me to the hearing room. It had no appearance at all of being a court. Persons just sat around a table and talked about me and asked a few questions. I had told someone of my plan to agree to make myself a voluntary patient and when I achieved that status to demand discharge. That person happened to be one of the qualified mental health professionals at the inquest. He expressed a concern about me doing this to the judge who warned me not to try it. They granted me voluntary status and immediately on my return to the ward I demanded discharge. The nurse informed me the physician had gotten another seventy-two hour hold on me and the whole thing started again. I finally got so disgusted I never questioned my being there for the duration of my stay.

The lesson in this for me in retrospect suggests I tried to cheat the process and it won. I must also admit that I absolutely had no feelings of trust toward anyone that I could identify as being a part of the mental health system, which is about as nontherapeutic an attitude as there can be. I just felt that anything I said could be used to further confine me. My recommendation for anyone going through this process should first know to whom they are talking. What is the role of this person they are talking with and how is the information given to be used. If the person is unwilling to answer these questions then I recommend the patient also be equally obstinate. Remember it is okay to be as off the wall as can be. The standard is

not based upon mental competency - only on the threat to self or others.

Today I find myself no longer fearful of the process. At a stay in a hospital about three years ago the administrator advised me that he might seek an MIW when I demanded discharge. I no longer feel threatened by the system so I level none toward it. I had not harmed anyone there and no threat to myself precipitated my being there. My response to him involved complete agreement. I suggest go through the inquest. He backed down and processed me for discharge. They released me about two hours later.

A way I may be helpful in writing about the involuntary commitment could be to take myself through the process as I understand it. If I discovered such a warrant was being sought against me unless it happened to be a weekend or holiday I would probably go to my local community mental health center instead of being picked up by the police. The seventy-two hours is exclusive of weekends and holidays.

The most important thing to remember during these times is relatively simple. *It is not the thing that I fear that harms me, it is my failure to call it what it is.* This can be extremely difficult if I am moving in and out of the common reality. Just do what I must to hang on to that thought. At any time I start to feel paranoid, I ask myself if I am calling this or that what it is. If I still feel threatened then try calling it something else. This can be an internal process. I am a human being with this wonderful ability to think about what I am thinking about. I do not have to be afraid of my thoughts.

When confronted by the police I have learned not to resist. I have participated in civil disobedience and getting arrested happened to be a part of such demonstrations. Even in those situations the advice given by leaders has been the same. I may go limp and let them carry me however to never retaliate with any kind of force. Fighting the police in the streets is absolutely a no win situation. They have more training and experience fighting with people like me than I have with people like them. When I have been treated with any kind of brutality and I happened to be going to a hospital, I asked the doctor to examine me for injuries. I write down my version of the events

as soon as possible after the furor has quieted. I ask the staff to insert these in the chart. Every hospital I have been a patient has been cooperative about allowing me to insert material I have written in the chart.

The standard most often given the greatest consideration is threat to self or others. I know it pays to remember that it does not matter how far into the nonordinary reality I may be at any given time as long as I do not utter threats to myself or others. Fortunately, I am entitled to due process because my personal liberty is at stake and protected by the Constitution. The burden of proof is on the persons seeking the warrant by a preponderance of evidence. Unfortunately judges and juries tend to play it safe and rule on the side of the petitioners. Their fear is that if they let someone go and harm was to come from that they might be held responsible.

My experience when I have been under the gun to this procedure I have been dealing with my own paranoia and a greatly overblown sense of self-importance. Persons were out to get me and the truth is they were. I get caught up in believing it is the FBI or CIA. Every one of these I have seen was dealt with in a lowly district court without a single federal employee involved. Again just my failure to call it what it is.

My experience as a patient and a former professional advocate with several clients who have gone through these hearings is that most persons do not get to meet with their attorneys until shortly before they enter the courtroom. I have found that most persons have not even been asked to testify. If I felt it necessary to testify then I would make it clear to my attorney. I might wish to consider addressing all my issues to the judge or jury not to the prosecutor. One hospital I am familiar with trained their personnel on how to testify and stressed this point to them. I must be as honest as I can be. Most decisions are not based upon any real evidence because often none is introduced. The verdict tends to be based mostly on the demeanor and behavior of the patient while in the courtroom. If I answer the questions honestly then I don't have to remember as much, which is a big help any time I have to testify. Any inconsistency will ultimately be used in a verdict to hospitalize. I have been talked about is if I wasn't present and this depersonalization

can lead to anger or disgust. I have even thought some of the opinions stated about me were downright dishonest. I just try to remember that the dishonesty of others can be my way out of this.

I don't have to go through this alone. I might consider contacting Protection and Advocacy and where I do not understand be willing to ask questions. I can make advance directives while I am considered competent. A directive such as having an advocate present during the interview by the qualified mental health professional might be useful. I want my advocate to be allowed to review my chart to see if any incidents are described that which reflect badly at the hearing. I have never been allowed to amend charts. I have made insertions which may explain or contradict events that are recorded. Information in charts is not gospel. It is just the view of the person writing at the time. Often these charts are merely speculations about the patient and are sometimes not a part of the common reality either. I try to do my best to keep myself informed about how the persons providing treatment are thinking.

In all this, regardless of outcome, I keep telling myself this will pass. My view of the world tends to be static while the world is dynamic. It is not change that causes me difficulty. It is my resistance to it. By far, most people experiencing a psychiatric episode are in an extremely temporary situation. The quickest way to become overwhelmed is to try to control it. Call it what it is and it passes. The petition is sought *for up* to sixty days. By far, most clients are discharged before that time expires.

There it is as I see it. I hope this information can be used by mental health consumers to better understand the involuntary committal process.

- JOHN BASHAM

### **Treacherous Treatment**

Managing Bipolar Disorder is a precarious process for the Manic-Depressive, and sometimes seeking professional help to deal with the devastating "highs" and "lows" indigenous to the illness is ironically inviting their exacerbation by malevolent mistreatment.

Having been hospitalized more often in the manic state, I have found the most consuming throes of mania no match for the crass hostility and inhumanity of caregivers. Although the mental health professionals are operating under the assumption that a grandiose, delusional manic is also without cognitive ability (*i.e.* she won't remember when she's well), we do know when we are victims of outright punitive behavior.

Since the onset of my illness some twenty-four years ago, I have experienced two major depressions and ten manic episodes of the grossest sort. Hospitalized perhaps even twice for the same episode, I have encountered indifference, condescension, neglect and more often than not, outright physical abuse.

Practicing misanthropically toward the mental patient knows no rank among mental health professionals. Psychiatrists are capable of flagrant malpractice and cruelty. A case in point is my first experience with hospital treatment for mania. Beginning with feelings of elation following my son's birth and culminating in full-blown mania three months later, I was admitted to a private psychiatric facility and diagnosed as "acute schizophrenic."

When medication will not redress the condition as quickly as the doctor would have liked, he recommended "E.S.T." which I seem to recall meant "Electron Sleep Therapy" as opposed to "Electro Shock Treatment"... and convinced my husband to consent. To consider volts of electricity being sent through one's brain even while anesthetized is an ominous thought, and each time the crew prepared to shock me into reality, I was frozen with fear.

After three or so treatments, I still panicked as I was strapped down and the electrodes were attached to my head, but nothing could have prepared me for my last one. The usual preparation was made, but as I anticipated the habitual stick of the sodium pentathol needle, I was clutched by a sudden combination of cranial pain, agonizing muscle constriction, violent pressure on my chest and inexorable fear ... then, nothing... And not much of anything entered my mind for the next three months.

Living with the feeling that I had been, albeit nonsexually, "raped," I finally gathered my thoughts and my courage sufficiently to ap-

proach the attending psychiatrist on the matter of having been "shocked" without the benefit of "sleep." His answer confirmed my suspicion that the incident was indeed intentional. In a most glib and callous manner, he sighed, "Yes, that was a good one, wasn't it?"

The trauma of my initial treatment for mania, the agony of which made childbirth seem like a baby tooth extraction and the least of which included misdiagnosis, set the tone for the treatment, or the lack of it, I have encountered in private and state hospitals since. A milieu of leather restraints, overmedication, wrong medication and the apathy with which they have been administered have been punctuated with instances of veritable physical desecration.

My first stay in a Kentucky state facility (e.g., Western State) included just such an instance. Taking note of the drab, inauspicious atmosphere on a locked ward where people's physical development seems to have been dictated by their mental aberrations, I believed during the grip of mania -- not metaphorically, but literally -- that I had somehow died and gone to Hell. Having no recourse but to stay, I felt that I could not be openly hostile to the staff, but I was more than inconvenienced by their complacency.

One day as we were herded out to the "back porch" which also served as a dining room, I found my way to a table in the back. As the aide passed out the food trays to her packed and drooling "audience," she reminded me of a stewardess who hadn't quite made it. When she called my name, I got up and walked forward to accept my tray. As I reached out to take it, I (admittedly) allowed my wrist to go limp, and the tray fell to the floor but not without splashing some chocolate pudding on her crisp, blue cotton skirt.

In an instant, her fist crashed upward against my chin loosening one of my lower teeth. For years, I had a noticeable space between that tooth and the next and the memory of my throbbing chin as she muttered something about how much it would cost to dry clean her skirt.

On that same locked ward a few years later, we had been instructed by the aides to sit quietly in the row of chairs lining the wall opposite the nurse's station... so, I suppose,

they would not have to move from their "thrones" the two hours until bedtime. Having difficulty sitting still, I chose to get up and walk up the hall out of sight... past the clothing closet into the bathroom. After being seated and told not to do it again, I proceeded to get up and walk toward the bathroom. As I reached the door, I encountered all three aides. I walked past them and just as I got even with the bathtub, I felt them grab me, heave me into the bathtub, and spray water in my face. The next thing I recall is waking up in my chair at the end of the row in dry clothes but with dripping hair. I can't clearly say whether they sprayed water up my nose or held my head under water, but whatever their method, they had rendered me unconscious... for how long I don't know. Besides the sexual advances by staff members and their ever-present manipulation in my experience, neglect and abuse at this state facility is apparently widespread. The cases that have been brought to my attention are many, but my concern is that if those of us who are educated, ambulatory, live independently, and have manageable psychosis are victimized by this level of villainous mistreatment, what happens to the totally dependent patient who lives in the facility amid the evils that lurk in those uncensored halls? That we won't remember their cruelty or, if we do, we will not be believed since we are "insane" at the time are misconceptions which lull the caregiver into believing his outlet for sadism is a safe one. His mental supremacy and the power surge propelling him as he "cares" for his victims might be altered by considering that the typical mental patient knows what is happening around him even though his interpretation of the events may be distorted by his psychosis.

For example, if someone strikes me and I feel excruciating pain, I know it; the fact I think I am Jesus Christ at the time, does not alter the fact that I have been brutalized... And the fact that one choosing to work in the mental health field also chooses to inflict irreparable abuse on someone in that vulnerable state is irrevocably criminal.

**MARY LOU WOOLEN**



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# Using Intensive Case Management to Reduce Violence by Mentally Ill Persons in the Community

*Aggressive and intensive case management and a comprehensive array of community support services are the keys to reducing the risk of violence by people with serious mental illness in the community. The authors describe the elements of intensive case management for potentially violent clients, including use of individual case managers responsible for small caseloads, 24-hour availability of case managers, and strong linkages to agencies providing mental health services, substance abuse treatment, and social services as well as to the criminal justice system. They summarize the results of three recent studies of intensive case management programs suggesting that this intervention is effective in reducing clients' dangerousness in the community. They discuss cultural and human resource issues that affect planning of intensive case management services. Intensive case managers need to be "boundary spanners" with the training, experience, and personality to bridge the often-broad gap between human service and criminal justice systems.*

On December 13, 1992, nearly one-third of the television program *60 Minutes* was devoted to the case of Larry Hogue, a 48-year-old African-American man living in New York City. According to the press (1-3), he annually received \$36,000 in disability payments from the Department of Veterans Affairs, but he did not use the benefits to gain housing or other basic necessities. Instead, he spent his income on alcohol, marijuana, and crack cocaine, and he was chronically homeless.

It was reported that when he was under the influence of these substances, his behavior terrorized the entire Upper West Side of Manhattan. He was reported to throw garbage and feces at passers-by, destroy property, and light fires under automobiles or stuff rags in their gas tanks. He was once convicted in a jury trial of reckless endangerment for pushing a young girl in front of an oncoming truck, which barely managed to stop without hitting her. Yet, when he was civilly committed to inpatient psychiatric treatment and was away from street drugs, it was reported that his behavior became peaceful and even docile, and hospital administrators concluded that he should be released.

If there are treatments available that will reduce violence associated with mental disorder, how can they be delivered most effectively? How can the Larry Hogue across the U.S. be managed while both their rights to liberty, due process, and least restrictive setting and the public's right to be safe are properly balanced? This paper examines these questions and proposes that intensive case management is an effective intervention to reduce the risk of violent behavior by mentally ill persons in the community. Case management can be an appropriate strategy for risk management if individual case managers are responsible for small caseloads and if a comprehensive array of services are available in the community.

## Case Managers as Risk Managers

Many mental health systems in the U.S. are not able to offer truly comprehensive services and thus have difficulty providing the continuous care that is needed by mentally ill people in the community, including those who sometimes engage in violent behavior. However, effective intensive case management that coordinates the services of a wide variety of community agencies can facilitate their living safely in the community. The case manager, with appropriate caseloads, works to manage both the risks faced by the client and the risk the client could possibly pose to the community. The organizing theme of all case management services is the management of a wide variety of risks. We concentrate here on only one of those risks, the risk of violence associated with mental illness in the community.

People with mental illness, especially those with histories of violent behavior, most often require continuous rather than episodic care. The medical paradigm that treatment is provided only when symptoms are evident is inconsistent with effective community supervision and support of persons with mental illness who have a history of violent behavior. Such persons need regular monitoring, especially when symptoms are absent or at a low ebb, to contain the individual and situational factors that may result in violence.

One of the most important roles of the case manager as risk manager is teaching clients to recognize and respond to high-risk situations, the nature of which varies from client to client. Case managers can help clients to gain insight into the kinds of situations that have led to violence in the past and to develop strategies for avoiding such situations and ways of resolving them if they cannot be avoided.

Definitions of case management abound and include many different processes and responsibilities (4-6). However, all models of case management involve the case manager as "a vehicle for implementing continuity in the care of mentally ill persons" (4). Our purpose here is not to assess the value of various models, which has been addressed in a useful review by Solomon (5). Rather, we will discuss case management as it relates to issues of violence, as both a service modality and an operating system that seeks to organize and synthesize ele-

ments of the mental health, social services, and criminal justice systems.

During the last 15 years, case management has evolved as a service modality that usually targets persons with serious mental illness who have been ill served by or unwilling to participate in the generic mental health system. In New York State, for example, the State Office of Mental Health recently began a major intensive case management program for persons with mental illness who are frequent users of expensive psychiatric services such as emergency rooms and inpatient care.

Surles and colleagues (7) have identified eight characteristics of this initiative. First, the client (as opposed to a particular treatment program) is the central focus for the case manager. Second, persons are "nominated" locally for participation in the program by those responsible for treatment. Third, persons cannot be removed from the program roster for "failure to improve." Fourth, caseloads are limited to ten persons per case manager. Fifth, activities are expected to occur in the client's community. Sixth, case managers are expected to be accessible. Seventh, case managers serve as advocates and develop support for clients, who are encouraged to express their own goals and concerns. Eighth, services are not time limited.

So far we have been discussing case management as a system of services. However, there is debate in the field about the optimum way of delivering services. In this paper, the primary mode of service delivery we describe relies on each client's being assigned an individual case manager. Stein (8) recently proposed an alternative service delivery model involving continuous care teams-interdisciplinary teams with low patient-to-staff ratios that operate seven days a week. Stein recommended that these teams should not be thought of as treatment, rehabilitation, or case management teams but as vehicles for providing wherever service or practical assistance a patient requires. He suggested that because the continuous care team provides most services itself and brokers for only a few, services are integrated and responsive to the client's current needs.

We suggest that continuous care teams, as proposed by Stein, constitute a comprehensive outpatient treatment program. Although we agree with Stein that a full array of integrated and

responsive services could remove the need for an individual case manager, such ideal systems exists in few places in the United States. In the absence of such systems, we remain convinced of the necessity for individual case managers who integrate services through creative brokering and advocacy. Whether some version of the proposed continuous care team is ultimately preferable awaits future research. In the meantime, intensive case management programs that rely on individual case managers constitute the most practical method of managing violence associated with mental illness in the community.

Specific clients must be identified and assigned by name to individual case managers. Such assignments are perhaps the most important facet of case management and its greatest value because they prevent case managers from disavowing responsibility for clients who may engage in violent, criminal, psychotic, embarrassing, or threatening behavior. Although case managers may occasionally need to rely on the resources of the criminal justice system or on emergency psychiatric services to respond to clients in potentially violent situations, they continue to be responsible for providing the person with case management and support services, even if the person goes to jail.

Many persons with mental illness who frequently interact with the criminal justice system have been disenfranchised for a variety of reasons. Many are from lower social classes, either because their family of origin was poor or because their mental illness has forestalled employment necessary to maintain social status. Many are unmarried, young, and homeless and may view the mental health and social services systems as their enemy.

Obviously, engaging such a group in treatment is difficult. Mental health systems have traditionally attempted to do so by developing a finite variety of treatment modalities and attempting to fit clients into those services. Such an approach may be suitable for clients who are passive, dependent, and compliant. However, persons with mental illness who have recently come into contact with the criminal justice system because they have been violent are likely to be active, independent, and unwilling to obey orders. Furthermore, many of these people have not had the long hospital stays

that characterized an earlier generation of people with serious mental illness. Patients with long hospital stays often learned compliant behaviors that prepared them to accept traditional community mental health services. People with mental illness who are at risk for violent behavior not only may lack these compliant behaviors but may actively antagonize providers in community mental health programs (9).

As in New York's intensive case management program, case managers in effective programs for potentially violent clients must have extremely low caseloads and must be available to clients 24 hours a day, either individually or via teams. Many violent acts and arrests occur in the evening or during the night, when traditional programs are closed. The case management program must have the ability to respond quickly when violence is part of a psychiatric crisis that occurs during these off hours.

One important reason for having low caseloads for intensive case managers is that developing a personal relationship with a client takes a great deal of time and individualized attention. Furthermore, most of this work does not take place in offices, but on the streets and other locations where the clients live and hang out. The importance of this relationship cannot be overstated. One of the simple ways violence can be avoided is to talk about anger. For someone who is socially isolated or whose entire peer support group is made up of people who repetitively act out violent thoughts and feelings, this modulating and inhibiting does not exist. Often, the ability simply to express anger verbally to someone who is perceived as being interested can allow a person an alternative to violent behavior that may not otherwise exist.

Another advantage of a personal relationship with a case manager is that it offers clients an appropriate way to seek more intense treatment services. Tragically, some clients who feel they need to be hospitalized may believe that the only way to receive such help is to commit a violent act. Clients who can go to their case manager for help may no longer feel the need to be violent.

Sometimes, of course, a poor personal match between an individual client and a case manager may occur. Case managers should meet as

teams to flexibly address the needs of clients who might be better off with a case manager from a different gender, race, culture, or generation.

Before accepting case management and other services, clients first ask themselves "What's in it for me?" Clients who perceive the case manager as an agent of the state whose sole intention is to make the client "toe the line" will be unlikely to invest any effort in forming a relationship with a case manager. The case manager must thus be seen as an advocate for the client even if other agencies such as the criminal justice system are at the same time dealing with the client in more coercive or authoritarian ways.

What form should this advocacy take? Certainly, case managers should not suggest to clients that they need nor be held accountable for criminal or violent acts. However, other forms of advocacy are both necessary and appropriate. For example, as Massaro (10) and others have pointed out, health care for people with serious mental illness is often quite deficient. Case managers could advocate for clients in this area by helping them apply for Medicaid and gain access to a physician or other health care professional. The case manager could assist the client in obtaining other human services and entitlements, such as Social Security Disability Insurance, Supplemental Security Income, or food stamps, and in enrolling in and seeking resources to fund training in their desired vocation.

Case managers may have additional options, depending on the particular provisions of the case management program in which they work. For example, New York's intensive case management program provides service dollars that are intended to be used to meet a range of clients' needs, not only those related to traditional clinical concerns. A case manager may help a client use this money to make a rent payment and thus make a tenuous housing situation more permanent.

### **Linkages to Other Systems**

To assist severely mentally ill clients in gaining access to the services they need, a case manager must be familiar with the services offered by departments of social services, mental health agencies, medical or health providers,

and criminal justice agencies. The case manager may be the client's only social and constructive link to these systems, which have very different goals and practices and use very different terms. Case managers must be able to facilitate communication and cooperation among these agencies. The case manager must have the authority to convene meetings of appropriate staff from each service agency when necessary. Agencies' support for such meetings can be confirmed through interagency agreements or memoranda of understanding.

For clients who are at high risk of becoming violent, convenient access to services is especially important. For a client who is known to respond to homelessness with violent or criminal behavior, being put on a two-year waiting list for subsidized housing is of little help. Although one may debate the moral propriety of giving someone high-priority access to services simply because of violent or criminal behavior, some spots in community support programs should be reserved for clients who present the highest risk to both their own and the community's safety. Such alternatives are especially necessary for clients whose behavior has not escalated to the level at which other coercive measures such as involuntary civil commitment or incarceration are legally justified.

For the client, linkages to the criminal justice system are as important as linkages to the mental health and human service delivery systems. The importance of case managers' working cooperatively with police and criminal justice agencies cannot be overstated. Case managers for high-risk clients must be able to converse fluently in the sometimes idiosyncratic language of the criminal justice system. They must be seen by police and officials in other criminal justice agencies not as helping people with mental illness avoid responsibility for crime, but rather as partners whose main vocational goal is to help make the community safer.

Case managers with links to the criminal justice system may be able to use criminal justice sanctions to facilitate potentially violent clients' adherence to treatment. Judges may release a defendant with mental illness before trial through a variety of mechanisms, including conditional probation, release on one's own recognizance, and adjudication in contempla-

tion of dismissal, on the condition that the person is actively participating in mental health programming. Many judges have expressed to us their frustration over not being able to use these mechanisms for release more frequently because they feel there is no one to accept responsibility for organizing such programming. Judges are often as uncomfortable with the nomenclature and organization of the mental health system as mental health professionals are with that of the legal and criminal justice systems.

Probation and parole officers are important treatment allies. In addition to having the role of oversight and enforcement, parole officers provide important social supports for many of their clients. Most probation and parole officers view engaging a client in education or vocational training as important as monitoring their adherence to the conditions of their release.

However, parole and probation officers typically have caseloads that are far too large for them to adequately address the needs of mentally ill clients at high risk for violence. In addition, parole and probation officers are not likely to be able to negotiate the mental health service delivery system and are usually very grateful for the assistance of case managers. On the other hand, parole and probation officers can provide an external structure that may increase the chances that a client will adhere to an agreed-on treatment plan.

### **Outcome Research**

To date, little research has focused specifically on violence reduction as an outcome of case management. However, one study of New York State's intensive case management program (11) and two reports on forensic clients (12,13) strongly suggest that intensive case management services are effective in safely serving potentially violent clients in the community.

In an evaluation of New York's statewide intensive case management program (11), follow-up data on a variety of community functioning variables were gathered on 5,121 adult clients who received services through the program between 1989 and 1992. Some clients were followed for as long as 18 months. Results on measures of harmful behavior, antisocial behavior, and alcohol and drug abuse suggest

that the program was effective in reducing clients' dangerousness in the community. Overall scores on the three measures decreased significantly for patients followed for 18 months. In addition, scores on the measures of harmful behavior and alcohol and drug abuse decreased significantly between entry and six months in the program.

The two studies of forensic populations used rearrest as a proxy measure for violent or harmful behavior. The first study assessed the effectiveness of an assertive case management program for mentally ill offenders on probation from a provincial correctional center in Vancouver, British Columbia (12). Case managers in the program each had caseloads of about ten clients, and clients received a minimum of 24 months of intensive case management. The study included a comparison group of offenders who were eligible for the program but who could not be fit into available program slots, declined to participate, or resided outside the Vancouver area. The comparison group was followed through agency records for 36 months.

During the first six months of the study, the clients who received case management averaged eight days in jail, compared with 51 days for the comparison group. At 12 months, the case management group averaged 40 days in jail, compared with 137 days for the comparison group. For the full 18 months of the study, the case management group averaged 80 jail days, while the comparison group averaged nearly three times that number (214 days). All of these differences were statistically significant, indicating the effectiveness of intensive case management in substantially reducing jail days.

A similar finding emerged from the recent evaluation of Project Action in Texas. (13) From 1990 to 1997 six case managers coordinated services for 229 adult offenders released from the Harris county criminal justice system. Most of the data on the project do not relate specifically to the issues of violence. However, the evaluation showed that 75 percent of the program participants had no arrests within one year of entry into the program, 92 percent did not return to state prison, and 80 percent of the program participants who were on parole had no parole violations.

These studies are far from definitive, but they do provide preliminary empirical support for an association between intensive case management and reduced violent behavior by high-risk clients in the community.

### Service Planning

The case manager for a potentially violent client must be viewed as a member of any treatment team that interacts with the client. The team should assess both individual clients' strengths and their weaknesses. For example, it is quite common for a client's above-average intelligence to be viewed as an impediment to treatment. Phrases such as "too smart for his own good" and "manipulative" often appear in the records of such clients. It is ironic and unfortunate that what for most people would be deemed a strength has been considered a weakness by the mental health care providers who claim to help such clients. The presence of the case manager on the treatment team can encourage mental health care providers to enlist the client's street survival skills as important strengths that can foster rather than impede the person's recovery.

*Substance abuse treatment.* A full discussion of substance abuse treatment is well beyond the scope of this paper. However, in some jurisdictions, as many as 80 percent of people arrested are reported to have illegal drugs or alcohol in their systems at the time of the arrest (14). Moreover, awareness that substance abuse disorders often co-occur with major psychiatric disorders is growing. Abrams and Teplin (15) found that 59 percent of the inmates in the Cook County jail who had a diagnosis of schizophrenia also had a current alcohol abuse disorder, and 42 percent had a current drug dependence disorder.

Case managers for potentially violent clients with substance abuse problems should actively and aggressively pursue substance abuse treatment for their clients. In addition, as case managers develop trusting relationships with clients, case managers should reinforce that staying away from alcohol and illegal drugs will increase clients' chances of remaining in the community.

*Cultural issues.* Traditional mental health programs are staffed by credentialed mental health professionals who are typically white

and middle-class. However, clients who are likely to be arrested generally do not share this demographic profile and may have opted not to use traditional mental health services because they feel disenfranchised. Many variables that influence the development of violence and crime among people with mental illness in the community may also contribute to their poverty, low levels of education, and under-employment.

To increase the relevance of case management services to these clients, mental health systems should try to employ case managers who are culturally similar to the clients they serve. In our opinion, cultural similarity may be more important than an advanced degree in one of the mental health professions in preparing the case manager to serve high-risk clients.

Cultural issues may include a variety of factors in addition to race and ethnicity. For example, clients with a hearing impairment typically grow up in a subculture quite different from that of persons without such impairments. Clients who are homosexual may need a different array of social supports than heterosexual clients. Persons who are arrested while passing through an area will require linkages with different types of services than will lifelong residents.

*Human resources.* Intensive case managers tend to have particular characteristics that distinguish them from staff of typical mental health programs. They should be creative, self-directed, independent people with little need for formal structure. Clearly, this work is not for everyone. In our experience, the most crucial element is experience, not formal education.

The best intensive case managers for clients at high risk of becoming violent are those who have prior experience in a variety of service locations in both the mental health and criminal justice systems. Former police officers may be particularly appropriate candidates for this job. Many police officers and others who work in the criminal justice system view themselves primarily as human service professionals. Their work involves supervising and supporting individuals, besides enforcing the law. Many police officers have a college degree when they begin police work or obtain a degree during their police career. They typically retire

after 20 or 25 years of police service and thus constitute a potential cadre of experienced, yet young, service professionals with strong linkages with the criminal justice system.

Another group of potential intensive case managers are people who have succeeded in gaining control of their life circumstances despite their own serious mental illnesses (16). In addition to having developed networks of peer support, knowledge of responsive treatment providers, and strategies for meeting various needs, people who have been treated for mental illness may also be perceived as more credible sources of information by their prospective clients. More generally, case managers of every background can benefit from the insights and support of the emerging self-help movement of mental health service recipients (17).

Case management is a stressful business. Clients who are not cooperative can be frightening and a source of frustration to case managers. Yet if such clients form a bond with a case manager, the relationship may become intensely dependence and leave the case manager feeling drained. Case managers' salaries are typically low, and case managers are unlikely to receive benefits enjoyed by law enforcement officials, such as retirement after 20 years.

Further, case managers may feel that they are in personal danger, especially if they work with clients who have been violent in the past or if their work includes visiting the high-crime areas where many people with serious mental illness live. Case managers must frequently provide coverage after usual working hours, which can put a strain on their health as well as on their relationships. Finally, case managers may not have the prospect of upward career mobility. All of these factors lead to job stress and a high turnover rate. Administrators should thus pay attention to the need for ongoing training and support of case managers.

### Conclusions

The keys to reducing the risk of violence by persons with mental disorder in the community are aggressive case management and a comprehensive array of support services. Although some specialized clinical services aimed at reducing violence per se may be needed, most of the services required by this client population are those that any person with serious

mental disorder needs. The crucial difference is the increased intensity of case management for potentially violent clients.

Intensive case management for potentially violent clients requires case managers with special skills and low caseloads. The case managers must truly be "boundary spanners" (18) who understand and are able to negotiate the medical care, social service, housing assistance, and criminal justice systems as well as the mental health system.

This special kind of case manager does exist. We have seen them in many intensive case management and jail diversion programs throughout the U.S. They know what kinds of services are available and how to help their clients gain access to them. If clients drop out of a treatment program, intensive case managers attempt to find them and reconnect them to the services they need. If clients are arrested, intensive case managers do not drop them from their caseloads but continue working for them.

Intensive case management is not a panacea. It will fail if appropriate treatment and human services are not available in the community. As Goldman and colleagues (19) observed, the brokering and linkage roles of case management mean little if services are not available in the community to be brokered or linked. Case management may be but one piece of a comprehensive mental health care system, but it is the key to managing the risk of violence in the community among people with mental illness.

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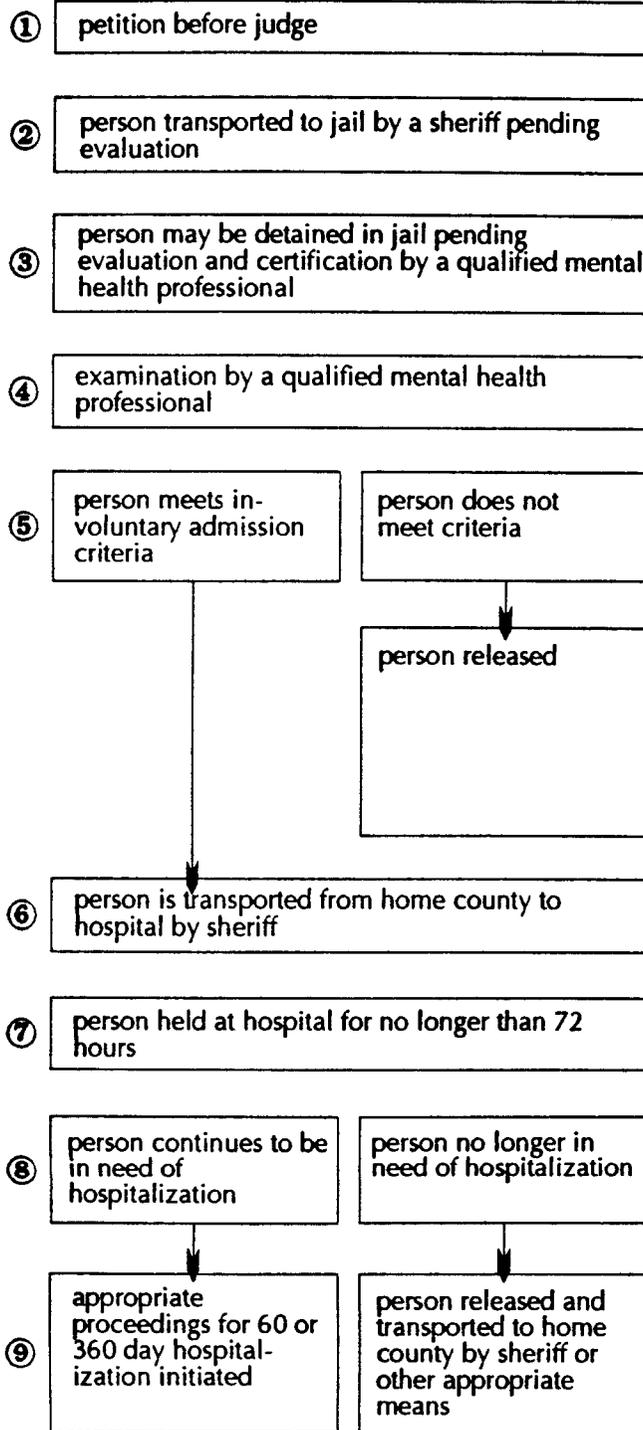


# Department for Mental Health and Mental Retardation Services

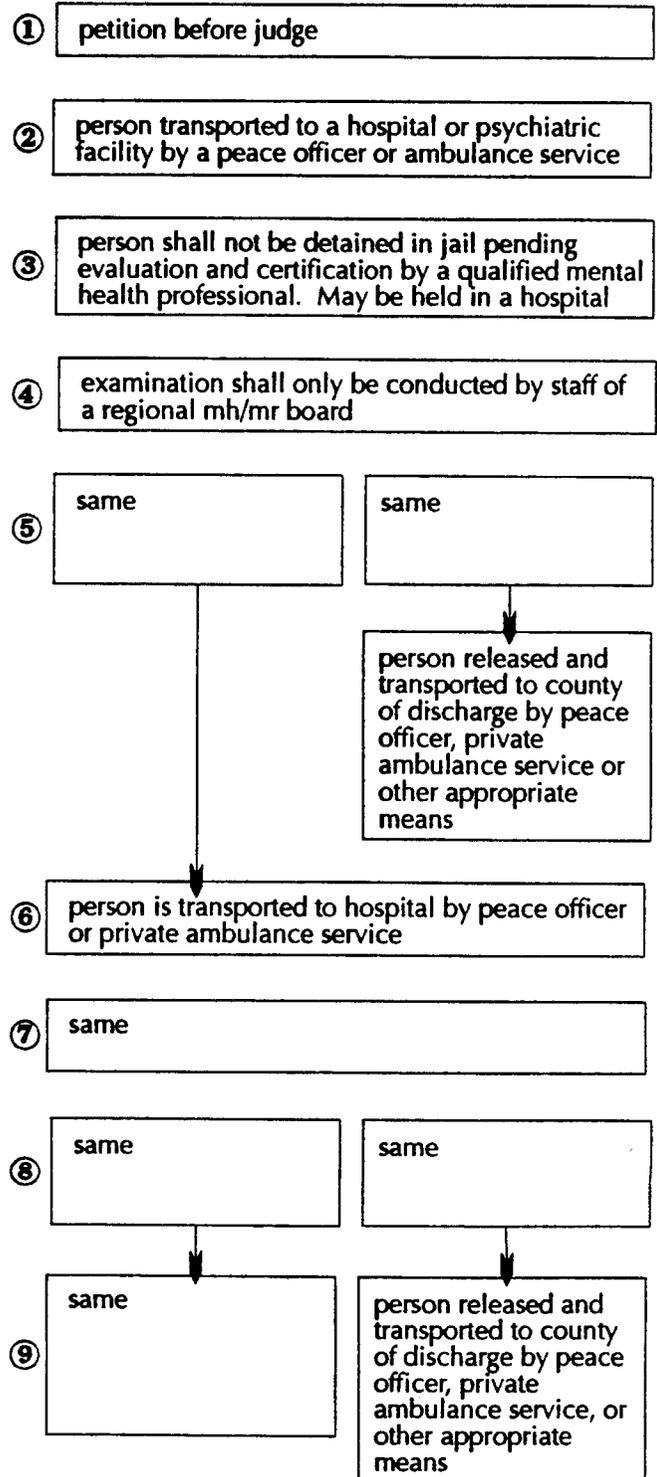
## 1994 Revisions to KRS 202A (HB 207)

*CONDITION: petition for 72-hour court order to a state psychiatric hospital or local hospital (KRS 202A.02)*

### Previous Law



### Current Law



# Department for Mental Health and Mental Retardation Services

## 1994 Revisions to KRS 202A (HB 207)

*CONDITION: peace officer has reasonable grounds to believe that an individual is mentally ill and presents a danger or threat of danger to self, family, or others if not restrained (KRS 202A.041).*

### Previous Law

### Current Law

① peace officer has reasonable ground to believe person is mentally and presents danger

① same

② peace officer takes person into custody, detains without a warrant, swears out a warrant, and takes person before a judge

② peace officer takes person into custody and transports him to a hospital or psychiatric facility; peace officer provides written documentation to hospital or facility staff which describes the behavior of the person which caused the officer to take the person into custody

③ person held in jail pending evaluation by a qualified mental health professional

③ person held in a hospital or psychiatric facility pending evaluation by a qualified mental health professional

④ examination by qualified mental health professional(s) and certification to the court within twenty-four (24) hours

④ examination by a qualified mental health professional and implementation of procedures under 202A.028, 202A.031, or 202A.051 within 18 hours

⑤ person meets involuntary admission criteria

⑤ same

person does not meet involuntary admission criteria

same

person released

person released and transported home by a peace officer, ambulance service or other appropriate means

⑥ appropriate court proceedings for further hospitalization initiated

⑥ same

if the peace officer has probable cause to believe the person has committed a criminal offense, the peace officer may swear out a warrant for the person's arrest

# Department for Mental Health and Mental Retardation Services

## 1994 Revisions to KRS 202A (HB 207)

*CONDITION: proceedings for 60 day or 360 day involuntary hospitalization (KRS 202A.051)*

### Previous Law

① petition filed by a qualified mental health professional, peace officer, county or Commonwealth's attorney or other person

② court implements proceedings under KRS 202A.028 and orders person examined by a qualified mental health professional

or

sets a date for a preliminary hearing and orders person examined by two (2) qualified mental health professionals within twenty-four (24) hours

③ person may be detained in jail awaiting examination

④ if the person is not currently detained, the court may issue a warrant for the person's arrest in order that the person may be examined

and

may issue a summons

⑤ if, upon completion of the preliminary hearing, the court finds probable cause to believe that the person should be hospitalized, the court shall order a final hearing

or

if the court finds no probable cause, person shall be released

⑥ if, upon completion of the final hearing, the court finds that the person should be hospitalized, the court shall order that the person be hospitalized

### Current Law

① petitions may also be filed by "any other interested party"

② same. If the person is not already being held, the court may order a peace officer to transport the person to a hospital or psychiatric facility. The peace officer may designate other transporter

or

same. The preliminary hearing shall be held within six (6) days from the date of holding

③ person shall not be held in jail awaiting examination. May be held in a hospital or psychiatric facility

④ if the person is not currently being held, the court may order that a peace officer transport the respondent to a hospital or psychiatric facility designated by the cabinet

and

may issue a summons

⑤ same. The final hearing shall be held within 21 days from the date of holding

⑥ same

# Department for Mental Health and Mental Retardation Services 1994 Revisions to KRS 645 (HB 207)

CONDITION: Emergency hospitalization of children (KRS 645.120)

## Previous Law

① a child appears in need of immediate hospitalization; peace officer or other interested party takes child to a hospital, secure juvenile detention facility, juvenile holding facility or another less restrictive alternative or files a petition for emergency hospitalization.

② upon the filing of a petition for emergency hospitalization, a peace officer may place a child up to twenty-four (24) hours in a mental health facility, secure juvenile detention facility or juvenile holding facility or another less restrictive alternative

③ within twenty-four (24) hours of the filing of a petition, the court may deny the petition or issue an order authorizing a peace officer to transport the child to a designated hospital for evaluation

④ an emergency hospitalization of a child may not exceed seven (7) days, exclusive of weekends and holidays, unless a certified petition is filed before the seven (7) days expire

⑤ if it appears that a child committed to the Cabinet is mentally ill, the Cabinet may use state mental health facilities or other resources for observation for a maximum of 30 days

## Current Law

① a child appears in need of immediate hospitalization; peace officer or other interested party takes child to a hospital, mental health facility or other less restrictive alternative

no child shall be held in a secure detention facility or juvenile holding facility unless a status offense or public offense action is also pending

② upon the filing of a petition for emergency hospitalization, a peace officer may place a child up to twenty-four (24) hours in a hospital, mental health facility or another less restrictive alternative

③ within twenty-four (24) hours of the filing of a petition, the court may deny the petition or issue an order authorizing a peace officer to transport the child to a designated hospital or mental health facility for evaluation

the peace officer may authorize the Cabinet, a private agency on contract with the Cabinet or an ambulance service to transport the child

if, after evaluation, the child is found not to meet the commitment criteria for involuntary hospitalization, the child shall be released immediately and transported back to the child's home county by an appropriate means of transportation

④ same

⑤ this section has been removed

# Talking to the Media

On your way out of court, you encounter a reporter who asks some questions about the case of the client you are defending. Playing it safe, you merely say, "No comment."

Here is an excerpt from the story that runs in the next day's paper:

"Furthermore,' the prosecutor continued, 'the defense is obviously pandering to the basest instincts of the jury, playing the race card from the bottom of the deck, and pinning its meager hopes on a series of feeble, pathetic arguments.'

"The defense attorney had no comment."

Embarrassed that your caution has helped propagate such a bad impression, you vow to do better next time. So when the reporter approaches you again, you talk at length, providing thoughtful, articulate answers to all her questions.

But the next day, you discover that the story bypasses all your trenchant points, printing only one comment, which you tossed off in passing. Taken out of context, it sounds like a criticism of the judge.

Uh-oh.

Criminal trials will always be newsworthy, so all criminal defense lawyers should be prepared to talk to the media at some point. You will need all of the judgment and rhetoric that you bring to the courtroom. Journalism, however, operates with its own additional set of rules and goals, which you need to become aware of - preferably before the reporter sticks the microphone in your face.

Why is the reporter seeking a comment from you? Good reporters inform themselves by gathering background information that will help them write coherently and factually about the topic at hand. Sometimes, however, even a good reporter is a hurried reporter, close to deadline, who simply needs to know the latest facts, or needs a quote from your side, to provide the appearance of balance.

Especially in law stories, where the antagonism of defense and prosecution clearly indicates the two sides which balance each other, the reporter's most immediate task may be to make sure that each side gets quoted in the story, even if the quote is "No comment."

If it should ever happen that a newspaper article or TV spot omits your side of the story, to the point of bias, then you have the right to ask for a clarification or an elaboration. This is a vaguely defined and variably enforced right, but claim it nonetheless. Possible remedies might include the printing of a tiny correction, having your position aired in an update of the story, or perhaps writing an opinion piece of your own. Note that lopsided but unbiased reporting can result if a reporter's attempts to reach you are unsuccessful. Usually, she will then mention that you were "unavailable for comment" or "did not return a phone call."

Most media trouble, however, derives not from being ignored but from being misconstrued when the reporter does talk to you. Here are some strategies to bear in mind:

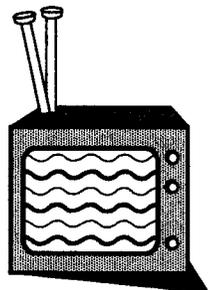
- o Identify one to three main points which you would like the reporter to present. If you can anticipate that you will be interviewed, rehearse your main points beforehand, write them down, bounce them off your colleagues.
- o Make sure to mention your main points, even if you have to volunteer them because the reporter didn't ask a suitable question. Politicians constantly promote their agendas by responding with prefab statements, which may or may not be germane to the question being asked; you can make this tactic work for you too.
- o Reinforce the importance of your main points. Slow down. Enunciate. Get louder. Say "If I could say only one thing about this subject, I'd want you to know that..."
- o Once you have said what you want to say, stop. This way, the reporter will have to select a quote from among the jewels you have provided. If you ramble, you're giving the reporter some less-desirable material

from which to choose. To fix this situation, return to your main point after you've stopped rambling, and put your faith in the rhetorical devices of repetition and recency.

- o Avoid saying "No comment" - it sounds guilty and will not cancel out any damage done by the more effusive comments from the other side. The decision not to comment, although neutral on its face, will always be outweighed by the damaging comments from the other side. If neither side comments, there is no story; if only one side comments, its views go unchallenged and are more persuasive; if both sides comment, the winner is the side with better facts, accessibly and persuasively presented.
- o If you're not sure, say so, volunteer to get the information and call the reporter later. Or refer her to someone who can provide the answers. If you say "I'll get back to you on that," be sure to follow up. (Lawyers are admonished never to ask a question you don't already know the answer to. You shouldn't *answer* questions either, if you don't know the answer.)
- o If asked for a response to a statement by someone else, make sure you know exactly which statement is meant. Don't give a response to someone else's sound bite unless you are secure about its full meaning and context.
- o Don't be afraid to ask permission to write down your answers to the reporter's questions, and promptly fax them. (This approach is more appropriate for feature or "news analysis" stories than for "breaking news" stories, where deadlines are shorter.) Some reporters don't like to operate this way, but ask anyway, if you need time to gather facts or compose your statement. Similarly, if an interview is being scheduled in advance, you should inquire about the subject matter to be covered, so that you can better prepare your responses.
- o If the reporter asks a question you don't like, ask for clarification before proceeding, provide a little background to correct his error, or restate the question more positively in your response. You don't have to let the reporter dictate the context of the discussion.
- o Don't ask the reporter to let you review the story before it goes to press. He will almost never do it.
- o Know the reporter's "angle." You might assume that the story is simply an update on the Jones case, only to find out later that he was asking about Jones in the context of an investigation into prison overcrowding - and you have provided irrelevant or possibly detrimental perspectives while missing an opportunity to address the real topic. Also, be alert for any possible hidden agendas the reporter may have, or any of his misperceptions that you may be able to correct.
- o You have the right to make your own recording of an interview. You have the right to stop an interview.
- o In TV interviews, maintain eye contact with the questioner, not with the camera. You will appear more natural and sincere, and you'll be able to continue monitoring the questioner's subtle visual cues, which makes your conversation more effective. Do not speak directly to the camera unless you are very comfortable doing it and there is some unusual overriding reason to bypass the interviewer and speak directly to the viewer.
- o For TV or radio, remember that airtime is limited. Be concise. The reporter will be drawn to any statement that compactly presents a strong or interesting point. Conversely, the reporter will be impatient with rambling stretches where you are speaking in sentence fragments, pausing a lot, or "thinking out loud."
- o When making your main point for radio or TV, beware of excessive pauses - a tape editor might regard a pause as a good place to cut. One lawyer tells of trying to compare the prosecution and the defense, while being interviewed on camera. Unfortunately, the finished spot included only the first part, cutting away before the lawyer continued to say, "On the other hand..." - which provided the meaningful context of the comment.
- o It doesn't hurt to write a thank-you note after a reporter does an especially good job with your story.

Attorneys may feel that their workload is already heavy enough, without the added burden of worrying about making statements to the

media. The Department of Public Advocacy, however, is increasing its attention on the media, as part of an ongoing process of making agency viewpoints better known. One of the objectives of the Department's evolving Strategic Plan is to "increase public education, to explain the criminal defense role in the criminal justice system."



Allison Connelly, Kentucky's Public Advocate, says, "The Department needs to be more proactive in two areas: In representing our clients, we need to be more educated about how to talk to the media. In representing the agency, we need to remember that our power is in fact-based comments." Connelly prepares for media interviews by assembling hard statistics that support her arguments.

The media have not always treated public defenders fairly, and "we've been slow in responding to that," says Connelly. "We want to become more proactive in initiating articles that present our side clearly. At the same time, we don't want every DPA attorney speaking on behalf of the agency. If someone has been interviewing you about your client's case, and they shift to questions about policy or politics, you should tell them to speak to [DPA General Counsel] Vince [Aprile] or the Public Advocate or someone else who can give them the facts they need."

Reporter Thomas Tolliver, who has covered the courts for the Lexington *Herald-Leader* for years, says, "I have found that defense attorneys - especially in criminal cases - will criticize the press for being one-sided. But the reason for that is that we have access to so much more of the prosecution's side: witnesses, the police, past court records. Defense attorneys could help us out by providing more information." He admits that this would make his job easier, but notes that it would ultimately be in the service of stories with more balance.

DPA attorney Kelly Gleason has had frequent contact with the news media. She says that in

her training on media relations, trainers often focus on "spin control." Gleason maintains, however, that "if you're 'up front' with your information," there will be no negative spin to control. Keeping professional ethics guidelines in mind, Gleason tries to provide complete information to reporters - furnishing them, for example, with copies of her motions and other matters of public record, instead of obliging the reporter to request such items from the court.

Gleason practices caution in speaking to reporters, and does not speak "off the record," but she says she works on developing a working relationship with reporters she has come to trust.

Gleason has worked on a case in which the court imposed a gag order. Although gag orders are often requested by the defense in an effort to stanch the flow of damaging impressions about the defendant, Gleason says that a gag order was not helpful in this instance. "Once the gag order was on," she said, "the information that came out of the media was incredibly inaccurate, but my hands were tied."

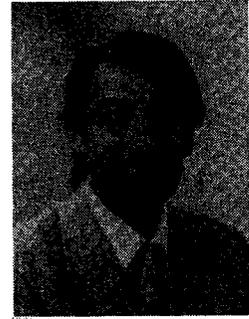
In training facilitated by the NAACP Legal Defense Fund at Airlie, Virginia, during the summer of 1995, Gleason found that the trend among defense lawyers is to "embrace the media," instead of avoiding them. "You can't ignore the media. People like Steve Bright and Bryan Stevenson tell you to try to incorporate the media into your case," she said.

The media are there, and they're not going away. Defense attorneys should train themselves to deal with the media in ways that help communicate the best facts about their work, their image, and their value to the justice system.

[DPA library materials on media relations include: video V-541, *Representing Clients in the Court of Public Opinion* by Vince Aprile and Ed Monahan, and its accompanying handout, *The Care and Feeding of the Media by Defenders*; and *Media Relations under Fire*, a pamphlet by McKone Public Relations. All are available from the librarian.]

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# Multicultural Initiative in Psychiatric Hospitals



**Bill Stewart**

In addition to individual advocacy, the Protection and Advocacy Division focuses on systems level disability issues to address and impact. To determine which issues should be addressed as priorities, we rely heavily on input from our citizen advisory bodies, as well as the volume of individual cases and public surveys.

In 1993, the Mental Health Advisory Council of the mental health advocacy section reviewed several potential priority areas. An African-American Council member asserted that racism is prevalent in public and private mental health facilities and that the council should recommend to the agency that this situation should be addressed as a priority area. Her concern was corroborated by an observation by a P & A staff member that on one occasion, 80% of the patients in the most secure psychiatric ward in public facilities had been African-American men. We had an extensive discussion of the agency's ability to impact broad social issues such as homelessness, poverty, racism, etc. Although those issues obviously affect persons called mentally ill, P & A staff is inclined to focus on quantifiable issues rather than general goals.

A decision was made to review literature on the topic, identify units characterized as "secure" or for "violent" patients at each of the three public psychiatric hospitals, and take a snapshot of the racial composition of each.

Our initial information on discrepancies in mental health service related to race and/or cultural background was based on a document developed by the Mental Health Law Project titled *Impediments to Services and Advocacy for Black and Hispanic People with Mental Illness* (June, 1988). That document summarized literature pertaining to the issue, with several conclusions which reinforced our original concerns. Data collected by the National Institute for Mental Health indicated that black men were hospitalized at a rate 2.8 times greater than white men, and black women at a rate 2.5 times greater than white women.

Among those hospitalized, 56.6% of nonwhite men and women of all diagnoses were held involuntarily compared 48.9% for white patients. Black patients were diagnosed as having schizophrenia at twice the rate of white patients. That skew was even greater for women. Schizophrenia ranked last as a diagnosis leading to hospitalization of white women, but it was the leading diagnosis supporting the admission of black women. African-Americans were diagnosed as having bipolar disorder with significantly less frequency compared to European-Americans. One professional speculated that the reason for the latter statistic is that whites exhibiting the symptoms of mania are called mentally ill while blacks exhibiting the same symptoms are characterized as "happy-so lucky."

Deborah J. Garretson, in an article in the *Journal of Multicultural Counseling and Development* titled *Psychological Misdiagnosis of African Americans* (April, 1993) confirms significant differences in diagnoses and treatment among blacks and whites and speculates that cultural differences are significant contributors to this data. The observation of "paranoia," in a black patient by a white professional might be construed as healthy caution around whites in that individual's culture.

There are numerous anecdotes by minority consumers of mental health services which support the perception of a culturally insensitive system. These range from overt racial slurs to a being denied equal privilege levels given to white patients.

A parallel set of anecdotes relates to patients being treated by psychiatrists from different countries. In one well-known story, a psychiatrist with marginal understanding of English asked a patient how he was doing. The patient replied "cool." The psychiatrist ordered extra

blankets should be made available.

It should be noted at this point that issues of cultural sensitivity are not limited to treatment of African-Americans by the system. The Protection and Advocacy Division has provided representation to individuals incarcerated in psychiatric hospitals who were from Kenya, Iran, Iraq, Nationalist China, Korea, and Vietnam. We have represented individuals who were deaf, blind, or deaf and blind. We have had clients who openly characterized themselves as gay or lesbian. Many individuals in public hospitals are from the so-called Appalachian culture. Other consumers have told us that their appearance or physical stature affected their treatment in hospitals. This complex situation is further complicated by socioeconomic status, cultural background of treating professionals, and lack of availability of minority professionals, among numerous other factors.

Our initial survey of secure wards was revealing, if not strictly scientific. Almost eight percent of Kentuckians were characterized in the 1990 census as nonwhite, with over seven percent being African-American. The population of minorities in public hospitals was about 14%, again predominantly African-American persons. At Central State Hospital, with an admissions rate of 23.5% of admissions being black or "other," 67% of the patients on the most secure unit were persons of color. At Eastern State Hospital, with a minority admissions rate of 6.5%, 23% of the patients on the secure ward were black. At Western State Hospital, with 16% minority admissions, 25% of patients on secure wards were black. Overall, 36% of patients on the most secure wards were persons of color, significantly higher than the overall hospital population of 14%.

With the above information, our Advisory Council recommended that we adopt correction of apparent overrepresentation of minorities on secure wards as a systemic priority. We summarized the above in a May, 1993 letter to Dennis Boyd, who was Commissioner of the Department for Mental Health/Mental Retardation, and we requested further review of the data consideration of multicultural training for hospital staff, and review of specific cases.

Commissioner Boyd responded by appointing an internal work group to gather long term

information, review specific cases, and make recommendations regarding the concerns raised by the advisory council. On September 30, 1994, after numerous delays/acting Commissioner Don Ralph met with Protection and Advocacy staff to discuss the work group's summary document, titled *Persons of Color on Secure Wards*. That document stated in part that: "At every facility, at the time of the chart review, there was a disproportionate number of persons of color on the secure units as compared to the number of persons of color in the total population." The report further stated that the number of African-Americans characterized as having schizophrenia was 84%, while 62% of Caucasian patients had that diagnosis. The report stated that reasons given for secure ward placement were similar for both groups. It pointed out that such factors as socioeconomic status and involvement with community mental health centers were variables which affected hospitalization rates. The work group recommended that the Department work with P & A in "developing and implementing a training curriculum related to culture, awareness and sensitivity," and that a "racially mixed clinical review team" should review the status of each person on the secure wards.

The clinical review team was also asked to develop culturally sensitive recommendations for on-going reviews of placement and continued stay for individuals on these units. The recommendations were then to be submitted to their governing bodies for approval.

Those teams began functioning in early 1995. Recommendations were made for several individuals regarding their need for a secure placement. Criteria for placement on more secure units was also reviewed. At Western State Hospital, the criteria for placement on a locked ward is as follows:

- 1) Patients who have been identified as AWOL risk.
- 2) Patients who have a high potential for violence.
- 3) Patients who require active psychiatric treatment of an intensive nature such as frequent seclusion, frequent mechanical or chemical restraints.
- 4) Patients who require consistent and ongoing monitoring of whereabouts of patient to assure safety such as patients with extreme

psychosis or patients who are too confused to function on an open ward.

According to all the charts reviewed on identified locked units at WSH, each patient must "no longer display episodes of agitation" in order to be released from the secure wards. One 59 year old African-American woman had been on a secure unit since 1977. She had not yet met her treatment plan goal of "no further episodes of agitation" for a period of time.

In 1993, 15% of persons admitted to that facility were African-American. Twenty per cent of the patients on secure wards were African-American. In 1996, 14.5% of persons admitted were African-American. Over twenty-one percent of persons on the locked units were black.

The admission criteria to the Grauman unit at Central State Hospital is as follows:

- 1) Mentally ill patients found incompetent to stand trial for felony offenses. Such patients are usually court-ordered there for treatment.
- 2) Patients from other state psychiatric units with aggressive or violent behaviors likely to respond to the...expertise available on Grauman. These are patients who cannot be managed in the general hospital population and for whom treatment in that setting has proven ineffective.

In 1993, 32% of persons admitted to Central State were African-American. Sixty-three percent of the persons on the Grauman Unit were African-American. In 1996, 31% of persons admitted to the hospital were African-American. Forty-one percent of persons on the Grauman Unit were black.

Effective 8-1-95, Eastern State Hospital (ESH) had eliminated Wendell 2, its "violent" ward. As a result, admission to any ward is now based on anticipated length of stay. The patients on their long-term ward have been identified as "unable to handle an open ward." To get off this ward, the patients must go through a series of "levels." When they maintain an "A" level for a predetermined length of time, they can be released to an open ward or to home. We found that a number of patients on this unit have been in the hospital in excess of three years.

From 1993 to 1996, the percentage of African-Americans on secure units decreased from 31%

to 27%. This number is still in excess of the 16% of African-Americans in the 1996 general hospital population.

Elizabeth Rehm-Wachtel succeeded Dr. Ralph as Commissioner for Mental Health/Mental Retardation. She assured P & A staff that she was committed to completing the initiatives begun by her predecessors. A tentative date for training persons to train facility staff on multicultural sensitivity was set for July 1995. Five months after that date, the training had still not been implemented.

We invited Commissioner Wachtel to our February 23, 1996 Advisory Council meeting, as well as civil rights leaders and representatives of the media. She responded by directing that a Multi-Cultural Training curriculum be completed and implemented by April/1996. She further directed that the Clinical Review Teams be placed fully active. The first MCT training was done the fourth week in April and consisted of 30 facility employees who will in turn train all facility staff. All public facilities were represented. The training was excellent by all accounts, focusing on a wide variety of issues. We are awaiting a timetable for training to be completed for all facilities. All new hospital employees are to be trained. Commissioner Wachtel and her staff are to be commended for their commitment to addressing this issue.

Our long range plan is to return to the facilities and take another snapshot subsequent to completion of the training of all employees and take another snapshot. Our goal is elimination of disparities based on race and cultural background, along with heightened awareness of cultural issues among persons treating persons with mental illness.

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# Appalachians as a Cultural Group: Part II



Cris Brown

Understanding a culture requires gaining insight into the rituals of a culture. One such ritual, is the burial of a corpse. In life outside the mountains, loved ones are spared preparing the deceased for burial by a funeral service. The Appalachian culture still clings to the old ways of burial, in some families. Here are some areas to explore deaths of loved one which is a significant stressor and event in a person's life:

**Significant People in Defendant's Life Who Have Died** - Parents, brothers or sisters, grandparents, friends, neighbors, etc. Date of death? Cause of death.

Any premonitions, unexplained matters/dreams that portend the death, family signs that someone will die?

How they learned of the death.

What funeral home was used to handle the service, anything that they avoid during a funeral: looking into the coffin, going to the interment, etc.

Were photos taken of the deceased in the coffin?

If the client saw the death happen [*see section under traumatic event*] saw the person dead before ambulance arrived/hospitalization, visited the person in the hospital, prepared the corpse for burial, attended the wake/funeral.

Particularly note: death by abuse or accidental poisonings, farm accidents, drowning in floods, trailer fires, suicides, car wrecks, murders, shoot-outs with police or law enforcement officers.

Particularly note if client/family member was incarcerated and could not attend the service or interment.

Coffin open or closed, embalmed or not, type of casket, was the wake at the family home? Who stayed drunk during the days before burial?

Family problems over burial, property of the deceased, arguments after the death.

How often do they think of the dead person, do they have any mementos that particularly cause them to remember them? How often do they go to the grave?

Grieving process: length of time. Ability to mourn, family attitude toward death and illness. If the client's life changed in any way. Recurring dreams about the death/loved one.

Land disputes or lawsuits regarding the distribution of the deceased property or the land line.

Any regrets about things left undone or left unsaid.

## Exercise:

To demonstrate the kind of detail that can be given on a question or subject group in this screening device, what follows is a discussion of my personal experience with a "home" burial.

I heartily recommend that anyone who conducts interviews answer the social history questions yourself. Only then can you get an idea of the kind of detail that exists, versus the kind of responses you receive from persons you interview. Once you've done that, you will appreciate the detail, difficulty, and the time it will take for clients to begin telling their story—the life and times of the client.

When my brother, John, age 26, committed suicide in 1980, the day before my son's first birthday, I received word when the city police came to my door with a note to call home as there was an emergency. As we didn't have a tele-

phone, I used my Indian neighbor's phone to call home.

My brother, Charlie, told me that John had shot himself. I asked Charlie what hospital he was in, and then Charlie told me he was dead. My Aunt Loretta sent money for us to come home for the funeral as we were poor college students.

John shot himself at my Dad's house. Dad convinced the Kentucky State Police not to perform an autopsy. My mother kept insisting that my father had killed John. John was shot between the eyes like Dad killed the livestock we butchered for food. Dad refused to have John at a funeral home. Mom wanted to storm Dad's house and get the body. I told Mom that it didn't matter now.

As this was the first family member who had died in my family, I was very shaken. My husband was no comfort. He stated that my brother was better off dead, and he envied him.

My husband refused to stay at my mother's house, as he considered it too primitive. I was torn between hurting my mother, who needed me, and dealing with my husband. We stayed at my aunt's house. I had to care for my one year old son all the while, as, of course, my husband wouldn't.

I didn't grieve outwardly. I was numb. I couldn't sleep. I felt like a failure: "why couldn't my brother have turned to me or someone before he killed himself?" The irony of his having survived a horrible childhood, only to kill himself, stayed with me. I was angry at God. I felt guilty to be alive. I kept obsessing about what his last thoughts were before he pulled the trigger. The despair he must have felt when he pulled the trigger haunted me. I wondered if he felt pain. I wondered if he died instantly.

My brother, Bill, washed and dressed John in a brown suit for the coffin. The suit had been worn by various family members for formal occasions, most recently my baby brother's graduation from high school.

My Uncle, a carpenter, made the coffin hastily. My mother lined John's coffin with a satin material. Red, I believe.

Mom insisted on lilies for the coffin. My husband worked at the EKV Agricultural building and all we had were red roses. I tried several florists, but as it was late November I couldn't find any lilies. An aunt made a rose blanket spray for the coffin. I thought it was suitable for the coffin. Mom clearly wasn't happy with the roses, even though there were dozens of them.

On the evening of the day he died, a wake or the sitting up with the body, was held by the men of the community and family, some of whom drank, and got very drunk.

Due to rather warm conditions for November, John had to be buried immediately. John was buried unembalmed, as is our way, in the Brown family plot. The coffin was opened at the graveside. I ran to the opposite end of the graveyard with my back to the assembly, until my mother asked me to come and see John. I remembered thinking that if my mother could look down on the corpse of her son, I could do as she asked. That was one of the longest trips I have ever taken from the end of the graveyard to the coffin. Although I was loathe to see my brother horribly disfigured, I supported my mother as she said her good-byes. A small bandaid had been placed between John's eyes where the bullet entered. Bloody cotton was in his nose and ears. His eyelids and sockets were bluish, as were his lips and fingers. His folded hands weren't placed just so, and his legs weren't either, as the feet had splayed apart, but he wasn't disfigured as I had imagined. I kept waiting for him to move and open his eyes, but he didn't.

I came to understand why flowers were associated with funerals, aside from their beauty and meaning. Their scent covers the odor of death and decay. I can still remember the odor of his decaying body.

My family had the family pastor, Rev. Short, say a few words on the hoary morning, John was buried. My grandfather, who I had never seen cry, wept copiously. When the Minister began to weep and pray, my father, said to him, "Keep it short, Short." To my horror as I looked on, my father retrieved a handkerchief from John's suitcoat pocket, I thought to wipe some leakage, but instead he had planted the handkerchief on the body to use to interrupt the service and end it.

My brother, Bill, took a photograph of John in the coffin, as is common in Eastern Kentucky. I have forbade him from ever showing the photos to me.

John's final resting place was not coincidental. Years ago my great-grandmother had a dear friend of the last name, McClees, that wanting to wake up for the Resurrection with her, and so, she was buried in the Brown family plot. When the woman's daughter died, naturally, she wanted to be buried next to her mother. My father had the grave dug beside the "intruders," in order to prevent further burials of non-family members.

If you do as I suggest, you will realize that when you address a topic you are giving not just facts, you are giving feelings and the undercurrents. If the same information is drawn from the client, that will help you understand the client, and his rearing, and the meaning that he/she attaches to events that have occurred.

### Siblings

Part of your job in screening is to collect potential sources of information or witnesses, and record the means of contacting them. Family members are always important resources.

Prosecutors often point out through cross-examination that the siblings are all law-abiding citizens and haven't killed anyone. One of the tasks of the mitigation investigation is to answer the question, "Why this client, and not one of the other children?" Gaining an understanding of this requires looking at the favorite children of the family, who received support

from a family member, another adult, the school or any intervening person or entity in a sibling's life that validated the person and served as a support system for the sibling.

Matters to explore:

- Obtain a listing in order of birth full and half blooded siblings or taken-in children.
- Get the names of siblings, ages, the names of their spouses, addresses or phone numbers, and the names of their children.
- When they last visited, telephoned, wrote the client, if they have a history of alcoholism, or drug use, mental problems or "nerves," significant health problems.
- Find out if the client lived with them for any length of time, level of education, occupation, length of employment, were they in the service, criminal convictions? Any problems with the client, why?
- Are any of the children "lost," living on the street or have never been heard from in many years.
- Were any of the children thought to be by someone other than the father?
- Find out why if there are great age differences between the children;
- What was each child known for?
- Explore regarding any dead siblings.
- Ask about half-brothers and sisters, and if any children were adopted or taken-in.
- Find out who the client is closest to in the family and why.
- Were there any favorites in the family, comparisons made, conditional love; by father/mother; grandparents?
- If the client was the last child in family or if appropriate ask about babying of the client; (e.g. Communication style; calling older child "cute"; holding child on lap when too old; having the child sleep in the parent's bed.) Overprotectiveness or clinginess. Age inappropriate

(under or over) demands by the parents (e.g. regarding home chores, dressing).

- Parental expectations of the client- what did they want for the child: financially, future, career. Particularly any unreasonable expectations given the level of ability, opportunities available to the child or limitations.

## Home Life

### A. Quality of Life

Find out how many rooms the houses they lived in had. Did the houses have running water and an inside toilet; sleeping arrangements; allowed privacy, T.V. - how much T.V. did you watch, was that controlled?;

How were clothes washed and dried? Wringer type washer, clothesline, laundromat, relative, clothes hung around stove?

Method of heating - gas or electric, coal stove, wood stove, heat from oven, fireplace, kerosene heater? Were portions of the house closed up or unheated in the winter?

Method of cooking and preservation of food: wooden stove, open fire, portable stove, gas or electric, refrigeration, cold storage shed, underground cellar.

Did the family slaughter chickens, cows, lambs, and pigs, etc.? How did the client feel about that?

Food stuff: was there a lot of fat and sugar in your diet, did you eat mayonnaise/lard sandwiches, cornbread in milk, no breakfast, one meal a day and that always the same food. Poor nutrition, was the client a picky eater who did not eat garden vegetables.

Did the family practice any homemaking skills such as making butter, making soap, making baskets or containers, making brooms or tools, making of toys, making of meal from corn?

Any decorative utilitarian skills: quilt making, weaving, cornshuck crafts, horsehair brushes, etc.

Did the family take vacations - who went along, where did they go, Was it mostly to visit family in other states or counties of Kentucky?

How were summers when school was out spent? Hoeing corn, raising tobacco, berry picking, harvesting cash crops such as pickles, canning foods, working on the farm, hired out as hired help to others?

What did the family do for fun - recreational and shared family activities: fishing, picnicking, card playing, watching T.V. programs together?

Did the family go to the county seat for books or magazines, trips to library; or go the bookmobile, if read to;

What were bedtimes like? Was there a set bedtime?

Who did you most want to grow up to be like when you were a kid?

Isolation: living far away from others, far from children your own age, far from town or the road or at the head of a hollow. Having little contact with persons other than your immediate family.

Eccentricities of the family: Use of soap powder for shampoo, extreme thriftiness, doing things you later find out isn't the norm.

### B. Chores

Did the client and siblings have to work around the house and help out; what were their responsibilities, were any of them dangerous such as working with a machine or electricity, did they receive an allowance; were there nights you were kept up working, were there times when you were kept out of school to fence or find a stray animal, were the children paid to help out; were they required to serve the others in the family: were girls and mother required to wait until after the men had eaten to eat; were girls required to clean up after men, including their dishes, clothes, and sleeping quarters?

**Parent's Marriage:** How did the parents meet? How long did they date? Where were they married?

How many times had mother/father been married?

How would the client describe his parent's marriage, were they physically affectionate toward each other in front of the children;

Did the parents work as a team, communicate well, were they friends, take time to be alone, or trips, just they two?

Who was the disciplinarian? What was the division of labor like in terms of chores?

Extra-marital affairs. Other children somewhere.

Were the parents happy? Was one parent gone for any length of time. Any period when one or the other went home to their parents. Why?

Any male/female role reversal?

### C. Domestic Violence

Domestic violence occurs in one of four families as a regular occurrence. Fifty percent of all marriages have experienced at least one violent incident. Although domestic violence is not a class issue, my experience has been that most of the clients I have interviewed revealed a domestic violence background.

Violence was present in my family. There is fundamentally a view in Eastern Kentucky regarding the need to "myob" and not get involved in someone's family business, that married people "have a license to fight," a belief that men have dominion over women by Scripture, or other traditional views regarding male/female roles, and an apathy by local officials to the criminality of domestic violence. Not one time, did the police respond to calls regarding my father abusing my mother. There is a pattern of children who witness abuse growing up, solving problems with aggression as they have learned. There is a correlation between a loosening of inhibitions through drugs and alcohol and aggression. The abuser may excuse their violence as a result of being high or drunk.

There are many kinds of abuse: physical, sexual, financial and emotional. Some physical abuses are: locking a person out of the house, abandonment such as stopping a car and throwing a person out and driving away, refusing medical help for an illness, and subjecting a person to reckless driving. Some sexual abuses are: publicly showing interest in

another person, criticizing a person sexually, forcing sex acts that are unwanted, having sex when a person is just home from the hospital or sick. Some financial abuses are: harassing a person at work, destroying books, homework, clothing supplied by job, and making a person beg for money for necessities. Some emotional abuses are: refusing to socialize with a person, manipulating a person with lies and contradictions, and public or private humiliation.

Explore if there was any violence between the parents at any time, what that was about, specific instances. How did that make him feel; was there ever any gun play?, attempts to intervene. Level of violence, if it was greater at any time, did the children have to leave the home to escape the violence, go to an abuse shelter, did the mother ever retaliate or try to get the kids to retaliate? Were the police ever called? Did the Sheriff refuse to come to the home to intervene? Violence directed toward kid as well? Any adult aware of this violence, apartment manager, and if any complaints were filed with the police. Any State agency notified of the abuse?

Explore the documentation that might exist about incidents of violence. Who was aware of the violence? Who did the client ask to help? How badly was the parent hurt; ever require medical attention?

Was any relative aware of the abuse of their daughter, but refused to intervene as that was a woman's role to be beaten by her husband or not their business.

Controlling behaviors: excessive possessiveness, isolation geographical and from other people, controlling what mother wears - clothes, hairstyle, or makeup, who she sees, refuses to allow her to go to grocery store or church, takes mode of transportation away from her, locks her in the house or in a room, where she goes, times her absence, leaves marks or bruises so that she can't leave the house, goes with her everywhere, records mileage, questions everything she says or does.

Be aware that a parent may teach or enlist the children's help in abuse by undermining the parent's authority and by children also abusing the parent verbally, emotionally or physically. Boundaries are more permeable.

## **Divorce**

Did the parents separate or divorce, what was the reason for the divorce, was the divorce amicable, who got custody of the kids, did the other parent visit regularly, contact with other family members for mother and father/step-parents and their children after the divorce, did the parent pay the child support, did the parent give up parental rights to avoid paying support, did the divorce cause the client to lose contact with a parent, did the family's financial status change after the divorce. How did the client's life change?

### **D. Housing**

Did anyone else lived in the family home for awhile; get names, current addresses/phone number, relationship and details about what incidents that they might have witnessed, and how long they stayed with the family.

### **E. Alcohol/Drug Abuse**

Was there any alcohol (siblings, parents) or drug abuse (could be prescribed medicine) in the family;

Smoking of jimsonweed, which contains a narcotic poison; or any other herb.

Family history. Who in the family drank/used drugs?

Use of moonshine, drinking of other than ethanol such as shaving lotion, rubbing alcohol, over the counter cough or cold, medicine products, or fermented honey/ canned goods.

Frequency of drinking, problems when the parent drank.

Did anyone drink a bad batch of moonshine? Awareness of the ingredients in moonshine such as battery acid to increase potency of the moonshine. Loss of eyesight permanent or temporary due to bad moonshine.

### **F. Runaway**

Was there ever a time when the client ran away from home overnight, stay in a cave or cliff overhang? Did the client ever run away to avoid abuse? Did the client spend most of his time somewhere other than in the home? Stay

with his grandparents, aunts and uncles, etc. to run away from problems at home. Marry early, quit school and go to work early, and join the service at an early age to get away from a bad homelife. [Note when siblings did so, as well.]

### **G. Money**

Was the lack of money a problem at your house? Has the family ever moved to avoid paying rent? Been turned out of a house? Have you ever been sued for a bad debt or had things repossessed/bankruptcy?

Has the parent/sibling ever made money illegally - growing pot, stealing, criminal activities, prostitution, making moonshine or running moonshine or alcohol, selling drugs, cock fighting, dog fighting.

Cheating on welfare, not reporting father in the house, not reporting income, intentionally get pregnant to attempt to get married to father/for more money, buy goods with food stamps illegally such as cigarettes or liquor.

Did you help make money by collecting ginseng or bloodroot, pick up pop bottles or cans, etc. Ever been hired out as help, but receive no money as parent collected the money?

### **H. Homelessness**

Have you ever travelled around without a home or any regular place to live? Did you ever camp out all summer and winter. Live in a cave or cliff hanging. Live in a house that was abandoned. Live on the river. Stay with strangers. Leave the state and hitchhike. How did the client get by? Exposure to hunger, bad experiences, extremes of heat and cold, stay in missions/ flop houses? Prostitute self for money, food, warmth. Same sex/opposite sex, older man/ woman? Arrests for vagrancy/prostitution.

### **I. Discipline**

An interesting phenomenon has come up recently in several cases: Parents who force their kids to fight. While reading the newspaper, I saw an AP blurb on a Michigan couple who were placed in jail for making their twins, a boy and girl age 6, fight each other "to teach them a lesson about their constant quarreling."

[AP, *Lexington Herald-Leader*, June 26, 1996.] This discipline method quixotically attempts to teach them not to fight, by fighting. Another form of the known discipline taboo, "Don't do as I do, do as I say."

In my experience the favorite child of a parent is championed by the parent and egged on to beat up the weaker, sick child. Be aware of this phenomenon as you screen for family pathology.

Another common thread that runs through investigations I have undertaken is the parent who cannot admit their child has done wrong, and will not allow the usual consequences to take place to teach the child that they will be punished if they do wrong. An added feature to this parenting style is to keep their kids home most of the time to avoid confrontations that occur when someone, such as a teacher, corrects their child. These parents fight the battles for the child, give the message to the child that the other person was wrong, not the child, bail the child out when they get into trouble, and have fights, verbal or physical, with teachers and family members if they tried to correct the child or punish them.

Problems with power in the family, occur in families where a parent is weak, either through illness, depression or weariness. Younger children may be subjected to abuse by older siblings.

In families where the mother is absent or unavailable due to illness, an older daughter may take her mother's place in every sense of the word. It may be that the father turns to the daughter without the mother's knowledge or as sometimes happens, the mother assists the father and holds the daughter down and asks the daughter to submit to the father's sexual advances as he has needs the mother can not meet.

Ask the following questions:

Talk to the client about discipline and the differences between the way the mother or the father would discipline, if there are any times when the client left home because of discipline, thought about running away, parental overwhelmedness. Were there different rules for boys and girls in your family? Was the father/mother jealous of the children? Did they take

out anger that arose out of another situation on the children?

Role reversal where the child was a "little parent" to siblings or parent's caregiver.

Do parents or others in the household tease or harass the child? Frequency; terms; phrases; client's response: ignore/withdraw/complain to adults/tease back/physical fighting.

**Psychological Abuse.** Told lazy, stupid, incompetent, ugly, useless, would wind up in jail or the gutter. Called or said anything else that hurt? Humiliated for bedwetting, the way you talked, or looked.

When you were growing up, did you:

- Have an imaginary friend?
- Ever feel your parent (caretaker) was going to abandon you? Did (he/she) ever threaten to leave you?
- Ever fear for your life? Did anyone ever threaten to kill you? - Ever fear serious injury? Did anyone ever threaten to cut/mutilate/hurt you?
- Ever think about or attempt suicide?
- Describe incident(s). Find out what client did in response to these actions, feelings.
- Did anyone ever say things to you that were hurtful or embarrassing? Say things that made you feel worthless or different?
- Did you ever feel ignored or rejected?
- Did anyone ever take away or destroy something special of yours (e.g. pet, pictures)?
- Did anyone ever force you to be away from someone you loved for a long period of time? (*Get details*)
- Were you treated any differently from other children in your home? In your neighborhood? In your school? Shamed. Told that you were a bastard. Told by a parent that he or she wished you would die.

- When you were a young child, did anyone show you pictures or movies about sex? About violent murders?
- How old were you when you first used alcohol? Drugs? Did a parent (caretaker) give you any alcohol or drugs?
- Did anyone make you (as a child) do things you felt were wrong?
- Ever feel that you were mistreated.

**Physical Abuse.** Ask if adult/caretaker ever did any of these things to the client as a child (and get description of incident(s):

- eye injury
- appropriate medical treatment not sought
- slap, claw, scratch
- hit with fist or object (e.g. - belt, cord)
- burn
- twist arm, leg or neck
- hair pulled
- kick
- thrown bodily
- strangled/choke
- object thrown at
- locked in a closet or other place
- dunked, tried to drown
- tied up
- threatened with knife or gun
- used knife or gun
- burnt by cigarettes
- made to eat hot foods
- electrical shocks

Ask if client (as a child) ever saw an adult do any of the above things to another child or adult. Get description of the incident(s).

Always find out:

- Who was the perpetrator; relation to the child
- If anyone witnessed the situation; get confirmation from witness if possible
- What did the client do after acts of maltreatment;
- Who could he (she) tell; if he (she) told, what did the person do? Who could he (she) turn to for help?

- Source of resilience: social support, self-esteem
- Ask about what usually happened when the client got into trouble at home as a child... as a teenager.... What was the worst thing that ever happened when he/she was in trouble?
- Ask about what usually happened when the client got into trouble at school (or residential institution or other setting according to the social history). What was the worst thing that ever happened when he/she was in trouble?

For every incident that is described that suggests use of physical force against the child, find out:

- Was he/she injured? Any marks, broken bones? Medical attention given? Look for scars, medical records.
- How frequent was the use of such force? (e.g. daily, weekly, monthly)

**Sexual Abuse.** By anyone, playing doctor, approached by a sibling because you slept in the same bed, had an older sibling expose him or herself to you, forced to perform sexual acts, such as cunnilingus or fellatio, other family members, state intervention. Had a neighbor touch you or expose himself to you.

Been exposed to animals breeding by an adult who forces you to watch, seen a human have sex with an animal.

Knowledge of a minister's sexual escapades with church members, approach by a church member, or deacon in a sexual manner.

Shown photographs, books, movies, or sexual materials of any kind. Videotaped or photographed nude.

Invasions of privacy by coming into bathroom when bathing, or performing bodily functions, bedroom when changing, peeping, etc. Comments on developing body: nipples, periods, etc.

Incidents where the client sexually abused someone, forced into sexual behaviors.

Always find out:

- Who was the perpetrator; relation to the child
- If anyone witnessed the situation; get confirmation from witness if possible;
- What did the client do after acts of maltreatment;
- Who could he (she) tell; if he (she) told, what did the person do? Who could he (she) turn to for help?
- Source of resiliency: social support, self-esteem;
- Has anyone ever tried to touch you or fondle you in any way that you didn't want to be touched?
- Has anyone ever tried to have you touch/fondle them against your will?

- Has anyone ever tried to have sexual intercourse with you against your will? Get description.
- Find out if it was anal, oral, genital, whether penetration occurred.
- Was force or threat of force used?
- How many times did it happen?
- Did anyone else try to do this?

Ask if client (as a child) ever saw an adult do any of the above things to another child or adult. Get description of the incident(s).

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**George Sornberger**

## Preliminary Hearings



**John Niland**

The preliminary hearing may very well be the most important stage of your client's criminal proceeding. It will likely be the first opportunity that you have to question the prosecution's witnesses under oath. More importantly, it is a powerful "reality check" for your client. Oftentimes your client is still in denial about the severity of his or her situation. However, once the first police officer takes the stand and presents testimony about the arrest, your client may develop a better appreciation of the seriousness of the matter. It is an opportunity to educate the defense team, your client and your client's family about the nature of the charges and the relative strength of the prosecution's case. And just like the previews of coming attractions at the theater, it gives us the highlights of the events that lie ahead. The preliminary hearing is also a forum to make motions for immediate relief such as NOTICE TO PRESERVE PHYSICAL EVIDENCE or REQUEST TO INSPECT CRIME SCENE, as well as set-

ting up issues such as the right to a SEPARATE TRIAL in cases with multiple defendants.

Armed with a *subpoena* you can now compel testimony and require the production of records. As far in advance of the hearing as possible issue *subpoena duces tecum* for the records you want to see such as insurance company reports, phone records, ER and other medical records, photographs and test results. You can attach a letter to your *subpoena* explaining that the records custodian may or may not be called as a witness on the day in question, and that the *subpoena* may be complied with by furnishing true copies of the documents to you, with the witness "on call." Always explain that if they prefer they can actually appear in person with the originals. Most people are happy to give you the copies as long as they have the *subpoena* to cover them.

The following suggestions will help you in the preparation for the hearing. Some will be ob-

vious, but are often overlooked. The preliminary hearing can expose fatal weaknesses in the Commonwealth's case. Your interrogation of the prosecution's witnesses can set the tone for future relations with that witness and can serve as an impeachment tool at trial. The testimony can preserve favorable evidence from a witness who is later unable to appear. The preliminary hearing transcript will assist you in trial preparation. See **RCr 3.16** concerning your right to secure a copy of the tape or recording of the hearing. Also, the preliminary hearing can assist you in making effective arguments such as the necessity for early psychiatric examination or identifying areas early on where you will need expert assistance. In your *ex parte* application for funds you can cite to the testimony at the preliminary hearing in support of your requests.

### Time Frame

You are entitled to a preliminary hearing within 10 days of arraignment if your client is in custody, or 20 days if free on bond. See **RCr 3.10**. Don't waive these time periods unless you need more time to investigate the case and you know that your client can make bond and that the Grand Jury won't be meeting in the meantime. Be extra careful in the high profile case where the prosecution may convene a Special Grand Jury or a special session of the regular Grand Jury. But see **KRS 29A.220**. Don't waive the hearing unless you get something very good in return. Consider waiving only the time requirements (10 or 20 days), assuming that the Grand Jury will not meet in the meantime and if they will lower the bond to something the client can make. Otherwise make them conduct the hearing within 10 days. See **RCr 3.10(2)**. Your client **SHALL** be discharged from custody if the preliminary hearing is not held within the prescribed time limits.

### Confrontation

See *California v. Green*, 399 U.S. 149, 90 S.Ct. 1930 (1970) and **RCr 7.22** on the issue of whether the preliminary hearing testimony of an unavailable witness is admissible at trial.

Section 11 of the Kentucky Constitution and the Sixth Amendment to the United States Constitution require an accused to have the right to confront his witnesses face to face. However, in *Ohio v. Roberts*, 448 U.S. 56, 100 S.Ct. 2531, 65 L.Ed.2d 597 (1980), the United States Supreme Court held it proper to allow

the prosecutor to introduce at preliminary hearing testimony of an unavailable witness at the defendant's trial. The witness had been subject to cross-examination by defense counsel at the preliminary hearing, and therefore no Sixth Amendment violation was present. In *Commonwealth v. Bugg*, 514 S.W.2d 119 (Ky. 1974), the Kentucky court ruled that the prior transcribed testimony of a witness, now deceased, which was given under oath at an examining trial, subject to cross-examination, in a lower court, was not admissible as evidence in chief at the trial of the defendant in the Circuit Court without the defendant's consent. In reaching this result, the court construed **KRS 422.150**, **RCr 7.20**, and **RCr 7.22**.

### Preparing for the Hearing

(1) Talk to the client to find out who to subpoena.

(2) Get a copy of the Citation, Complaint and Warrant. Read the complaint that forms the basis of the warrant. Check with the County Attorney and see if he required the alleged victim to sign any other information sheets or affidavits prior to taking the complaint. Look for any discrepancies between this and any other statements made by the alleged victim prior to the preliminary hearing.

(3) Subpoena police officers and try to get all of them to testify at the preliminary hearing. Your judge may not let you go that far, but you may very well find that each police officer tells a different story. In any event, this will probably be one of the only times that you will be able to get their testimony under oath. There is no substitute for a thorough investigation prior to the preliminary hearing and the development of the theory which you can carry through the preliminary hearing to trial. This is particularly important if you have issues that could be the subject of pre-trial motions to suppress. Check with the Clerk to see if there is a record of any applications for search warrants and any returns. Oftentimes such records are maintained in a separate file. This will help you understand what your suppression issues will be. You can try to elicit testimony that will help at a later suppression hearing. You should also ask questions designed to find out what evidence was seized and where. Such issues might be:

A. Was there a bad search?

B. Can you suppress any statements that your client may have given? *Miranda* issues? Was the client denied the right to counsel? Statements taken after he/she requested counsel?

C. Are there chain of custody issues?

D. If the investigation began with a misdemeanor offense, was it committed in the officer's presence?

But see **RCr 3.14(3)** which states that motions to suppress evidence must be made in the trial court and are not properly made at the preliminary hearing. So you are developing testimony to be used later in conjunction with **RCr 9.78**.

(4) Get the name of all the officers who participated in the investigation. Ask if the investigation is still open, and if so, what aspects of the case are still being investigated. Determine which officers prepared reports and whether the witness has a copy.

(5) Question the officer about the name, address and phone number of each civilian witness and whether or not any written or recorded statements were obtained. See **RCr 7.26**.

### **The Preliminary Hearing and Your Client**

It is important to explain the preliminary hearing procedure to your client. He or she will want to know why you are soliciting all that damaging information, why you are asking the police officer for a list of all of the people who will say that your client is guilty and why neither the client nor other family members are going to testify, why the Judge made a decision in a relatively short period of time. The client should be made aware that the preliminary hearing is designed primarily to determine probable cause and that generally it is not in his best interest to put on your evidence at a preliminary hearing. Usually it will not change the Judge's mind, but will merely tip off the prosecution as to what your theory of defense will be and will give them an opportunity to perhaps impeach your witnesses at a later date with prior inconsistent statements. Bring in supporters - especially members of your client's family - for the hearing. This provides an excellent opportunity to meet and evaluate your client's friends, neighbors and relatives while at the same time showing the public and Court participants that there is support in the community for your client.

This is a real opportunity for your client to watch you work in the courtroom. But make sure your client and his family understand why the preliminary hearing is not the time for Mom to be an "alibi witness."

### **Challenging Probable Cause**

The preliminary hearing is a determination of whether "...there is probable cause to believe that an offense required to be prosecuted by indictment pursuant to Section 12 of the Kentucky Constitution has been committed and that the defendant committed it..." **RCr 3.14 (1)**. To find out information relevant to this determination, you should not be afraid to ask those open-ended questions that you would never ask during a trial. You might ask:

- ◆ Was there a line-up or other identification procedure?
- ◆ Was anything taken from your client such as hair, blood or clothes?
- ◆ Were any tests performed (*i.e.*, gunshot residue tests?)
- ◆ Who are the other suspects they considered?
- ◆ Was any information obtained from a confidential informant?
- ◆ Did this officer ever have any prior contact with or knowledge of your client?
- ◆ Can the witness remember anything else important about what they heard, saw, said or did?
- ◆ What do they believe really happened?
- ◆ What do they believe was the motivation for this incident?
- ◆ Does the witness believe anyone else shares responsibility with your client for what occurred?

You want to hear all of the evidence, especially the bad, against your client so that you might properly prepare for it or have an opportunity later to explain it away. A typical question might be "What other evidence did you find that suggests my client was involved?" Certainly there is a place for the closed-ended questions that we typically use in cross-examination when you are trying to pin down a prosecution witness to help your theory. You can use the preliminary hearing to close some doors with a question such as "And there was no evidence of drug use, correct?" In addressing whether a person was entitled to counsel at the preliminary hearing, *Coleman v. Alabama*, 399 U.S. 1, 90 S.Ct. 1999, 26 L.Ed.2d 387 (1970) identified tasks of counsel at the hearing to insure against an "erroneous or improper pro-

secution": "the lawyer's skilled examination and cross-examination of witnesses may expose fatal weaknesses in the State's case that may lead the magistrate to refuse to bind the accused over. Second, in any event, the skilled interrogation of witnesses by an experienced lawyer can fashion a vital impeachment tool for use in cross-examination of the State's witnesses at the trial, or preserve testimony favorable to the accused of a witness who does not appear at the trial. Third, trained counsel can more effectively discover the case the State has against his client and make possible the preparation of a proper defense to meet that case at the trial. Fourth, counsel can also be influential at the preliminary hearing in making effective arguments for the accused on such matters as the necessity for an early psychiatric examination or bail." *Id.* at 2003.

### Conducting the Hearing

After you have properly prepared, and explained the preliminary hearing procedure to your client, the hearing will begin. The first thing to do is invoke the rule, sequestering the witnesses (**RCr 9.48**). This is also helpful because then the prosecution's witnesses will parade through the courtroom into a room off to the side of the Court and you have an opportunity to see who they might call. Make mental note of who these people are. If you don't know them, you might think about asking the first witness who the other people are so that you might call them yourself if the Commonwealth decides not to call them during the preliminary hearing. This will give you an opportunity to find out what they are going to say. Again, they will be under oath. You should have a good idea who they are because a good practice is to check the clerk's office the afternoon before, or the morning of, the preliminary hearing to see what subpoenas have been issued and returned.

### Evidentiary and Statutory Considerations

Remember that the Kentucky Rules of Evidence do not apply to preliminary hearings (**KRE 1101**). You can expect hearsay and should even encourage it, as this will lead to the names of other witnesses that may have relevant information and who you might be able to interview later on. So don't hesitate to ask what others said or know. Prior to the hearing, make a list of the elements of the offense and check those off as the testimony

comes in. Should the Commonwealth be unable to offer any testimony on an element, move the Court to find that no probable exists and dismiss the complaint, or if the evidence does not establish an element that would require the matter to be heard by a Grand Jury, move that it be kept in District Court. If you are looking for something specific, or if you feel like there is a specific weakness in the Commonwealth's case, you might consider advising the District Judge ahead of time and say, "Judge, I'm looking for something here and here's the case or statute supporting it." There is nothing more upsetting than to be at a critical stage of the preliminary hearing where the Commonwealth witness is testifying that the stolen item was valued at TWO HUNDRED Dollars (\$200.00) and, with glee, you look toward the District Judge and he is signing some Domestic Violence Orders and misses the point entirely. Judges want to look good, just like lawyers do, and if you give them the opportunity to do so, they will appreciate it and generally return the favor. Also, don't overlook pertinent statutes. For example, see **KRS 500.050(4)**, setting forth the requirement that allegations of deviate sexual intercourse or sexual intercourse by the other spouse shall not be prosecuted unless formally reported to the police within one year after the commission of the offense with a report signed by the alleged victim.

### Working with Your Judge

What should you do if the Judge cuts you off and says, "Counsel, I have found probable cause and we will terminate the preliminary hearing at this point"? Remind the Judge that pursuant to **KRS 3.14(2)**, we have the right not only to cross-examine the witnesses, but to present evidence. *Cf. Kuhnle v. Kassulke*, 489 S.W.2d 833, 835 (Ky. 1873) ("...appellant should have been permitted to examine the chief prosecuting witness at the hearing to reduce bail to the extent that the object of such an examination had any relevant bearing upon" pretrial release factors.) Therefore, the issue of what is probable cause is a malleable concept. It may appear to be probable cause at one point, but with the opportunity to continue the hearing and offer additional evidence or further weaken the Commonwealth's case, you might be able to change the Judge's mind. In any event, if you are cut off at this stage, it is always nice to be able to tell a jury, if the case goes to trial, that you tried to ask the witness about a particular issue or you tried to offer

evidence at the preliminary hearing, but were prevented from doing so. In an appropriate case, follow up this with a request to present evidence to the Grand Jury. **RCr 5.08**. If you are denied again, you can tell the jury at trial that you tried on two separate occasions to offer evidence. See *U.S. v. King*, 482 F.2d. 768 (D.C. Cir. 1973), on the issue of evidence that tends to negate the showing of probable cause. See **RCr 3.14(2)** and note what it says and what it doesn't say. It states in part that the "...defendant may cross-examine witnesses against him and may introduce evidence in his own behalf." It **does not say** "... until the Judge finds probable cause." Argue that you have the right to challenge, to explore, and to test the probable cause.

Naturally, since **3.14(2)** gives you the right to introduce evidence, is the Judge's failure to allow you to exercise that right reversible error? We believe before an Appellate Court will make a determination on that issue, you will need to make an avowal and if the Judge knows that you're going to put on evidence by way of avowal, you're going to take up more time than you would if he had let you go through with it in the first place. Accordingly, this may be a way of letting him know that you will not be denied and he may very well give in, in order to save time in the long run.

### Another Bond Review

An important aspect of the preliminary hearing is the opportunity for the Court to reconsider your client's bond if he or she has not been able to make the bond after arraignment. It is usually a good time to renew your motion for bond, particularly if the evidence is weak. You may elicit testimony that might help you on the bond issue. It could be a good opportunity to have a family member testify on behalf of your client as to those issues that are relevant to reduction in bond. Having the client testify is generally not a good idea at this point, but family members can usually offer the same information.

It does little good to ask a judge to reduce bond if you don't know what you can make. Accordingly, it is important to talk to the defendant's family members ahead of time and find out what he or she has to make bond. If property is the only possibility, make sure that you have done several things ahead of time to make the process go smoother.

A. Talk to the Pre-trial Release Officer and find out how many points your client has. Eight points or better and you are eligible for a reduced bond.

B. If someone will put up some property for your client, make sure that they have the assessment from the PVA Office and a copy of their deed and that all grantees on the deed are available to sign. Make sure that you know what the equity is after reducing the PVA assessment by any outstanding indebtedness. A cash or property bond will require twice the amount of property as cash, so keep that in mind when asking the judge to reduce to a specific amount. If property is not available and your client does have access to some cash, consider "raising the bond" by asking the judge if he would modify the bond to 10% of a larger cash amount. In other words, if the bond is set at \$5,000.00, and your client has \$1,000.00, ask the Judge to consider making it 10% of \$10,000.00, perhaps along with some non-financial conditions, such as no use of drugs or alcohol, stay away from the victim, etc. Make sure to advise the client of **KRS 431.530** that allows the clerk to keep 10% of the cash deposited on a 10% bond.

You can ask the County Attorney what bond he might be comfortable with and get his agreement ahead of time. The Judge is not likely to refuse to modify the bond if the County Attorney is agreeable. Be creative with the non-financial conditions that may satisfy the Court. Make sure that the bond decision form is signed and taken to the clerk as soon as possible so that the clerk can prepare the papers for your client's signature.

### To Waive or Not to Waive

The preliminary hearing should not be waived, except in very limited circumstances. While as a general rule counsel is cautioned against waiving, there are some additional factors to be considered. You may have noticed a mistake in the charging documents that is likely to be repeated in the Indictment unless it is caught and corrected by the prosecutor or the Judge during the preliminary hearing. There may be a situation where you have a high profile case and you want to minimize publicity. You may not want to preserve damaging testimony that might not be available to the Commonwealth later on. And sometimes waiving the hearing is the only way to get your client out of jail. But this will be a hollow and short-lived victory if

your client is likely to have a bond set on the Indictment that can't be made. Also, in some cases, waiving the preliminary hearing may be a means to get a whole "package" of charges including both felonies and misdemeanors sent up together for Grand Jury action and you may know that your Commonwealth Attorney will not prosecute the misdemeanor charges. And before you waive a preliminary hearing in order to get expedited discovery, ask yourself if you are really getting anything other than the information you'll get shortly in Circuit Court anyway. Most of the time having the hearing will be far more beneficial than waiving in exchange for those reports.

Don't overlook the fact that if you regularly conduct extensive preliminary hearings on your cases, and the County Attorney and the District Judge know you are willing to spend the time it takes to do them properly, you will be approached on many occasions with an offer to reduce the charges to misdemeanor level in order to avoid the hearing.

#### **Educating Your District Judge and County Attorney**

When you are denied a meaningful hearing, you can begin to set in motion certain forces that will eventually bring your District Judge or your County Attorney around.

When you give notice under **RCr 5.08** of your desire to present evidence to the Grand Jury, put the blame where it belongs. (In your cover letter to the Commonwealth Attorney, let them know that you tried to present this evidence at the preliminary hearing but you were cut off by the Judge or prosecutor, etc. And send the offending party a copy of the letter.)

File a motion under **RCr 3.10(3)** asking to join with the Commonwealth Attorney in their demand for a preliminary hearing. Set forth how you were prevented from presenting that evidence at the preliminary hearing. Put the blame where it belongs. Argue why it would benefit the Commonwealth to have it. Send a copy to the offending party.

When you file your **MOTION FOR BILL OF PARTICULARS**, argue in the motion how you tried to obtain this information from the witness when they were testifying at the preliminary hearing but you were prevented from doing so by the Judge or prosecutor. Send a copy to the offending party.

At some point your Circuit Judge and/or Commonwealth Attorney is going to have a discussion with the County Attorney or District Judge.

#### **How Being Turned Down Can Make Things Look Up**

Excerpt from your **FINAL ARGUMENT**:

"You know, men and women of the jury, you are the very first people to hear our evidence with any power to do something with it.

We tried to present this evidence to the District Judge at a preliminary hearing, **but the Commonwealth objected.**

We tried to present this evidence to the Grand Jury when they were considering whether to accuse my client of this crime, **but the Commonwealth objected.**

But the prosecutor couldn't keep the truth away from you any longer, and now finally, our side has been heard and justice will prevail."

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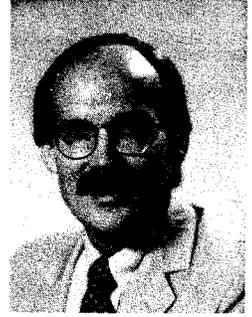
*The authors would like to acknowledge the invaluable assistance of the Hon. David Zahniser in the preparation of this article and pay tribute to the memory of Hon. Frank E. Haddad, Jr., whose outline on "Preliminary Hearings In Kentucky" formed the underpinnings of this endeavor.*



All cruelty springs from weakness.

- Seneca (4 B.C. - A.D. 65)

# Plain View



**Ernie Lewis**

***Whren and Brown v. United States***,  
116 S.Ct. 1769, 135 L.Ed.2d 89 (1996)

***Ornelas v. United States***,  
116 S.Ct. 1657, 134 L.Ed.2d 911 (1996)

***United States v. Weatherspoon***,  
82 F.3d 697 (1996)

***United States v. Bates***,  
84 F.3d 790 (1996)

***State v. Hendrickson***,  
917 P.2d 563 (Wash. 1996)

***Maryland v. Wilson***,  
664 A.2d 1 (Md. 1995)

***Commonwealth v. Stoute***,  
665 N.E.2d 93 (Mass. 1996)

***People v. Fernengel***,  
549 N.W.2d 361 (Mich. 1996)

***State v. Huddleston***,  
924 S.W.2d 666 (Tenn. 1996)

***Whren and Brown v. United States***,  
116 S.Ct. 1769, 135 L.Ed.2d 89 (1996)

The United States Supreme Court has issued a long-awaited opinion on pretextual stops. In a unanimous opinion written by Justice Scalia, the Court rejected the argument that a court should look at whether a police officer has stopped a person with an ulterior motive in mind. Rather, the Court held that where an officer has probable cause to believe that some crime has been committed, he may stop the person.

This case arose out of a routine traffic stop in Washington, D.C. Two young black men were in a Pathfinder parked at a stop sign. Police officers faced the other direction. The Pathfinder sat at the stop sign for 20 seconds, turned without signalling, and pulled off at an unreasonable rate of speed. They were later stopped, and plastic bags of crack cocaine were seen in the driver's hands. A motion to suppress was overruled. The Court of Appeals affirmed, holding that "regardless of whether a police officer subjectively believes that the occupants of an automobile may be engaging in some other illegal behavior, a traffic stop is permissible as long as a reasonable officer in the same circumstances could have stopped the car for the suspected traffic violation." 53 F.3d 371 (C.A. D.C. 1995).

The Court first considered three different proposed standards. First, Petitioners urged the Court to consider "whether a police officer, acting reasonably, would have made the stop for the reason given." The Court considered what it viewed as Petitioner's unstated standard, that being whether the police officer had a pretextual motive for making the stop. Finally, the Court looked at the so-called objective standard, whereby a stop is legal if there was prob-

able cause to believe that any violation had occurred.

The Court came down unanimously on the side of the objective standard. The Court analyzed past decisions, and found that they had repeatedly rejected a holding that an "officer's motive invalidates objectively justifiable behavior under the Fourth Amendment." "Subjective intentions play no role in ordinary, probable-cause Fourth Amendment analysis."

The Court specifically relied upon *United States v. Robinson*, 414 U.S. 218 (1973), where the Court "held that a traffic-violation arrest (of the sort here) would not be rendered invalid by the fact that it was 'a mere pretext for a narcotics search,'...and that a lawful post-arrest search of the person would not be rendered invalid by the fact that it was not motivated by the officer-safety concern that justifies such searches."

The Court rejected Petitioner's effort to have the Court engage in balancing the interests of law enforcement with the rights to privacy. The Court states that where probable cause exists, by definition that factor "'outbalances' private interest in avoiding police contact."

Significantly, the Court agreed that where selective enforcement of the law exists "on considerations such as race" that one arrested is not without recourse. Under such circumstances, the one arrested could use the Equal Protection Clause rather than the Fourth Amendment.

Interestingly, three traffic violations were made out. One violation was for failing to give "full time and attention to the operation of the vehicle." Another violation was for turning without "giving an appropriate signal." A third violation was for speeding at a speed "greater than is reasonable and prudent." One can readily see the potential for misuse of provisions such as these.

Yet, the Court was not impressed with this argument. "[W]e are aware of no principle that would allow us to decide at what point a code of law becomes so expansive and so commonly violated that infraction itself can no longer be the ordinary measure of the lawfulness of enforcement."

This is at the heart of what defenders know is the problem. If police officers can pull over any person for a traffic violation and articulate that probable cause existed for the stop, then the Fourth Amendment analysis will end at this point. We have seen all too much racism and other arbitrariness in law enforcement over the last few years. This opinion puts blinders to that racism over the eyes of judges. It gives free rein for the cop on the beat to pull over Black and Hispanic drivers, to stop black kids in neighborhoods, and to have virtually free rein over the "undesirables" in our society. And the Fourth Amendment will have nothing to say about that.

Section Ten is not affected by this. Yet. It is up to us to assert that while the Fourth Amendment cares little about pretextual stops, Section Ten must.

***Ornelas v. United States***,

116 S.Ct. 1657, 134 L.Ed.2d 911 (1996)

The United States Supreme Court has issued a significant 8-1 opinion penned by the Chief Justice establishing the standard of review for appellate courts reviewing probable cause and reasonable suspicion. "We hold that the ultimate questions of reasonable suspicion and probable cause to make a warrantless search should be reviewed *de novo*."

The facts of the case were not in dispute. Essentially, the Milwaukee Police found suspicious a 1981 two-door Oldsmobile with California license plates located in a motel parking lot. They investigated, and found out that the car was owned by either Miguel Ledesma Ornelas or Miguel Ornelas Ledesma. Ismael Ornelas had registered at 4:00 a.m. in the motel. The police staked out the car, and eventually confronted the defendants when they left their room. They defendants consented to a search of the car. One officer found a loose panel near the right rear passenger armrest, searched and found two kilos of cocaine.

After arrest, the defendants challenged their seizure of the cocaine, and thereafter entered conditional guilty pleas. The district court overruled their suppression motions, and the 7th Circuit found no "clear error."

The issue considered by the Court was a narrow one. What standard should the Seventh

Circuit have used when considering the actions of the district court. Should the decision of the court have been affirmed if no clear error was found? Or should the decision be reviewed *de novo*?

The Court held that independent appellate review should occur. This was based primarily upon the fact that the reviewing court is looking at a mixed question of law and fact, and not solely a factual question. The Court also wanted consistent determinations of search and seizure issues, which could best be accomplished through independent appellate review. Finally, the Court wanted to ensure that the law enforcement community received unambiguous instruction on search and seizure law. One wonders the effect of this opinion on RCr 9.78, which states that after the trial court in a Kentucky case resolves "the essential issues of fact raised by the motion or objection and necessary to support the ruling...If supported by substantial evidence the factual findings of the trial court shall be conclusive." Appellate counsel should explore using this opinion to require the appellate court to give less deference to the findings of fact of the trial court.

An interesting part of the decision is the preference expressed for searches conducted pursuant to a warrant. "The Fourth Amendment demonstrates a 'strong preference for searches conducted pursuant to a warrant,'...and the police are more likely to use the warrant process if the scrutiny applied to a magistrate's probable-cause determination to issue a warrant is less than that for warrantless searches. Were we to eliminate this distinction, we would eliminate the incentive."

In sum, the Court held that "determinations of reasonable suspicion and probable cause should be reviewed *de novo* on appeal. Having said this, we hasten to point out that a reviewing court should take care both to review findings of historical fact only for clear error and to give due weight to inferences drawn from those facts by resident judges and local law enforcement officers."

Justice Scalia dissented, saying that requiring *de novo* review of reasonable suspicion and probable cause determinations would have little benefit.

***United States v. Weatherspoon,***  
82 F.3d 697 (1996)

The issue in this case is succinctly stated in the opinion written by Judge Jones, and joined by Judges Nelson and Norris: "If, after police officers have made a lawful stop of a motor vehicle, one of the officers looks through the car's windshield and sees the barrel of a gun that the driver has just placed under the front seat, may the weapon be seized without a warrant?"

In this case, the Shelby County, Tennessee police pulled over the accused after noticing a left tail light that was not working. Weatherspoon was asked to get out; one officer checked his driver's license, while the other officer shined his flashlight through the windshield. The flashlight revealed the barrel of a pistol under the seat. Weatherspoon was arrested, and the officer searched the car, finding another weapon. Weatherspoon was initially charged with the Tennessee misdemeanor of carrying a firearm with the intent to go armed. Thereafter, Weatherspoon was charged in federal court with being a convicted felon in possession of a firearm shipped in interstate commerce. After his motion for suppression was overruled, he entered a conditional guilty plea and was sentenced to 57 months in prison.

The Court's analysis of these facts was simple. First, the Court found that the car had been pulled over legally. Using *Texas v. Brown*, 460 U.S. 730 (1983), the Court found further that the officer had a right to shine his flashlight into the car. Upon seeing the gun, the officer had a right to ask the defendant why he was carrying a weapon. When he stated that he was looking for the people that had stolen the fender skirts from his car, the police had probable cause to believe that a crime was being committed. As a result, the decision of the district court overruling the motion to suppress was affirmed.

***United States v. Bates,***  
84 F.3d 790 (1996)

The Sixth Circuit has issued an important decision exploring the recent knock and announce requirements of *Wilson v. Arkansas*, 115 S.Ct. 1914, 131 L. Ed. 2d 976 (1995). That case, for the first time, held that police officers, absent exigent circumstances, were required to knock

and announce their presence prior to executing a search warrant.

In this case, the Memphis Police Department had evidence from an informant that certain individuals were selling cocaine, that they were expecting a major cocaine shipment, that they barricaded their door, and that they kept a handgun on the refrigerator. A warrant was obtained. In executing the warrant, the officers used a battering ram to knock down the front door, while other officers entered the apartment through a window in the back.

In a decision written by Judge Keith and joined by Judges Nelson and Siler, the Court held that the search and seizure of the apartment was violative of the Fourth Amendment. It was clear that *Wilson* had been violated. The only consideration was whether exigent circumstances existed.

The Court first considered the presence of a weapon. In order for this exigent circumstance to exist, the government had to prove "that the suspect was armed and likely to use a weapon or become violent." Because "nothing in the record indicating anyone inside the Apartment was dangerously armed and prone to violence," this exigent circumstance failed.

The Court next looked at the possibility of the destruction of evidence as an exigent circumstance. Here, 15 kilograms of cocaine was involved. The standard was whether the government had a "reasonable belief that the loss or destruction of evidence [was] imminent." The Court found that this circumstance failed because "it is unreasonable to think that fifteen kilograms of powder cocaine could be quickly disposed of by flushing it down the toilet or dumping it down the sink drain."

Finally, the Court held that barricading the front door did not create an exigent circumstance. The Court reasoned that because the police planned to enter the apartment through a rear window while the front door was being rammed, that again the fact that the front door was barricaded did not create an exigency negating the knock and announce requirement.

## The Short View

1. *State v. Hendrickson*, 917 P.2d 563 (Wash. 1996). The defendant, while on work release, was charged with trafficking in cocaine. His truck was seized for forfeiture purposes, inventoried, and nothing found. Thereafter, based upon a tip, the police searched the truck without a warrant, and found cocaine. The Washington Supreme Court held that under these circumstances, the warrantless search of the truck was a violation of both state and federal constitutions. The Court explicitly rejected a number of federal cases holding that once a vehicle is seized for forfeiture purposes, that it may be searched thereafter without a warrant.

2. *Maryland v. Wilson*, 664 A.2d 1 (Md. 1995). The United States Supreme Court has taken *cert* on an important search and seizure case. They have agreed to decide whether a police officer making a lawful stop can legally require the passenger to get out of the car. This would be an extension of *Pennsylvania v. Mimms*, 434 U.S. 106, 98 S.Ct. 330, 54 L.Ed.2d 331 (1977).

3. *Commonwealth v. Stoute*, 665 N.E.2d 93 (Mass. 1996). The Massachusetts Supreme Judicial Court has held that the definition of seizure found in *California v. Hodari D.*, 499 U.S. 621 (1991) will not be followed in Massachusetts. The Court instead held that under article 14 of the Massachusetts Declaration of Rights, the test would be whether a reasonable person would have felt free to leave under the circumstances. "Were the rule otherwise, the police could turn a hunch into a reasonable suspicion by inducing the conduct [flight or the abandonment of potential evidence] justifying the suspicion."

4. *People v. Fernengel*, 549 N.W.2d 361 (Mich. 1996). The Michigan Court of Appeals has held that the *Belton* rule allowing for a search of a vehicle incident to a lawful arrest does not apply to a situation where an accused leaves his car and is arrested some distance from the car. "The confrontation with the police in this case did not occur until defendant had voluntarily left the van and was twenty to twenty-five feet away from it. Therefore, the search was outside the scope of both *Belton* and *Chimel*."

5. *State v. Huddleston*, 924 S.W.2d 666 (Tenn. 1996). The Tennessee Supreme Court has put some teeth into a violation of the 48 hour rule of *Riverside County, Calif. v. McLaughlin*, 500 U.S. 44 (1991). Where the defendant was arrested on Friday afternoon, and confessed on Monday without being taken before a magistrate, suppression of the confession was the appropriate remedy. "Ignoring the requirements of *McLaughlin* is functionally the same as making warrantless searches or arrests when a warrant is required. In both situations, law enforcement officials act without necessary judicial guidance or objective good faith. The cost of applying the exclusionary sanction to a violation of *McLaughlin* is that evidence obtained as a result of the illegal detention will be suppressed. The bene-

fit is the same as that obtained from the application of the exclusionary rule to certain warrantless arrests. It will deter law enforcement officials from ignoring the Fourth Amendment mandate of a judicial determination of probable cause... Violation of *McLaughlin* can be easily avoided and applying the exclusionary rule to evidence obtained as a result of the illegal detention will deter further violations."

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## Ask Corrections

**QUESTION #1:** Recently there have been several organizational changes in state government. Can you provide any information regarding the major changes in the Department of Corrections?

**ANSWER #1:** The Department of Corrections is a department within the Justice Cabinet. The Secretary of the Justice Cabinet is **E. Daniel Cherry**. **Martin J. Huelsmann** is the Deputy Secretary for the Justice Cabinet.

Commissioner **Doug Sapp** is the head of the Corrections Department. **Tom Campbell** is Deputy Commissioner for the Office of Adult Institutions and **Vertner Taylor** is Deputy Commissioner for the Community Services and Local Facilities. **Steve Durham** is the newly appointed General Counsel for the Department of Corrections. **Barbara Jones** is now General Counsel for the Justice Cabinet.

**QUESTION #2:** I heard that juveniles will now be committed to the Corrections Department. Is this correct?

**ANSWER #2:** In July 1996 the Department of Juvenile Justice within the Justice Cabinet was formed to oversee Juvenile Justice issues. The new Commissioner is **Ralph Kelly**.

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# West's Review

**Prater v. Cabinet for Human Resources, et. al.**, Ky., \_\_\_ S.W.2d \_\_\_ (7/25/96)

**Beach v. Commonwealth**, Ky., \_\_\_ S.W.2d \_\_\_ (rendered 6/20/96)

**Miller v. Commonwealth**, Ky., \_\_\_ S.W.2d \_\_\_ (rendered 9/21/95, withdrawn and reissued 6/20/96)

**Stroud v. Commonwealth**, Ky., 922 S.W.2d 382 (5/23/96)

**Robinson v. Commonwealth**, Ky., \_\_\_ S.W.2d \_\_\_ (4/25/96)

**Phipps v. Commonwealth**, Ky.App., \_\_\_ S.W.2d \_\_\_ (7/26/96)

**Commonwealth v. Guess**, Ky.App., \_\_\_ S.W.2d \_\_\_ (7/26/96)

**Commonwealth v. Estes**, Ky.App., \_\_\_ S.W.2d \_\_\_ (7/26/96)

**Eaken v. Commonwealth**, Ky.App., \_\_\_ S.W.2d \_\_\_ (6/14/96)

**Wolfenbarger v. Commonwealth**, Ky.App., \_\_\_ S.W.2d \_\_\_ (6/14/96)

**Shelton v. Commonwealth**, Ky.App., \_\_\_ S.W.2d \_\_\_ (6/14/96)

**Commonwealth v. Wortman and Commonwealth v. Sisco**, Ky.App., \_\_\_ S.W.2d \_\_\_ (5/24/96)

**Hubbard v. Commonwealth**, Ky. App., \_\_\_ S.W.2d. \_\_\_ (5/10/96)

**Rushin v. Commonwealth**, Ky.App., \_\_\_ S.W.2d \_\_\_, (4/26/96)

**Akemon, Toler and Johnson v. Commonwealth**, Ky.App., \_\_\_ S.W.2d \_\_\_ (4/26/96)

**Carter v. Commonwealth**, Ky.App., \_\_\_ S.W.2d \_\_\_ (4/19/96)

**Johnson v. Commonwealth**, Ky.App., \_\_\_ S.W.2d \_\_\_ (4/12/96)



**Julie Namkin**

## Kentucky Supreme Court

**Prater v. Cabinet for Human Resources et. al.**, Ky., \_\_\_ S.W.2d \_\_\_ (7/25/96)

The Cabinet for Human Resources [CHR] removed Prater's three children from his custody. CHR then filed a petition to terminate Prater's parental rights. At the termination hearing, CHR offered the testimony of three CHR social workers to support the termination petition. Two of the social workers testified extensively from CHR records made by persons other than themselves. The circuit court found the children were abused and neglected as defined in KRS 600.020(1) and granted the termination petition.

Prater appealed the termination of his parental rights to the Court of Appeals of Kentucky which upheld the circuit court's decision. The Kentucky Supreme Court granted discretionary review to clarify the relationship between KRE 803(4), KRE 803(6) and KRE 803(8)(B).

The specific issue concerns the admissibility of CHR's records and the testimony of CHR employees based on those records. Prater argued the information contained in the records should have been excluded under KRE 803(8)(B) which contains an express exclusion clause for investigative reports prepared for or by a government or an agency when offered by it in a case in which it is a party. CHR argued the records were admissible under the business records exception to the hearsay rule (KRE 803(6)), and *Cabinet for Human Resources v. E.S.*, Ky., 730 S.W.2d 929, 932 (1987) (holding that "entries in the case record made by the social worker which constitute statements of factual observations are admissible under the business entries exception to the hearsay rule

[but] those statements which express opinions and conclusions are not").

The Kentucky Supreme Court pointed out that *CHR v. E.S.*, *supra*, was decided before the adoption of the Kentucky Rules of Evidence. The Court stated the important distinction between KRE 803(6), the business records exception, and 803(8), the investigative reports exclusion, is the emphasis on government reports in subsection (8). The Court pointed out the basis for the exclusion was "for reasons relating to reliability." Thus, the Court concluded the admissibility of the CHR records was governed by KRE 803(8) and it was reversible error to admit the hearsay evidence contained in the CHR reports.

Prater also argued the circuit court erred when it failed to make independent fact findings as required by CR 52.01. The Kentucky Supreme Court found it was not error for the circuit court to adopt the fact findings drafted by CHR over those drafted by Prater.

The opinion of the Court of Appeals was reversed and the case was remanded to the circuit court for further proceedings in accordance with the Kentucky Supreme Court's opinion.

***Beach v. Commonwealth***,  
Ky., \_\_\_ S.W.2d \_\_\_ (rendered 6/20/96)

Kimberly Beach was convicted in the Harrison County District Court of driving under the influence, first degree. The circuit court affirmed her conviction. The Court of Appeals denied her motion for discretionary review, but the Kentucky Supreme Court granted review.

Beach drove her car over an embankment. The police officer who responded to the accident gave Beach a number of field sobriety tests as well as a portable breath test. Beach failed them all. The officer took Beach to a local hospital for a blood test. Beach consented to the blood test.

Beach's motion to suppress the results of the blood test was denied. At trial, the results of the blood test were introduced over Beach's objection.

The issue before the Kentucky Supreme Court was whether Beach could be given a blood test

without her first submitting to a breathalyzer test.

Beach's argument on appeal was that the statutory language of KRS 189A.103 (the informed consent statute) requires she be given a breathalyzer test prior to having her submit to a blood test. Since the police officer failed to take her to the local police headquarters for a breathalyzer test, the results of the blood test should have been suppressed.

The Kentucky Supreme Court disagreed. The Court concluded the provisions of the informed consent statute had not been breached by failing to give Beach a breathalyzer test before having her submit to a blood test; that even if the statutory provisions had been breached, said breach was not grounds for suppression of the blood test results in the absence of a violation of a constitutional right; and there was no violation of a constitutional right. The Court held that KRS 189A.103(1) and (5) do not require a police officer to first offer a DUI suspect a breath test before asking her or him to submit to a blood test. Beach's conviction was affirmed.

The dissent notes that since Beach consented to the blood test there was no need for the majority to reach the issue of statutory interpretation.

***Miller v. Commonwealth***,  
Ky., \_\_\_ S.W.2d \_\_\_ (rendered 9/21/95,  
withdrawn and reissued 6/20/96)

Thirty-five year old Blaine Miller was accused of forcing a six-year old neighbor child into his apartment, tying her to a chair and sexually molesting her. As a result of these allegations, Miller was convicted of first-degree sexual abuse, kidnapping, terroristic threatening and indecent exposure.

The alleged incidents occurred on June 28, 1993 and July 16, 1993. On August 20, 1993, the child was seen for about one hour by Dr. Sugarman to whom the child had been referred by her family doctor.

Dr. Sugarman testified the child came to her for "evaluation of sexual abuse," but upon questioning by the Commonwealth explained the purpose of the visit was to "treat" the child. Over defense objection, Dr. Sugarman testified

the child named Miller as the person who had rubbed his penis against her arm, had threatened her with a gun, and had touched her genital area with his fingernail. Dr. Sugarman further testified there was a thinning of the child's hymenal area which suggested the vagina "may" have been penetrated with a blunt object, which "could have been a finger or a penis, or pencil, whatever." Dr. Sugarman's records, containing additional statements by the child, were also admitted into evidence.

On appeal, Miller challenged the admission of Dr. Sugarman's testimony because she was not the child's treating physician. The Commonwealth argued Dr. Sugarman was a treating physician and her testimony was admissible under KRE 803(4), the hearsay exception for statements for purposes of medical treatment or diagnosis, or in the alternative, that the probativeness of the doctor's testimony outweighed the prejudice to Miller.

Citing *Sharp v. Commonwealth, Ky.*, 849 S.W.2d 542 (1993), the Kentucky Supreme Court held Dr. Sugarman was not a treating physician because she saw the child only one time, for only one hour for an "evaluation of sexual abuse," and gave neither medication nor counseling to the child. Since the Court concluded Dr. Sugarman was not a treating physician, the test to be applied for determining the admissibility of her testimony is whether the probative value of her testimony outweighs its prejudicial effect. The Court pointed out the discrepancy between the physical findings made by the doctor (some thinning of the hymen which "may" have been caused by penetration) and the child's description of the alleged abuse which failed to suggest any contact with her genitals, much less penetration. Since the only other evidence of Miller's guilt was the child's vague testimony in response to leading questions, the Court held the doctor's improperly admitted testimony unfairly bolstered the child's testimony severely prejudicing Miller. The Court reversed Miller's conviction and remanded for a new trial.

Miller raised five other issues on appeal, none of which the Court deemed to be reversible error. First, Miller claimed the trial judge should have recused himself because (a) his wife had been a supervisor in the Cabinet for Human Resources, Child Protection Division,

at the time of the Cabinet's initial investigation into the alleged incidents, and (b) he had commented that "cases of this nature" need to be tried in a speedy fashion. The Court held Miller failed to meet his burden of demonstrating "facts which necessarily show prejudice or bias sufficient to prevent the judge from fairly or impartially trying the case."

Second, Miller argued that evidence of the victim's having pulled on the trouser's of the apartment complex maintenance man should have been admitted as evidence of the child's past sexual history or behavior, but the Court concluded such evidence was not relevant and thus properly excluded.

Third, Miller argued it was error for the trial court to fail to excuse a juror who came forward during the trial and informed the court the testimony had triggered her memory that she lived next door to the apartment complex where the alleged incident occurred. The juror also stated there was a conflict between her husband and Miller's brother, a prominent contractor and businessman in the community, that had yet to be resolved. The Court found the issue was not properly preserved for review because no objection or mistrial motion had been made, and even if the error had been preserved, the Court found the relationship "so tenuous" that it could not have affected the impartiality of the juror.

Fourth, Miller argued a mistrial should have been declared after an outburst by the complaining witness during the trial. The Court found the trial judge did not abuse his discretion because a mistrial was not necessary.

Fifth, the Court found no merit to Miller's argument that his convictions for first-degree sexual abuse and kidnapping violate the kidnapping exemption statute and double jeopardy principles. *Brewer v. Commonwealth, Ky.*, 922 S.W.2d 380 (5/23/96).

Brewer pled guilty to two counts of felony theft and was sentenced to one year on each count to run concurrently. The trial court probated Brewer's sentences on the condition that he not violate the law in the future.

While on probation, Brewer was indicted for a felony. He pled guilty and was sentenced to one year. The Commonwealth then moved to revoke

Brewer's probation due to his subsequent felony conviction. Brewer's probation was revoked and the trial court ordered Brewer's original one year sentence run consecutively to his one year sentence on his subsequent felony conviction.

On appeal Brewer argued that under KRS 533.040(3) his original one year sentence should run concurrently with his one year sentence on the subsequent conviction. The Court of Appeals held that KRS 533.060(2) is the controlling statutory authority and it mandates the sentences run consecutively. The Kentucky Supreme Court granted Brewer's motion for discretionary review and adopted the opinion of the Court of Appeals.

The Supreme Court noted the consecutive sentencing provisions required by KRS 533.060(2) only apply in cases involving a *felony*. The provisions of KRS 533.040(3) still apply where the parolee or probationer commits a misdemeanor or violates a condition of parole or probation which does not constitute a felony.

***Stroud v. Commonwealth,***  
Ky., 922 S.W.2d 382 (5/23/96)

Stroud was tried for and convicted of first-degree robbery and being a second degree persistent felony offender. Stroud entered a guilty plea to the second-degree escape charge which was based on Stroud's disconnection of a bracelet required to be worn by him by the Jefferson County home incarceration program.

Stroud raised three arguments on appeal.

First, Stroud argued members of the jury panel were improperly selected since the trial court allowed a jury pool official to choose members of the panel rather than making a selection in open court. The Kentucky Supreme Court rejected this argument on two grounds. First, it was not properly preserved for review. Second, RCr 9.30 only requires that the selection of the petit jury from the jury panel be in open court. The random selection of the names that compose the jury panel, from which the petit jury is selected, need not be performed in open court. The Administrative Procedures of the Court of Justice permit the Chief Circuit Judge, or a designee thereof, to select a suffi-

cient number of names from the randomized list to constitute a jury pool.

Second, the Court held Stroud was properly sentenced as a second degree persistent felony offender.

Third, Stroud argued he could not properly be convicted of escape because his participation in the Home Incarceration program did not amount to "custody" as required by the escape statute. KRS 520.030. The Kentucky Supreme Court pointed out that Stroud, his counsel and the trial judge signed an agreed order stating the conditions and limitations of the home incarceration program. The document contained language stating in part, "I understand the penalty for escape...." The Court held that participation in the Home Incarceration Program constitutes custody sufficient to support a charge of second degree escape.

Stroud's convictions were affirmed.

***Robinson v. Commonwealth,***  
Ky., \_\_\_ S.W.2d \_\_\_ (4/25/96)

Robinson was convicted of first degree manslaughter, as a result of beating his girlfriend to death, and received the maximum punishment of twenty years. The Kentucky Supreme Court reversed his sentence due to two errors that occurred during the truth-in-sentencing phase of his trial.

First, pursuant to KRS 532.055, a local police officer testified from a certified, but not exemplified, computer printout from an Ohio municipal court that not only listed Robinson's alleged convictions but also listed charges against Robinson that had been dismissed, as well as fines, short jail stays, and suspended sentences Robinson had received. Robinson objected to the accuracy of the contents of the printout.

Distinguishing the instant case from *Hall v. Commonwealth*, Ky., 817 S.W.2d 228 (1991), the Kentucky Supreme Court held the use of the computer printout, which was not a judgment, amounted to reversible error for the following reasons: 1) the truth-in-sentencing statute permits the introduction of prior convictions, not prior charges subsequently dismissed; 2) the Kentucky police officer who testified to the contents of the printout did not

compile the Ohio printout and thus had no personal knowledge as to its accuracy (which Robinson challenged) and whether it was kept in the ordinary course of business. The Kentucky Supreme Court made it clear it was not willing to expand *Hall's* holding "to embrace any compilation of data by any court or police agency in the absence of exemplification, as required by KRS 422.040, or a witness who can testify that the record comports with the business record exception to the hearsay rule."

Second, also pursuant to KRS 532.055, the Commonwealth called a prior assault victim to testify at length as to the specific details of her assault by Robinson. Robinson argued the prior victim's testimony was too extensive and went beyond "the nature of prior offenses for which he was convicted" as allowed by the statute. If such extensive testimony is routinely permitted, prior crimes would be completely relitigated because under the statute the defendant is permitted to introduce evidence which negates evidence introduced by the Commonwealth.

The Kentucky Supreme Court held "that all that is admissible as to the nature of a prior conviction is a general description of the crime," such as the final judgement with testimony Robinson had assaulted the woman with whom he had been living. The Court pointed out that counsel for the prosecution and the defense should negotiate an agreement on the language to be used to describe the prior crime [hopefully prior to trial], and if an agreement cannot be reached, the trial court should make the determination.

Robinson's sentence was reversed for a new sentencing hearing.

### Kentucky Court of Appeals

*Phipps v. Commonwealth*,  
Ky.App., \_\_\_ S.W.2d \_\_\_ (7/26/96)

Pursuant to a misdemeanor conviction, Phipps was ordered to serve ninety days and was placed in River City Correctional Center (RCCC), a private facility in Jefferson County owned by U.S. Corrections Corporation. After three days, Phipps failed to return from an approved leave. He was subsequently tried and

entered a conditional guilty plea to second degree escape.

On appeal Phipps argued that Jefferson County was not authorized to contract with U.S. Corrections Corporation for housing inmates at RCCC, and thus the government had relinquished its right to insist on completion of his sentence by sending him to RCCC. The Court of Appeals disagreed.

The Court of Appeals concluded that KRS 441.025(2)(a), KRS 67.083(3)(e) and KRS Chapter 67B allow Jefferson county to contract with a private corporation to provide and maintain a jail. Thus, Phipps' transfer to RCCC did not constitute and unauthorized release.

The Court of Appeals also disagreed with Phipps' argument that RCCC is not a "detention facility" from which he could be guilty of second degree escape. The Court of Appeals stated RCCC falls within the definition of detention facility set out in KRS 520.010(4)(a). The Court of Appeals also pointed out that when Phipps arrived at RCCC he signed a document saying he had read and agreed to abide by RCCC's policies and regulations. The document also informed Phipps of the consequences of not returning to RCCC after a temporary approved leave, *i.e.*, that he would be charged with second degree escape.

Phipps guilty plea to second degree escape was affirmed.

*Commonwealth v. Guess*,  
Ky.App., \_\_\_ S.W.2d \_\_\_ (7/26/96)

Guess was indicted for operating a motor vehicle under the influence of intoxicants and operating a motor vehicle with a suspended license. He was released prior to trial, but the trial court ordered him to enter a drug and alcohol treatment center for thirty days and then return to jail to await trial. After spending several weeks in jail, Guess was ordered to enter a halfway house for substance abusers. After a month in the halfway house, Guess pled guilty to both offenses and the court sentenced him to two years imprisonment. The trial court credited Guess with the time spent in the treatment center and halfway house and probated the remainder of his sentence for five years.

The Commonwealth appealed the trial court's order arguing it was error for the court to give Guess credit for the time he spent in the treatment center and the halfway house. The Commonwealth maintained the time spent in these facilities was not time "in custody" for purposes of determining jail credit under KRS 532.120(3).

Custody is defined in KRS 520.010(2). The Court of Appeals concluded that neither the time Guess spent at the treatment center nor the time he spent at the halfway house met the statutory definition of custody because he was not under the supervision of law enforcement personnel at either facility. Since Guess was not "in custody" while he was at either facility, he had not served the minimum 120 days imprisonment required under KRS 189A.010(5) prior to being released on probation.

The Court of Appeals recognized the trial court's concern that Guess receive treatment for his alcohol problem, but pointed out that since KRS 189A.010(5) was mandatory, there was no room for the trial court's discretion to treat pre-conviction court-ordered treatment as custody for purposes of determining jail time credit. The case was remanded to the trial court to calculate the actual time Guess had spent in jail and he would be required to spend whatever additional time was necessary to meet the 120 day minimum required by KRS 189A.010(5).

***Commonwealth v. Estes,***  
Ky.App., \_\_\_ S.W.2d \_\_\_ (7/26/96)

Estes was charged with operating a motor vehicle without insurance in violation of KRS 304.39-080(5), which provides that every *owner* of a motor vehicle shall have proof of insurance. Estes was not the *owner* of the car, but he was the *operator*. Estes entered a conditional guilty plea to the charge.

On appeal Estes argued the statute did not apply to non-owner operators. The circuit court held the statute did not apply to non-owner operators and reversed Estes' conviction. The Court of Appeals granted discretionary review.

KRS 304.99-060 was amended on July 15, 1994 to include vehicle owners and operators. Prior to that date, the statute applied only to owners. Reading the two statutes together, and

construing them consistent with legislative intent, the Court of Appeals concluded that a non-owner operator can be charged with failure to maintain proper insurance.

The Court of Appeals also held, contrary to Estes' argument, that the statutes were not vague or overly broad.

The order of the circuit court was reversed and Estes' conviction was reinstated.

The dissenting opinion pointed out that the statutory "scheme mandates that every automobile should be covered by insurance, not that every individual be insured.... As evidence, the law requires proof of insurance upon a vehicle before licensing, but not upon an individual before obtaining a driver's license."

***Eaken v. Commonwealth,***  
Ky.App., \_\_\_ S.W.2d \_\_\_ (6/14/96)

Eaken was charged with driving under the influence, fourth offense. Prior to trial Eaken moved to suppress his first DUI conviction, which was the result of a guilty plea and occurred in Montana, because he was not represented by counsel. After a hearing on the motion to suppress, the trial court made contradictory findings. On one hand the court found Eaken was not represented by counsel, was not advised of his right to counsel, and did not understand all of his constitutional rights under *Boykin v. Alabama*, 395 U.S. 238 (1969). On the other hand the court found there was not a complete denial of the right to counsel, presumably because Eaken testified he knew he had a right to hire a lawyer but had no money to do so.

The Court of Appeals reversed Eaken's conviction because the trial court's finding that there was not a complete denial of counsel was clearly erroneous. The Court of Appeals pointed out that since Eaken had never been advised of his right to counsel, he could not be deemed to have waived that right. Thus, it was reversible error for the trial court to use the Montana conviction to support Eaken's present conviction for DUI fourth offense.

A petition for rehearing is pending.

***Wolfenbarger v. Commonwealth,***  
Ky.App., \_\_\_ S.W.2d \_\_\_ (6/14/96)

Wolfenbarger was tried for and convicted of first degree assault and second degree assault. The charged offenses occurred in Boone County.

On the morning of trial, defense counsel informed the court Wolfenbarger was in the hospital in Kenton County. [The opinion does not reveal the reason for Wolfenbarger's hospitalization.]. All parties, including the defendant, defense counsel, the trial court and the Commonwealth, agreed to select a jury in Boone county in the defendant's absence and then hold the trial in the hospital in Kenton County. Wolfenbarger was convicted on both counts.

On appeal Wolfenbarger argued it was error to hold his trial in Kenton County because the trial court did not follow the proper procedure for a change of venue.

The Court of Appeals, citing Supreme Court Rule (SCR) 1.040(1) and *Evans v. Commonwealth*, Ky., 645 S.W.2d 346, 347 (1982), concluded the trial court went beyond the scope of the powers granted to it and the issue was not waivable (as the Commonwealth argued) and reversed Wolfenbarger's convictions for a retrial in Boone County.

The Court of Appeals noted it was reluctant to reverse Wolfenbarger's convictions, but felt compelled to do so in light of the Kentucky authorities it cited. A concurring opinion urged the Kentucky Supreme Court to follow the trend of foreign jurisdictions which would find the error harmless based on the facts of the case so as to uphold the convictions.

A motion for discretionary review is pending.

***Shelton v. Commonwealth,***  
Ky.App., \_\_\_ S.W.2d \_\_\_ (6/14/96)

Shelton was charged with trafficking in a controlled substance, cocaine, subsequent offense and trafficking in a controlled substance, methamphetamine, subsequent offense. The charges arose out of his simultaneous possession of cocaine and methamphetamine. Shelton pled guilty to each charge and in exchange for his plea the Commonwealth dismissed charges of

carrying a concealed deadly weapon and first degree persistent felony offender. Pursuant to the agreement, Shelton received two ten year sentences to be run consecutively.

One year later Shelton filed a *pro se* RCr 11.42 motion alleging his two trafficking convictions violated principles of double jeopardy under Section 13 of the Kentucky Constitution and that his counsel was ineffective for allowing him to plead guilty to both charges when he could have been punished for only one offense. The trial court denied Shelton's RCr 11.42 motion without a hearing.

On appeal, the Court of Appeals reviewed the history of double jeopardy law in Kentucky. Concluding that *Ingram v. Commonwealth*, Ky., 801 S.W.2d 321 (1990) (convictions for selling marijuana to a minor and trafficking in marijuana within 1000 yards of a school, which arose out of a single act, violated double jeopardy principles under Kentucky constitution), was the prevailing law at the time of Shelton's guilty plea, the Court of Appeals found Shelton's counsel's performance, in advising Shelton to plead guilty to two offenses when he could only be punished for one, fell "outside the wide range of professionally competent assistance."

The Court of Appeals vacated Shelton's guilty plea and the plea bargain upon which the plea was based and remanded the case to the trial court for further proceedings in conformity with its opinion.

A petition for rehearing is pending.

***Commonwealth v. Wortman and***  
***Commonwealth v. Sisco,***  
Ky.App., \_\_\_ S.W.2d \_\_\_ (5/24/96)

Wortman was charged with stalking on a complaint made by his wife. At the preliminary hearing in district court, the Commonwealth established probable cause through the testimony of the police officer who investigated the complaint and arrested Wortman. The defense called Wortman's wife to testify, but since he "did not articulate any reason, or indicate the nature of the testimony or its relevance to the determination of probable cause," the court refused to let her testify.

Sisco was charged with bribing a public servant (a deputy jailer). At the preliminary

hearing, the Commonwealth established probable cause through the testimony of the jailer. The defense called the deputy jailer (who took the alleged bribe), but since he did not indicate "how the testimony of the proposed witness would bear on the issue of probable cause," the court refused to let him testify.

Wortman and Sisco brought *mandamus* actions in the Henderson circuit court, pursuant to CR 81, seeking permission to reopen the preliminary hearing and the right to call witnesses in their defense. The relief was granted and the Commonwealth appealed.

The Court of Appeals stated the sole purpose of a preliminary hearing is to determine whether there is probable cause to believe the defendant committed a felony and whether and under what conditions he is to be released pending indictment. The preliminary hearing is not a mini-trial nor a discovery tool for the defense.

Although RCr 3.14(2) state "[t]he defendant may cross-examine witnesses against him and may introduce evidence in his own behalf," the Court of Appeals stated the privilege is not unrestricted.

The Court of Appeals narrowly interpreted RCr 3.14(2) stating the evidence tendered by the defense must be relevant to the two issues addressed by the rule and those two issues only. The district court "has great discretion in controlling the introduction of evidence [and] this discretion will not be disturbed absent a clear showing of abuse."

Because the defense did not articulate "the value, competence, or relevancy of the proffered testimony," the Court of Appeals held the district court did not abuse its discretion in refusing to let the witnesses testify. The orders of the circuit court were reversed.

A motion for discretionary review is pending.

***Hubbard v. Commonwealth,***  
Ky. App., \_\_\_ S.W.2d. \_\_\_ (5/10/96)

Hubbard was tried and convicted of first degree robbery. He raised three issues on appeal.

First, Hubbard argues the trial court's dismissal of one of the jurors as an alternate

violated his rights to random jury selection, due process and a fair trial.

At the conclusion of all the evidence, but prior to the trial court's instructions to the jury, one juror informed the court her religious beliefs prevented her from sitting in judgment of another individual. The court dismissed the juror as an alternate and the case was decided by the remaining twelve jurors.

The Court of Appeals held that since the juror admitted she could not return a fair and impartial verdict due to her religious beliefs, the court's dismissal of the juror as an alternate was proper and not clearly erroneous so as to amount to an abuse of discretion.

Second, Hubbard argues he was entitled to a directed verdict of acquittal because the Commonwealth failed to prove the element of physical injury beyond a reasonable doubt. The seventy-four (74) year old victim testified she was taken to the hospital immediately after the robbery due to pain in her left hip. X-rays did not reveal a fracture and she sought no further medical treatment. She testified she had had no problem with her hip prior to the robbery, but afterwards she had to use a wheelchair around the house, could no longer do her own shopping, and at the time of trial her hip still hurt and it felt like her leg "gives away." No expert medical testimony was presented as to the extent of the victim's injury.

The Court of Appeals held the victim's testimony was sufficient to prove the element of physical injury beyond a reasonable doubt because any impairment of physical condition meets the definition of physical injury.

Third, the Court of Appeals rejected Hubbard's argument that he was denied equal protection because a conviction for first degree robbery (a Class B felony) only requires proof of "physical injury," while a conviction for first degree assault (also a Class B felony) requires proof of "serious physical injury." The Court of Appeals noted that first degree robbery also required the element of theft and a physical injury is an aggravating factor.

Hubbard's conviction was affirmed.

A motion for discretionary review is pending.

***Rushin v. Commonwealth,***  
Ky.App., \_\_\_ S.W.2d \_\_\_, (4/26/96)

Rushin entered a conditional guilty plea to two counts of trafficking in a controlled substance. He was sentenced to five years on each count to run concurrently. The facts leading up to the guilty plea are as follows.

On September 29, 1993, the Hardin County Grand Jury indicted Rushin on two counts of trafficking in a controlled substance. The indictments were sealed the following day. On October 2, 1993, an arrest warrant was issued but it was not delivered to the county sheriff until more than one year later on November 9, 1994. Rushin, who was in custody on other charges learned of the indictments and on January 31, 1994 filed a *pro se* motion (in the form of a letter) for a speedy trial. Although a note placed in the file by the Hardin Circuit Court clerk shows Rushin's letter was forwarded to the Commonwealth's Attorney, no response was made. Rushin made a second request on May 29, 1994. Once again, no response was made. On September 20, 1994, the Commonwealth moved to unseal the indictments and Rushin was arraigned on November 15, 1994.

At arraignment, the Commonwealth acknowledged Rushin's May 29, 1994 speedy trial request through its statements that it had only until November 28, 1994 to try Rushin.

On November 22, 1994, Rushin's newly appointed counsel moved to dismiss the charges since more than 180 days had elapsed since Rushin's January 31, 1994 request for a speedy trial. The motion was denied and trial was set for November 28, 1994. The Commonwealth stated that if counsel could not be ready to try the case on November 28, he would have to move for a continuance, thereby waiving the 180 time limit. Rushin entered a conditional guilty plea on November 18, 1994.

On appeal, Rushin argued he was denied his right to a speedy trial when he was not brought to trial within 180 days of his January 31, 1994 request and thus it was error for the trial court to deny his motion to dismiss the charges.

The Court of Appeals held that since a detainer had not been lodged against Rushin, his right to a speedy trial had not attached and thus the

Court of Appeals did not have to decide whether KRS 500.110 or KRS 440.450 was applicable.

Rushin also argued that he was wrongfully forced to choose between his right to a speedy trial and his right to effective assistance of counsel.

The Court of Appeals noted that although a defendant does not have to show prejudice to establish a speedy trial violation, he does have to show prejudice to establish ineffective assistance of counsel. The Court of Appeals held that since Rushin did not proceed to trial, it could not determine whether he would have been prejudiced by "the allegedly short amount of preparation time."

The Court of Appeals affirmed the trial court's denial of Rushin's motion to dismiss.

A motion for discretionary review is pending.

***Akemon, Toler and Johnson***  
***v. Commonwealth,***  
Ky.App., \_\_\_ S.W.2d \_\_\_, (4/26/96)

Each of these three defendants challenges the constitutionality of KRS 635.020(4), the mandatory transfer of juvenile firearm felonies to circuit court. The statute mandates that "if a child charged with a felony in which a firearm was used in the commission of the offense had attained the age of fourteen years at the time of the commission of the alleged offense, he shall be tried in the circuit court as an adult offender and shall be subject to the same penalties as an adult offender...." In each case the district court found the defendant was over the age of fourteen at the time of the commission of the offense and that a firearm was used in the commission of the offense. Pursuant to the statute, each case was transferred to circuit court where the defendants were to be tried as adults.

Each defendant challenged the constitutionality of the statute in circuit court, but their challenges were rejected. Each then entered a conditional guilty plea.

On appeal, the defendants argued the statute was unconstitutional on three grounds: 1) the General Assembly overstepped its authority in enacting the statute; 2) the statute violates

dues process because it is unconstitutionally vague as to what offenses it applies to as well as what procedure is to be followed; and 3) the statute violates the doctrine of separation of powers in sections 27-28 of the Kentucky Constitution.

The Court of Appeals disagreed and held the statute to be constitutional. As to the defendants' first claim, the Court of Appeals stated that the Judicial Article of the Kentucky Constitution did not take away the General Assembly's authority to assign jurisdiction to the circuit courts, and the defendants' conceded that the General Assembly can take juvenile jurisdiction away from the district courts since their jurisdiction is limited to the powers provided them by the legislature. See KRS 24A.130.

As to the defendants second challenge to the statute, the Court of Appeals interpreted the phrase "use of a firearm" to require a showing that the weapon was used in any manner to further the commission of the offense. Akemon and Toler's offense involved a theft from a convenience store and brandishing of a gun. Jackson's offense was second degree assault arising from a shooting. Thus, the defendants charged offenses fell within the scope of the statute. As to the apparent inconsistency in the use of the terms "public offender" in KRS Chapter 635 and "youthful offender" under KRS Chapter 640 and "adult offender" under KRS 635.020(4), the Court of Appeals found this inconsistency to be a result of poor draftsmanship and not an attempt to create a new classification for juveniles charged with firearms offenses. The Court interpreted the term "adult offender" in KRS 635.020(4) to mean the same as the term "adult" in KRS 640.010(2)(c). Under KRS 635.020(4) a child indicted for a firearm felony will be automatically transferred for trial in circuit court. The statutory findings required by KRS 640.010(2)(a) and (b) will not be required.

Thirdly, the Court of Appeals found the statute did not violate the separation of powers doctrine because the legislature already has the authority to prescribe the jurisdiction of the district court under section 113(6) of the Kentucky Constitution. Thus, the legislature can exempt felony firearm charges from this jurisdiction.

The defendants' convictions were affirmed.

A motion for discretionary review is pending.

*Carter v. Commonwealth,*  
Ky.App., \_\_\_ S.W.2d \_\_\_ (4/19/96)

Carter was tried and convicted for felony theft by deception arising out of falsely reporting his car as being stolen. Carter was then granted shock probation on the condition that he pay \$2,200.00 to his insurance company for restitution and \$10.00 per month to the Commonwealth for probation supervision fees.

Prior to having been granted shock probation, Carter had filed a motion for correction of presentence investigation report alleging that the report was in error by stating the insurance company had paid him for the allegedly stolen car, when it had not. The circuit court never ruled on this motion. Carter renewed his motion after he was granted shock probation, but the court still did not rule on his motion.

While Carter was on probation he filed a petition for writ of habeas corpus in the federal district court. After the district court granted his petition, Carter filed a motion in the state circuit court "for return of fees paid as a result of conviction and removal of conviction from record." The circuit court denied the motion and Carter appealed.

Carter argued that the writ of habeas corpus voided the judgment of conviction under which he paid restitution and probation supervision fees. The Court of Appeals pointed out that the issuance of a writ of habeas corpus by a federal court is not the equivalent of a reversal of a state conviction and does not void the conviction. Thus, Carter was not entitled to relief under this theory.

Carter also argued he was entitled to relief under either RCr 11.42 or CR 60.02 because the circuit court mistakenly ordered \$2,200 in restitution, rather than \$450.00 which was the actual amount paid by his insurance company. The Court of Appeals treated the motion as being pursuant to CR 60.02(c) and held that it was timely based on Carter's prior motion to correct the presentence investigation report. However, the Court of Appeals concluded that since the circuit court has broad discretion in setting the terms for shock probation, there

was no abuse of discretion in setting the restitution terms that it did.

The circuit court's denial of Carter's motion was affirmed.

A motion for discretionary review is pending.

***Johnson v. Commonwealth,***  
Ky.App., \_\_\_ S.W.2d \_\_\_ (4/12/96)

Johnson was convicted of first degree assault and sentenced to ten years for allegedly beating, squeezing and dropping his two month old son causing him serious physical injury. Johnson raised three issues on appeal.

First, Johnson argued his hand is not a dangerous instrument under KRS 500.080(3) and that unless he was a martial arts expert he could not be found guilty of first degree assault under KRS 508.010(a). The Court of Appeals disagreed. The Court of Appeals stated whether a human body part meets the definition of dangerous instrument "depends on the facts of the case and the capability of the body part to cause death or serious physical injury." Where an adult man strikes a two month old child in the head with his hand serious physical injury or death can be a direct result thus meeting the statutory definition of dangerous instrument.

Second, Johnson argued the injuries sustained by his son were not so serious as to constitute first or second degree assault. A physical

examination of the baby revealed he was black around the eyes and his cheeks and forehead were bruised. An x-ray and CT examination revealed a large skull fracture with underlying bruising of the brain, bleeding and swelling. Four ribs were fractured, the right forearm was broken and the femur was broken in both legs. Although the examining doctor testified the baby was not in danger of death and there was no permanent injury, she had seen other children die from similar injuries. The Court of Appeals held Johnson was not entitled to a directed verdict of acquittal because the baby's injuries "leave no doubt" a substantial risk of death was created and the Court was amazed the baby was able to survive such trauma.

Third, Johnson argued he was entitled to instructions on first, second and third degree criminal abuse. The Court of Appeals found no error because criminal abuse is not a lesser included offense of assault. However, the Court noted the Commonwealth could have sought an indictment for criminal abuse since the baby was in Johnson's custody when the alleged injuries occurred.

Johnson's conviction was affirmed.

A motion for discretionary review is pending.

**JULIE NAMKIN**

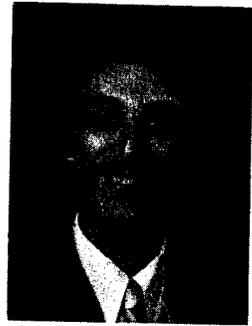
Assistant Public Advocate  
100 Fair Oaks Lane, Suite 302  
Frankfort, Kentucky 40601  
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E-mail: jnamkin@dpa.state.ky.us

**1997 ANNUAL DPA CONFERENCE - 1972 MEMORABILIA SOUGHT**

1997 marks the 25th Anniversary of the establishing of the Department of Public Advocacy. We will be celebrating these past 25 years of work in representing indigent clients accused of committing a crime and convicted of a crime. We seek people who have memorabilia - pictures, etc. - that they would like to either donate or loan to the Department to use for this Anniversary celebration at our 25th Annual Public Defender Training Conference in June of 1997. If you have anything you would like to donate or loan, please send or contact:

Tina Meadows, Department of Public Advocacy, Education & Development  
*25th Anniversary Memorabilia*  
100 Fair Oaks Lane, Suite 302  
Frankfort, Kentucky 40601  
Tel: (502) 564-8006; Fax: (502) 564-7890; E-mail: tmeadows@dpa.state.ky.us

# Retrospection Parole in Kentucky



**Bob Hubbard**

**Initial Parole Hearings**

**All Parole Hearings**

**Parole Board Decisions  
By Most Serious Crime**

**Drug Offenders**

**Sex Offenders**

**Violent Offenders**

**Property Offenders**

**Other Offenders**

**Parole Board Decisions  
by Length of Sentence**

**Life Sentence Paroled  
at Initial Hearing**

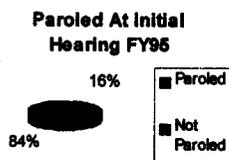
**Returned Parole Violators**

One of the greatest concerns of, and most frequently asked questions by the criminal defendant is *when will I be eligible for parole?* **When** a defendant will be eligible for parole however, is not the real question for the answer to that question reveals only half the story. In actuality, the answer our clients seek is in response to the often unspoken query *when will I be released.* Of course, this question we, as criminal defense practitioners, are incapable of answering with any degree of certainty.

Our courts have consistently maintained that counsel is not required to advise the defendant of all possible indirect and collateral consequences which may follow a guilty verdict or the entry of a guilty plea. Nevertheless, "gross misadvice concerning parole eligibility can amount to ineffective assistance of counsel." *Sparks v. Sowders*, 852 F.2d 882, 885 (6th Cir. 1988). This holding has strong implications for counsel particularly in light of the various statutory enactments which directly effect an individual's parole eligibility. *See e.g.*, KRS 532.080(7); 439.340; and 439.3401. Thus, it is our responsibility to understand and communicate accurate parole information to our clients.

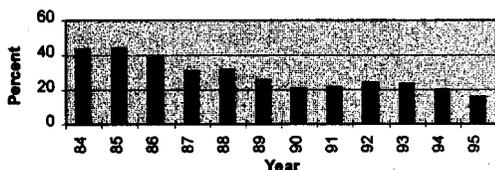
To aid in fulfilling our obligations, reliable statistics exist from which a more realistic picture of our client's prospects for release may be drawn. What follows is a retrospective look at various parole statistics from the 1980's through fiscal year 1995. These statistics are presented under the following headings:

- a) parole at initial hearings,
- b) parole for all hearings,
- c) parole based upon seriousness of the offense,
- d) parole by length of sentence,
- e) returned parole violators.



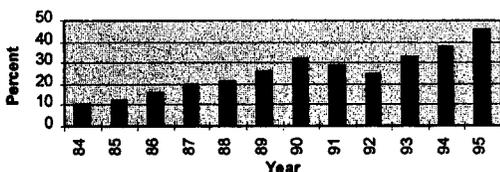
**Table 1**

**% Paroled At Initial Hearing FY 84 - 95**



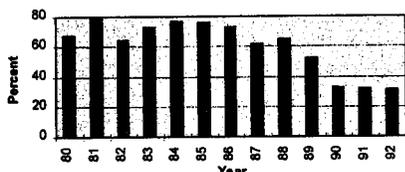
**Table 2**

**% Given Serve Out At Initial Hearing FY 84-95**



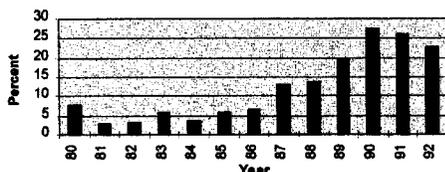
**Table 3**

**Drug Offenders Paroled At Initial Hearing**



**Table 4**

**Drug Offenders Given Serve Out At Initial**



**Table 5**

From these statistics one fact is for certain, the Parole Board is requiring inmates to spend substantial more time in prison compared to the early 80's and is quick to revoke parolees returned as parole violators.

### INITIAL PAROLE HEARINGS

Over the last 12 years, the Board has chosen to drastically reduce the number of inmates who are paroled when first eligible for parole, and likewise has chosen to dramatically increase the number of inmates who serve out their sentences.

In FY 84, 2,475 inmates came before the Parole Board for the first time. Of these, 43.6% were paroled while only 10% were required to serve out their sentences.

By FY 1995, there were 4,497, approximately 2,000 more, inmates appearing before the Parole Board for the first time. Yet, only 16% received parole while 46% were required to serve out or complete the sentences given them. 38% were deferred parole meaning they were told by the Board that they were denied parole and would not be considered again for parole by the Board for a certain period of time set by the Board. Therefore, 84% did not receive parole at their initial hearing. (Table 1).

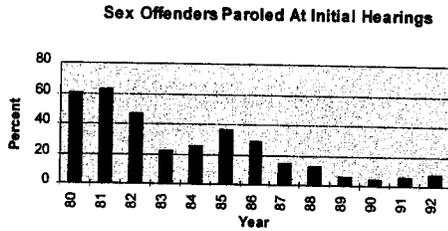
In the last 12 years, the percentage of inmates paroled when first eligible has declined 27.6% (Table 2). Over this same time period those inmates being required to serve out their sentences rose 36%. (Table 3).

### ALL PAROLE HEARINGS

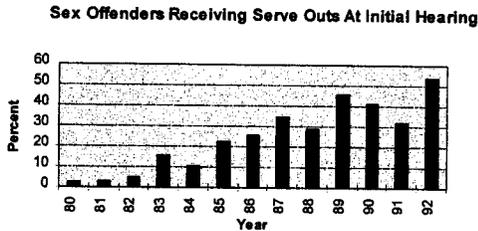
Looking at all initial and deferred parole hearings over the last 12 years reveals the Parole Board has significantly reduced the number of inmates who receive parole, and have more than doubled the number who serve out their sentences.

In FY 84, 55% of the 3,845 inmates who had parole hearings were granted parole, and 7.6% were required to complete their sentence.

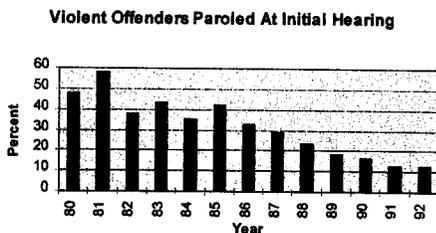
The results of all initial and deferred parole hearings in FY 95 indicate that of the 7,279 inmates considered for parole, parole was recommended for 36% of the inmates, while 32% received serve outs.



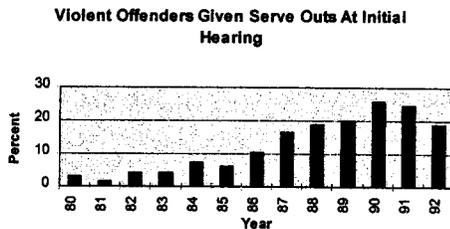
**Table 6**



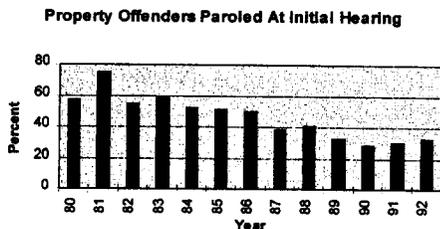
**Table 7**



**Table 8**



**Table 9**



**Table 10**

In the last 12 years, the percentage of inmates paroled declined 19% from 55% to 36%. During the same period of time, the percentage of inmates receiving a serve out jumped 25.3% from 7.6% to 32.9%.

## PAROLE BOARD DECISIONS BY MOST SERIOUS CRIME

Parole statistics reflecting the Board's actions relevant to parole by most serious crime were reported between 1980 and 1992. These statistics are compiled under separate categories for Drug Offenders, Sex Offenders, Violent Offenders, Property Offenders and Other Offenders.

### DRUG OFFENDERS

#### Initial Hearings

In FY 80, 67% of drug offenders were paroled at their initial hearing, 25.2% were deferred and 7.8% received a serve out.

In FY 92 the percentage of drug offenders paroled at their initial hearing had dropped to 30.9%, deferments and serve outs had risen to 46.5% and 22.7% respectively. (Tables 4, 5).

#### All Hearings

In FY 80 for all hearings, 64.7% of drug offenders were paroled, 29.4% received deferments and 5.9% received serve outs.

In FY 91, only 34.6% were paroled, 42.2% were deferred and 23.3% received serve outs.

### SEX OFFENDERS

#### Initial Hearings

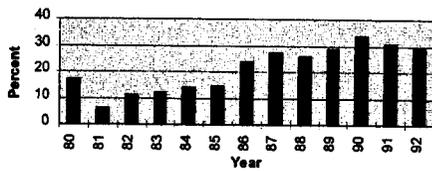
In FY 80, 60.6% of sex offenders were paroled at their initial hearing, 36.6% were deferred and 2.8% received a serve out.

In FY 92 only 8% of sex offenders were paroled at their initial hearing, 38.4% were deferred and 53.6% were given serve outs. Thus, 92% of sex offenders were not paroled at their initial hearings in FY 92. (Tables 6, 7).

#### All Hearings

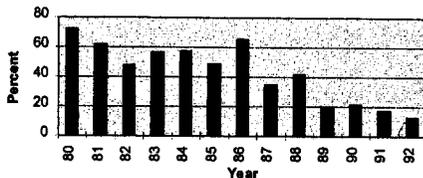
In FY 80 for all hearings, 60.7% of sex offen-

**Property Offenders Given Serve Out At Initial Hearing**



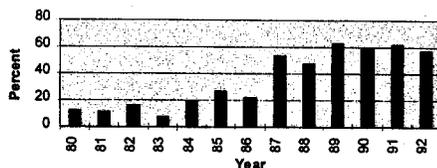
**Table 11**

**Other Offenders Paroled At Initial Hearing**



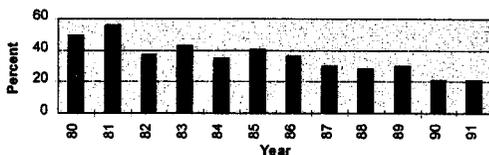
**Table 12**

**Other Offenders Given Serve Out At Initial Hearing**



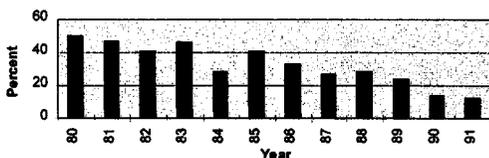
**Table 13**

**Paroled On Sentences of 1-5 Years**



**Table 14**

**Paroled On Sentences of 5-10 Years**



**Table 15**

ders were paroled, 36.2% received deferments and 3.1% received serve outs.

In FY 91, 8.6% were paroled, 44.6% received deferments and serve outs jumped to 46.8%.

## VIOLENT OFFENDERS

### Initial Hearings

In FY 80, 48.1% of violent offenders were paroled at their initial hearing, 48.7% were deferred and 3.1% received a serve out.

In FY 92, only 12.4% violent offenders were paroled at their initial hearing, 67.4% were deferred and 19% received a serve out. (Tables 8, 9).

### All Hearings

In FY 80, for all hearings 52.6% of violent offenders were paroled, 43.5% were deferred and 4% received serve outs.

In FY 91, only 21.6% were paroled, 60.4% were deferred while serve outs were given in 18% of the cases.

## PROPERTY OFFENDERS

### Initial Hearings

In FY 80, 57.3% of property offenders were paroled at their initial hearing, 25.7% were deferred and 17% received a serve out.

By FY 92, only 32.8% of property offenders were paroled at their initial hearing, 37.8% were deferred and 29.1% were served out. (Tables 10, 11).

### All Hearings

In FY 80 for all hearings, 55.1% of property offenders were paroled, 29% were deferred while 15.8% were given serve outs.

In FY 91, only 32.4% were paroled 39.3% were deferred while serve outs rose to 28.4%.

## OTHER OFFENDERS

### Initial Hearings

In FY 80, 72% of all other offenders received

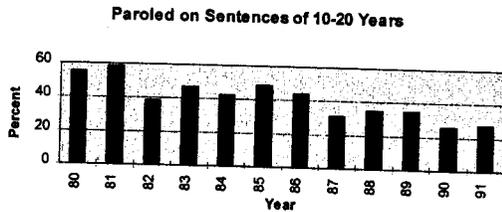


Table 16

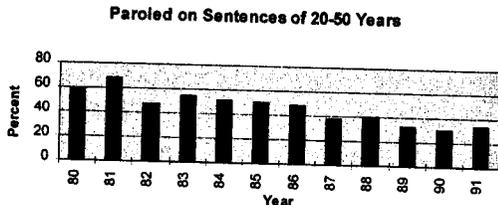


Table 17

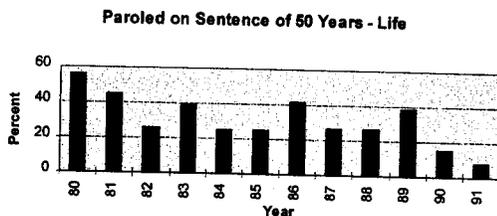


Table 18

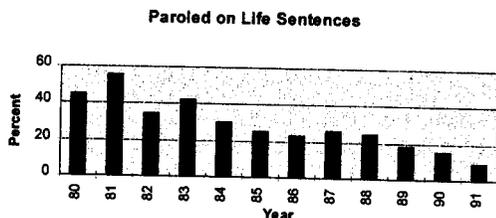


Table 19

**Prejudice**

The tendency of the casual mind is to pick out or stumble upon a sample which supports or defies its prejudices, and then to make it the representative of a whole class.

- Walter Lippmann, *Public Opinion* (1929)

parole at their initial hearing, 16% were deferred and 12% received serve outs.

In FY 92, only 13% received parole at their initial hearing, while 29.7% were deferred and 57.3% were given a serve out. (Tables 12, 13).

**All Hearings**

In FY 80 for all hearings, 69.8% of all other offenders were paroled, 18.6% were deferred, while 11.6% were given a serve out.

By FY 91, only 21.9% of all other offenders were paroled, 20.2% were deferred, while the serve out rate rose to 57.9%.

**PAROLE BOARD DECISIONS BY LENGTH OF SENTENCE**

Statistics reflecting the Board's actions relevant to parole by sentence length were reported between 1980 and 1991.

In FY 80, persons serving sentences of 1-5 years were paroled 49.4% of the time. By 1991 that figure had dropped to 21%. (Table 14).

Those persons serving sentences of 5-10 years were paroled 50.2% of the time in FY 80 but only 12.5% by FY 91. (Table 15).

For persons serving sentences of 10-20 years the percentages of those paroled dropped from 55.5% in 1980 to 27.4% in FY 91. (Table 16).

In FY 80, 59% of those serving sentences between 20 and 50 years were paroled. However, by FY 91 the number paroled declined to 33.2%. (Table 17).

For those serving sentences varying from 50 years to life the parole rate declined from 56.4% in FY 80 to only 8.3% in FY 91. (Table 18).

Persons receiving life sentences were paroled 45.1% of the time in FY 80 but only 9.4% of the time by FY 91. (Table 19).

**LIFE SENTENCES PAROLED AT INITIAL HEARING**

Aside from the information immediately preceding, reflecting the percentage of persons serving life sentences paroled for all hearings,

further analysis reveals that between 1985 and 1995, only 20 (6.25%) of the 320 individuals serving a life sentence were paroled at their initial interview. (Table 20).

**RETURNED PAROLE VIOLATORS**

Aside from the prospect of parole another aspect to be considered is the likelihood that the paroled individual will be successful during their period of supervision. Unfortunately, monthly statistics from January, 1994 through December, 1995 indicate that between 15% to 25.5% of all admissions are returned technical parole violators. (Table 21).

Further, monthly statistics covering January to December, 1995 reveal that approximately 1-2% of all admissions will be parole violators returned for the commission of a new offense. (Table 22).

Statistics for FY 95 reflect that the Board conducted 1,451 final revocation hearings. Of that number 549 (38%) individuals were given serve outs, 860 (59%) were deferred and only 42 (3%)

were reinstated to parole. Thus, following their return to the institution as a parole violator, 97% of those returned may expect to have their parole revoked.

**CONCLUSION**

The above reveals a clear reality:

- 46% of all inmates receive a serve out at their 1st parole hearing;
- less than 85% of all inmates are paroled when first eligible;
- serve outs have risen from 7.6% to 32.9% over the last 12 years;
- nearly 1/4 of all drug offenders receive serve outs;
- 9 out of 10 times sex offenders are not paroled;
- nearly 1/2 of sex offenders receive a serve out of their sentence;

<b>Life Sentences Paroled at First Hearing with the Board (1985-1995)</b>			
<b>Year</b>	<b>Paroled</b>	<b>Total Interviewed</b>	<b>% Paroled at First Hearing</b>
1985	0	20	0.00%
1986	3	25	12.00%
1987	0	11	0.00%
1988	0	11	0.00%
1989	3	16	18.75%
1990	2	26	7.69%
1991	1	41	2.44%
1992	2	31	6.45%
1993	1	22	4.55%
1994	3	16	18.75%
1995	0	3	0.00%
<b>TOTAL</b>	<b>20</b>	<b>320</b>	<b>6.25%</b>

**Table 20**

- 18% of violent offenders are required to serve out their sentence;
- approximately 30% of property offenders are given serve outs;
- other offenders are required to serve out their sentences over 57% of the time;
- although the percentage varies for each existing sentencing range, the probability of receiving parole ranges from a low of 8.3% to a high of only 27.4%;
- only 9% of persons with life sentences are being paroled;

<b>Technical Admissions vs. All Admissions</b>			
	<b>All Admissions</b>	<b>Technical</b>	<b>Percent (%)</b>
January 1994	486	86	18%
February 1994	513	84	16%
March 1994	641	143	22%
April 1994	538	79	15%
May 1994	609	117	19%
June 1994	597	126	21%
July 1994	416	77	18.5%
August 1994	589	138	23%
September 1994	597	130	22%
October 1994	563	97	17%
November 1994	576	112	19%
December 1994	559	143	25.5%
January 1995	592	114	19%
February 1995	575	123	21%
March 1995	730	170	23%
April 1995	566	119	21%
May 1995	630	101	16%
June 1995	644	133	20%
July 1995	478	101	21%
August 1995	608	137	22.5%
September 1995	603	104	17%
October 1995	601	118	20%
November 1995	554	110	20%
December 1995	552	95	17%

**Table 21**

- only 6.25% of those serving life sentences are paroled at their initial hearing; and,
- returned parole violators will be revoked 97% of the time.

Criminal defense attorneys must heed these statistics when advising clients what is in store for them if sentenced. Attorneys must communicate to clients the clear, reliable trend these statistics afford us.

Those interested in obtaining more detailed statistics should contact Molly Cone or Joanie Abramson with the Kentucky Parole Board

(502) 564-3620 or Louie Smith, Bill Clark or Colleen Williams with the Planning and Evaluation Branch of the Department of Corrections (502) 564-4360. The mailing addresses of both agencies is State Office Building, 5th Floor, Frankfort, KY 40601. Thanks to those named for their assistance to me in compiling the statistical information provided herein.

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<b>Parole Violators Returned for New Crime</b>			
	<b>All Admissions</b>	<b>New Crimes</b>	<b>Percent (%)</b>
January 1995	592	13	2%
February 1995	575	10	2%
March 1995	730	15	2%
April 1995	566	9	2%
May 1995	630	12	2%
June 1995	644	13	2%
July 1995	478	11	2%
August 1995	608	7	1%
September 1995	603	14	2%
October 1995	601	10	2%
December 1995	554	9	2%

**Table 22**



When hope is taken away from people, moral degeneration follows swiftly after.

- Pearl S. Buck (1941)

## Criminal Justice Mental Health Forum: A Dialogue to Greater Meaning



*The Advocate's* substantial dialogue on what constitutes a competent mental health evaluation for indigent criminals accused of a crime continues. Columbia, South Carolina attorney **John Blume**; Lexington psychologist, **Harwell Smith, Ph.D.**; Louisville, Kentucky attorney and psychologist, **Eric Drogin, Ph.D.** and **Curtis Barrett, Ph.D.**, Louisville, Kentucky psychologist **Lee Norton, Ph.D.**, Florida mitigation specialist and **Tony Semone, Ph.D.**, Pennsylvania neuropsychologist, are currently exchanging ideas. In the August, 1995 *Advocate* John Blume set out what his experience reveals as the components of competent evaluations. In the November, 1995 issue Dr. Smith took issue with the practicality of Mr. Blume's views. In the January, 1996 issue Mr. Blume replied and Dr. Drogin entered the dialogue. Dr. Smith responded in the May, 1996 issue to Mr. Blume. That issue also carried a description of the Kentucky Correctional Psychiatric Center by its director, **Greg Taylor**. That article indicated that KCPC provides \$500 for a competency and criminal responsibility evaluation and any resulting testimony across the 400 cases done out-patient in Kentucky. **Lee Norton, Ph.D.**, one of the country's leading mitigation specialists, provided a May, 1996 article on the special skills necessary to reveal information relevant to the life and death decisions factfinders make in capital cases. In that issue **Drs. Drogin and Barrett** discussed the critical importance of being an advocate for your expert opinion, and they explored the components of the psychological evaluation.

This issue in responds to Dr. Smith, **Tony Semone, Ph.D.**, a specialist in the Halstead-Reitan neuropsychological battery, provides his reflections on the inadequacy of neuropsychological screening evaluations, and **Dr. Norton** calls for an understanding of the need for competent social histories, and an understanding of the role of the psychologist in addressing mitigating factors evidenced from the competent mental health evaluation. We invite your reflection, inquiry and dialogue.

"Science is rooted in conversations. The cooperation of different people may culminate in scientific results of the utmost importance." *Physics and Beyond: Encounters and Conversations*, Werner Heisenberg. There is a dearth of dialogue in our criminal justice system. The "truth" of science and of the criminal justice process is better approached by interdependent dialogue rather than destructive discussion.

A leading quantum theorist, David Bohm, see *The Special Theory of Relativity* (1965) is developing a theory of *dialogue* when a group of people "becomes open to the flow of a larger intelligence." He has explored the analogy between the collective properties of particles and the way we think together. "As with electrons, we must look on thought as a systematic phenomena arising from how we interact and discourse with one another." He distinguishes *discussion*, an exchange that has winning as its purpose from dialogue. Bohm sees groups using dialogue to access a greater "pool of common meaning" which individuals cannot obtain. "The whole organizes the parts." Three conditions Bohm sees as necessary for dialogue are:

- 1) participants must "suspend" their assumptions;
- 2) participants must see each other as colleagues; and
- 3) a facilitator must "hold the context."

*The Advocate's* trying to hold the context of this very important dialogue.

### Dialogue vs. Discussion

The discipline of team learning starts with "dialogue," the capacity of members of a team to suspend assumptions and enter into a genuine "thinking together." To the Greeks *dia-logos* meant a free-flowing of meaning through a group, allowing the group to discover insights not attainable individually. Interestingly, the practice of dialogue has been preserved in many "primitive" cultures, such as that of the American Indian, but it has been almost completely lost to modern society. Today, the principles and practices of dialogue are being rediscovered and put into a contemporary context. (Dialogue differs from the more common "discussion," which has its roots with "percussion" and "concussion," literally a heaving of ideas back and forth in a winner-takes-all competition.)

- Peter M. Senge, *The Fifth Discipline:  
The Art of Practice of the Learning Organization* (1990) at 10.

# Commentary on Neuropsychological Screening Examinations

## The Blume v. Smith Dialogue

Dr. Smith argues that (1) with regard to the role of neuropsychological testing in forensic examinations, the referral questions asked by a lawyer can "in almost all cases...be answered with a neuropsychological screening (sic)," (2) "In most cases neuropsychological testing provides more documentation of a deficit noted upon screening but doesn't provide either better localization of the brain dysfunction or an improved idea about any connection between any dysfunction and the criminal behavior." (3) that the "issue of mitigation doesn't really enter into the question asked of the expert."

I would disagree strongly with both Dr. Smith and Mr. Blume that the Reitan battery is "time consuming to give." What conceivable justification could there be for depriving a defendant of the power of a full, validated, neuropsychological test battery, especially when the neuropsychological tests themselves, in the hands of a trained and experienced examiner, add only about four to five hours of testing beyond those tests already given as part of a general clinical psychological workup?

To what questions do these gentlemen refer when Dr. Smith says that the "role of the neuropsychological testing in forensic examinations is to answer the questions of the referring party?" Now in fairness, we have had attorneys refer individuals to us with the question "Is my client brain damaged?" But would we answer this on the basis of some purported "screening examination?" Absolutely not! Why? Because the goal of a neuropsychological evaluation is as Dr. Reitan has said on the record in multiple fore: "The Battery is the screening test. Do more testing if you want/need to, but, if the goal is to understand the brain-behavior relationships of a single individual, why on earth "screen out" the very data which would provide for a meaningful understanding of your patient?" It would be especially egregious an error since the relationship between neurological status and criminal behavior is not unequivocal in the first place.

How about the question "Does my client have any evidence for traumatic brain injury, Korsakoff syndrome, Episodic Dyscontrol, Temporo- limbic seizing? The crime with which my client has been charged, could it have happened because of Transient Ischemic Attacks?" Does the good Dr. Smith really believe that a neuropsychological screening test is as able to specify in as rich detail, for or against the hypothesis of neurological impairment, as would a validated neuropsychological test battery, particularly in combination with highly detailed psychosocial and medical histories? In the cases I have worked, not only is it the rare case when those histories are NOT available it has also never been the case that a 20 minute neuropsychological screening test could provide valid data on either side of the diagnostic question.

As I write this, there is a case being heard in Ohio in which a young man allegedly initiated a conflagration in fireworks store which led to the deaths of several people. During his arraignment, court people were amazed at how glib, seemingly indifferent to the gravity of the context, jocular and "off the wall he appeared." On one of the many court related television programs a neuropsychiatrist ventured the opinion that the defendant had suffered "actual damage to his brain, probably involving his frontal lobes" and that as a consequence the defendant's behavior was understandable on that basis. Clearly in this gentleman's case, neuropsychological assessment will be critical to specify the particular and unique ways in which whatever alleged injury he may have suffered has played itself out in or factored itself into the context of the crime for which he stands accused. Would we presume to gauge his unique neuropsychological pattern on the basis of some "single, screening test for brain damage?" Not on your life; not on his life, either.

Furthermore, there is a growing body of literature to which we have already referred, which

describes in substantial detail, the impact upon brain structure of exposure to and receipt of abusive-giver behavior. The works of van der Kolk, Herman, Garbarino, the Lowenstein clinic at Columbia University, and especially Bruce Perry at Baylor University, make it abundantly clear that there is 'no such thing as a free lunch' when it comes to abuse and violence. We do in fact reap what is sown. As Perry has written, trauma in an adult will change behavior; trauma in a child will change the brain. Unfortunately, psychological trauma especially if pervasive and on-going from early development onward, may be undetectable on MRI and CT scanning (although in this context I should mention that Perry has found some radiographic evidence to suggest structural anomalies in mid-brain systems in children exposed to persistent abuse). There may be better ways to assess for potential impairment in brain function and its relationship to violent criminal behavior than on the basis of a battery of tests which is validated in terms of underlying neurological conditions. I would argue that 20 minute screening examination is absolutely NOT one of them.

Finally, it is difficult to understand Dr. Smith's assertion, apparently on *a priori* grounds alone, that "the issue of mitigation doesn't really enter into the question asked of the expert." Shame on the referring attorney. If brain damage is a statutory or non-statutory mitigator, a qualified neuropsychologist can derive data from a validated battery of tests which will rule on that hypothesis. If the data support the inference of brain damage, and the psychosocial, medical and other evidentiary materials support the conclusion that defendant's brain condition played a significant role in the crime, then the jury is utterly entitled to hear that

testimony offered in mitigation. It is my view that too much havoc is already being wrought by drive-by shootings; we may perhaps play a small role in the service of ameliorating secondary havoc by refusing to engage in "drive-by evaluations."

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*Tony Semone, Ph.D., is a clinical neuropsychologist in Wyndmoor, Pennsylvania. Trained by Dr. Ralph Reitan, Dr. Semone is one of a handful of practitioners personally certified by Dr. Reitan in the use of the Halstead-Reitan Neuropsychological Battery. Dr. Semone received training in the neurosciences at the University of Pennsylvania Medical School and has worked extensively in the evaluation and rehabilitation of brain injured individuals. He has provided neuropsychological assessments, employing the Halstead-Reitan, to attorneys involved in criminal and death penalty cases since 1973. Within the past 18 months, he has served as a neuropsychologist expert in 10 cases in which the death penalty was being sought or in which failure to provide for a comprehensive neuropsychological examination was one of the issues involved in appeals alleging ineffectiveness of counsel. He has developed programs in which local law enforcement officers have played singularly important roles as members of treatment teams whose charge was to provide for the community-based care of violent adolescents. Dr. Semone also provides consultation and training to law enforcement in the psychophysiological aspects of violent confrontations, critical incident stress debriefing and post-violent event encounters.*



## DPA's Recent Departures

**Kim Combs** was a Legal Secretary for Frankfort's Trial Services Administration. She now works in a private law office in Lexington.

**Chris Craig** has worked in Frankfort's Law Operations Unit since 1985. He has accepted a position with Office for Petroleum Storage Tank Assurance Fund as an Administrative Assistant.

**Wendy Craig** was an Assistant Public Advocate in Frankfort's Trial Unit for 4 years. She has accepted a position as a Hearing Officer with the Justice Cabinet in Frankfort.

**Danny Dees** was an Investigator with DPA's Hopkinsville Office for 17 years. He transferred to Probation & Parole in Hopkinsville.

**Doug Moore** was an Assistant Public Advocate in DPA's Paducah Office for 14 months. He is now in private practice.

**Adam Zeroogian** was an Assistant Public Advocate with DPA's Hopkinsville Office for 3 years. He has accepted a position with the Massachusetts Public Defender Office in Springfield.

# Toward a Better Understanding of the Importance of Psychosocial Histories in Forensic Evaluations

I was confused and troubled by several of Dr. Smith's remarks in his May, 1996 reply to Mr. Blume, [see Harwell F. Smith, Ph.D., *Further into the Murk: Reflections on Mr. Blume's Reply*, *The Advocate*, Vol. 18, No. 3 at 10 (May, 1996)], regarding the appropriate scope of mental health evaluations and the process used by psychologists to arrive at accurate conclusions in forensic cases. Central to Dr. Smith's argument was the role of the psychologist in presenting mitigating evidence, the role of the social history in forensic evaluations, and the use of neuropsychological evaluations and their relation to the offense. I will address each of these points.

The role of the psychologist in criminal cases is determined primarily by the potential punishment that can be imposed in the case. In criminal cases, psychologists are called upon to determine competency (whether the client understands the nature of the charges against him, the adversarial process, whether he can assist his lawyer in the defense, and the possible punishments if convicted) and sanity (whether, at the time of the offense, the client knew right from wrong and, in some states' whether he could comport his conduct to the requirements of the law) and submit these findings to the court. Psychologists are also used to assist counsel in developing a theory of defense when the client's mental condition or unique perspective of events played a significant role in the commission of the offense. For example, the effects of a history of chronic depression with delusional features or having been repeatedly battered may not be so great as to rise to the level of insanity (or substantially impaired competency), but could provide the foundation for an argument of a lesser included offense or even self defense.<sup>1</sup>

In capital cases, psychologists are also called upon to render opinions regarding the client's competency and sanity, and assist in determining theories of defense. However, where the client is adjudicated guilty of first-degree

murder and the jury must make a recommendation regarding sentence (a term of years -- usually life with no chance of parole -- or death) the psychologist has the added role of addressing issues of mitigation: the complex interplay of variables that shaped the client's perception, judgment and behavior, and that may militate her culpability. The areas in which psychologists receive education and training make them uniquely qualified to perform this role. Investigators certainly are helpful in gathering critical historical information, but in no way do they possess the extensive education and experience necessary to conduct sophisticated psychometric testing and provide the skilled analyses offered by psychologists. Only a psychologist can explain the implications for learning, social development and judgment, of an I.Q. of 72. Only a psychologist can explain the effects of long-term abuse, lack or loss of essential attachment figures, or the isolation associated with a chronic medical condition. Indeed, psychologists are often the most important mitigation witnesses because they are able to engender within the jury an understanding for the client's own suffering and his confused, ill-conceived actions.

An adequate social history is integral to the psychologist's conclusions regarding competency and sanity, theories of defense, and mitigation. Most psychologists request as much historical information -- in the form of records and collateral interviews - about the client as can be obtained, and review these materials thoroughly prior to conducting an evaluation. For example, when competency is an issue, psychologists typically consider not only whether the client can appreciate the charges against her, the nature of the adversarial system, etc., but -- and perhaps more important -- whether she can make decisions in her own best interest, and meaningfully assist counsel. The latter questions often can be best understood in the context of the client's past experiences and history of social functioning. Thus, if the client has a borderline I.Q. and a

history of repetitive psychological and physical abuse that included witnessing violence, being scapegoated within the family system, and being forced to assume blame for and falsely confess to the infractions of others, she *may* demonstrate windows of competence in which she is able to answer basic competency status questions but, over an extended period, show marked decompensation and eroding competence. In such cases, the social history can be especially helpful to the evaluator. Interviews with family members may reveal that the client has a twenty-year history of self-defeating behavior, chronic confusion, periods of black out and/or dissociation, inability to assess social cues, and being exploited by others, all of which symptoms increase when the client is experiencing heightened stress. School records may provide indicators of abuse and severe learning problems, as well as developmental retardation and social deficiencies. Medical records may document traumatic injuries or multiple admissions for mental health treatment, with varying diagnoses. Together, these data may suggest to the evaluator that the client suffers from complex post-traumatic stress disorder or other conditions that result in disturbance of attention, cognition, behavior, and affect, which in turn at times render the client incapable of effectively assisting in her own defense. For these reasons, competency must be viewed as a temporal variable to be considered in the larger context of the client's mental health history and current conditions.

The same reasoning applies to sanity issues. If the client suffers from complex post-traumatic stress -- chief symptoms of which are affective constriction, dissociation, increased autonomic arousal, hyperstartle response, involuntary intrusive memories, and, in some cases, psychotic episodes -- and committed an offense while experiencing a severe flashback, she may not have been able to appreciate the nature of her acts (especially if she wrongly perceived threat) or comport her conduct to the requirements of law. However, the nature of disorders such as these often prevent clients from being able to accurately express what they were experiencing at the time of the offense (they will often simply state, "I don't know" when asked what happened) and they will respond impassively, seemingly disinterestedly, when queried by mental health professionals. Unfortunately, much mental illness is well-hidden and requires a comprehensive social history to ade-

quately identify and understand. It is often only through a thorough review of collateral information that the client's history of acute or chronic trauma (for example, witnessing one parent kill another or being repeatedly raped) or other conditions is discovered, and the relationship of the condition to the offense revealed.<sup>2</sup>

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

Social histories for use in capital cases are quite involved and require not less than 200 hours of work by those with extensive training and experience conducting mitigation investigations. The two chief means of obtaining psychosocial information are 1) identification, location and acquisition of records, and 2) collateral interviews. All medical, psychological, educational, social services and educational records pertaining to the client and the relatives or individuals with whom he lived are especially important. Obtaining records is not a task for psychologists. Psychologists are not trained to find and retrieve hard-to-locate records, nor is it an appropriate use of their time. Instead, the psychologist must make it clear to the capital attorneys that a review of records is an essential component of a competent mental health evaluation, and should provide to the attorneys an itemized list of records needed.

What about missing records? Naturally, some records will have been destroyed or cannot be located. This is to be expected. It is not necessary to defer one's opinion indefinitely simply because one set of records is unavailable. On the other hand, an avenue of inquiry should not be abandoned when records cannot be found. Rather, attempts should be made to obtain the information from other credible sources. For instance, if the birth records have been lost, it may be possible to locate individuals who accompanied the mother to the hospital and remained with her and the infant after delivery. Similarly, criminal records may not exist, but co-defendants still live in the area. School records could have been destroyed,

but teachers remain at the schools the client attended. The goal is to triangulate the data, making every effort to obtain information not only from different sources, but different kinds of sources; *i.e.*, records and lay witnesses. In this way, a good amount of important information can be uncovered and understood in the proper context, answering questions to do with the way in which the offense occurred and those factors likely to be considered mitigating by a judge and/or jury.

The ecological model is the framework typically used to conduct collateral interviews. Individual, family and community domains are explored. Inquiries include: birth, medical (including all major illnesses and injuries), developmental, educational, mental health, employment/ military, marriage and relationship, and psychological trauma histories. Interviews are conducted in the homes in order to achieve better rapport and assess socioeconomic status, family dynamics, and the availability of community support. As with records, not all collateral witnesses can be located. However, it is important to interview as many witnesses as possible, as each witness provides another piece of the puzzle of the client's life, deepening the understanding of how the client came to see and react to the world around her.

Review of records and interviews of collateral witnesses has increasingly become the expected standard of care in forensic cases, in large part because collateral research has consistently been found to enhance the reliability of mental health evaluations. Additionally, extensive knowledge of the client and the facts of the case increases the credibility of the expert in the eyes of the judge and jury. Psychologists should not be shy about enforcing this unnegotiable requirement of collateral information in completing forensic mental health evaluations. Every case can be seen as an opportunity to educate attorneys and other members of the legal team about what is entailed in confidently determining competency, sanity, and issues concerning guilt-innocence and mitigation. The chief aim is to expend as much time and energy as is necessary to obtain a comprehensive picture of the client, while using resources as efficiently as possible.

Neuropsychological examinations are another necessary component of the mental health eval-

uation. The neuropsychological battery (typically the Halstead-Reitan or Luria-Nebraska) identifies organic causes of behavior and helps to explain behavior in the context of specific deficits. A full neuropsychological evaluation is needed because screening tests often miss important data, and are clinically and statistically much less reliable. Testimony based on neuropsychological screenings contributes little to a full understanding of the client or the case, and is vulnerable even to lackluster cross-examination. The increased scope and validity of the information generated by a full battery more than justifies the extra few hours work involved, and provides a more reliable standard for assessing with confidence brain deficits and the implications for reasoning and behavior.

The effects of generational poverty are well known. Lack of education, lack of resources, and disenfranchisement result in isolation and powerlessness. An inability to alter one's destiny creates shame, depression and an endless repetition of self-defeating behaviors. The costs of the cumulative effects of abuse, neglect and simply being forgotten are dear: Victims more often than not find themselves in the mental health or criminal systems, or being shuffled back and forth between the two. Each failure further reinforces a sense of inadequacy and worthlessness. In the face of the ravages of inhumanity, one can be silently complicit with the perpetrator or share the burden of the victim's pain. One of the most important roles of mental health professionals is to intervene in this cycle, bearing witness to suffering and in so doing helping to restore hope and dignity. Mental health evaluations are a tool for dispelling the silence. Narrative reports bring meaning to chaos and give victims a voice where they once stood mute. Conducting mental health evaluations in forensic cases as mindfully and compassionately as one would with solvent, clinical patients is the only professional standard mental health practitioners can morally or ethically support.

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*Lee Norton, Ph.D., M.S.W., is a social worker specializing in conducting psychosocial histories and developing mental health teams in capital*

*cases. She is the principal author of a chapter on mitigation investigations in the Florida Handbook of Capital Cases, and has trained extensively for the National Legal Aid and Defender Association and numerous other legal and social work organizations. Dr. Norton has worked on more than 70 capital cases at trial, post-conviction, and clemency levels, in state, federal and military courts. She practices in Tallahassee, Florida with her associates, Lisa Moody, M.S.W. and Cori Bauserman.*

#### FOOTNOTES

<sup>1</sup>In one case, a man was charged with killing another man following an argument in a bar. A mitigation investigation revealed that the defendant's son was murdered just six weeks prior to the offense for which the defendant was charged. It was further learned that the victim in the offense had given the knife to the man who had killed the defendant's son. The defendant and the victim argued in the parking lot of the bar and the victim stated "And if you don't quit talking to me, I'll kill your other son" and then dropped to his knees. Ordinarily, this gesture would have held no meaning. However, both the defendant and the victim were Hispanic migrant farm workers who planted and harvested tomatoes and kept knives in their boots for tying string the plants. The defendant, who suffered from a neurological deficit that prevented him from running and limited his range of motion, thought the man

had dropped to his knees in order to reach for a knife. The defendant reflexively pulled a small caliber gun from his payroll pouch and shot the victim. Jury acquitted the defendant on the basis of self defense, accepting the argument that the defendant perceived threat to himself and acted defensively. Absent a thorough investigation and the involvement of a psychologist, this theory of defense likely would not have been discovered.

<sup>2</sup>In another case, involving a client who had been evaluated three times previously, it was learned that the client had stepped on a "Willie Peter" (phosphorus) mine in Viet Nam, sustained burns over 80% of his body, was packed in mud (there were no field medics) for three days until he could be evacuated, and subsequently was treated for over a year at various burn centers. Later, he became very symptomatic, was discharged from the military (the only career he had ever wanted) and, though having no previous criminal record, began acting aberrantly, drinking heavily (to fend off the flashbacks) and engaging in criminal acts. The offense for which he was charged (battery) occurred during a severe flashback that distorted his perception of reality and prevented him from acting in accordance with the law. Despite three evaluations spanning five years, no one had learned of the client's experiences in Viet Nam or his ensuing problems.



## DPA's Recent Hires & Internal Transfers

### New Employees

**Mike Jarman** is an Investigator with DPA's Covington Office as of August 5, 1996. He was formerly employed as a police officer in Boone County, Kentucky for 21 years.

**Amy Kratz** is an Assistant Public Advocate with DPA's Pikeville Office as of July 1, 1996. She received her J.D. from Indiana University Law School in 1996.

**Melinda Sears** is an Investigator with DPA's Pikeville Office. She received her BS in Police Administration from Eastern Kentucky University in May 1996.

### Internal Transfers

**Richard Hoffman** is an Assistant Public Advocate transferring from the Morehead Trial Unit where he's been since December, 1993 to Frankfort's Appellate Section as of August 15, 1996.

**Linda Smith** is an Assistant Public Advocate transferring from the LaGrange Post-Conviction Office where she's been since May 1995 to the Frankfort Trial Unit as of August 12, 1996.

**Bill Spicer** is an Assistant Public Advocate transferring from Director of the Stanton Trial Office to DPA's Covington Trial Office as of September 1, 1996. Bill directed the Stanton Office for 7 years.

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**\*\* NLADA \*\***

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**\*\* NCDC \*\***

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Nothing that is worth anything can be achieved in a lifetime;  
therefore we must be saved by hope.

- Reinhold Niebuhr,  
*The Irony of American History* (1952)

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