JUDGE'S GUIDE TO HANDLING CASES INVOLVING PERSONS

WITH MENTAL DISORDERS

JUDGES GUIDE:
Handling Cases Involving Persons with Mental Disorders

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JUDGE'S GUIDE TO HANDLING CASES INVOLVING PERSONS WITH MENTAL DISORDERS

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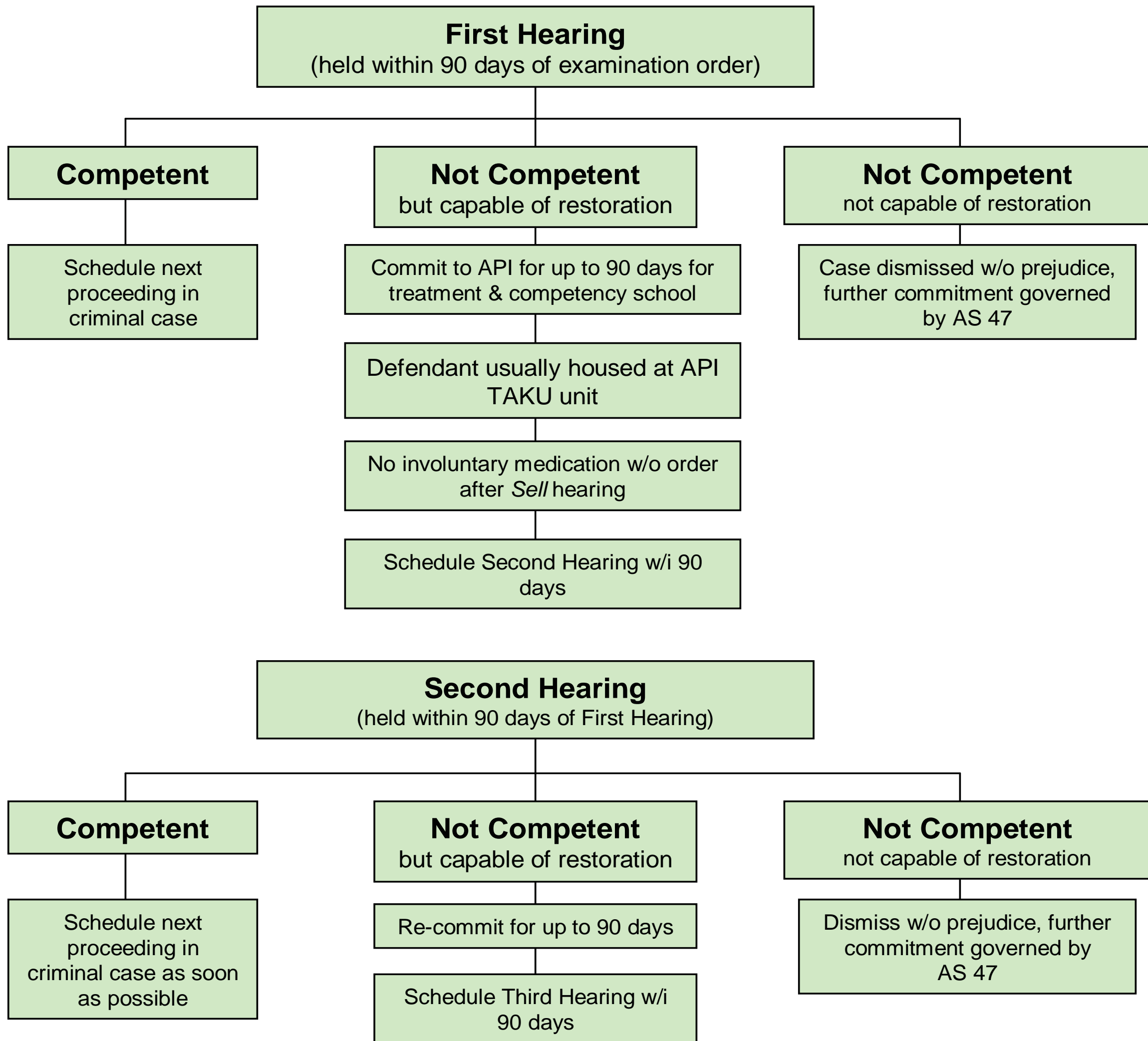
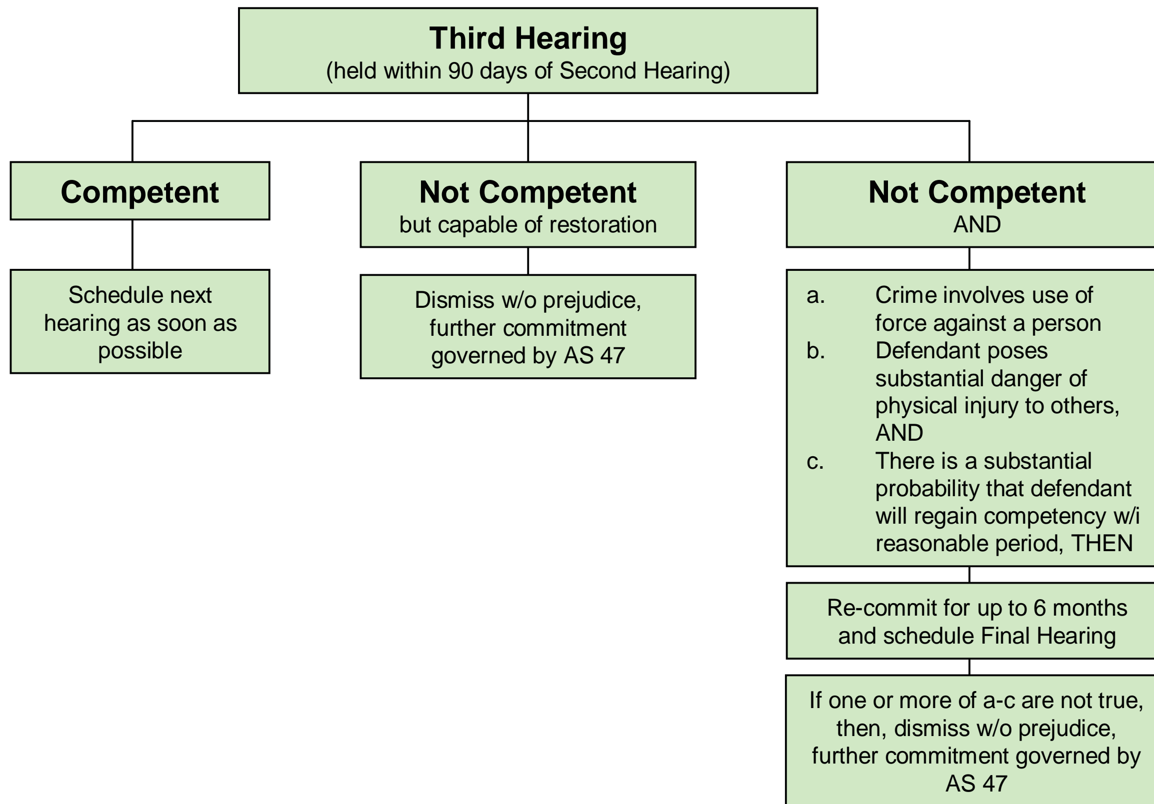
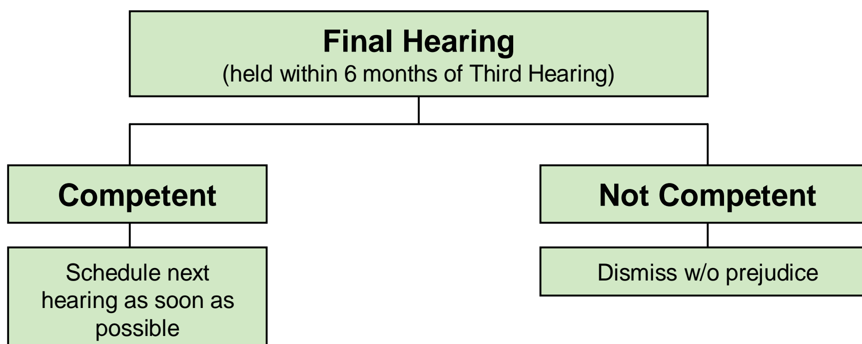
COMPETENCY TO PROCEED FLOWCHART




Third Hearing
(held within 90 days of Second Hearing)
Competent
Schedule next hearing as soon as possible
Not Competent
but capable of restoration
Dismiss w/o prejudice, further commitment governed by AS 47
Not Competent
AND
a. Crime involves use of force against a person
b. Defendant poses substantial danger of physical injury to others, AND
c. There is a substantial probability that defendant will regain competency w/i reasonable period, THEN
Re-commit for up to 6 months and schedule Final Hearing
If one or more of a-c are not true, then, dismiss w/o prejudice, further commitment governed by AS 47


Final Hearing
(held within 6 months of Third Hearing)
Competent
Schedule next hearing as soon as possible
Not Competent
Dismiss w/o prejudice

Competence for Legal Proceedings Hearing Checklist
FIRST EVIDENTIARY HEARING

Hold within 90 days of Order for Psychiatric Examination

Burden of Proof Preponderance of the evidence

Who has the burden Party arguing for finding of incompetence

Statutory references AS 12.47.070, AS 12.47.100, AS 12.47.110, AS 12.47.130

Law Defendant presumed competent unless, due to a mental disease or defect, the defendant is:

1. unable to understand the proceedings against him/her *AND/OR*
2. unable to assist in own defense.

Evidence

1. API REPORT OF EXAM
   Report shall contain the following:
   - Description of nature of the exam
   - Diagnosis of mental condition
   - Opinion as to whether defendant suffers from mental disease or defect, lacks capacity to understand the proceedings or assist in own defense
   - Whether exam could not be conducted due to defendant's unwillingness
   - Opinion as to whether the unwillingness is result of mental disease or defect
   - If requested, opinion as to whether the defendant is capable of self representation

2. OPINION OF DEFENSE COUNSEL
   Defense counsel's estimation of *competence* should be accorded substantial weight[1]) however, defense counsel's estimation of client's *incompetence* need not be given the same weight. [2]

3. OTHER EVIDENCE
   Other expert testimony proffered by the prosecutor or defense; defendant may testify.

[1] Fajeriak v. State 520 P.2d 795, 802-03 (Alaska 1974)
[2] McKinney v. State, 566 P.2d 653, 660 (Alaska 1977)

Statutory Considerations for the Court (AS 12.47.100):

Determining Intellectual Functioning

- Does defendant have a driver's license?
- Is defendant able to maintain employment?
- Is defendant competent to testify as a witness under Rules of Evidence?

Determining Ability to Understand Proceedings

- "Understand the proceedings" mean "the defendant has a reasonably rational comprehension of the proceedings." (AS 12.47.130(5).
- Does the defendant understand that he or she has been charged with a crime and what penalties could be imposed?
- Does the defendant understand the roles of judge, jury, prosecutor, defense counsel?
- Can defendant be expected to tell defense counsel the circumstances surrounding the alleged offense?
- Can the defendant distinguish between a guilty and not guilty plea?
- Any other relevant factors.

Determining Ability to Assist in Own Defense

- Can defendant recall and relate facts re: his/her actions at times relevant to the charges? If not, is the failure of recall due to the mental disease or defect?
- Can defendant respond coherently to counsel's questions?
- Any other relevant factors.

Note: Defendant is considered able to assist counsel even if: memory is impaired, s/he refuses to accept course of action that counsel or court believes is in defendant's best interest, or is unable to suggest a strategy or unable to chose a defense.

FINDINGS AND ACTIONS

FINDING 1: DEFENDANT NOT COMPETENT, CAPABLE OF RESTORATION

ACTION:

1. Court shall commit in felony case; may commit in misdemeanor case for restoration
2. Case stayed
3. Rule 45 tolled
4. Use **Court Form CR-265** Order of Commitment and Transport Order
5. Must schedule second hearing within 90 days

Note best practice: ask psychologist how long it took for the defendant to respond to previous treatment in last API stay, if any. Schedule second hearing within that amount of time.

Also note: the defendant **may not be involuntarily medicated** under the Order for Psychiatric Examination for Legal Competence or the Order of Commitment and Transport. A hearing pursuant to Sell v. United States, 539 U.S. 166 (2003) must be requested by the prosecutor and held by the court. (See **Involuntary Medications for Competency Restoration Hearing Checklist**)

FINDING 2. DEFENDANT NOT COMPETENT, NOT CAPABLE OF RESTORATION

ACTION:

1. Case dismissed without prejudice
2. Any further commitment governed by the civil commitment process. (AS 47.30.700-47.30.915)

FINDING 3. DEFENDANT COMPETENT

ACTION: Stay lifted, schedule case for further proceedings (trial, plea, or sentencing

Best practice: Schedule further proceedings as soon as possible. Defendant may not remain competent – competency is a dynamic process. Once found competent, defendant is returned to the Department of Corrections. Competence may not continue in that environment.

Competence for Legal Proceedings Hearing Checklist
SECOND EVIDENTIARY HEARING

Hold within 90 days of First Evidentiary Hearing

Burden of Proof Preponderance of the evidence

Who has the burden Party arguing for incompetence finding

Law Does the defendant remain:
unable to understand the proceedings against him/her *AND/OR*
unable to assist in own defense, due to mental disease or defect?

Evidence and Statutory Considerations See First Evidentiary Hearing Checklist

FINDING 1: DEFENDANT NOT COMPETENT, CAPABLE OF RESTORATION

ACTION:
1. Court may re-commit **felony or misdemeanor** case for up to 90 days restoration
2. Case stayed
3. Rule 45 tolled
4. Use Court Form CR-265 Order of Commitment and Transport Order
5. Must schedule third hearing within 90 days

Note best practice: Ask psychologist how long it took for the defendant to respond to previous treatment in last API stay, if any. Schedule third hearing within that amount of time.

Also note: the defendant **may not be involuntarily medicated** under the Order for Psychiatric Examination for Legal Competence or Order of Commitment and Transport. A hearing pursuant to Sell v. United States, 539 U.S. 166 (2003) must be held by the court. (See **Involuntary Medications for Competency Restoration Hearing Checklist**)

FINDING 2: DEFENDANT NOT COMPETENT, NOT CAPABLE OF RESTORATION

ACTION:
1. Case dismissed without prejudice
2. Any further commitment governed by the civil commitment process (AS 47.30.700-47.30.915)

FINDING 3: DEFENDANT COMPETENT

ACTION: Stay lifted, schedule case for further proceedings

Best practice: Schedule further proceedings as soon as possible. Defendant may not remain competent – competency is a dynamic process. Once found competent, defendant is returned to the Department of Corrections. Competence may not continue in that environment.

Competence for Legal Proceedings Hearing Checklist
THIRD HEARING

Hold within 90 days of Second Hearing

Burden of Proof Preponderance of the evidence

Who has the burden Party arguing for incompetence finding

Law Does defendant remain:
unable to understand the proceedings against him/her *AND/OR*
unable to assist in own defense, due to a mental disease or defect?

FINDINGS AND ACTIONS

FINDING 1: DEFENDANT NOT COMPETENT, NOT CAPABLE OF RESTORATION AND CASE DOES NOT INVOLVE USE OF FORCE AGAINST A PERSON

ACTION: Case dismissed without prejudice; Any further commitment governed by civil commitment (AS 47.30.700-47.30.915)

FINDING 2: DEFENDANT NOT COMPETENT, CAPABLE OF RESTORATION, CASE INVOLVES USE OF FORCE AGAINST A PERSON

ACTION: Consider these questions and make findings:

1. Is defendant is a substantial danger of physical injury to others? and
2. Is there is a substantial probability defendant will regain competency in reasonable period of time?

If findings are affirmative, then court may recommit for up to 180 days.

Schedule final hearing within 180 days.

Also note: the defendant **may not be involuntarily medicated** under the Order for Psychiatric Examination for Legal Competence or Order for Commitment and Transport. A hearing pursuant to Sell v. United States, 539 U.S. 166 (2003) must be requested by the prosecutor and held by the court. (See **Involuntary Medications for Competency Restoration Hearing Checklist**)

Competence for Legal Proceedings Hearing Checklist
FINAL HEARING

Hold within 180 days of Third Hearing

Burden of Proof Preponderance of the evidence

Who has the burden Party arguing for incompetence finding

Law Does defendant remain:
unable to understand the proceedings against him/her *AND/OR*
unable to assist in own defense, due to a mental disease or defect?

Evidence and Statutory Considerations See Initial and Second Hearing Checklists

FINDINGS AND ACTIONS

FINDING 1: DEFENDANT COMPETENT

ACTION Stay lifted, schedule case for further proceedings

FINDING 2: DEFENDANT NOT COMPETENT

ACTION Case dismissed without prejudice; Any further commitment governed by the civil commitment process (AS 47.30.700-47.30.915); felony cases only – rebuttable presumption that defendant is mentally ill and likely to cause serious harm to self or others.

IN THE DISTRICT/SUPERIOR COURT FOR THE STATE OF ALASKA
AT ___________________________

STATE OF ALASKA)
)
Plaintiff,)
)
vs.)
)
)
) CASE NO. ________________________CR
Defendant.)
DOB:__________________________________)

ORDER FOR PSYCHIATRIC EXAMINATION

I. APPOINTMENT OF PSYCHIATRIST

The Director/CEO of the Alaska Psychiatric Institute (API) is appointed to name a qualified psychiatrist who shall examine the defendant for the purposes described in Section II below and report findings to the court. If the examination is to determine mental culpability, two qualified psychiatrists or two forensic psychologists certified by the American Board of Forensic Psychology must be named.

This matter is set for further hearing as follows:

DATE: ____ TIME: _________________
COURT LOCATION: ______________________________ COURTROOM: _________

The report is due to the court prior to the above date and time. If the report is completed prior to the date above and if, in the medical judgment of the evaluator, the defendant is considered to be mentally competent for criminal proceedings prior to the above hearing date, the undersigned judge's chambers shall be promptly notified so that an expedited hearing pursuant to AS 12.47.100 can be scheduled.

II. PURPOSE OF EXAMINATION

A. Examination for Competency to Proceed (AS 12.47.100)

The purpose of the examination is to determine if the defendant, by reason of mental disease or defect, is incompetent for criminal proceedings. The report of the examination of the defendant shall contain the following:

1. a description of the nature of the examination;
2. a diagnosis of the mental condition of the defendant; and
3. an opinion as to whether the defendant suffers from a mental disease or defect and, as a result of the mental disease or defect, lacks the capacity to understand the proceedings against defendant or properly assist in defendant's own defense.
4. If the examination cannot be conducted because of the defendant's unwillingness to participate, the report shall so state and shall include, if possible, an opinion as to whether the unwillingness of the defendant is the result of mental disease or defect.

5. (if box checked) An opinion as to whether the defendant is mentally capable of conducting defendant's defense without qualified counsel or whether, due to mental incompetence, defendant is not capable of doing so.

B. Examination for Mental Culpability (AS 12.47.070)

The purpose of the examination is to make a determination and report the following:

1. a description of the nature of the examination;
2. a diagnosis of the mental condition of the defendant;
3. an opinion as to whether the defendant suffers from a mental disease or defect, and an opinion as to defendant's capacity to understand the proceedings against defendant and assist in defendant's own defense.
4. the defendant has filed notice of a defense under:

   AS 12.47.010(b). Therefore, the report must include an opinion as to the extent, if any, to which the capacity of the defendant to appreciate the nature and quality of defendant's conduct was impaired at the time of the crime charged;

   AS 12.47.020(a). Therefore, the report must include an opinion as to the capacity of the defendant to have a culpable mental state which is an element of the crime charged; namely the culpable mental state of ______
   ____

5. Defendant has filed a notice under AS 12.47.090(a). Therefore, the report must consider whether the defendant is presently suffering from any mental illness that causes the defendant to be dangerous to the public.

III. GENERAL PROVISIONS

IT IS FURTHER ORDERED:

A. The examination was requested by the
   District Attorney Defendant Court

B. The prosecuting attorney shall within _______ days (5 days if not otherwise noted) send a copy of the charging document, police report(s) and the defendant's criminal history directly to API in a large envelope with the words "Confidential - Court Ordered Examination" written on the bottom of the envelope.

C. The defense attorney shall within _______ days (5 days if not otherwise noted) send to API in the manner described in paragraph B above a copy of all reports required to be disclosed to the prosecution under Criminal Rule 16(c)(4).

D. The defense or prosecuting attorney may provide any other relevant information for consideration during the psychiatric examination by delivering it to API in the manner described in paragraph B above within the required timeframe.

E. The clerk of court shall immediately send to API a copy of: this order, the temporary order, the charging document in this case, any presentence report filed in this case and any psychiatric report filed in this case if the report was prepared by a psychiatrist other than one designated in this order. The clerk shall place copies of any confidential reports in a separate sealed envelope labeled "Confidential - Court Ordered Examination."

F. The examining psychiatrists or psychologists may use any medically acceptable source of information available.

G. If the defendant is in custody, the Department of Corrections shall make available to API all current medical records concerning the defendant.

H. The report ordered herein shall be filed with the clerk of the court at ___________ __________________________________, Alaska who shall deliver copies of the report to the prosecuting attorney and to the defendant's attorney.

IV. COMMITMENT AND TRANSPORTATION (In-Custody Examination Only)

Commitment. Defendant is ordered committed to a secure facility to be designated by the Department of Corrections (DOC) for a period of commitment not to exceed 60 days. Upon completion of the examination, defendant may be released on bail as previously set.

Transportation. The examination will be conducted at API or at the correctional facility in Anchorage where defendant is held as agreed to by DOC and API. If necessary, the Alaska State Troopers (AST) are ordered to arrange for transportation of defendant to API, and upon completion of the examination, return the defendant to Corrections. Transportation to and from API from outside Anchorage will occur as soon as practicable.

If the defendant is in either DOC or API custody by the authority of a court order, AST shall arrange for the transportation of defendant to court for the hearing listed in Section I above.

AST shall arrange for transportation of defendant to Anchorage for examination. Transportation to and from API from outside Anchorage will occur as soon as practicable. Prior to transportation, AST will coordinate the transportation with DOC and API. DOC shall notify API when defendant arrives in Anchorage if the defendant is committed by the court to DOC. AST will notify API when the defendant arrives in Anchorage if the defendant is committed by the court to API.

V. OUTPATIENT EXAMINATION (Only For Defendants Who Are Not In Custody)

Defendant's counsel Defendant is ordered to contact the Alaska Psychiatric Institute within the next _________________days to schedule an examination.

_________________________ Date

_____________________________________ Judge

I certify that on ______________
a copy of this order was sent to:
AST (2 copies of order & T.O.), API
Prosecuting Attorney, Defense Attorney

Clerk: ___________________

_____________________________________ Type or Print Judge's Name

IN THE DISTRICT/SUPERIOR
COURT FOR THE STATE OF ALASKA
AT ___________________________

STATE OF ALASKA)
)
Plaintiff,)
)
vs.)
CASE NO. ___________________________CR
)
Defendant.)
DOB:___________________________________)

ORDER OF COMMITMENT AND TRANSPORT ORDER

Based on a finding of mental incompetence, the proceedings in this matter are STAYED.

1. COMMITMENT

Defendant is ordered committed to the custody of the Commissioner of Health and Human Services' authorized representative, Alaska Psychiatric Institute (API), for further evaluation and treatment* until:

the defendant is rendered mentally competent to stand trial; or
the pending charges in this matter are disposed of according to law; or
the expiration of this order.

During the period of commitment, the Commissioner of Health and Social Services, or the Commissioner's appropriate medical representatives, will administer treatment* as necessary to render the defendant competent to stand trial, will evaluate the defendant's competence, and will submit a report of competency to the court prior to the hearing date below.

The undersigned judge's chambers must be promptly notified so that an expedited hearing pursuant to AS 12.47.100 can be scheduled if, prior to the hearing scheduled below, the defendant's custodian considers the defendant to be mentally competent to stand trial or to be enabled by treatment to understand the proceedings and to properly assist in his or her own defense.

* Defendant may not be involuntarily medicated pursuant to this order. *See Sell v. United States,* 539 U.S. 166 (2003).

2. TRANSPORTATION

The Alaska State Troopers must transport the defendant to API for commitment as soon as practicable.

3. HEARING ON COMPETENCE is set for:

Date:____________________________________Time:____________________ am pm
Location:____

This order expires 90 days from the date of this order unless renewed at the hearing (set in #3 above) or at another hearing.

_______________________________ _______________________________
Date Judge

I certify that on _________________ a copy of this order was sent to: AST API Prosecuting Attorney Defense Attorney Clerk:___________________

____
Type or Print Name

IN THE SUPERIOR COURT FOR THE STATE OF ALASKA
___________JUDICIAL DISTRICT AT _____________

IN THE MATTER OF:)
)
)
)
A Minor Under 18 Years of Age.)
)
DOB:)

Case No. ________________CP

ORDER FOR COMPETENCY EXAMINATION OF JUVENILE

TO: Department of Health and Social Services: Division Juvenile Justice

This court has determined that a competency examination of the above-named juvenile is necessary to allow the court to properly proceed.

1. Reason: This examination is being ordered because of (example: the juvenile's apparent inability or unwillingness to maintain self-control during court hearings, including outbursts and failure to comply with requests from the court and his attorney to refrain from such inappropriate behaviors).

2. Purpose: The purpose of the examination is to determine if the juvenile, by reason of mental incompetence, is unable to understand the proceedings or properly assist in his/her own defense.

3. Scope: The assessment shall include the full range of abilities for competency to stand trial. The scope of the examination shall address the juvenile's understanding and appreciation of the following areas, some of which may not be relevant to examination of an adult, but all of which apply in an examination of a juvenile:

   a. Juvenile's past legal experiences
   b. Understanding of the charges, consequences and trial process,
   c. Nature and seriousness of the offense charged
   d. Nature and purpose of the juvenile court trial
   e. Possible pleas.
   f. Guilt and punishment/penalties
   g. Roles of participants, including the prosecutor, juvenile's attorney, probation officer and judge.
   h. Assisting juvenile's attorney.
   i. Plea bargains/agreements.
   j. Reasoning and decision-making about the issues of having a defense

attorney, how to assist the attorney, deciding how to plead and evaluating a plea bargain.

k. Participating at juvenile court hearings, including ability to focus on what is going on, ability to maintain self-control and ability to testify.

l. Cognitive, attentional, communication, and interpersonal abilities relevant for assisting counsel meaningfully, and

m. Capacities for decision making about rights that are essential for due process.

4. Report: The report of the examination of the juvenile shall contain the following: An opinion, based on an evaluation of the juvenile's understanding and appreciation of the areas listed in 3, above, as to whether the juvenile lacks the capacity to understand the proceedings against him or properly assist in his own defense.

IT IS ORDERED, that the Department of Health and Social Services arrange for the competency examination of the juvenile and for a written report of the findings and evaluation to be submitted to this court on or before __________.

Effective Date:________________

Recommended:

__________________ ______________________________

Date Superior Court Judge

Mental Competency Evaluations:

Guidelines for Judges and Attorneys

Patricia A. Zapf and Ronald Roesch

Competency to stand trial is a concept of jurisprudence allowing the postponement of criminal proceedings for those defendants who are considered unable to participate in their defense on account of mental or physical disorder. It has been estimated that between 25,000 and 39,000 competency evaluations are conducted in the United States annually.[1] That is, between 2% and 8% of all felony defendants are referred for competency evaluations.[2]

In this article, we will present an overview of competency laws, research, methods of assessment, and the content of reports to the courts conducted by clinicians, with the aim of providing a summary of relevant information about competency issues. The purpose of this article is to inform key participants in the legal system (prosecutors and defense attorneys, as well as judges) about the current state of the discipline of forensic psychology with respect to evaluations of competency.[3]

BACKGROUND & DEFINITION

Provisions allowing for a delay of trial because a defendant was incompetent to proceed have long been a part of legal due process. English common law allowed for the arraignment, trial, judgment, or execution of an alleged capital offender to be stayed if he or she "be(came) absolutely mad."[4] Over time, statutes have been created that have further defined and extended the common-law practice.

The modern standard in U.S. law was established in Dusky v. United States.[5] Although the exact wording varies, all states usea variant of the Dusky standard to define competency.[6] In Dusky, the United States Supreme Court ruled that a minimum level of rational understanding of the proceedings and ability to help one's attorney was required:

> [I]t is not enough for the district judge to find that "the defendant [is] oriented to time and place and [has] some recollection of events," but that the "test must be whether he has sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding—and whether he has a rational as well as factual understanding of the proceedings against him."[7]

Although the concept of competency to stand trial has been long established in law, its definition, as exemplified by the ambiguities of Dusky, has never been explicit. What is meant by "sufficient present ability"? How does one determine whether a defendant "has a rational as well as factual understanding"? To be sure, some courts[8] and legislatures[9] have provided general direction to evaluators in the form of articulated Dusky standards[10], but the typical forensic evaluation is left largely unguided except by a common principle, in most published cases, that evaluators cannot reach a finding of incompetency independent of the facts of the case at hand.

This article was adapted from Ronald Roesch, Patricia A. Zapf, Stephen L. Golding & Jennifer L. Skeem, Defining and Assessing Competency to Stand Trial, in HANDBOOK OF FORENSIC PSYCHOLOGY 327 (Irving B. Weiner & Allen K. Hess, eds., 2d ed. 1999)

Footnotes

1. Steven K. Hoge, et al., The MacArthur Adjudicative Competence Study: Development and Validation of a Research Instrument, 21 LAW & HUM. BEHAV. 141 (1997); Henry J. Steadman & E. Hartstone, Defendants Incompetent to Stand Trial, in MENTALLY DISORDERED OFFENDERS: PERSPECTIVES FROM LAW AND SOCIAL SCIENCE 39 (John Monahan & Henry J. Steadman eds., 1983).
2. Richard J. Bonnie, The Competence of Criminal Defendants: A Theoretical Reformulation, 10 BEHAV. SCI. & L. 291 (1992); STEPHEN L. GOLDING, INTERDISCIPLINARY FITNESS INTERVIEW-REVISED: A TRAINING MANUAL (1992); Steven K. Hoge, et al., Attorney-client Decision-making in Criminal Cases: Client Competence and Participation as Perceived by Their Attorneys, 10 BEHAV. SCI. & L.385 (1992).
3. This article focuses on competency issues within the United States. For a review of competency issues with respect to Canadian laws and practice, the reader is referred to Patricia A. Zapf & Ronald Roesch, Assessing Fitness to Stand Trial: A Comparison of Institution-based Evaluations and a Brief Screening Interview, 16 CAN. J. COMMUNITY MENTAL HEALTH 53 (1997); and Patricia A. Zapf & Ronald Roesch, A Comparison of Canadian and American Standards for Competence to Stand Trial, INTL. J. L. & PSYCH. (in press).
4. Hale, 1973, cited in P. R. Silten & R. Tullis, Mental Competency in Criminal Proceedings, 28 HASTINGS L.J. 1053, 1053 (1977).
5. 362 U.S. 402 (1960).
6. R. J. Favole, Mental Disability in the American Criminal Process: A Four Issue Survey, in MENTALLY DISORDERED OFFENDERS: PERSPECTIVES FROM LAW AND SOCIAL SCIENCE 247 (John Monahan & Henry J. Steadman eds., 1983).
7. 362 U.S. at 402 (quoting from brief of U.S. Solicitor General).
8. See, e.g., Wieter v. Settle, 193 F. Supp. 318 (W.D. Mo. 1961).
9. See, e.g., Utah Code Ann. § 77-15-1 et seq. (2000).
10. Standards of competence have been one area of inquiry; the conceptualization of competence is another. Some researchers and scholars have provided reconceptualizations of competence to stand trial. Bruce J. Winick has persuasively argued that, in some circumstances, it might be in the best interests of the defendant to proceed with a trial, even if he or she is incompetent. See Bruce J. Winick, Restructuring Competency to Stand Trial, 32 UCLA L. REV. 921 (1985); and Bruce J. Winick, Reforming Incompetency to Stand Trial and Plead Guilty: A Restated Proposal and a Response to Professor Bonnie, 85 J. CRIM. L. & CRIMINOLOGY 571 (1995). Winick postulated that this could take the form of a provisional trial in which the support of the defense attorney would serve to ensure protection of the defendant. This would allow the defendant to proceed with his or her case while maintaining decorum

OVERVIEW OF LEGAL PROCEDURES

The issue of competency may be raised at any point in the adjudication process.[11] If a court determines that a bona fide doubt exists as to a defendant's competency, it must consider this issue formally,[12] and usually after a forensic evaluation, which can take place in a jail, an outpatient facility, or in an institutional setting.

One legal issue that may concern evaluators of competency to stand trial is whether information obtained in a competency evaluation can be used against a defendant during the guilt phase of a trial or at sentencing. While some concerns have case. been raised about possible self-incrimination,[13] all jurisdictions in the United States provide, either statutorily or through case law, that information obtained in a competency evaluation cannot be introduced on the issue of guilt unless the defendant places his or her mental state into evidence at either trial or sentencing hearings.[14]

Once a competency evaluation has been completed and the written report submitted,[15] the court may schedule a hearing. If, however, both the defense and the prosecution accept the findings and recommendations in the report, a hearing does not have to take place. It is likely that in the majority of the states, a formal hearing is not held for most cases. If a hearing is held, the evaluators may be asked to testify, but most hearings re quite brief and usually only the written report of an evaluator is used. In fact, the majority of hearings last only a few minutes and are held simply to confirm the findings of evaluators.[16] The ultimate decision about competency rests with the court, which is not bound by the evaluators' recommendations.[17] In most cases, however, the court accepts the recommendations of the evaluators.[18]

> Although the exact wording varies, all states use a variant of the Dusky standard to define competency.

At this point defendants found competent proceed with their case. For defendants found incompetent, either their trials are postponed until competency is regained or the charges are dismissed, usually without prejudice. The disposition of incompetent defendants is perhaps the most problematic area of the competency procedures. Until the case of *Jackson v. Indiana*,[19] virtually all states allowed the automatic and indefinite commitment of incompetent defendants. In *Jackson*, the U.S. Supreme Court held that defendants committed solely on the basis of incompetency "cannot be held more than the reasonable period of time necessary to determine whether there is a substantial probability that he will attain that capacity in the foreseeable future."[20] The Supreme Court did not specify how long a period of time would be reasonable nor did it indicate how progress toward the goal of regaining competency could be asessed.

The Jackson decision led to revisions in state statutes to provide for alternatives to commitment as well as limits on the length of commitment.[21] The length of confinement varies from state to state, with some states having specific time limits (e.g., 18 months) while other states base length of treatment on a proportion of the length of sentence that would have been given had the defendant been convicted.

Once defendants are found incompetent, they may have only limited rights to refuse treatment.[22] Medication is the most common form of treatment, although some jurisdictions have established treatment programs designed to increase understanding of the legal process,[23] or that confront problems that

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in the courtroom and without violating the defendant's constitutional rights. As well, Richard J. Bonnie has provided a reformulation of competence to stand trial. Bonnie proposed a distinction between two types of competencies—competence to assist coun- sel and decisional competence. He argued that defendants found incompetent to assist counsel would be barred from proceeding until they were restored to competence. *See* Richard J. Bonnie, *The Competence of Criminal Defendants: Beyond Dusky and Drope,* 47 U. MIAMI L. REV. 539 (1993). Defendants found decisionally incompetent, on the other hand, may be able to proceed in certain cases where his or her lawyer is able to present a defense. Although these reformulations are consistent with psychological perspectives on competence, they have not yet been adopted by the courts. Until the courts have accepted these ideas they will not significantly impact psychological practice.

11. Stephen. L. Golding & Ronald Roesch, *Competency for Adjudication: An International Analysis, in LAW AND MENTAL HEALTH: INTERNATIONAL PERSPECTIVES* 73 (David N. Weisstub ed., Vol. 4. 1988).

12. Drope v. Missouri, 420 U.S. 162 (1975); Pate v. Robinson, 383 U.S. 375 (1966).

13 *See, e.g.,* W. T. Pizzi, *Competency to Stand Trial in Federal Courts: Conceptual and Constitutional Problems*, 45 U. CHI. L. REV. 20 (1977).

14. Estelle v. Smith, 451 U.S. 454 (1981); GOLDING & ROESCH, *supranote* 11.

15. *See*, for a discussion of the content of these reports, Gary B.Melton, John Petrila, Norman G. Poythress & Christopher Slobogin, PSYCHOLOGICAL EVALUATIONS FOR THE COURTS: A HANDBOOK FOR MENTAL HEALTH PROFESSIONALS AND LAWYERS (1987); Russell C. Petrella & Norman G. Poythress, *The Quality of Forensic Evaluations: An Interdisciplinary Study,* 51 J. CONSULTING & CLINICAL PSYCH. 76 (1983); Jennifer L. Skeem, Stephen L. Golding, Nancy B. Cohn & Gerald Berge, *The Logic and Reliability of Evaluations of Competence to Stand Trial,* 22 LAW& HUMAN BEHAV. 519 (1998).

16. HENRY J. STEADMAN, BEATING A RAP?: DEFENDANTS FOUND INCOMPETENT TO STAND TRIAL (1979).

17. *See, e.g.*, State v. Heger, 326 N.W.2d 855 (N.D. 1982).

18. Stephen D. Hart & Robert D. Hare, *Predicting Fitness for Trial: The Relative Power of Demographic, Criminal and Clinical Variables*, 5 FORENSIC REP. 53 (1992); Steadman, *supra* note 16.

19. 406 U.S. 715 (1972).

20. 406 U.S. at 738.

21. RONALD ROESCH & STEPHEN L. GOLDING, COMPETENCY TO STAND TRIAL (1980).

22. *See generally*, Bruce J. Winick, I*ncompetency to Stand Trial: Developments in the Law, in MENTALLY DISORDERED OFFENDERS: PERSPECTIVES FROM LAW AND SOCIAL SCIENCE* 3 (John Monahan & Henry J. Steadman eds., 1983).

23. L. Pendleton, *Treatment of Persons Found Incompetent to Stand Trial*, 137 AM. J. PSYCH. 1098 (1980); Christopher D. Webster, F. A. S. Jenson, L. Stermac, K. Gardner & D. Slomen, *Psychoeducational Programmes for Forensic Psychiatric Patients,* 26 CANADIAN PSYCH. 50 (1985).

Jennifer Skeem and her colleagues demonstrated that examiner agreement on specific psycholegal deficits (as opposed to general competency) averaged only 25% . . . .

hinder a defendant's ability to participate in the defense.[24] Laws regarding competence vary from state to state, although most jurisdictions follow procedures similar to those described above.

RESEARCH FINDINGS

Though there has been some confusion over the definition of competency per se, there nevertheless appears to be generally good agreement between evaluators about whether a defendant is conpetent or not. The few studies of reliability that have been completed report that pairs of evaluators agree in 80% or more of the cases.[25] When evaluators are highly trained and use semistructured competence assessment instruments, even higher rates of agreement have been reported.[26]

When base rates of findings of competency are considered, however, these high levels of agreement are less impressive and they do not suggest that evaluators are necessarily in agreement about the criteria for a determination of competency. A psychologist, without even directly assessing a group of defendants, could achieve high levels of agreement with an examining clinician, simply by calling all defendants competent (base-rate decision). Since in most jurisdictions, approximately 80% of all referred defendants are competent, the psychologist and the examiner would have modest agreement, even with making no decisions at all. Most disturbingly, Jennifer Skeem and her colleagues demonstrated that examiner agreement on specific psycholegal deficits (as opposed to overall competency) averaged only 25% across a series of competency domains.[27] It is the more difficult decisions, involving cases where competency is truly a serious questions, that are of concern. How reliable are decisions about these cases? To date, no study has acculuated enough of these cases to answer this question.

High levels of reliability do not, of course, ensure that valid decisions are being made. Two evaluators could agree that the presence of psychosis automatically leads to a finding of incompetency. As long as the evaluators are in agreement about their in which assessment of a defendant's performance could continue. If a defendant was unable to participate, then the trial could be stopped. If a verdict had already been reached and the defendant was convicted, the verdict could be set aside.

As we have indicated, the courts usually accept mental health judgments about competency. Does this mean that the judgments are valid? Not necessarily, since courts often accept the evaluator's definition of competency and his or her conclusions without review, leading to very high levels of examiner-judge agreement.[28]

We have argued that the only ultimate way of assessing the validity of decisions about incompetency is to allow defendants who are believed to be incompetent to proceed with a trial anyway.[29] This could be a provisional trial (on the Illinois model),in which assessment of a defendant's performance could continue. If a defendant was unable to participate, then the trial could be stopped. If a verdict had already been reached and the defendant was convicted, the verdict could be set aside.

We suspect that in a significant percentage of trials, alleged incompetent defendants would be able to participate. In addition to the obvious advantages to defendants, the use of a provisional trial could provide valuable information about what should be expected of a defendant in certain judicial proceedings (e.g., the ability to testify, identify witnesses, describe events, evaluate the testimony of other witnesses, etc.). Short of a provisional trial, it may be possible to address the validity issue by having independent experts evaluate the information provided by evaluators and other collateral information sources. In the next section, we will review various methods for assessing competency.

CURRENT STATE OF ASSESSMENT

A major change that has occurred within the past few decades has been the development of a number of instruments specifically designed for assessing competence. This work was pioneered by A. Louis McGarry and his colleagues.[30] Their work was the starting point for a more sophisticated and systematic approach to the assessment of competency. In 1986, Thomas Grisso coined the term "forensic assessment instrument" (FAI) to refer to instruments that provide frameworks for conducting forensic assessments.[31]

FAIs are typically semistructured elicitation procedures and lack the characteristics of many

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24. D. L. Davis, *Treatment Planning for the Patient Who Is Incompetent to Stand Trial,* 36 HOSPITAL & COMMUNITY PSYCH. 268 (1985); A. M. Siegel & A. Elwork, Treating Incompetence to Stand Trial, 14 LAW & HUM. BEHAV. 57 (1990).
25. Norman G. Poythress & H. V. Stock, *Competency to Stand Trial: A Historical Review and Some New Data,* 8 PSYCH. & LAW 131 (1980); Roesch & Golding, *supra* note 21; Skeem, et al., *supra* note 15.
26. Stephen L. Golding, Ronald Roesch & Jan Schreiber, *Assessment and Conceptualization of Competency to Stand Trial: Preliminary Data on the Interdisciplinary Fitness Interview,* 8 LAW & HUM. BEHAV. 321 (1984); Robert A. Nicholson, & Karen E. Kugler, *Competent and Incompetent Criminal Defendants: A Quantitative Review of Comparative Research,* 109 PSYCH. BULL. 355 (1991).
27. *See* Skeem, *et al. supra* note 15. Competency domains might include ability to understand the nature of the proceedings, a factual understanding of the proceedings, and rational understanding of the proceedings and are set out in each state's competency statutes.
28. Hart & Hare, *supra* note 18; Skeem, *et al., supra* note 15.
29. *See* ROESCH & GOLDING, *supra note* 21.
30. Paul D. Lipsitt, D. Lelos & A. Louis McGarry, *Competency for Trial: A Screening Instrument,* 128 AMER. J. PSYCH. 105 (1971); A. Louis McGarry, *Competency for Trial and Due Process via the State Hospital,* 122 AM. J. PSYCH. 623 (1965); A. LOUIS MCGARRY, & W. J. CURRAN, COMPETENCY TO STAND TRIAL AND MENTAL ILLNESS (1973).
31. THOMAS GRISSO, EVALUATING COMPETENCIES: FORENSIC ASSESSMENTS AND INSTRUMENTS (1986).

traditional psychological tests. However, they serve to make forensic assessments more systematic. These instruments help evaluators to collect important and relevant information and to follow the decision-making process that is required under the law. Since the time that the term was coined, a number of assessment instruments have been developed that are designed to work in this way, and it appears that the use of FAIs has been slowly increasing.[32] This trend is encouraging in that empirical data suggest that trained examiners using FAIs achieve the highest levels of inter-examiner and examiner-adjudication agreement.[33] Next, we will briefly describe a few of these recently developed instruments.

The MacArthur Competence Assessment Tool—Criminal Adjudication. This measure, known as the MacCAT-CA,[34] was developed as part of the MacArthur Network on Mental Health and the Law. It was developed from a number of research instruments[35] and assesses three main abilities: understanding, reasoning, and appreciation.

The MacCAT-CA consists of 22 items and takes approximately 30 minutes to administer. The basis of the items is a short story about two men who get into a fight and one is subsequently charged with a criminal offense. The first eight items assess the individual's understanding of the legal system. Most of these items consist of two parts. The defendant's ability to understand is first assessed and, if it is unsatisfactory or appears to be questionable, the information is then disclosed to the defendant and his or her understanding is again assessed. This allows the evaluator to determine whether or not the individual is able to learn disclosed information. The next eight items assess the individual's reasoning skills by asking which of two disclosed facts would be most relevant to the case. Finally, the last six items assess the individual's appreciation of his or her own circumstances. National norms for the MacCAT-CA have been developed and published.[36]

Other Specialized Assessment Instruments. In recent years, there has been a move toward the development of competence assessment instruments for specialized populations of defendants. We will not go into detail about these specialized instruments here but the reader should be aware that they exist. Carol Everington has developed an instrument designed to assess competence with mentally retarded defendants called the Competence Assessment for Standing Trial for Defendants with Mental Retardation (CAST-MR).[37] Recent research on the CAST-MR has indicated that this instrument shows good reliability and validity.[38] Other researchers have focused their efforts on another special population—juvenile defendants,[39] finding that younger defendants are more likely to be found incompetent.

While an assessment of the mental status of a defendant is important, it is not sufficient as a method of evaluating competency.

THE FUNCTIONAL EVALUATION APPROACH

Although there are numerous ways in which to conduct competency evaluations, we believe that the most reasonable approach to the assessment of competency is based on a functional evaluation of a defendant's ability matched to the contextualized demands of the case.[40] While an assessment of the mental status of a defendant is important, it is not sufficient as a method of evaluating competency. Rather, the mental status information must be related to the specific demands of the legal case, as has been suggested by legal decisions such as the ones involving amnesia. As in the case of psychosis, a defendant with amnesia is not per se incompetent to stand trial, as has been held in a number of cases.[41] In State v. Davis,[42] the defendant had memory problems due to brain damage. Nevertheless, the Missouri Supreme Court held that amnesia by itself was not a sufficient reason to bar the trial of an otherwise competent defen-

32. Randy Borum & Thomas Grisso, *Psychological Test Use in Criminal Forensic Evaluations*, 26 PROF. PSYCH.: RES. & PRAC. 465 (1995).
33. Golding, Roesch & Schreiber, supra note 26; Nicholson & Kugler, *supra* note 26; Skeem, *et al., supra* note 15.
34. STEVEN K. HOGE, RICHARD J. BONNIE, NORMAN G. POYTHRESS & JOHN MONAHAN, THE MACARTHUR COMPETENCE ASSESSMENT TOOL CRIMINAL ADJUDICATION (MACCAT-CA) (1999).
35. For a complete discussion of its development, *see* Hoge, et al.,*supra* note 1.
36. *See HOGE, ET AL.*, *supra*note 34.
37. Carol T. Everington, *The Competence Assessment for Standing Trial for Defendants with Mental Retardation (CAST-MR): A Validation Study*, 17 CRIM. J. & BEHAV. 147 (1990).
38. Carol Everington & C. Dunn, *A Second Validation Study of the Competence Assessment for Standing Trial for Defendants with Mental Retardation (CAST-MR)*, 22 CRIM. J. & BEHAV. 44 (1995).
39. Deborah K. Cooper, *Juvenile Competency to Stand Trial: The Effects of Age and Presentation of Factual Information in the Attainment of Competency in Juveniles,* 56 (10-B) DISSERTATION ABSTRACTS INTERNATIONAL 5761 (1995); V. L. Cowden & G. R. McKee, *Competency to Stand Trial in Juvenile Delinquency Proceedings—Cognitive Maturity and the Attorney-Client Relationship*, 33 U. LOUISVILLE J. FAM. L. 629 (1995).
40. A recent Supreme Court decision (*Godinez v. Moran*, 509 U.S. 389 (1993), discussed later) has been interpreted by some as being in opposition to a functional evaluation approach and, therefore, indicative of tension between the application of good social science principles and the views of the U.S. Supreme Court. The ruling in *Godinez* indicated that the standard for all types of competence was to be the same (i.e., that set out in *Dusky*) to meet the constitutional minimum. In *Godinez*, the Court noted that "while States are free to adopt competency standards that are more elaborate than the *Dusky* formulation, the Due Process Clause does not impose these additional requirements." *Id.* at 402. Therefore, it appears that the functional evaluation approach may still be used in those states that have adopted more elaborate standards of competence while still satisfying the minimum *Dusky* standard.
41. *See, e.g., Wilson v. United States,* 391 F. 2d. 460 (D.C. Cir. 1968); Ritchie v. Indiana, 468 N. E. 2d. 1369 (Ind. 1984).
42. 653 S. W. 2d. 167 (Mo. 1983).

[C]ompetence should be considered within the context in which it is to be used: the abilities required by the defendant in his or her specific case should be taken into account . . . .

dant. In State v. Austed,[43] the Montana Supreme Court held that the bulk of the evidence against the defendant was physical and not affected by amnesia. Finally, in a Maryland decision,[44] the court held that, because of the potential for fraud, amnesia does not justify a finding of incompetence. The court also stated that everyone has amnesia to some degree since the passage of time erodes memory. These decisions are of interest because they support the view that evaluators cannot reach a finding of incompetency independent of the facts of the legal case—an issue we will return to later. Similarly, a defendant may be psychotic and still be found competent to stand trial if the symptoms do not impair the defendant's functional ability to consult with his or her attorney and otherwise rationally participate in the legal process.

Some cases are more complex than others and may, as a result, require different types of psycholegal abilities. Thus, it may be that the same defendant is competent for one type of legal proceeding but not for others. In certain cases, a defendant may be required to testify. In this instance, a defendant who is likely to withdraw in a catatonic-like state may be incompetent. But the same defendant may be able to proceed if the attorney intends to plea bargain (the way in which the vast majority of all criminal cases are handled).

The functional approach is illustrated in the famous amnesia case of Wilson v. United States.[45] In that decision, the U.S. Court of Appeals for the District of Columbia held that six factors should be considered in determining whether a defendant's amnesia impaired the ability to stand trial:

- The extent to which the amnesia affected the defendant's ability to consult with and assist his lawyer.
- The extent to which the amnesia affected the defendant's ability to testify in his own behalf.
- The extent to which the evidence in suit could be extrinsically reconstructed in view of the defendant's amnesia. Such evidence would include evidence relating to the crime itself as well as any reasonable possible alibi.
- The extent to which the government assisted the defendant and his counsel in that reconstruction.
- The strength of the prosecution's case. Most important there will be whether the government's case is such as to negate all reasonable hypotheses of innocence. If there is any substantial possibility that the accused could, but for his amnesia, establish an alibi or other defense, it should be presumed that he would have been able to do so.
- Any other facts and circumstances that would indicate whether or not the defendant had a fair trial.[46]

One could substitute any symptom for amnesia in the above quote. If this were done, the evaluation of competency would certainly be one based on a determination of the manner in which a defendant's incapacity may have an effect on the legal proceedings. In fact, some states, such as Florida[47] and Utah,[48] already specify that the evaluators must relate a defendant's mental condition to clearly defined legal factors, such as the defendant's appreciation of the charges, the range and nature of possible penalties, and capacity to disclose to the defense attorney pertinent facts surrounding the alleged offense.[49] Utah's statute goes the furthest in this direction, specifying the most comprehensive range of psycholegal abilities to be addressed by evaluators (including the negative effects of medication as well as decisional competencies) and also requiring judges to identify specifically which psycholegal abilities are impaired when a defendant is found incompetent.

The most important aspect of assessing competence, therefore, is an assessment of the specific psycholegal abilities required of a particular defendant. That is, competence should be considered within the context in which it is to be used: the abilities required by the defendant in his or her specific case should be taken into account when assessing competence. This contextual perspective was summarized by Stephen Golding and Ronald Roesch[50] as follows:

> Mere presence of severe disturbance (a psychopathological criterion) is only a threshold issue—it must be further demonstrated that such severe disturbance in this defendant, facing these charges, in light of existing evidence, anticipating the substantial effort of a particular attorney with a relationship of known characteristics, results in the defendant being unable to rationally assist the attorney or to comprehend the nature of the proceedings and their likely outcome.[51]

The importance of a contextual determination of specific psycholegal abilities has been repeatedly demonstrated by empirical findings that competency assessments in one area of functioning are rarely homogeneous with assessments in other areas of functioning.[52] For example, assessments of competency to

43. 641 P. 2d. 1373 (Mont. 1982).
44. *Morrow v. Maryland*, 443 A. 2d. 108 (Md. 1982).
45. 391 F. 2d. 460.
46. *Id.* at 463-64.
47. Fl. R. Crim. Pro. § 3.21 (a)(1); *see* Bruce Winick, *supra* note 22, at 38.
48. Utah Code Ann. § 77-15-1 *et seq.* (2000).
49. Winick, *supra* note 22, at 38.
50. Golding & Roesch, *supra* note 11.
51. *Id.* at 79 (emphasis in original).
52. Bonnie, *supra* note 2; Bonnie, *supra* note 10; Thomas Grisso, Paul Appelbaum, Edward Mulvey & K. Fletcher, *The MacArthur Treatment Competence Study II: Measures of Abilities Related to Competence to Consent to Treatment,* 19 LAW & HUM. BEHAV. 127 (1995); Skeem, *et al., supra* note 15; Karen E. Whittemore, James R. P. Ogloff & Ronald Roesch, *An Investigation of Competency to Participate in Legal Proceedings in Canada,* 42 CANADIAN J. PSYCH.1 (1997); Patricia A. Zapf, *An Investigation of the Construct of Competence in a Criminal and Civil Context: A Comparison of the FIT, the MacCAT-CA, and the MacCAT,* DISSERTATION ABSTRACTS INTERNATIONAL (1998).

stand trial may not necessarily correspond with assessments of competency to plead guilty. Likewise, assessments of competency to waive *Miranda* may not correspond with assessments of competency to stand trial or competency to plead guilty.

A more recent Supreme Court decision, however, has confused this issue by finding that the standard by which competency to be judged is not context-specific. In *Godinez v. Moran*,[53] the United States Supreme Court held that the standard for the various types of competency (i.e., competency to plead guilty, to waive counsel, to stand trial) should be considered the same. Justice Thomas wrote for the majority:

> The standard adopted by the Ninth Circuit is whether a defendant who seeks to plead guilty or waive counsel has the capacity for "reasoned choice" among the alternatives available to him. How this standard is different from (much less higher than) the Dusky standard—whether the defendant has a "rational understanding" of the proceedings—is not readily apparent to us. . . . While the decision to plead guilty is undeniably a profound one, it is no more complicated than the sum total of decisions that a defendant may be called upon to make during the course of a trial. . . Nor do we think that a defendant who waives his right to the assistance of counsel must be more competent than the defendant who does not, since there is no reason to believe that the decision to waive counsel requires an appreciably higher level of mental functioning than the decision to waive other constitutional rights.[54]

In his dissent, Justice Blackmun argued that the "majority's analysis [was] contrary to both common sense and long-standing case law."[55] He reasoned that competency could be considered in a vacuum, separate from its specific legal context. Justice Blackmun argued that "[c]ompetency for one purpose does not necessarily translate to competency for another purpose"[56] and noted that prior Supreme Court cases had "required competency evaluations to be specifically tailored to the context and purpose of a proceeding."[57] What was egregiously missing from the majority's opinion in *Godinez*, however, was the fact that Moran's competency to waive counsel or plead guilty to death penalty murder charges was never assessed by the forensic examiners, regardless of which standard (rational choice or rational understanding) was employed.

The *Godinez* holding has been subsequently criticized by legal scholars[58] and courts alike. In a concurring opinion, one federal appellate judge wrote that the case under review "presents us with a window through which to view the real-world effects of the Supreme Court's decision in *Godinez v. Moran*, and it is not a pretty sight."[59] The problem is not whether or not the standards for various psychelegal competencies are higher, different, or the same, but rather, more fundamentally, whether or not the defendant has been examined with respect to these issues in the first place.

The Godinez holding has been subsequently criticized by legal scholars and courts alike.

REPORTS

In this final section, we will outline the information that should be contained in reports that are submitted to the court with respect to the issue of competence. One of the first pieces of information that should be contained in the report is the defendant's identifying information. This usually includes the defendant's demographics, the circumstances of the referral, the defendant's criminal charges, and some statement about the current stage of proceedings. Another piece of information that should be included relatively early in the report is some statement about the procedures that were used for the competency evaluation. This should include the dates and places that the defendant was interviewed, any psychological tests or forensic assessment instruments that were administered to the defendant, other data gathered, collateral information or interviews used, documents reviewed, and the techniques used during the evaluation. A section on the defendant's relevant history, usually including psychiatric/medical history, education, employment, and social history, is necessary to give the defendant's background and to note any important aspects of the defendant's background that may impact upon his or her case in some way.

There are two areas that must be addressed in a competency report: the defendant's current clinical presentation (including the defendant's presentation and possibly his or her motivation, test results, reports of others, and diagnosis) and some statement about the defendant's ability to proceed to trial (or the next stage in the proceedings). These two areas are the focal point of the evaluation.

Since we advocate for a functional assessment of a defendant's competencies, we believe that it is necessary that the evaluator ask questions that are pertinent to the individual defendant's case. A good competency report will set out each of the specific criteria that are required within the jurisdiction and will offer an opinion as to whether the defendant meets each of the specific criteria. These statements should be supported with the evaluator's behavioral observations of the defendant or through illustrative dialogue between the defendant and the evaluator. In addition to these two areas that must be addressed, a useful report will also contain a section where the evaluator will present his or her opinion

53. 509 U.S. 389 (1993).
54. *Id.* at 397-99.
55. *Id.* at 409.
56. *Id.* at 413.
57. *Id.* at 2694.
58. Michael L. Perlin, *"Dignity Was the First to Leave": Godinez v. Moran, Colin Ferguson, and the Trial of Mentally Disabled Criminal Defendants*, 14 BEHAV. SCI. & L. 61, 81 (1996).
59. Government of the Virgin Islands v. Charles, 72 F.3d 401, 411 (3rd Cir. 1995)(Lewis, J., concurring).

[A] functional evaluation of competence is consistent with psychological theory and research. Competence is not a global construct, but rather is context-specific.

opinion regarding the defendant's competency to proceed. Although evaluators are prohibited from speaking to the ultimate legal issue of competency, they are expected to arrive at some conclusion about a defendant's competency. A good report should include the evaluator's final opinion as to whether or not a defendant meets the required criteria to proceed. As we indicated earlier, in the majority of cases, the court accepts the recommendation of the evaluator.[60]

A poorly prepared report is one that does not include the basic information described above. Those components of a report that are considered to be essential include names, relevant dates, charges, data sources, notification to defendant of the purpose of the evaluation, limits on confidentiality, psychiatric history, current mental status, current use of psychotropic medication, and information specific to each forensic question being assessed.[61] With respect to the use of forensic assessment instruments or formal psychological testing, Randy Borum and Thomas Grisso found, in a survey of assessment practices, that one-third of respondents reported using forensic assessment instruments regularly, whereas most respondents reported using general psychological instruments (such as the Wechsler Adult Intelligence Scale) in forensic assessments.[62] In light of the advances in the area of forensic assessment and the development of specialized forensic assessment instruments, the practice of routinely using only general psychological instruments, in lieu of forensic assessment instruments, appears to be inadequate.

A poorly prepared report will include opinions that have no basis. If the author of a report states opinions without also including the bases for the opinion, one should be skeptical. It is good psychological practice to back up any stated opinion with observations, descriptions, and justifications for why that opinion was reached. It is also good practice to detail behavioral observations and descriptions that lend support for an opinion as well as any other observations that may be in opposition to the opinion reached. That is, any inconsistencies that were noted throughout the evaluation as well as any alternative hypotheses that may be reached will also be documented in a good report.

The Florida Rules of Criminal Procedure[63] provide a useful report checklist by requiring that each of the following elements must be contained in a written report submitted by an expert:

- the specific matters referred for evaluation,
- the evaluative procedures, techniques and tests used in the examination and the purpose or purposes for each,
- the expert's clinical observations, findings and opinions on each issue referred for evaluation by the court, indicating specifically those issues, if any, on which the expert could not give an opinion, and
- the sources of information used by the expert and the factual basis for the expert's clinical findings and opinions.

In some jurisdictions, if the evaluator concludes that the defendant could be considered incompetent to proceed, some statement about the restorability of the defendant is required to be included in the report. In addition, some jurisdictions require evaluators to include an opinion regarding whether the defendant would meet criteria for commitment. Finally, some jurisdictions require the evaluator to include other recommendations, such as the possibility of counseling for the defendant, treatment for the defendant while incarcerated, or other special observation precautions.

SUMMARY AND CONCLUSIONS

To conclude, we leave the reader with a summary of the five main points discussed in this article. First, the *Dusky* standard sets the foundation for every state's competency-to-stand-trial standard. In addition, as per the decision in *Godinez*, the *Dusky* standard also sets the foundation for every state's standards for other types of criminal competencies (e.g., competency to waive Miranda rights, competency to plead guilty, competency to confess). Each state is free to elaborate standards for different types of competencies; however, the *Dusky* standard is the minimum constitutional requirement.

Second, there is no true way to assess the validity of competency determinations short of a provisional trial. The only way to truly determine that an individual is not able to participate in his or her own defense is to allow that individual to proceed. As we have described, some states have these provisions but they are not utilized.

Third, a functional evaluation of competence is consistent with psychological theory and research. Competence is not a global construct, but rather is context-specific. It is possible for an individual to be competent with respect to one area of functioning but incompetent with respect to another. A good forensic evaluation will assess a specific individual's competence with respect to a particular set of abilities, in light of the specific characteristics of the individual and the circumstances of the individual's case.

Fourth, there have been a number of forensic assessment instruments developed to assist evaluators in the assessment of competency. In general, reliability increases with the use of these instruments.

Fifth, a good forensic report must include information about the defendant's current clinical presentation as well as information about the specific forensic question being assessed (i.e., competency to proceed). In

60. Hart & Hare, *supra* note 18.
61. Randy Borum & Thomas Grisso, *Establishing Standards for Criminal Forensic Reports: An Empirical Analysis,* 24 BULL. AMER. ACAD. PSYCH. & L. 297 (1996).
62. Borum & Grisso, *supra* note 32.
63. Fl. R. Crim. Pro. § 3.211 (a).

addition, a good forensic report should include descriptions and observations that serve as the basis for the opinions or conclusions stated in the report.

The purpose of this article was to present an overview of competency laws, research, methods of assessment, and the content of competency reports submitted to the courts by expert evaluators. We believe that by informing legal professionals of the current state of the discipline with respect to competency evaluations we will begin to bridge the gap that often exists between psychology and the legal profession. There exists a body of research and literature that examines issues that are at the heart of both psychology and the law; however, often this literature is only accessed by one set of professionals or another. We hope that publishing articles such as this, in sources that are easily accessed by legal professionals, and in a format familiar to legal professionals, will facilitate a better understanding of psychology as it pertains to the legal system.

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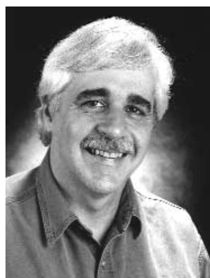

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AMERICAN JUDGES ASSOCIATION Future Conferences

2001 Midyear Meeting
March 29-31, 2001
Hot Springs, Arkansas
Austin Hot Springs Convention Center
($90 single or double)

2001 Annual Conference
September 30-October 5, 2001
Reno, Nevada
Silver Legacy Resort
($89 single or double)

2002 Midyear Meeting
Biloxi, Mississippi
(Dates and hotel to be determined)

2002 Annual Conference
September 8-13, 2002
Maui, Hawaii
The Westin Maui
($155 single or double, golf/mountain view;
$169 single or double, ocean view)

2003 Midyear Meeting
Billings, Montana
(Dates and hotel to be determined)

2003 Annual Conference
Montreal, Quebec
(Dates and hotel to be determined)

Involuntary medication for Competency[1] Restoration
HEARING CHECKLIST

Hold when prosecutor requests an Order for Involuntary Medication of defendant to restore competence to stand trial

Burden of Proof Clear and Convincing[2]

Who has the burden Prosecutor

Evidence Expert testimony

Law *United States v. Sell, 539 U.S. 166 (2003)*
If the government seeks to medicate a defendant to restore competence to stand trial, court must weight four important factors (see below) and then balance the government's interest in bringing the defendant to trial against the defendant's liberty interest in remaining free from unwanted medical treatment.

Legal Considerations: **To order involuntary medication, court must find:**

1. Important governmental interests are at stake in bringing the defendant to trial. (Considerations: Is the charge "serious"? Are there "special circumstances" that lessen government's interests, such as the likelihood of civil commitment or confinement for a significant amount of time?)

2. Forced medication will significantly further the state interests. The medication is significantly likely to render defendant competent to stand trial and substantially unlikely to have side effects that will interfere significantly with the defendant's ability to assist counsel in conducting a defense.

3. The medication is necessary to make the defendant competent and alternative, less invasive treatment is unlikely to produce substantially the same result.

4. The specific medication proposed is "medically appropriate" and is in the patient's best medical interest in light of his or her medical condition.

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[1] If the purpose for the involuntary medication is not to achieve competence or is based on an emergency, this procedure is not applicable. Involuntary medication for dangerousness is governed by *Washington v. Harper,* 494 U.S. 210 (1990).

[2] Neither the United States Supreme court nor the Alaska appellate courts have decided this issue. Most courts apply "clear and convincing. *See, e.g., United States v. Bradley,* 417 F.3d 1107, 1114 (10th Cir. 2005); *United States v. Gomes,* 387 F.3d 157, 160 (2d Cir. 2004).

5. If court finds all four factors above are satisfied, must then proceed to weigh those factors against the defendant's Fifth Amendment interest to be free from unwanted medication

FINDINGS AND ACTIONS

FINDING 1 COURT FINDS ALL FOUR FACTORS SATISFIED AND FIFTH AMENDMENT BALANCING WEIGHS IN FAVOR OF INVOLUNTARY ADMINISTRATION OF MEDICATIONS

ACTION Court may issue an order for involuntary administration of medications.

FINDING 2 COURT DOES NOT FIND ALL FOUR FACTORS SATISFIED

OR

COURT FINDS ALL FOUR FACTORS SATISFIED BUT CONCLUDES FIFTH AMENDMENT BALANCING WEIGHT IN FAVOR OF THE DEFENDANT'S RIGHT TO CHOSE NOT TO BE MEDICATED

ACTION

1. Deny order for involuntary administration of medication.
2. If evidence defendant may be capable of restoration to competence for legal proceedings without involuntary medication and within the statutory time frames, court may commit the defendant to API and hold the required hearings under AS 12.47.110 to determine if the defendant has achieved competence without the administration of involuntary medication
3. If evidence that defendant is not capable of restoration without administration of involuntary medications, dismiss case without prejudice; any further commitment is governed governed by the civil commitment process (AS 47.30.700-47.30.915).

<u>Practice Tip</u>: The United States Supreme Court predicted that involuntary administration of drugs solely for trial competence purposes would be rare.

DEVELOPMENTS IN THE LAW

THE LAW OF MENTAL ILLNESS

"[D]oing time in prison is particularly difficult for prisoners with mental illness that impairs their thinking, emotional responses, and ability to cope. They have unique needs for special programs, facilities, and extensive and varied health services. Compared to other prisoners, moreover, prisoners with mental illness also are more likely to be exploited and victimized by other inmates."

HUMAN RIGHTS WATCH, ILL-EQUIPPED: U.S. PRISONS AND OFFENDERS WITH MENTAL ILLNESS 2 (2003), available at http://www.hrw.org/reports/2003/usa1003/usa1003.pdf.

"[I]ndividuals with disabilities are a discrete and insular minority who have been faced with restrictions and limitations, subjected to a history of purposeful unequal treatment, and relegated to a position of political powerlessness in our society, based on characteristics that are beyond the control of such individuals and resulting from stereotypic assumptions not truly indicative of the individual ability of such individuals to participate in, and contribute to, society . . . ."

Americans with Disabilities Act of 1990, Pub. L. No. 101-336, § 2(a)(7), 104 Stat. 327, 329 (codified at 42 U.S.C. § 12101 (2000)).

"We as a Nation have long neglected the mentally ill . . . ."

Remarks [of President John F. Kennedy] on Proposed Measures To Combat Mental Illness and Mental Retardation, PUB. PAPERS 137, 138 (Feb. 5, 1963).

"[H]umans are composed of more than flesh and bone . . . . [M]ental health, just as much as physical health, is a mainstay of life."

Madrid v. Gomez, 889 F. Supp. 1146, 1261 (N.D. Cal. 1995).

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I. INTRODUCTION

Three traditions have dominated mental health law scholarship: "doctrinal constitutional scholarship focusing on rights, therapeutic jurisprudence scholarship focusing on the therapeutic implications of different laws, and theoretical scholarship focusing on philosophical issues underpinning mental health law."[1] These strands are well represented in the six Parts of this Development, which focus on the interaction between mental illness and the law in its many forms. The separate Parts address the doctrines created by the Supreme Court and implemented by lower courts, federal and state legislation that enables or hinders the participation of the mentally ill in society, new institutional forms and their effects on the mentally ill, and underlying conceptual constructs about the nature of criminal punishment, competency, and active participation in society.

However, this Development does not take for granted the constructions of mental illness present in legal scholarship. The Parts delve into and recognize the law's impact on and therapeutic potential for the mentally ill, a nontrivial portion of the general population. An estimated 26.2% of Americans aged eighteen years and older suffer from a diagnosable mental disorder in a given year.[2] Because the criminal justice system has become home to many mentally ill individuals,[3] several of the Parts focus on this area. This Development notes that society has often failed to craft and interpret the law in ways that are cognizant of mental illness and sympathetic to mentally ill individuals. One might assume that the situation of the mentally ill in the legal system is continually improving as advocates demand more rights, but some Parts note that such a meliorative trend has not been present in recent years, especially in the criminal justice setting. However, the various Parts also note bright spots or opportunities ripe for legal solutions.

Part II discusses how lower courts have interpreted the Supreme Court's decision in *Sell v. United States*,[4] a case that discussed the standard for involuntarily medicating defendants in order to render them competent to stand trial. This Part finds that lower courts have on the whole misapplied Sell, leading to decreased protections for

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[1] Elyn R. Saks, *Mental Health Law: Three Scholarly Traditions*, 74 S. CAL. L. REV. 295, 296 (2000).

[2] Ronald C. Kessler et al., *Prevalence, Severity, and Comorbidity of 12-Month DSM-IV Disorders in the National Comorbidity Survey Replication*, 62 ARCHIVES OF GEN. PSYCHIATRY 617, 617 (2005).

[3] *See* Fox Butterfield, *Prisons Replace Hospitals for the Nation's Mentally Ill*, N.Y. TIMES, Mar. 5, 1998, at A1.

[4] 539 U.S. 166 (2003).

mentally ill defendants. Sell set out four factors that must be met before a trial court can balance the state's interest in prosecution with the defendant's liberty interests against forced medication. Using the narratives of the defendants in two cases, Susan Lindauer in *United States v. Lindauer*[5] and Steven Paul Bradley in *United States v. Bradley,*[6] the Part focuses on the first and fourth factors of the *Sell* test. Lower federal courts have evaluated the first factor, which asks whether the government has an important interest in bringing the defendant to trial, by using the potential maximum sentence for the crime. This Part argues that such an approach is flawed, and courts should instead use the approach of *Lindauer* (set forth in an opinion written by then Judge Michael Mukasey), which considers the totality of the circumstances in assessing the severity of an offense and whether an important government interest exists. The Part further argues that the fourth factor, whether the medication is appropriate or in the best interests of the patient given her medical condition, should be directly addressed by courts and given independent meaning, even if this inquiry requires grappling with difficult medical and legal issues.

Part III explores how *United States v. Booker,*[7] which invalidated the provisions of the Sentencing Reform Act of 1984[8] that made the Federal Sentencing Guidelines mandatory,[9] increased judicial discretion to the potential detriment of mentally ill defendants. The U.S. Sentencing Guidelines Manual deals with mental illness in only a limited way, noting that such conditions are not normally relevant to sentencing[10] and allowing departures only to a very limited extent.[11] This Part discusses two *pre-Booker* cases, *United States v. Hines*[12] and *United States v. Moses*,[13] to illustrate how the Ninth and Sixth Circuits took divergent approaches to mental illness during this period. After *Booker*, judges have the discretion to refer to the sentencing factors articulated in 18 U.S.C. § 3553(a)[14] to impose sentences outside the Guidelines framework. This Part contends that as applied to violent mentally ill offenders, such variances are likely

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5 448 F. Supp. 2d 558 (S.D.N.Y. 2006).

6 417 F.3d 1107 (10th Cir. 2005).

7 543 U.S. 220 (2005).

8 Pub. L. No. 98-473, tit. II, ch. II, 98 Stat. 1987 (codified as amended in scattered sections of 18 and 28 U.S.C.).

9 Booker, 543 U.S. at 245 (Breyer, J., delivering the opinion of the Court in part).

10 U.S. SENTENCING GUIDELINES MANUAL § 5H1.3 (2007).

11 *See id.* § 5K2.0.

12 26 F.3d 1469 (9th Cir. 1994).

13 106 F.3d 1273 (6th Cir. 1997).

14 These factors include the "nature and circumstances of the offense," "the history and characteristics of the defendant," and the "need for the sentence imposed" to do such things as "reflectthe seriousness of the offense," "afford adequate deterrence," "protect the public from further crimes of the defendant," and provide the defendant "medical care, or other correctional treatment in the most effective manner." 18 U.S.C. § 3553(a) (2000 & Supp. IV 2004).

to be upward ones. Noting that early sentencing decisions indicate that judges are using their discretion in this troubling way,[15] the Part puts this topic in the larger context of the purposes of criminal punishment of the mentally ill and ultimately favors a policy of post-prison civil commitment over above Guidelines prison sentences.

The problems of the mentally ill do not end when they enter prison. Part IV examines the impact of the Prison Litigation Reform Act of 1995[16] (PLRA) on mentally ill inmates and offers interpretations of key provisions that would help lessen the law's negative effects on this vulnerable population. The PLRA's exhaustion requirement[17] places a special burden on mentally ill inmates, who may for various reasons relating to their illness be incapable of meeting the Act's stringent requirements. This Part argues for a contextual definition of availability of grievance procedures that recognizes individual capability and is sensitive to the needs of mentally ill inmates. The PLRA's "physical injury" requirement[18] similarly impairs suits by mentally ill inmates. The Part suggests that the provision should be read not to bar constitutional claims, including violations of the Eighth Amendment right to correctional mental health care. The Part concludes by documenting some of the systemic effects of the PLRA, such as the underelaboration of judicial standards caused by the reduced quantity of judicial decisions addressing PLRA provisions.

Part V looks at the Court's procedural, as opposed to substantive, focus in three areas of criminal law: mens rea, the insanity defense, and competency. It argues that in two recent cases, *Clark v. Arizona*[19] and *Panetti v. Quarterman*,[20] the Court avoided creating substantive standards to govern these important areas, instead opting for procedural regulation. This Part claims, however, that creating procedural standards without some underlying substantive norm is meaningless and gives states the incentive to provide minimal substantive protections while ensuring that procedural safeguards are in place. Although substantive lawmaking is difficult, the Court should not shy away from it, and instead should create a substantive floor for the constitutional rights of the mentally ill. The Part claims that such substantive regulation could be justified under the Eighth Amendment or the Due Process Clause of the Fifth and Fourteenth Amendments.

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[15] *See, e.g.*, *United States v. Gillmore*, 497 F.3d 853 (8th Cir. 2007).

[16] Pub. L. No. 104-134, §§ 801–810, 110 Stat. 1321-66 (1996) (codified as amended in scattered sections of 11, 18, 28, and 42 U.S.C.).

[17] *See* 42 U.S.C. § 1997e(a) (2000).

[18] *Id.* § 1997e(e).

[19] 126 S. Ct. 2709 (2006).

[20] 127 S. Ct. 2842 (2007).

Despite the problems discussed above, Parts VI and VII offer some hope that the rights of the mentally ill may expand through awareness and advocacy. Both Parts indicate trends that, on the whole, are likely to benefit the mentally ill — by offering mentally ill offenders treatment instead of punishment, and by protecting mentally ill individuals' voting rights.

Part VI discusses the rise of mental health courts, which focus on rehabilitation and treatment of mentally ill offenders, and considers whether this phenomenon might indicate a shift toward a more rehabilitative view of punishment in the larger criminal justice system. This Part begins by outlining the general parameters of mental health courts and discussing their considerable growth in recent years. Although the start-up costs of forming these courts may be high, these courts could offer considerable cost savings in the long run by reducing recidivism rates. Recognizing the success and potential of these courts, the federal government has increasingly provided funding.[21] Federal funding for starting mental health courts, this Part argues, may indicate the country's increased willingness to move from a punitive model of justice to a rehabilitative model. In support of this trend, the Part cites a 2003 speech by Justice Kennedy to the American Bar Association (ABA),[22] a subsequent ABA report urging greater emphasis on rehabilitation,[23] and an ABA commission developed to follow up on that report. Mental health courts are a subset of this larger trend, but some practitioners and commentators have questioned both the rehabilitative focus and the perceived decrease in procedural protections available in these courts. Despite continuing controversy, the Part concludes that the trend toward use of specialized, rehabilitative courts is increasing and is generally beneficial.

Part VII considers the disenfranchisement of the mentally ill by exploring recent legislative and case-based developments in state and federal law that indicate increased sensitivity to mentally ill individuals' right to vote. In the past, most states simply disenfranchised those under guardianship for mental illness without considering whether the illness actually affected the capacity to vote. This Part argues that, because equal access to voting is a fundamental right, procedures for disenfranchising the mentally ill should be narrowly tailored to serve a compelling state interest. In response to advocacy for reform, states have begun to tailor their laws more narrowly to the real capacities of their mentally ill citizens, both by creating forms of limited guardianship and by

[21] *See* President's New Freedom Commission on Mental Health, Exec. Order No. 13,263, 3 C.F.R. 233 (2003) (superseded 2003).

[22] JUSTICE KENNEDY COMM'N, AMERICAN BAR ASS'N, REPORT TO THE HOUSE OF DELEGATES 3–6 (2004), available at http://www.abanet.org/media/kencomm/rep121a.pdf.

[23] *Id.* at 24, 32–33.

changing outdated state laws and constitutional provisions. Beyond these legislative and constitutional reforms, advocates are turning to the courts as a means of changing the law. A victory in a Maine federal district court[24] by three disenfranchised women under guardianship identified some of the basic reasons that states should look to an individual's capacity to vote before disenfranchising that individual. In addition, a recent Supreme Court case, *Tennessee v. Lane*,[25] has great promise for advocates, opening the door to suits against the states for money damages resulting from the discriminatory removal of voting rights. This Part concludes by identifying possible ways to challenge remaining outdated disenfranchisement provisions and noting that the mentally ill could draw on lessons from and victories by the physically disabled.

II. SELL V. UNITED STATES: FORCIBLY MEDICATING THE MENTALLY ILL TO STAND TRIAL

For more than half a century, the Supreme Court has struggled to articulate the circumstances under which a court may force an individual to submit to medical procedures against his or her will.[1] In 2003, the Court concluded in *Sell v. United States*[2] that a nondangerous defendant could be forcibly medicated solely to achieve competence to stand trial, provided certain conditions, set out in a four-factor test, were met.[3] The Court offered little guidance on how to interpret these factors, and unsurprisingly, lower courts' methods of applying the *Sell* factors have varied significantly. This Part examines how lower courts have applied the *Sell* factors and argues that these courts have misinterpreted *Sell*. In order to avoid difficult questions at the intersection of medical and legal ethics, the lower courts have adopted weaker protections for the liberty interests of mentally ill defendants than what Sell requires.

Section A describes the decision in *Sell* and then discusses how the lower courts have applied each of the *Sell* factors. Section B focuses on the first factor, the so called "importance" determination, and argues that courts have inconsistently and often incorrectly defined what constitutes an important state interest. Section C examines the fourth factor, whether forcible medication is medically appropriate, and argues that courts often conflate this determination with the earlier determination, under the second and third factors, of whether treatment will be necessary and effective.

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[24] Doe v. Rowe, 156 F. Supp. 2d 35 (D. Me. 2001).

[25] 541 U.S. 509 (2004).

[1] *See, e.g., Rochin v. California*, 342 U.S. 165, 173 (1952) (holding unconstitutional the pump- ing of a suspect's stomach against his will to obtain evidence).

[2] 539 U.S. 166 (2003).

[3] *See id.* at 180–81.

Section D briefly discusses the second and third *Sell* prongs, which hinge most directly on the facts of individual cases.

A. *The Sell Decision*

In the early 1990s, the Supreme Court concluded that criminal defendants and convicted inmates could be medicated against their will,[4] but only if leaving them unmedicated posed a danger to themselves or others.[5] Those cases left unresolved the question of whether a nondangerous defendant could be forcibly medicated for the sole purpose of making him or her competent to stand trial.

In *Sell*, Justice Breyer, writing for the Court, explained that medication may be forced only "in limited circumstances, i.e., upon satisfaction of conditions that we shall describe."[6] The trial court first ought to consider whether there are other grounds, such as a defendant's dangerousness to himself or others, upon which to order his forcible medication.[7] If the only reason the government seeks to medicate the defendant is to make him competent to stand trial, then the court must consider four factors. First, "a court must find that important governmental interests are at stake" in bringing the defendant to trial.[8]

4 Those cases in which a mentally ill defendant might be medicated against his will to achieve competence typically involve one of three types of psychological conditions: (1) schizophrenia, schizoaffective disorder, and other psychotic disorders; (2) bipolar and other mood disorders; and (3) melancholic depression. (Dementia is another principal psychological disorder that would ren- der a defendant incompetent to stand trial, but because it cannot be reversed medically or other- wise, it is irrelevant to the present discussion.) Telephone Interview with Dr. Khalid Khan, Mount Sinai Sch. of Med., New York, N.Y. (Oct. 17, 2007). The characteristic symptoms of schizophrenia are "delusions," "hallucinations," "disorganized speech," "grossly disorganized or catatonic behavior," and "restrictions in the range and intensity of emotional expression . . . , in the fluency and productivity of thought and speech . . . , and in the initiation of goal-directed be- havior." AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 299 (4th ed., text rev. 2000). Psychiatrists estimate that 0.5% to 1.5% of the world population is schizophrenic. Id. at 308. Bipolar disorder is characterized by manic episodes and, sometimes, major depressive episodes. Id. at 382. Manic episodes are "period[s] of abnormally and persistently elevated . . . mood" that last at least one week and are severe enough to cause a "marked impairment" in occupational or social activities, involve psychotic features, or otherwise require hospitalization to prevent harm. Id. at 362. Many of the same medications can be pre- scribed for schizophrenic and bipolar patients, including Risperdal, Abilify, and Zyprexa. Re- searchers have not determined how these drugs work, although they believe that schizophrenia and bipolar disorder are caused by imbalances of neurotransmitters in the brain. Researchers believe these drugs regulate levels of dopamine and other neurotransmitters. See PHYSICIANS' DESK REFERENCE 882, 1676, 1830 (61st ed. 2007).

5 *See Riggins v. Nevada*, 504 U.S. 127, 135 (1992); Washington v. Harper, 494 U.S. 210, 236 (1990).

6 *Sell,* 539 U.S. at 169.

7 *Id.* at 182; see, e.g., United States v. Kourey, 276 F. Supp. 2d 580, 580–81 (S.D. W. Va. 2003) (holding forced medication to be inappropriate under Sell, but potentially appropriate on Harper grounds because the defendant was dangerous).

8 *Sell*, 539 U.S. at 180.

Trial on a "serious" charge is an important government interest, but the government's interest may be lessened by "[s]pecial circumstances," such as if the defendant will likely be civilly committed if he is not tried or if he has already been confined for a significant amount of time.[9] Second, the trial court must conclude that the medication will be effective — that it will "significantly further" the goal of making the defendant competent to stand trial and that the medication's side effects are not likely to interfere with the defendant's ability to assist counsel.[10] Third, the trial court must find that no less invasive treatment is likely to produce the same result — that the medication is "necessary."[11] Finally, the court must determine that the medication is "medically appropriate, i.e., in the patient's best medical interest in light of his medical condition."[12]

The Court implied that after a trial court evaluates these factors, it must then weigh these interests against the defendant's liberty interests in remaining free from unwanted medical treatment.[13] Still, the Court was somewhat ambiguous about what, if anything, a trial court must do, beyond determining whether the four factors have been met. The Court did not help matters by describing the test as a "standard"[14] while also setting a somewhat mechanical process by which courts should evaluate defendants. The proper reading of Sell embraces both approaches. A trial court must first ensure that each of the four factors is satisfied, and it then must weigh those factors against the defendant's Fifth Amendment liberty interest to be free from unwanted medical treatment.[15] But once the trial court has concluded that the four factors are satisfied, there is likely to be little balancing left to do. This is because there are few, if any, defendants who would be incompetent to stand trial but competent to make medical decisions. That is, the courts applying *Sell* are looking at a population that is very likely incompetent to make medical decisions and that, even if not in the criminal justice system, would have medical decisions made by a guardian or a court. Therefore, because the defendant would not otherwise be free from unwanted treatments that a third party found

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9 *Id.*

10 *Id.* at 181.

11 *Id.*

12 *Id.*

13 *See id.* at 183 ("Has the Government, in light of the [second through fourth factors], shown a need for that treatment sufficiently important to overcome the individual's protected interest in refusing it?").

14 *Id.* at 180.

15 *See id.* at 177; United States v. Schloming, Mag. No. 05-5017 (TJB), 2006 WL 1320078, at *4 (D.N.J. May 12, 2006) ("The *Sell* criteria, taken as a whole, must outweigh a Defendant's significant interest in avoiding the unwanted administration of antipsychotic drugs. . . . Each of the *Sell* criteria must be met in order to show that the Government's interests are overriding.").

medically appropriate, he or she would not have a meaningful liberty interest in this context either.[16]

B. An "Important" Government Interest

As early as age seven, Susan Lindauer claimed to have the gift of prophecy.[17] Through adulthood, she continued to believe she was the instrument of divine intervention, "suggest[ing] that she reported 11 bombings before they occurred, . . . plac[ing] herself at the center of events in the Middle East, and declar[ing] herself to be an angel."[18] A federal district judge summed up Ms. Lindauer's situation: "[E]ven lay people can perceive that Lindauer is not mentally stable."[19] In March 2004, FBI agents arrested Lindauer at her Maryland home.[20] A federal indictment charged her with four felonies: conspiracy to act as an unregistered agent of the government of Iraq, acting as an unregistered agent of Iraq, accepting payments from the Iraq Intelligence Service, and engaging in financial transactions with the government of Iraq.[21]

The indictment alleged that Lindauer met with Iraqi officials in New York and Baghdad between 1999 and 2002, and that she delivered a letter on behalf of the Iraqis to the home of an unspecified government official, possibly Andrew Card, the then White House chief of staff and a distant cousin of hers.[22] Government and defense mental health experts agreed that *Lindauer* was incompetent to stand trial.[23] On September 6, 2006, Judge Michael Mukasey[24] decided that Sell did not permit him to order Lindauer medicated against her will.[25] Two days later, Judge Mukasey ordered Lindauer released.[26] Judge Mukasey's opinion, although atypical in its approach, provided a template for courts weighing the first *Sell* factor: the importance of the government interest in bringing the defendant to trial. Judge Mukasey began his analysis of the *Sell* factors with a remarkably humanistic assessment of the

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16 *See* Robert F. Schopp, Involuntary Treatment and Competence To Proceed in the Criminal Process: Capital and Noncapital Cases, 24 BEHAV. SCI. & L. 495, 503–08 (2006); see also CHRISTOPHER SLOBOGIN, MINDING JUSTICE 227–30 (2006).

17 *United States v. Lindauer*, 448 F. Supp. 2d 558, 562 (S.D.N.Y. 2006).

18 *Id.*

19 *Id.* at 564.

20 David Samuels, *Susan Lindauer's Mission to Baghdad*, N.Y. TIMES, Aug. 29, 2004, § 6 (Magazine), at 25.

21 *Lindauer*, 448 F. Supp. 2d at 560.

22 *Id.*

23 *Id.* at 559.

24 *Lindauer* was the last opinion Judge Mukasey published before retiring from the bench. On November 9, 2007, Mukasey was sworn in as the country's eighty-first Attorney General. *See Mukasey Takes Oath of Office*, N.Y. TIMES, Nov. 10, 2007, at A9.

25 *Lindauer* 448 F. Supp. 2d at 559.

26 Anemona Hartocollis, *Ex–Congressional Aide Accused in Iraq Spy Case Is Released*, N.Y. TIMES, Sept. 9, 2006, at B1.

Sell regime, quoting Justice Frankfurter's iconic decision in *Rochin v. California*[27]:

> Although the Court's discussion of a defendant's interest in avoiding forced psychotropic medication seems at times curiously anodyne, I think it is not inappropriate to recall in plain terms what the government seeks to do here, which necessarily involves physically restraining defendant so that she can be injected with mind-altering drugs. There was a time when what might be viewed as an even lesser invasion of a defendant's person — pumping his stomach to retrieve evidence — was said to "shock[] the conscience" and invite comparison with "the rack and the screw." The Supreme Court's rhetoric seems to have toned down mightily since then, but the jurisprudential principles remain the same.[28]

Judge Mukasey concluded that it was beyond dispute that no alterna- tive to medication would render *Lindauer* competent (the third factor).[29] There was no evidence as to whether medication was particularly in *Lindauer's* interest (the fourth factor), but inquiry into this question was unnecessary because the judge also concluded that the government had failed to convince him by clear evidence that the government had an important interest in bringing *Lindauer* to trial (the first factor) or that the medicine would be effective in restoring *Lindauer's* competence (the second factor).[30]

The government argued that the court should conclude that it had a strong interest in bringing *Lindauer* to trial because of the ten-year maximum sentence *Lindauer* faced if convicted on even a single count.[31] Judge Mukasey disagreed.[32] In his view, "the high-water mark of defendant's efforts . . . was her delivery of a letter . . . to the home of an unspecified government official, in what is described even in the indictment as 'an unsuccessful effort to influence United States foreign policy.'"[33] "[T]here is no indication that *Lindauer* ever came close to influencing anyone, or could have."[34] He therefore concluded, even without evaluating whether the evidence was sufficient to secure a conviction, that the government did not have an important interest in bringing the defendant to trial.[35]

Despite the intuitive appeal of the *Lindauer* approach, it has not been adopted elsewhere. Indeed, it is at odds with what has become the dominant approach.

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27 342 U.S. 165 (1952).

28 *Lindauer*, 448 F. Supp. 2d at 567 (alteration in original) (citation omitted) (quoting *Rochin*, 342 U.S. at 172).

29 *Id.* at 571. The Second Circuit has ruled that the government must satisfy the Sell factors by clear and convincing evidence. See United States v. Gomes, 387 F.3d 157, 160 (2d Cir. 2004).

30 Lindauer, 448 F. Supp. 2d at 571–72.

31 *Id.* at 571.

32 *Id.*

33 *Id.* at 560–61.

34 *Id.* at 571–72.

35 *Id.* at 572.

Most courts have judged the importance of bringing a defendant to trial based on the maximum penalty the defendant could face if convicted. The Fourth Circuit noted that although the *Sell* Court did not indicate how lower courts were to judge the seriousness of crimes, the Supreme Court in other contexts had condoned evaluating the seriousness of a crime based on the potential penalty a defendant faced if convicted.[36] Courts following this approach have focused on the potential maximum sentence, not the much lower probable sentence under the Federal Sentencing Guidelines.[37] Other courts that do not perform a specific analysis of a defendant's potential sentence have evaluated the seriousness of a charge based on its legislative classification.[38] While strict adherence to legislative determinations of crime severity via maximum sentences is appealing because it creates "sharp, easily administrable lines" for judges,[39] this approach could not have been what the *Sell* Court intended. "Had it been the Supreme Court's intention to classify a charge as serious based on the maximum penalty, it could have done so."[40] Instead, *Sell* leaves the term "serious crime" largely undefined.[41] The majority of courts, which base state interest decisions on the potential sentence, appear to respect legislative decisions about the seriousness of the crime. This approach is consistent with other criminal doctrines, such as that of the Sixth Amendment jury right, that determine the seriousness of a crime by its potential sentence.[42] However, the *Sell* test for seriousness would seem to be distinguishable from these other

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36 United States v. Evans, 404 F.3d 227, 237 (4th Cir. 2005) (citing *Duncan v. Louisiana,* 391 U.S. 145, 159 (1968)).

37 *See, e.g., id.* at 237–38 (concluding that courts ought to refer to the statutory maximum, not a probable guideline range, because given the lack of a presentencing report and other information not available until sentencing, a pretrial estimate of a probable sentence would be too speculative); *see also* United States v. Palmer*,* 507 F.3d 300, 304 (5th Cir. 2007) (following Evans); United States v. Archuleta, 218 F. App'x 754, 759 (10th Cir. 2007) (same). *But see* United States v. Hernandez-Vasquez, 506 F.3d 811, 821 (9th Cir. 2007) (advising district courts to consider, among other factors, the Guidelines range, not the statutory maximum, when determining crime seriousness); United States v. Thrasher, 503 F. Supp. 2d 1233, 1237 (W.D. Mo. 2007) ("[T]he expected sentence' can be more fairly appraised by estimating a Guideline sentence . . . . The court should place itself in the position of a prosecutor who is fair-minded and objective. That should allow evaluation of the 'governmental interest,' not some abstraction like the statutory maximum.").

38 *See U*nited States v. Kourey, 276 F. Supp. 2d 580, 585 (S.D. W. Va. 2003) ("Defendant is not facing serious criminal charges . . . . Defendant is charged with violating the terms and conditions of his supervised release imposed for his admitted commission of a Class A misdemeanor.").

39 Eugene Volokh, *Crime Severity and Constitutional Line-Drawing*, 90 VA. L. REV. 1957, 1973 (2004).

40 United States v. Schloming, Mag. No. 05-5017 (TJB), 2006 WL 1320078, at *5 (D.N.J. May 12, 2006).

41 *See Sell v. United States*, 539 U.S. 166, 180 (2003).

42 *See* Duncan v. Louisiana*,* 391 U.S. 145, 161–62 (1968); *see also Welsh v. Wisconsin*, 466 U.S. 740, 753 (1984) (imposing a higher standard for exigency on warrantless home arrests involving minor offenses); Duke v. United States, 301 U.S. 492, 494–95 (1937) (affirming the "well-settled rule" that "any misdemeanor not involving infamous punishment might be prosecuted

seriousness determinations because in other cases, the Court is concerned with whether the seriousness of the charge will entitle the defendant to certain rights, such as the right to a jury trial or indictment by a grand jury. Here, by contrast, the Court is determining whether the seriousness of the crime creates a sufficiently important state interest in bringing the defendant to trial that outweighs his or her independent right to be free from unwanted medical procedures. While the sentence length is a reasonable consideration for determining whether a defendant-protective right should apply, it is a less useful signal of whether there is a serious state interest in seeing a defendant brought to trial. Even when the defendant faces little or no jail time, the state may still have an important interest in bringing him to trial, for instance in symbolic prosecutions of high-profile defendants.[43]

Like the analogy to other situations in which courts evaluate the "seriousness" of crimes, the argument for honoring legislative intent does not quite fit the Sell setting either. Congress, after all, is not making individualized decisions about specific defendants, and certainly not about the specific question of whether the state has a strong interest in bringing the defendant to trial. Indeed, with the adoption of the Federal Sentencing Guidelines,[44] Congress seems to have urged the reverse: the seriousness of a crime, as judged by a sentence, cannot be determined by rote consultation of the maximum possible sentence, but can only be evaluated by looking to the circumstances of a particular offense and offender.[45] Given the broad determination that is being made here — whether or not a serious crime has been committed — reference to a potential Guidelines range is more effective, and fairer to the defendant, than reference to the statutory maximum.[46]

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by information instead of by indictment").

43 *See, e.g.,* Jeff Yates & William Gillespie*, The Problem of Sports Violence and the Criminal Prosecution Solution*, 12 CORNELL J.L. & PUB. POL'Y 145, 168 (2002) (advocating selective prosecution of assaults committed in the course of professional sports).

44 Sentencing Reform Act of 1984, Pub. L. No. 98-473, tit. II, ch. II, 98 Stat. 1987 (codified as amended in scattered sections of 18 and 28 U.S.C.).

45 The Sentencing Guidelines, of course, were adopted to restrain judges' sentencing discretion. *See* Kate Stith & Steve Y. Koh, *The Politics of Sentencing Reform: The Legislative History of the Federal Sentencing Guidelines*, 28 WAKE FOREST L. REV. 223 (1993). But as modified by United States v. Booker*,* 543 U.S. 220 (2005), the Guidelines preserve a great deal of judicial discretion to tailor sentences to the severity of the crime, in light of all circumstances.

46 In light of *Booker,* which rendered the Guidelines advisory, sentencing judges have more discretion to make individualized decisions. Still, the now nonbinding nature of the Guidelines does not mean they lose their value as indicia of crime seriousness. Indeed, the Guidelines will still be sufficiently predictive of actual sentences to make them a relevant indicator of crime seriousness. *See* Recent Case, 120 HARV. L. REV. 1723, 1730 (2007).

Sell asked the lower courts to consider the overall significance of the state interest in bringing a defendant to trial, taking into account both the seriousness of the crime and the consequences if the defendant is not brought to trial. The *Lindauer* approach is not popular among lower courts, but it appears to be the most faithful articulation of the *Sell* command. Judge Mukasey's suggestion that a Rochinesque concern for defendants' Fifth Amendment liberty interests still applies must have informed his belief that judges are to make individualized determinations of the importance prong. Courts seeking to mirror Judge Mukasey's approach will need to consider the totality of the circumstances. Other judges might follow Judge Mukasey by looking at what harm the indictment alleges a defendant caused or could have caused. They might also consider the potential Guidelines sentencing range a defendant would face and the possible consequences of not bringing a defendant to trial. Courts should also consider other benefits of prosecution besides the potential incapacitation of the defendant, including the "retributive, deterrent, communicative, and investigative functions of the criminal justice system."[47] The process will not be mechanical or easy, but it will better fulfill the mandate of *Sell* than the current majority approach.[48]

C. "Medically Appropriate"

On January 30, 2003, Steven Paul Bradley, "dissatisfied with the purchase of a truck," drove by Cowboy Dodge in Cheyenne, Wyoming, and hurled a hand grenade at a group of salesmen in the parking lot.[49] "Attached to the grenade was a note [that] read[,] 'I want my $26,000.'"[50] Bradley was charged with attempted arson, possession of ammunition by a felon, extortion, and use of a firearm in a violent crime.[51] At a competency hearing, Bradley testified that he would not voluntarily take psychotropic medication that likely would have made him competent to stand trial:

[47] United States v. Weston, 255 F.3d 873, 882 (D.C. Cir. 2001); *see also* Christopher Slobogin, *The Supreme Court's Recent Criminal Mental Health Cases: Rulings of Questionable Competence*, CRIM. JUST., Fall 2007, at 8, 10.

[48] The unavoidable consequence of the first Sell prong is that judges will be in the position of questioning prosecutorial decisions. The Court did not address the separation of powers implications of its holding, perhaps indicating it did not believe such review to be an incursion on Article II power. *Cf.* Eric L. Muller, Constitutional Conscience, 83 B.U. L. REV. 1017, 1070 (2003) (citing United States v. Miller, 891 F.2d 1265, 1272 (7th Cir. 1989) (Easterbrook, J., concurring)) (reporting Judge Easterbrook's identification of a "separation of powers concern that might arise equally in the context of judicial review of a prosecutor's exercise of his discretion to charge an offense"); James Vorenberg, Decent Restraint of Prosecutorial Power, 94 HARV. L. REV. 1521, 1546 (1981) ("Courts often justify their refusal to review prosecutorial discretion on the ground that separation-of-powers concerns prohibit such review.").

[49] United States v. Bradley, 417 F.3d 1107, 1110 (10th Cir. 2005).

[50] *Id.*

[51] *See id.* at 100 & nn.2–5.

"[N]ot only did they take my money, they never gave me a truck either, and that's what the whole issue is over this here, was going out to buy a new truck, and I don't see where medication is going to help me with that."[52] The district court found that Bradley was incompetent and that the *Sell* criteria were met.[53] The court ordered Bradley to submit to the medication, on pain of civil contempt.[54] The defendant appealed from this order and the Tenth Circuit affirmed.[55] The Tenth Circuit, however, appeared to misread *Sell* by equating the medical appropriateness of forced medication with its potential effectiveness.[56] The Tenth Circuit's approach illustrates the key difficulties in applying this fourth *Sell* factor, the medical appropriateness of treatment. The court addressed this factor first, but clearly mischaracterized it by saying that "[t]his necessarily includes a determination that administration of the drug regimen is 'substantially likely to render the defendant competent to stand trial.'"[57] The court thereby conflated the second and fourth *Sell* factors. Then, seeming to remember that there were supposed to be four factors, the court said the next factor to examine was whether "administration of the drugs is substantially unlikely to have side effects that will interfere significantly with the defendant's ability to assist counsel in conducting a trial defense."[58]

Thus, the court merely created two factors out of *Sell's* second factor, which included both whether the medication will be directly effective at restoring competence and whether the side effects from the drug will undermine its effectiveness.[59] In allowing this single factor to take up two slots, the court crowded out the distinct medical appropriateness factor.[60]

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[52] Brief of Appellee at 10, *Bradley*, 417 F.3d 1107 (No. 03-8097), 2004 WL 3763208.

[53] *Bradley*, 417 F.3d at 1109.

[54] Brief of Appellee, *supra* note 52, at 13. In *Bradley*, the district court was not precisely in a *Sell* situation because it was not ordering that the defendant be forcibly medicated, only that the defendant submit to medication on pain of civil contempt. The *Sell* Court had suggested that courts consider the threat of contempt as an example of alternative mechanisms for achieving competence short of forcible mediation. *See* Sell v. United States, 539 U.S. 166, 181 (2003). On appeal, the Tenth Circuit ignored this distinction, treating *Sell* as directly applicable, *Bradley,* 417 F.3d at 1109, and so the case serves as an adequate example of the alternative approaches to *Sell.*

[55] *Bradley,* 417 F.3d at 1109, 1113.

[56] *Cf.* United States v. Lindauer, 448 F. Supp. 2d 558, 565 (S.D.N.Y. 2006) ("[T]he second element focuses on favorable and unfavorable outcomes only insofar as they affect a trial, whereas the fourth element focuses on the defendant's medical well-being in the large.").

[57] *Bradley*, 417 F.3d at 1114 (quoting *Sell*, 539 U.S. at 181).

[58] *Id.* at 1115 (quoting *Sell*, 539 U.S. at 181) (internal quotation mark omitted).

[59] *Sell* is quite clear that determining whether medication will have adverse side effects that will prevent a defendant from assisting counsel is part of the inquiry into whether the medication will be effective at rendering the defendant competent. *See* 539 U.S. at 181.

[60] This approach is well established in the Tenth Circuit. S*ee, e.g.,* United States v. Valenzuela-Puentes*,* 479 F.3d 1220, 1225–26 (10th Cir. 2007); United States v. Smith*,* No. 05-40002-01-JAR, 2007 WL 1712812, at *4 (D. Kan. June 12, 2007) (medical

Other courts have not been as cavalier as the Tenth Circuit about disregarding the fourth element, but even when they have considered it, they have tended to equate the patient's medical interest with restoring competency.[61] But given that these are separate factors, Sell's implication is that medical appropriateness is a separate question with which lower courts need to wrestle, independent of the other factors.[62] Courts have been loath to address it and are perhaps somewhat dishonestly avoiding the question.[63]

Even though courts have not spent much time considering this fourth factor, it is possible to give independent meaning to the medical appropriateness prong. An initial stumbling block is that doctors may conclude that any treatment that could result in a patient being prosecuted may not be medically appropriate — such treatment could conflict with doctors' Hippocratic oath to "do no harm."[64] A definition of medical appropriateness limited to the treatment being the "right treatment for the condition," assuming the defendant was not on trial, largely avoids these difficult

interest determination "includes the determination of whether administering [psychotropic medication] is 'substantially likely to render the defendant competent to stand trial'" (quoting *Sell*, 539 U.S. at 181)).

61 *See, e.g.,* United States v. Morris, No. CR.A.95-50-SLR, 2005 WL 348306, at *6 (D. Del. Feb. 8, 2005) ("This final prong of *Sell* has been adequately addressed in the analysis of the other three prongs."). *But see* United States v. Milliken, No. 3:05-CR-6-J-32TEM, 2006 WL 2945957, at *13–14 (M.D. Fla. July 12, 2006) (evaluating appropriateness of proposed medical treatment in light of defendant's condition, independent of its anticipated effectiveness in restoring competence).

62 *Cf.* Nat'l Ass'n of Home Builders v. Defenders of Wildlife, 127 S. Ct. 2518, 2536 (2007) ("[W]e have cautioned against reading a text in a way that makes part of it redundant."). The reference in *Defenders of Wildlife* is to statutory construction, but seems equally true for the interpretation of Supreme Court holdings.

63 Courts of appeals vary in their willingness to disregard the medical appropriateness factor. The Fourth Circuit requires the government to describe in detail the prescribed treatment and requires doctors to submit testimony that the treatment is appropriate for the particular defendant. *See* United States v. Evans, 404 F.3d 227, 241–42 (4th Cir. 2005). The Second Circuit has allowed relatively conclusory testimony — that given the defendant's diagnosis, "he needs . . . treatment [with] anti-psychotics" — to satisfy the medical appropriateness prong. *See* United States v. Gomes, 387 F.3d 157, 163 (2d Cir. 2004).

64 Psychiatrist Douglas Mossman concludes that psychiatrists can make medical appropriateness determinations because psychotropic medication would restore patient autonomy, not undermine it, and alternatively, because "[a] defendant's consent to treatment is one aspect of his larger consent to freedom under law within the original [social] contract." *Douglas Mossman, Is Prosecution "Medically Appropriate*"?, 31 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT 15, 73, 77 (2005). *But cf.* Donald N. Bersoff, *Autonomy for Vulnerable Populations: The Supreme Court's Reckless Disregard for Self-Determination and Social Science*, 37 VILL. L. REV. 1569 (1992) (arguing that the courts are insufficiently deferential to autonomy concerns); *Bruce J. Winick, On Autonomy: Legal and Psychological Perspectives*, 37 VILL. L. REV. 1705, 1774–77 (1992) (suggesting the courts have been too quick to find individuals incompetent). Some argue that prosecution can be medically indicated for some psychiatric patients. *See, e.g., Robert D. Miller, Ethical Issues Involved in the Dual Role of Treater and Evaluator, in ETHICAL PRACTICE IN PSYCHIATRY AND THE LAW* 129, 139–40 (Richard Rosner & Robert Weinstock eds., 1990) (arguing that prosecution may under some circumstances have direct therapeutic benefits).

questions.[65] Others have argued that the medical appropriateness prong requires more difficult weighing of the competing values of justice and patient autonomy,[66] but neglect the fact that these values are entirely accounted for in the other *Sell* factors, including the test for an important state interest and the required search for effective alternatives.

Sell defines medical appropriateness as being "in the patient's best medical interest in light of his medical condition."[67] The Court intended this definition to mean more than that the treatment will be effective in rendering a patient competent to stand trial. A suitable definition is that the proposed treatment is right for the defendant's condition, given his medical history.[68]

D. "Effective" and "Necessary"

Sell factor three — whether a less intrusive, yet effective alternative is available — and factor two — whether the treatment is likely to be effective — are determinations that are closely linked to the facts of an individual case. Because of recent developments in psychopharmacology, there is likely to be progressively less dispute on these elements of the *Sell* test.

For the incompetent defendant, medical treatment will often be more effective than any alternative.[69] Although some disorders are more amenable to alternative treatments such as psychotherapy, both government and defense medical experts frequently testify that no treatment but medication has been shown to be effective.[70] And although the conditions of *Bradley* show that courts do try to coerce defendants into "voluntarily" accepting a medication order, when such meansures fail (as they

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65 *See* Mossman*, supra* note 64, at 35–36 (describing this view).

66 *See id*. at 36 & n.89.

67 Sell v. United States, 539 U.S. 166, 181 (2003).

68 For instance, some antipsychotics may be contraindicated for diabetics because of their effects on metabolics. *See,* e.g., PHYSICIANS' DESK REFERENCE, *supra* note 4, at 1677 (noting that hyperglycemia is associated with Risperdal and other atypical antipsychotics).

69 *See* Douglas Mossman, *Unbuckling the "Chemical Straitjacket": The Legal Significance of Recent Advances in the Pharmacological Treatment of Psychosis*, 39 SAN DIEGO L. REV. 1033, 1048–49 (2002) (discussing improved effectiveness of medication for schizophrenia); *see* also Motion for Leave To File Brief and Brief for the American Psychiatric Ass'n et al. as Amici Curiae Supporting Respondent at 16–17, *Sell*, 539 U.S. 166 (No. 02-5664), 2003 WL 176630 ("With the newer medications, it is all the more firmly true that medications are commonly essential to responsible treatment of psychoses like schizophrenia."). *But see* Motion for Leave To File Brief for Amicus Curiae American Psychological Ass'n and Brief for Amicus Curiae American Psychological Ass'n at 11, Sell, 539 U.S. 166 (No. 02-5664), 2002 WL 31898300 ("There is a significant danger . . . that health-care professionals in a forensic setting may proceed immediately to medication without considering less intrusive alternatives that might be effective in restoring competence.").

70 *See, e.g.,* United States v. Morrison, 415 F.3d 1180, 1183 (10th Cir. 2005); United States v. Cortez-Perez, No. 06-CR-1290-WQH, 2007 WL 2695867, at *3 (S.D. Cal. Sept. 10, 2007).

often do), forced medication becomes "necessary."[71]

The effectiveness prong includes consideration of both the expected direct effectiveness of a drug regime in restoring a defendant to competency and whether the expected side effects of the drug will outweigh its benefits in rendering the defendant competent.[72] Dramatic "extrapyramidal" side effects that plagued early psychotropic drugs have greatly diminished in the current generation of pharmaceuticals.[73] These extrapyramidal symptoms appear to be the ones courts are most worried about.[74] Nevertheless, modern drugs still have significant side effects,[75] and depending on the conditions of the case, these effects could meaningfully affect the defendant's ability to receive a fair trial.[76]

E. Conclusion

Lower courts have not consistently applied the *Sell* standards, perhaps because the case asked lower courts to judge defendants according to standards that are ill-suited for application as bright-line rules. In both the importance and medical appropriateness prongs, courts have diverged from the *Sell* mandate, reading something that was not

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[71] Some believe that the Sell Court overstated the potential effect of the contempt power in persuading a mentally ill defendant to consent to medication. S*ee* Paul S. Appelbaum, *Treating Incompetent Defendants: The Supreme Court's Decision is a Tough Sell*, 54 PSYCHIATRIC SERVICES 1335, 1336 (2003). Given the range of potential defendants, it is hard to dismiss entirely the possibility that civil contempt could encourage a defendant to submit to medication.

[72] *See supra* p. 1129.

[73] The earliest generation of antipsychotic medicine was developed in the 1950s. The first antipsychotic was chlorpromazine, the generic name of Thorazine. These drugs had severe "extrapyramidal" side effects, which could include "stiffness, diminished facial expression, tremors, and restlessness." Because these effects were so unpleasant, patients would often stop taking the drugs. Mossman, *supra* note 69, at 1062–63 & n.147, 1068; *see also* United States v. Gomes, 387 F.3d 157, 162 n.* (2d Cir. 2004) ("'Typical' anti-psychotic drugs can potentially produce more severe side effects, such as neuroleptic malignant syndrome (temperature disorder and muscle breakdown) and tardive dyskinesia (involuntary movement of the face and tongue)."). In late 1989, the FDA approved clozapine, the first drug without these extrapyramidal symptoms. Clozapine and its class were dubbed "atypical" psychotropics. Mossman, *supra* note 69, at 1069– 70.

[74] *See, e.g.,* United States v. Grape, 509 F. Supp. 2d 484, 489 (W.D. Pa. 2007) ("The second generation medications are much less likely than first generation medications to cause neuroleptic malignant syndrome, tardive dyskinesia, or extrapyramidal side effects such as stiffness, and feelings of anxiety or agitation."); *see also* SLOBOGIN, *supra* note 16, at 223 ("[T]he recent developments of 'atypical' antipsychotic medications, which are purportedly more effective and have significantly fewer side effects, could be changing the terms of the debate . . . .").

[75] *See* Alex Berenson, *Schizophrenia Medicine Shows Promise in Trial*, N.Y. TIMES, Sept. 3, 2007, at A9 (describing newest generation of pharmaceuticals, which may be free from even the lesser side effects, such as weight gain and tremors, that had accompanied atypicals).

[76] *See, e.g.,* United States v. Dallas, No. 8:06CR78, 2007 WL 2875170, at *8 (D. Neb. Sept. 27, 2007).

quite there into the case and overlooking what was — no doubt because *Sell* required judges to wrestle with difficult questions.

III. *BOOKER*, THE FEDERAL SENTENCING GUIDELINES, AND VIOLENT MENTALLY ILL OFFENDERS

The Supreme Court's decision in *United States v. Booker*[1] dealt a strong blow to a system of federal sentencing guidelines that many viewed as unfair[2] and unsuccessful.[3] *Booker* granted judges more discretion, but such discretion is not a wholly positive outcome. This Part argues that, by permitting judges greater reliance on 18 U.S.C. § 3553(a) (the statute that sets forth Congress's sentencing objectives), the federal sentencing regime initiated by *Booker* allows for prison sentences for violent mentally ill offenders longer than those suggested by the Federal Sentencing Guidelines. The claim is not that defendants have been given longer sentences purely on account of mental illness. Rather, this Part argues that judges have imposed prison sentences beyond what the Guidelines recommend on some mentally ill offenders they view as dangerous or in need of treatment instead of supplementing Guidelines sentences as necessary with civil commitment.[4] Such lengthy prison sentences disregard the rights and interests of the offenders and provide little benefit to the public. Although this is not an area with many reported cases,[5] the cases that have been reported

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1 543 U.S. 220 (2005).

2 *See, e.g.,* Albert W. Alschuler, *Disparity: The Normative and Empirical Failure of the Federal Guidelines,* 58 STAN. L. REV. 85, 102–06 (2005) (arguing that the Federal Sentencing Guidelines failed to end disparities in sentencing along racial, gender, and ethnic lines); Frank O. Bowman, III, *The Failure of the Federal Sentencing Guidelines: A Structural Analysis*, 105 COLUM. L. REV. 1315, 1319–20 (2005) (describing the Guidelines as "a one-way upward ratchet increasingly divorced from considerations of sound public policy and . . . the common sense judgments of frontline sentencing professionals").

3 For instance, despite the goals of the Guidelines' framers, implementing the Guidelines did not remove discretion from the federal sentencing system. Instead, the combination of determinate sentences for offenses, overlapping sentences within the federal criminal code, and plea bargaining invested discretion in prosecutors rather than judges. *See* William J. Stuntz*, Plea Bargaining and Criminal Law's Disappearing Shadow,* 117 HARV. L. REV. 2548, 2550–62 (2004); *Ronald F. Wright, Trial Distortion and the End of Innocence*, 154 U. PA. L. REV. 79, 132 (2005).

4 Civil commitment is an option provided by both state commitment statutes and 18 U.S.C.§ 4246 (2000).

5 The limited number of reported cases involving a sentence that departs upward from the sentence indicated by the Guidelines on the basis of an offender's mental illness may not accurately reflect the prevalence and effect of this sentencing practice. The vast majority of cases in the federal system end in pleas: in 2002, for instance, more than 95% of defendants in adjudicated cases pleaded either guilty or no contest. Jennifer L. Mnookin, *Uncertain Bargains: The Rise of Plea Bargaining in America*, 57 STAN. L. REV. 1721, 1722 (2005) (book review); *see also Blakely v. Washington*, 542 U.S. 296, 337 (2004) (Breyer, J., dissenting) (noting that more than 90% of defendants reach plea agreements before trial). In cases involving violent crimes, a high sentence upheld on appeal creates a long shadow under which future parties in a plea "transaction" will bargain. See Stuntz, *supra* note 3, at 2563. In cases that do go to trial, sentencing judges are not required to issue a public, written

raise important questions about how society manages the often difficult intersections between the rights of the mentally ill[6] and the safety needs and behavioral expectations of society at large.

Section A offers an introduction to the Guidelines and their approach to mental illness. Section B argues that *Booker's* shift from mandatory to advisory guidelines has combined with certain dynamics of the criminal justice system and the language of 18 U.S.C. § 3553(a) to create an additional opportunity for judges to impose above Guidelines prison sentences on violent mentally ill offenders. Section C discusses the potential disadvantages of such above-Guidelines prison sentences. In contrast, section D discusses some of the challenges inherent in civil commitment and makes an affirmative argument for a system in which mentally ill defendants receive the same prison sentences as non–mentally ill defendants, but are civilly committed after prison as necessary. Section E concludes.

A. The Federal Sentencing Guidelines and Mentally Ill Offenders

The Sentencing Reform Act of 1984[7] (SRA) created the U.S. Sentencing Commission to promulgate binding sentencing guidelines in response to a regime of indeterminate sentencing characterized by broad judicial discretion over sentencing and the possibility of parole.[8] The Act sought to create a transparent, certain, and proportionate sentencing system, free of "unwarranted disparity" and able to "control crime through deterrence, incapacitation, and the rehabilitation of offenders"[9] by sharing power over sentencing policy and individual sentencing outcomes among Congress, the federal courts, the Justice Department, and probation officers.[10]

The heart of the Guidelines is a one-page table: the vertical axis is a forty-three point scale of offense levels, the horizontal axis lists six categories of criminal history, and the body provides the ranges of months of imprisonment for each combination of

sentencing opinion and are in practice only asked to provide very anemic information for appellate review. Steven L. Chanenson, *Write On!*, 115 YALE L.J. POCKET PART 146, 147 (2006), http://www.thepocketpart.org/2006/07/chanenson.html. The U.S. Sentencing Commission and other agencies collect data on sentencing, but whether offenders are mentally ill is not a datum that the Commission collects. *See* U.S. SENTENCING COMM'N, 2006 ANNUAL REPORT 31–46 (2006), *available* at http://www.ussc.gov/ANNRPT/2006/chap5_06.pdf.

[6] This Part does not seek to define mental illness; instead, it focuses on cases where courts believe that they are dealing with someone who is mentally ill.

[7] Pub. L. No. 98-473, tit. II, ch. II, 98 Stat. 1987 (codified as amended in scattered sections of 18 and 28 U.S.C.).

[8] *See* Bowman, *supra* note 2, at 1318–23; *see also* Mistretta v. United States, 488 U.S. 361, 363 (1989).

[9] U.S. SENTENCING COMM'N, FIFTEEN YEARS OF GUIDELINES SENTENCING, at iv (2004), *available at* http://www.ussc.gov/15_year/executive_summary_and_preface.pdf.

[10] *See* Bowman, *supra* note 2, at 1319.

offense and criminal history.[11] A sentencing judge is meant to use the guidelines, policy statements, and commentaries contained in the other 600-odd pages of the Guidelines Manual to identify the relevant offense and history levels, and then refer to the table to identify the proper sentencing range.[12] Though in all cases a sentence must be at or below the maximum sentence authorized by statute for the offense,[13] in certain circumstances the Guidelines allow for both upward and downward departures from the sentence that would otherwise be recommended.

Few of these circumstances involve the mental illness of an offender; in fact, the Guidelines deal explicitly with mentally ill offenders in only a limited way.[14] Section 5H1.3 of the Guidelines sets the tone, stating that "[m]ental and emotional conditions are not ordinarily relevant in determining whether a departure [from the range of sentences that would otherwise be given under the Guidelines] is warranted, except as provided in [the Guidelines sections governing grounds for departure]."[15] In general terms, that section permits departure from the Guidelines if there is an aggravating or mitigating circumstance "not adequately taken into consideration by the Sentencing Commission in formulating the guidelines," and if the departure advances the objectives set out in 18 U.S.C § 3553(a)(2), which include elements of incapacitation, deterrence, rehabilitation, and retribution.16 Downward departure is allowed when an offender suffers from a "significantly reduced mental capacity" and neither violence in the offense nor the offender's criminal history indicates a need to protect the public.[17]

This reticence is not wholly surprising: the Guidelines came along soon after the John Hinckley acquittal had helped turn public sentiment against the insanity defense[18] and at a time when the criminal justice system and the nation more generally were coping with the mass deinstitutionalization of the nation's mentally ill population.[19]

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11 U.S. SENTENCING GUIDELINES MANUAL ch. 5, pt. A, at 392 (2007).

12 *See id.* § 1B1.1; Bowman, *supra* note 2, at 1324–25.

13 *See* Bowman, *supra* note 2, at 1322.

14 Interestingly, the Guidelines deal more extensively with crimes against the mentally ill, providing for heightened sentences for those committing crimes against victims deemed incompetent because of mental illness. *See, e.g.,* U.S. SENTENCING GUIDELINES MANUAL § 2D1.1(b)(10)(D) & cmt. n.20(B).

15 *Id.* § 5H1.3.

16 *Id.* § 5K2.0(a)(1).

17 U.S. SENTENCING GUIDELINES MANUAL § 5K2.13. Although there is no necessary connection between a violent offense and future risk to the public, most courts construing section 5K2.13 have taken the position that an offense involving violence or the threat of violence disqualifies an offender from a downward departure under this section. *See* Eva E. Subotnik, *Note, Past Violence, Future Danger?: Rethinking Diminished Capacity Departures Under Federal Sentencing Guidelines Section* 5K2.13, 102 COLUM. L. REV. 1340, 1340–43, 1354–57 (2002).

18 *See* Ronald Bayer, *Insanity Defense in Retreat,* HASTINGS CENTER REP., Dec. 1983, at 13.

19 *See* TERRY A. KUPERS*, PRISON MADNESS*, at xv, 11–14 (1999).

Moreover, the Guidelines were crafted to ensure that drug dependence, which is perhaps most reasonably viewed as mental illness, would not act to mitigate sentences.[20] These factors coincided with the rise of the idea that punishment should be measured by offenders' dangerousness and not merely their culpability.[21] A key implication of the Guidelines' silence on mental illness was that downward departures for the mentally ill, and hence the dangerous or drug addicted among them, were rarely permitted.

Along with discouraging downward departure in cases of mental illness, prior to *Booker*, the Guidelines only allowed upward departure on the basis of mental illness under section 5K2.0, for extraordinary circumstances not otherwise taken into account by the Guidelines.[22] Courts were left to determine what manifestations of mental illness counted as sufficiently extraordinary. The Ninth Circuit's decision in *United States v. Hines*[23] suggested that lurid details and the specter of dangerousness fueled by mental illness might in combination count as extraordinary circumstances. Roger Hines was convicted of making threats against the President and being a felon in possession of a firearm.[24] In addition to traveling to Washington, D.C., apparently in hopes of killing President George H.W. Bush, Hines kept a diary and wrote letters in which he claimed to have molested and killed children.[25] At sentencing, the court gave Hines an upward departure because of his "extraordinarily dangerous mental state" and "significant likelihood that he [would] commit additional serious crimes."[26] The Ninth Circuit upheld the sentence, arguing that although upward departures based on a need for psychiatric treatment are barred, the sentencing court had departed not to treat Hines but because "Hines posed an '*extraordinary danger'* to the community because of his serious emotional and psychiatric disorders.'"[27]

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[20] *See, e.g.*, U.S. SENTENCING GUIDELINES MANUAL § 5H1.4 ("Drug or alcohol dependence or abuse is not a reason for a downward departure. Substance abuse is highly correlated to an increased propensity to commit crime.").

[21] Paul H. Robinson, Commentary, *Punishing Dangerousness: Cloaking Preventive Detention as Criminal Justice*, 114 HARV. L. REV. 1429, 1429–31 (2001).

[22] *See* United States v. Doering, 909 F.2d 392, 394–95 (9th Cir. 1990) (per curiam).

[23] 26 F.3d 1469 (9th Cir. 1994).

[24] *Id.* at 1473.

[25] *Id.* at 1472. Investigators found no evidence to corroborate these claims. Id.

[26] *Id.* at 1473 (quoting the district court's findings) (internal quotation marks omitted). The court justified this additional departure by reference both to Guidelines section 5K2.0 and to section 4A1.3, which allows departures where defendants' criminal histories do not adequately reflect their dangerousness. *Hines*, 26 F.3d at 1477. *But see* U.S. SENTENCING GUIDELINES MANUAL § 4A1.3 (2007) (enumerating the circumstances, which do not include mental illness, that may justify departures on these grounds).

[27] *Hines*, 26 F.3d at 1477.

The *Hines* court appeared to ignore the fact that in the criminal justice system — a system designed to deal with deviations from normal behavior — manifestations of mental illness are the stuff of everyday life.[28] In contrast, the Sixth Circuit in *United States v. Moses*[29] maintained that mental illness made poor grounds for extraordinary departures. The defendant, Dewain Moses, was a paranoid schizophrenic inhabited by "strange, violent fantasies" and "preoccupied with weapons" who had "overtly threatened the killings of several people, and fantasized the slaughter of still more."[30] He was convicted for making false statements in order to purchase guns and for receiving guns after having been adjudicated as a "mental defective."[31] In response to worries that Moses would cease taking the medications under which he had improved while in custody and return to his dangerous state, the sentencing court relied on section 5K2.0 of the Guidelines to give him a sentence almost six times greater than the sentence recommended by the Guidelines for his offense and criminal history.[32] The Sixth Circuit vacated the sentence, stating that, given the inclusion of section 5H1.3 in the Guidelines, upward departures for circumstances not taken into account in the drafting of the Guidelines did not apply to Moses.[33] Civil commitment, rather than an upward departure, was the appropriate mechanism for protecting the public.[34]

B. The Potential Impact of Booker on Sentences for the Mentally Ill

Following its decisions in *Apprendi v. New Jersey*[35] and *Blakely v. Washington*[36] on similar provisions in state sentencing schemes, the Supreme Court in *United States v. Booker* invalidated the provisions of the SRA that made the Guidelines mandatory, declaring them instead **to be** "effectively advisory."[37] *Booker* directed sentencing

28 *Cf.* HUMAN RIGHTS WATCH, ILL-EQUIPPED: U.S. PRISONS AND OFFENDERS WITH MENTAL ILLNESS 17 (2003), *available* at http://www.hrw.org/reports/2003/usa1003/usa1003.pdf (reporting that over 300,000 mentally ill people may be in American prisons on any given day).

29 106 F.3d 1273 (6th Cir. 1997).

30 *Id.* at 1275.

31 *Id.*

32 *Id.* at 1277.

33 *Id.* at 1278–81.

34 *See id.* at 1280; *cf.* United States v. Fonner, 920 F.2d 1330, 1334 (7th Cir. 1990) (noting that "[m]ental health is not a solid basis on which to depart upward," and that upward departures on the basis of a convict's potential to commit future crimes — perhaps due to mental illness — may impermissibly overlap with the recidivism penalties already included in the Guidelines). In particular, the Sixth Circuit noted that a civil commitment statute, 18 U.S.C. § 4246 (2000), was "directly designed to forestall [the danger to the community created by a convict's mental illness] through continued commitment after completion of the sentence." *Moses*, 106 F.3d at 1280.

35 530 U.S. 466 (2000).

36 542 U.S. 296 (2004).

37 United States v. Booker, 543 U.S. 220, 245 (2005) (Breyer, J., delivering the opinion of the Court in part).

courts to continue to consult the Guidelines, but did not make clear how they should go about doing so. In two subsequent cases, *United States v. Rita*[38] and *Gall v. United States*,[39] the Court clarified somewhat the advisory role of the Guidelines by explaining how appellate courts may review sentencing decisions in light of the Guidelines: the two cases to- gether suggest that this post-Booker advisory role will not itself much limit the discretion of judges in sentencing.[40]

For mentally ill defendants, *Booker's* main effect may have been to create a second pathway for judges to impose above-Guidelines sentences. As was the case before *Booker*, a judge may use sections 4A1.3, 5H1.3, and subpart 5K2 of the Guidelines to depart within the Guidelines themselves. However, judges may now also look to the sentencing factors in § 3553(a) to make variances *outside* the Guidelines framework. Section 3553(a) directs courts to impose sentences "sufficient, but not greater than necessary"[41] to "reflect the seriousness of the offense, to promote respect for the law, and to provide just punishment for the offense[,] to afford adequate deterrence to criminal conduct"; "to protect the public from further crimes of the defendant"; and "to provide the defendant with needed educational or vocational training, medical care, or other correctional treatment in the most effective manner."[42] Because the Guidelines already reflect the Sentencing Commission's reasoned interpretation of the § 3553 factors,[43] in many areas of the law, courts may only rarely resort to this new avenue to deviate.[44] The sentencing of mentally ill offenders is not such an area. Section 5H1.3 of the Guidelines limits consideration of mental illness to extraordinary circumstances, but the opportunity

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38 127 S. Ct. 2456 (2007).

39 128 S. Ct. 586 (2007).

40 In *Rita,* the Court held that "a court of appeals may apply a presumption of reasonableness to a district court sentence that reflects a proper application of the Sentencing Guidelines," 127 S. Ct. at 2462, but that "the presumption is not binding," and "does not, like a trial-related evidentiary presumption, insist that one side, or the other, shoulder a particular burden of persuasion or proof lest they lose their case," *id*. at 2463. In *Gall*, the Court rejected the Eighth Circuit's requirement that "a sentence outside of the guidelines range must be supported by a justification that '"is proportional to the extent of the difference between the advisory range and the sentence imposed,"'" 128 S. Ct. at 594 (quoting United States v. Claiborne, 446 F.3d 884, 889 (8th Cir. 2006)), holding instead that "while the extent of the difference between a particular sentence and the recommended Guidelines range is surely relevant, courts of appeals must review all sentences — whether inside, just outside, or significantly outside the Guidelines range — under a deferential abuse of discretion standard," *id.* at 591.

41 18 U.S.C. § 3553(a) (2000 & Supp. IV 2004).

42 *Id.* § 3553(a)(2)(A), (a)(2)(C)–(D).

43 *See Rita*, 127 S. Ct. at 2463–64.

44 *Cf.* Nancy Gertner, *From Omnipotence to Impotence: American Judges and Sentencing*, 4 OHIO ST. J. CRIM. L. 523, 525, 537 (2007) (asserting that since *Booker*, judges have shown little inclination to depart from the Guidelines, in part because of feelings of institutional incapacity).

to refer directly to § 3553(a) in addition to the Guidelines is an opportunity to consider mental illness despite this limitation.[45]

More, even in an advisory Guidelines regime, cases involving violent mentally ill defendants, if they produce any departures or variances at all, seem likely to produce upward ones. To begin with, recall that violent mentally ill offenders are not eligible for downward departure under section 5K2.13 of the Guidelines. Second, downward variances have proved much less likely than upward ones to be sustained on appeal.[46] The threat of being overturned might influence a judge to forgo varying downwards. Third, the wording of the § 3553(a) factors appears to encourage higher sentencing. The two factors that most obviously pertain to violent mentally ill defendants are "to protect the public from further crimes of the defendant"[47] and "to provide the defendant with needed . . . treatment in the most effective manner."[48] Considering the need to protect the community would, if it led to a variance at all, lead to an upward one. Similarly, it seems unlikely that the need to provide a violent mentally ill defendant with effective treatment would lead to a downward variance from the Guidelines.[49] Finally, when confronted with an obviously mentally ill defendant in a courtroom accompanied by the lurid particularities of illness and violent crimes, judges may react by seeking to remove the frightening person before them from society for as long as possible.

This last point merits further discussion. Judge Easterbrook once said of jurors that "[w]hat little scientific data we possess implies that trying to persuade the jury that the accused is mentally ill is worse than no defense at all. . . . [I]f persuaded that the defendants are indeed nutty, jurors believe that death is the only sure way to prevent

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45 *See Rita*, 127 S. Ct. at 2473 (Stevens, J., concurring) ("Matters such as age, education, [or] mental or emotional condition . . . are not ordinarily considered under the Guidelines. These are, however, matters that § 3553(a) authorizes the sentencing judge to consider.") (citation omitted).

46 *See* Regina Stone-Harris*, How To Vary from the Federal Sentencing Guidelines Without Being Reversed,* 19 FED. SENT'G REP. 183, 185–86 (2007); *see also* United States v. Meyer, 452 F.3d 998, 1000 n.3 (8th Cir. 2006) (opinion of Heaney, J.) (noting that since *Booker*, the Eighth Circuit had upheld twelve of thirteen sentences exceeding the Guidelines range, but had reversed sixteen of nineteen sentences lower than the Guidelines range). However, this trend may change with *Gall* and its directive that all sentences must be given abuse of discretion review. Gall v. United States, 128 S. Ct. 586, 591 (2007); *see also* id. at 595 (rejecting "an appellate rule that requires 'extraordinary' circumstances to justify a sentence outside the Guidelines range").

47 18 U.S.C. § 3553(a)(2)(C).

48 *Id.* § 3553(a)(2)(D). *But see id.* § 3553(a)(2)(A) (calling for "just punishment for the offense").

49 *Cf.* United States v. Mora-Perez, 230 F. App'x 836, 838 (10th Cir. 2007) (affirming a district court's refusal of a sentence below the Guidelines range on mental illness grounds for a previously deported alien convicted of illegal reentry, where the sentencing court refused to give the lower sentence because it believed the defendant would receive better treatment for his mental illness in prison than in his home country of Mexico).

future crimes."[50] Judges may not be driven to the same conclusion, but there is reason to think that they are subject to the same possibility of feeling fear and distaste.[51] This is not to claim that every judge, when faced with such a defendant, will seek to impose an upward departure or variance based on these effects; only that the possibility exists. Nor is it to claim that judges are biased against the mentally ill in the abstract; only that some may find it difficult to control their reactions to the mentally ill defendants they face in court.[52] While in general a system that empowers judges may be the best hope for justice,[53] in the case of mental illness, in which there is little to suggest that a judge will be any less susceptible to fear or revulsion than jurors, or particularly skilled at judging future dangerousness, judicial discretion has the potential to produce unjust sentences.

Cases since *Booker* bear out the above analysis. In a recent case with some resemblance to *Hines*, a convicted murderer who wrote letters from prison threatening to kill the President was sentenced by the district court to the statutory maximum of 60 months, an upward variance from the recommended Guidelines sentence.[54] In a memorandum opinion upon resentencing, the court offered a justification for its sentence for each of the § 3553(a) factors, but saved the bulk of its analysis for why the sentence was necessary "to protect the public from further crimes of the defendant."[55] The upward variance was necessary because "[t]he defendant's history of violent conduct, coupled with his obvious unstable mental condition . . . strongly suggest that [he] should never again be pardon [sic], paroled, or released into society."[56]

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50 Holman v. Gilmore, 126 F.3d 876, 883 (7th Cir. 1997); *see also* Jennifer Fischer, T*he Americans with Disabilities Act: Correcting Discrimination of Persons with Mental Disabilities in the Arrest, Post-Arrest, and Pretrial Processes,* 23 LAW & INEQ. 157, 172–73 (2005) ("[P]eople have a variety of views of persons with mental illness that include seeing them as different, less than hu- man, [or] dangerous and frightening . . . .").

51 *Cf*. Andrew J. Wistrich et al., *Can Judges Ignore Inadmissible Information? The Difficulty of Deliberately Disregarding*, 153 U. PA. L. REV. 1251 (2005) (arguing that like jurors, judges generally have difficulty not being influenced by relevant but inadmissible evidence). For a general discussion and some confirmatory evidence of the biases and cognitive illusions from which judges suffer, *see* Chris Guthrie et al., *Inside the Judicial Mind,* 86 CORNELL L. REV. 777 (2001).

52 Compare the neutral and even sympathetic stance of the Guidelines, which are prepared in general, abstract terms by a commission, some of whose members are judges, *see supra* pp. 1134– 35, with the almost hysterical tone of the sentencing judge in United States v. Cousins, No. 5:04-CR-169, 2007 WL 1454275 (N.D. Ohio May 17, 2007), discussed below.

53 *See* Wright, *supra* note 3, at 139.

54 *Cousins*, 2007 WL 1454275, at *2–4. The sentencing court found in the alternative that a sixty-month sentence was justified under the Guidelines because Cousins's threat during the sentencing process to kill the judge's wife was close enough to his original crime of threatening to kill the President's wife to negate the reduction Cousins had received for showing contrition. *Id.* at *2.

55 *See id.* at *7–8.

56 *Id.* at *8.

A similar line of reasoning motivated *United States v. Gillmore,*[57] in which the Eighth Circuit upheld a 110% upward variance for a murder conviction, to 396 months, for a woman suffering from depression and Post-Traumatic Stress Disorder who, while trying to obtain money to buy drugs, killed a man with a hammer and a knife, then attempted to burn down his house to cover up the murder.[58] The district court found that "Gillmore's history of sexual abuse, chemical dependency, and mental illness . . . made her a danger to herself and the public, warranting a significantly longer sentence than the Guidelines range."[59] Like the district court in *Cousins*, the Eighth Circuit pointed to the need to protect the public as justification for the sentence.[60]

C. Above-Guidelines Sentences for Violent Mentally Ill Offenders

Imposing upward departures or variances on violent mentally ill defendants is an approach to protecting the public and treating such defendants that appears to fail both the public and the defendants. On the one hand, applying the § 3553 factors to impose an above Guidelines sentence assumes a continuing need to protect the public and treat the offender in a confined setting — that the offender's dangerousness and need for treatment are immutable. If an offender, no matter the treatment he receives in prison, truly is so dangerous and so certain to reoffend as to warrant lengthening his sentence, using § 3553 to extend his sentence by adding years of imprisonment up to the statutory maximum offers only flawed protection to society; the next offense is merely postponed, not foreclosed.[61]

On the other hand, and just as importantly, this approach is unfair to the mentally ill defendant. Above Guidelines sentences are imposed before prison and treatment, and do not account for the possibility that treatment will in fact work: that the offender may improve and no longer require incarceration.[62] Moreover, there is reason to think that judges have little ability to determine accurately the future dangerousness of a defendant.[63] When an offender is held in prison because of a

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[57] 497 F.3d 853 (8th Cir. 2007).

[58] *See id.* at 854–58.

[59] *Id.* at 857.

[60] *See id.* at 861.

[61] Alternatively, if the defendant is not so immutably dangerous and, as such, is being imprisoned for no purpose, society may be harmed by a loss to the criminal justice system's moral credibility and a resulting loss of crime-control power. *See* Robinson, *supra* note 21, at 1455.

[62] Though "studies strongly suggest that prison often exacerbates psychiatric disabilities," Michael J. Sage et al., *Butler County SAMI Court: A Unique Approach to Treating Felons with Co-Occurring Disorders*, 32 CAP. U. L. REV. 951, 953 (2004), the possibility that mentally ill prisoners might grow worse in prison is no reason to either keep them there longer or fail to make allowances for those who do improve.

[63] *See* Erica Beecher-Monas & Edgar Garcia-Rill, *Danger at the Edge of Chaos: PredictingViolent Behavior in a Post-Daubert World*, 24 CARDOZO L. REV. 1845, 1845 (2003) (noting that neither psychiatrists nor non-mental health professionals

finding of dangerousness premised on a mental illness now controlled or in remission, that offender is being denied a fundamental liberty right.[64] Perhaps this dynamic is best understood in terms of the purposes of punishment outlined in § 3553(a). Where departure or variance is based on a dangerousness founded in mental illness, once the Guidelines recommended sentence is exhausted, the retributive purposes of the punishment have been fulfilled — such an offender is not being retained because his potential dangerousness or need for treatment makes him more deserving of punishment. Nor is deterrence at issue; manifestations of mental illness are considered undeterrable.[65] Only rehabilitation and incapacitation remain, but ex ante upward departures and variances ignore the possibility of rehabilitation, and impose purposeless incapacitation if rehabilitation is achieved.[66]

D. Civil Commitment and Its Challenges

The most obvious alternative to upward departures and variances for violent mentally ill offenders is civil commitment following prison. In the ideal, at least, commitment keeps the mentally ill confined and in treatment only so long as they display the symptoms that make them dangerous to the public. Indeed, there is a federal commitment statute, 18 U.S.C. § 4246, that provides for the commitment of a "person in the custody of the Bureau of Prisons whose sentence is about to expire" who "is presently suffering from a mental disease or defect as a result of which his release would create a substantial risk of bodily injury to another person or serious damage to property of another."[67]

Civil commitment following prison may not, however, be a perfect solution for dealing with violent mentally ill offenders. First, it is possible that the interrelation between retribution, treatment, and incapacitation is somewhat more nuanced than what was suggested above. Perhaps, to society — and to judges — a violent mentally ill person who has served out a Guidelines sentence is not blameless. Perhaps

— nor, presumably, judges — have any ability to accurately predict an individual's future dangerousness); Robinson, *supra* note 21, at 1452 ("It is difficult enough to determine a person's present dangerousness — whether he would commit an offense if released today. It is much more difficult to predict an offender's future dangerousness . . . . It is still more difficult, if not impossible, to predict today precisely how long a preventive detention will need to last.").

[64] *See, e.g.,* O'Connor v. Donaldson, 422 U.S. 563, 575 (1975) ("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. . . . [T]here is . . . no constitutional basis for confining such persons involuntarily if they are dangerous to no one and can live safely in freedom."); *see also* Subotnik, *supra* note 17, at 1359–60 (arguing that dangerousness determinations under the Guidelines should take into account the potential that treatment might mitigate dangerousness).

[65] *See* Kansas v. Hendricks, 521 U.S. 346, 362–63 (1997).

[66] *See* Richard S. Frase, *Punishment Purposes*, 58 STAN. L. REV. 67, 70 (2005).

[67] 18 U.S.C. § 4246(a) (2000).

once an individual is deemed blameworthy, all that follows, even treatment and incapacitation for the public safety, is tarred by the initial retributive purpose. Evidence for this possibility can be found in the text of § 3553, which plainly allows incarceration, rather than commitment, in order to protect the public and treat the offender.

Second, commitment is itself complicated.[68] It is not, for instance, clear that a violent mentally ill offender would actually be committed and, if committed, receive treatment. Commitment statutes are, with good reason, designed at least as much to avoid committing the sane as to provide an alternative to prison for the dangerously insane. A commitment statute is constitutionally sustainable if it combines "proof of serious difficulty in controlling behavior"[69] and "proof of dangerousness [coupled] with the proof of some additional factor, such as a 'mental illness' or 'mental abnormality.'"[70] Moreover, no one besides the director of the facility in which the offender is held before the end of his sentence can petition to have the offender committed.[71] An offender who is still dangerous or might become dangerous immediately after release might not be committed in light of these protections, perhaps most plausibly in a case where an offender's symptoms improve while being treated in custody but worsen when the offender ceases treatment post-release.[72] In addition, offenders who are committed will not always get treatment, removing some of whatever difference exists between commitment and imprisonment.[73] Commitment without treatment may last indefinitely, a result far harsher than a fixed prison term.

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68 However, this complication does not extend to the legal question of whether commitment may immediately follow a prison sentence. So long as the commitment is not intended to punish the offender or to deter the offender or others in the offender's situation, and normal requirements for commitment are met, the commitment is civil and so does not violate the Constitution's prohibition on double jeopardy. *See Hendricks*, 521 U.S. at 370. The state's task is made easier by the Supreme Court's willingness to posit that commitment statutes for the mentally ill are not intended to deter, since persons with a mental abnormality are unlikely to be deterred by the threat of confinement. *See id.* at 361–63.

69 Kansas v. Crane, 534 U.S. 407, 413 (2002). In *Hendricks*, the Court had suggested that a finding of mental illness would be sufficient "to limit involuntary civil confinement to those who suffer from a volitional impairment rendering them dangerous beyond their control." 521 U.S. at 358. In *Crane*, it modified this position to include a specific volitional element so as to limit com- mitment to the seriously mentally ill, rather than the "dangerous but typical recidivist." 534 U.S. at 413. At issue in *Hendricks, Crane,* and much of the recent scholarship on civil commitment was the post-prison commitment of sex offenders.

70 *Hendricks*, 521 U.S. at 358.

71 *See* United States v. Moses, 106 F.3d 1273, 1280–81 (6th Cir. 1997).

72 Consider the sentencing court's concern in *Moses*, *id.* at 1280.

73 The current state of the law appears to be that a state need not provide treatment to an in- dividual who has been committed if that individual suffers from an untreatable condition. *See Hendricks,* 521 U.S. at 367; Saul J. Faerstein, *Sexually Dangerous Predators and Post-Prison Commitment Laws,* 31 LOY. L.A. L. REV. 895, 897 (1998).

Post-prison civil commitment is far from a perfect solution for dealing with violent mentally ill offenders. It seems, nevertheless, a better solution than giving such offenders above Guidelines prison sentences. To impose post-prison civil commitment, the state is required to prove an offender's continuing dangerousness by clear and convincing evidence,[74] whereas an above Guidelines prison sentence relies on a possibly unreliable prediction of what the offender's mental health will be at the end of the Guidelines sentence. Not all offenders will require confinement past the Guidelines range, and an option like civil commitment that allows those offenders their freedom at the point non– mentally ill offenders would receive theirs must be preferred. Prison presents an extremely unhealthy environment for the mentally ill,[75] and it is difficult to advocate any solution that extends a mentally ill person's time behind bars.

E. Going Forward

If post-prison commitment is preferable to above Guidelines prison sentences as a means of dealing with violent mentally ill offenders, what measures might ensure that all such offenders get the one and not the other? At least two possibilities exist. First, there are some situations in which judicial discretion might be less desirable than in others. Defendants who have the potential to elicit strong reactions from judges, like violent mentally ill offenders, may in fact be better dealt with by abstracted, preformulated rules than by judges steeped in, and perhaps spooked by, the particulars of the situation. It may, for instance, make the most sense to recraft the standards of review for sentences such that upward departures and variances from the Guidelines in cases with mentally ill defendants are presumptively unreasonable. Alternatively, rather than force judges to sentence in a particular way, it might be possible to allay any fears they have that violent mentally ill offenders will slip through the cracks and not be committed post-prison, despite their continued dangerousness. One possibility would be to allow prosecutors — in addition to the directors of the facilities in which violent mentally ill offenders are held — to initiate commitment proceedings for such offenders, subject to strictures designed to prevent abuse or overuse.

[74] *See, e.g.*, 18 U.S.C. § 4246(d) (2000).

[75] *See* Sage *et al., supra* note 62, at 952–53; see also Nancy Wolff et al., *Rates of Sexual Victimization in Prison for Inmates with and Without Mental Disorders,* 58 PSYCHIATRIC SERVICES 1087, 1087 (2007) (reporting that the rate of sexual victimization of mentally ill inmates is nearly three times as high as for those without mental illness).

IV. THE IMPACT OF THE PRISON LITIGATION REFORM ACT ON CORRECTIONAL MENTAL HEALTH LITIGATION

Over the last four decades, prisons have replaced mental institutions as warehouses of the mentally ill.[1] The U.S. Department of Justice (DOJ) estimates that over one and a quarter million people suffering from mental health problems are in prisons or jails, a figure that constitutes nearly sixty percent of the total incarcerated population in the United States.[2] Yet psychiatric treatment in many correctional facilities is impaired by understaffing and underfunding, leaving many inmates with little if any therapy.[3] The mentally ill often have a particularly difficult time coping with prison conditions and complying with regulations.[4] In turn, many prison officials treat disordered behavior as disorderly behavior, responding with disciplinary measures that may reinforce the unavailability of treatment and exacerbate the illnesses contributing to the inmates' conduct.[5]

Consider one representative facility: Taycheedah Correctional Institution, a women's facility in Fond du Lac, Wisconsin. The DOJ inspected Taycheedah in 2005 and found that the prison failed "to provide for inmates' serious mental health needs."[6] As of the DOJ's report in 2006, two part-time psychiatrists attended to the approximately 600 prisoners at Taycheedah, leading to waits of two to four weeks before inmates received even an intake mental health screening and waits of up to four months before inmates diagnosed with mental illnesses saw a psychiatrist.[7] Medications were monitored by untrained correctional officers who were unable "to ensure that medication [was] taken properly or to identify the signs of potentially dangerous adverse reactions," which, for many medications, carry a significant risk of death.[8] Taycheedah "impose[d] a significant penalty on inmates whose behaviors [were] symptomatic of their mental illness" by placing them "in administrative segregation due to threats or

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1 *See* TERRY A. KUPERS, PRISON MADNESS, at xv–xvi, 12–14 (1999).

2 DORIS J. JAMES & LAUREN E. GLAZE, BUREAU OF JUSTICE STATISTICS, MENTAL HEALTH PROBLEMS OF PRISON AND JAIL INMATES 3 (2006), *available at* http://www.ojp. usdoj.gov/bjs/pub/pdf/mhppji.pdf.

3 *See generally* HUMAN RIGHTS WATCH, ILL-EQUIPPED: U.S. PRISONS AND OFFENDERS WITH MENTAL ILLNESS 94–126 (2003) [hereinafter ILL-EQUIPPED], *available at* http://www. hrw.org/reports/2003/usa1003/usa1003.pdf.

4 *See id.* at 53–69; KUPERS, *supra* note 1, at 15–25.

5 *See* ILL-EQUIPPED, *supra* note 3, at 75–86; KUPERS, *supra* note 1, at 29–38; Jamie Fellner, *A Corrections Quandary: Mental Illness and Prison Rules*, 41 HARV. C.R.-C.L. L. REV. 391, 395– 405 (2006).

6 Letter from Wan J. Kim, Assistant Att'y Gen., DOJ Civil Rights Div., to Jim Doyle, Governor of Wis. 2 (May 1, 2006) [hereinafter Doyle Letter], *available at* http://www.usdoj.gov/crt/ split/documents/taycheedah_findlet_5-1-06.pdf.

7 *Id.* at 3–7.

8 *Id.* at 6.

attempts to kill themselves";[9] one inmate, for example, was placed in administrative segregation for punching herself in the eye.[10] Inmates in segregation received no treatment except for medication; even in the specialized unit for mentally ill inmates, the DOJ found a "lack of active treatment" that created "a high risk of exacerbating psychiatric symptoms and dangerous behavior."[11]

Institutional reform litigation is an essential tool for improving correctional mental health care and the treatment of the incarcerated mentally ill. However, such suits became far more difficult to bring, win, and enforce with the passage of the Prison Litigation Reform Act of 199512 (PLRA). This legislation was intended to reduce frivolous litigation and to curb judicial micromanagement of prisons;[13] its sponsors disavowed a desire to impede meritorious claims.[14] Yet the PLRA has inarguably made many legitimate claims harder to pursue.[15]

Although the effect of the PLRA on litigants generally has been extensively discussed,[16] its particular hardships for mentally ill inmates have not been analyzed. This Part will discuss provisions of the PLRA that particularly affect suits to redress deficits in correctional mental health care or mistreatment of the incarcerated mentally ill; it will also consider interpretations that moderate, although by no means erase, some of the serious impediments the PLRA has placed between mentally ill prisoners and the courts. Section A will look at the PLRA's strict administrative exhaustion requirement[17] and argue that the "availability" of grievance procedures should be judged in terms of the personal capacity of mentally ill inmates to avail themselves of

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9 *Id.* at 10–12. Although administrative segregation at Taycheedah is not described in the letter, such segregation frequently involves conditions of total isolation that are particularly damaging for the mentally ill. *See infra* pp. 1153–54.

10 Doyle Letter, *supra* note 6, at 11.

11 *Id.* at 9.

12 Pub. L. No. 104-134, §§ 801–810, 110 Stat. 1321-66 (1996) (codified as amended in scattered sections of 11, 18, 28, and 42 U.S.C.).

13 For a brief legislative history of the PLRA, *see Developments in the Law—The Law of Prisons,* 115 HARV. L. REV. 1838, 1853–56 (2002). *See generally* A LEGISLATIVE HISTORY OF THE PRISON LITIGATION REFORM ACT OF 1996 (Bernard D. Reams, Jr. & William H. Manz eds., 1997).

14 *See* Anh Nguyen*, Comment, The Fight for Creamy Peanut Butter: Why Examining Congressional Intent May Rectify the Problems of the Prison Litigation Reform Act,* 36 SW. U. L. REV. 145, 155 (2007) (quoting Sens. Thurmond and Hatch as expressing the intent that the PLRA bar only frivolous claims).

15 *See generally John Boston, The Prison Litigation Reform Act: The New Face of Court Stripping,* 67 BROOK. L. REV. 429 (2001); Jennifer Winslow, Comment, T*he Prison Litigation Reform Act's Physical Injury Requirement Bars Meritorious Lawsuits: Was It Meant To?*, 49 UCLA L. REV. 1655 (2002).

16 The most thorough primer on the PLRA is John Boston's unpublished treatise, *John Boston, The Prison Litigation Reform Act* (2006), *available at* http://www.law.yale.edu/documents/ pdf/Boston_PLRA_Treatise.pdf.

17 42 U.S.C. § 1997e(a) (2000).

those procedures. Section B will suggest a reading of the PLRA's "physical injury" requirement[18] that is more cognizant of the physical nature of severe mental illness. Last, Section C will analyze the effect of the PLRA's reduction of the volume of prison litigation on the body of "clearly established" Eighth Amendment law and propose an alternate source of applicable precedent.

A. The "Availability" of Administrative Remedies to Acutely Mentally Ill Inmates

1. The Exhaustion Requirement and the Mentally Ill. — The PLRA's most significant limitation on access to courts might be 42 U.S.C. § 1997e(a), which requires that prisoners exhaust "such administrative remedies as are available" before filing actions "with respect to prison conditions."[19] Courts must dismiss any claim for which the plaintiff failed to comply with the confining institution's grievance procedures. Prior to the passage of the PLRA, grievance procedures had to be, among other things, "plain, speedy, and effective" before a court could bar a claim for failure to exhaust.[20] The PLRA made exhaustion mandatory and removed all substantive constraints on the rigor of grievance procedures.[21] Many institutions' procedures feature short windows in which prisoners must file or appeal their claims[22] while some leave officials significant discretion as to response time.[23]

As high a hurdle as the PLRA sets for any inmate, it is even higher for the mentally ill. Many grievances arise during acute psychotic breaks or other periods of decompensation, when inmates may be temporarily incapable of complying with grievance procedures.[24] Additionally, drawn-grievance procedures

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18 *Id*. § 1997e(e).

19 *See* Margo Schlanger, *Inmate Litigation*, 116 HARV. L. REV. 1555, 1649 (2003) ("The PLRA's exhaustion requirement has emerged as the highest hurdle the statute presents to individual inmate plaintiffs.").

20 42 U.S.C. § 1997e(a)(1) (1994).

21 *See id*. § 1997e(a) (2000). *See generally* Woodford v. Ngo, 126 S. Ct. 2378, 2382–83 (2006); Schlanger, *supra* note 19, at 1627–28.

22 Rhode Island, for example, requires that grievants file complaints "within three (3) days of the incident and/or actual knowledge of the origination of the problem," 06-070-002 R.I. CODE R. § 10 (Weil 2007), LEXIS, RIADMN File, and that they fulfill three levels of appeals, each similarly limited to three-day windows, id. § 5(B)(10), (C)(1), (D)(1), E(2). For a list of grievance procedures around the country, see Brief of the Jerome N. Frank Legal Services Organization of the Yale Law School as Amicus Curiae in Support of Respondents, at app., Ngo, 126 S. Ct. 2378 (No. 05-416), *available at* http://www.law.yale.edu/documents/pdf/woodford_ngo/Woodford_Amicus_ brief.pdf.

23 *See, e.g.*, ILL. ADMIN. CODE tit. 20, §§ 504.830(d), .850(f) (2007), LEXIS, ILADMN File (officials given two months to respond to grievances and six months to respond to appeals, but need only adhere to deadlines "where reasonably feasible under the circumstances").

24 *See, e.g.,* Whitington v. Sokol, 491 F. Supp. 2d 1012, 1014 (D. Colo. 2007) (plaintiff was in a psychotic state throughout grievance window); Bakker v. Kuhnes, No. C01-4026-PAZ, 2004 WL 1092287 (N.D. Iowa May 14, 2004) (improperly medicated plaintiff experienced symptoms including seizures and dizziness during his grievance window): *cf.* Thomas C. O'Bryant,

may produce months-long gaps in care before an inmate can seek an injunction to compel treatment.[25] In addition, many inmates fear losing access to medication or other forms of treatment as retaliation for filing grievances.[26]

2. Exceptions to Exhaustion. — Whether federal courts provide any recourse for plaintiffs who were temporarily (or permanently) incapable of completing grievance procedures turns on their interpretation of the PLRA's requirement that plaintiffs exhaust "such adminis- trative remedies as are available."[27] A grievance procedure is arguably "unavailable" to a prisoner who cannot comply with it.[28] Indeed, one court recently held that a prisoner who was transferred to a state hospital while "'mentally incompetent' and 'psychotic'" might be incapable of grieving and thus have no available procedures to exhaust.[29]

Although this definition of availability based on personal characteristics has rarely been considered by courts,[30] some circuits interpret the statute as requiring more than the mere existence of procedures. First, several circuits have held that exhaustion is satisfied where prison officials' conduct made procedures effectively unusable.[31] The Second Circuit has the most robust form of this allowance, holding that "'special circumstances' may excuse a prisoner's failure to exhaust."[32] This exception is usually invoked

The Great Unobtainable Writ: Indigent Pro Se Litigation After the Antiterrorism and Effective Death Penalty Act of 1996, 41 HARV. C.R.-C.L. L. REV. 299, 310–15 (2006) (describing difficulties mentally ill inmates face in complying with habeas corpus deadlines).

25 *See, e.g.,* Pratt v. Valdez, No. 3:05-CV-2033-K, 2005 U.S. Dist. LEXIS 30917, at *5 (N.D. Tex. Dec. 1, 2005) (rejecting argument that the plaintiff's need for immediate health treatment justified filing suit before the jail responded to his grievance).

26 Telephone Interview with Amy Fettig, Staff Counsel, ACLU Nat'l Prisons Project (Sept. 21, 2007); *see also* Boston, *supra* note 15, at 431 n.7 (compiling cases of "retaliation against prisoners who complain about their treatment, including those who use the grievance systems that the PLRA has now made mandatory").

27 42 U.S.C. § 1997e(a) (2000) (emphasis added).

28 *See* Days v. Johnson, 322 F.3d 863, 867 (5th Cir. 2003) (per curiam) ("[O]ne's personal ability to access the grievance system could render the system unavailable.").

29 Whitington, 491 F. Supp. 2d at 1014–15.

30 *See* Boston, *supra* note 16, at 114–15 ("[C]ourts have only begun to acknowledge the question whether administrative remedies are 'available' to prisoners who may lack the capacity to use them, by reason of mental illness or developmental disability .").

31 *See, e.g.,* Miller v. Norris, 247 F.3d 736, 740 (8th Cir. 2001) ("[A] remedy that prison officials prevent a prisoner from 'utiliz[ing]' is not an 'available' remedy under § 1997e(a) . . . ."); *see also* Giano v. Goord, 380 F.3d 670, 675 (2d Cir. 2004); Jernigan v. Stuchell, 304 F.3d 1030, 1032 (10th Cir. 2002). *See generally Boston, supra* note 16, at 114–23. The majority in Woodford v. Ngo, 126 S. Ct. 2378 (2006), expressly deferred this question. See id. at 2392–93.

32 *Giano,* 380 F.3d at 675 (quoting Berry v. Kerik, 366 F.3d 85, 88 (2d Cir. 2003)); *see also Vega v. U.S. Dep't of Justice*, No. 1:CV-04-02398, 2005 U.S. Dist. LEXIS 29740, at *16 (M.D. Pa. Nov. 4, 2005) (noting, though not applying, the special circumstances exception); Baker v. Andes, No. 6:04-343-DCR, 2005 U.S. Dist. LEXIS 43469, at *25–26 (E.D. Ky. May 12, 2005) (finding that "special circumstances" existed).

for unclear or reasonably misinterpreted grievance procedures[33] and has not yet been extended to cover nonexhaustion due to mental incapacity. A second doctrinal strand allows "substantial compliance" with grievance procedures to suffice for exhaustion.[34] These exceptions to proper exhaustion do not control the availability question,[35] but they signify courts' general attitude toward whether procedures must, in context, provide "a 'meaningful opportunity for prisoners to raise meritorious grievances.'"[36]

3. The Case for Personal Availability. — A contextual definition of availability recognizing personal capability is both preferable as a prudential matter and required under antidiscrimination principles. Even the majority in Woodford v. Ngo[37] recognized that "exhaustion requirements are designed to deal with parties who do not want to exhaust"[38] — not parties who are incapable of exhausting. An incentive mechanism has no benefit when applied against individuals who cannot change their behavior.

Moreover, a personal definition of availability may be necessary to avoid violating the Constitution and is certainly required to avoid a conflict with the Americans with Disabilities Act39 (ADA). As many commentators have noted with regard to other provisions of the PLRA,40 the Act seriously limits access to the courts; if its effects are

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[33] *See, e.g.,* Hemphill v. New York, 380 F.3d 680, 690 (2d. Cir. 2004).

[34] *Compare* Artis-Bey v. District of Columbia, 884 A.2d 626, 639 (D.C. 2005) ("[P]rocedural defects in an inmate's pursuit of administrative remedies do not bar a civil suit *per se*, provided that the inmate substantially complied with the established procedure . . . ."), *with Lewis v. Washington,* 300 F.3d 829, 834 (7th Cir. 2002) (declining to adopt the substantial compliance exception for post-PLRA causes of action).

[35] In addition, the validity of substantial compliance and the "special circumstances" exception is in some doubt after *Ngo*, which held that the PLRA required "proper exhaustion" of grievances. As Justice Breyer's concurrence makes clear, the majority opinion leaves room for some exceptions to exhaustion. 126 S. Ct. at 2393 (Breyer, J., concurring). Indeed, at least one circuit still finds "substantial compliance" sufficient after *Ngo. See Roscoe v. Dobson*, No. 07-1418, 2007 U.S. App. LEXIS 22773, at *4 (3d Cir. Sept. 25, 2007); *see also* Guillory v. Rupf, No. C-05-4395-CW, 2007 U.S. Dist. LEXIS 76122, at *15–16 (N.D. Cal. Sept. 27, 2007). The Second Circuit has expressly reserved the question of whether its special circumstances exception survives *Ngo. See, e.g.,* Reynoso v. Swezey*,* 238 F. App'x 660, 662 (2d Cir. 2007); *see also* Robin L. Dull, Note, *Understanding Proper Exhaustion: Using the Special-Circumstances Test To Fill the Gaps Under Woodford v. Ngo and Provide Incentives for Effective Prison Grievance Procedures,* 92 IOWA L. REV. 1929, 1953–55 (2007) ("The special-circumstances framework for proper exhaustion probably remains good law post-*Ngo*.").

[36] *Ngo*, 126 S. Ct. at 2403 (Stevens, J., dissenting) (quoting id. at 2392 (majority opinion)).

[37] 126 S. Ct. 2378.

[38] *Id.* at 2385 (emphasis added).

[39] 42 U.S.C. §§ 12101–12213 (2000).

[40] *See* Randal S. Jeffrey*, Restricting Prisoners' Equal Access to the Federal Courts: The Three Strikes Provision of the Prison Litigation Reform Act and Substantive Equal Protection*, 49 BUFF. L. REV. 1099 (2001) (arguing that the PLRA's "three strikes" rule violates the Equal Protection Clause); James E. Robertson, *Psychological Injury and the Prison Litigation Reform Act: A "Not Exactly," Equal Protection Analysis*, 37 HARV. J. ON LEGIS. 105 (2000) (arguing that PLRA's physical injury requirement cannot withstand strict scrutiny); Julie M. Riewe, Note, The *Least Among Us: Unconstitutional Changes in Prisoner Litigation*

so great as to deny certain individuals "the fundamental constitutional right of access to the courts,"[41] its provisions must be subjected to strict scrutiny.[42] Although appellate courts have consistently held that PLRA provisions increasing the cost of suit do not warrant heightened scrutiny,[43] they have yet to consider the impact of the exhaustion requirement as applied to a prisoner who is incapable of complying with grievance procedures.[44] Unlike the cost provisions, which are surmountable in theory (if not in practice, for many defendants), a strict exhaustion requirement as applied to prisoners who are mentally incapable of complying with grievance procedures bars access to courts altogether, a fundamental detriment that should receive strict scrutiny.

Even if an acontextual understanding of "availability" were to withstand strict scrutiny, or was found not to implicate fundamental rights, it would still have a severe exclusionary effect on the acutely mentally ill. Although the disabled, including the mentally ill, are not a suspect class for the purposes of the Equal Protection Clause,[45] they are protected by the ADA,[46] which mandates that "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity."[47] Given that Congress expressed no intent to supersede the ADA in the context of disabled prisoners, § 1997e(a) should be read in harmony with the ADA by incorporating a definition of availability that recognizes personal capability.

Under the Prison Litigation Reform Act of 1995, 47 DUKE L.J. 117 (1997) (arguing that PLRA's filing fee, three strikes rule, and physical injury requirement are unconstitutional).

[41] Bounds v. Smith, 430 U.S. 817, 828 (1977); *see also* Tennessee v. Lane, 541 U.S. 509, 533–34 (2004).

[42] *See generally* LAURENCE H. TRIBE, AMERICAN CONSTITUTIONAL LAW § 16-7, at 1454 (2d ed. 1988) ("Legislative and administrative classifications are to be strictly scrutinized . . . if they distribute benefits or burdens in a manner inconsistent with fundamental rights.").

[43] *See, e.g.*, Johnson v. Daley, 339 F.3d 582, 586 (7th Cir. 2003) (holding that cap on fee-shifting did not implicate a fundamental right); Lewis v. Sullivan, 279 F.3d 526, 528 (7th Cir. 2002) (same with respect to three strikes rule); Tucker v. Branker, 142 F.3d 1294, 1299–1301 (D.C. Cir. 1998) (same with respect to filing fee provisions).

[44] *Cf.* Woodford v. Ngo, 126 S. Ct. 2378, 2404 (2006) (Stevens, J., dissenting) (arguing that a strict exhaustion requirement would be subject to "searching judicial examination under the Equal Protection Clause").

[45] *See* City of Cleburne v. Cleburne Living Ctr., Inc., 473 U.S. 432, 446 (1985).

[46] Albeit weakly; recent Supreme Court rulings have made it far harder for the mentally ill to claim the protections of the ADA. *See* Michelle Parikh, Note, *Burning the Candle at Both Ends, and There is Nothing Left for Proof: The Americans with Disabilities Act's Disservice to Persons with Mental Illness*, 89 CORNELL L. REV. 721, 723–24 (2004) ("The problem mentally ill plaintiffs face under the ADA [in employment discrimination cases] . . . is practically insurmountable.").

[47] 42 U.S.C. § 12132 (2000).

B. Mental Illness as a "Physical Injury"

The PLRA provision that seems on its face to strike the gravest blow against mental health litigation is 42 U.S.C. § 1997e(e), which provides that "[n]o Federal civil action may be brought by a prisoner confined in a jail, prison, or other correctional facility, for mental or emotional injury suffered while in custody without a prior showing of physical injury."[48] This physical injury requirement's reach has been judicially cabined, however, as appellate courts have unanimously interpreted it to permit suits for injunctive and declaratory relief;[49] most circuits to consider the issue have found it to allow recovery of nominal or punitive damages as well.[50]

The physical injury requirement thus predominantly affects suits for compensatory damages. For mentally ill inmates, these claims have been made even harder by courts that disregard the fact that severe mental distress has a physical substrate[51] and deny that at least some kinds of mental suffering constitute physical injuries in and of themselves.[52] Given that physical injury must be "more than *de minimis*" to pass the § 1997e(e) threshold,[53] a greater recognition of the physical reality of mental illness would cover severe injuries without drawing in the apparently marginal cases that courts regularly reject.[54]

The capacious phrase "mental or emotional injury" perhaps suggests that the statute should be read to bar claims dependent on a modern understanding of mental illness.[55] Nevertheless, the dearth of legislative history[56] might signal that Congress intended a more moderate change in the law, preserving suits for severe exacerbation of mental illness as a result of Eighth Amendment violations.[57] Several

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[48] *Id.* § 1997e(e).

[49] *See* Boston, *supra* note 16, at 139–40 & nn.563–66 (collecting cases).

[50] *See id. But see* Smith v. Allen, 502 F.3d 1255, 1271 (11th Cir. 2007) (prohibiting punitive damages); Davis v. District of Columbia, 158 F.3d 1342, 1348 (D.C. Cir. 1998) (same).

[51] *See generally* DENNIS S. CHARNEY & ERIC J. NESTLER, NEUROBIOLOGY OF MENTAL ILLNESS (2d ed. 2004).

[52] *See, e.g.*, Weatherspoon v. Valdez, No. 3-05-CV-0586-P, 2005 U.S. Dist. LEXIS 9451, *5–6 (N.D. Tex. May 17, 2005) ("Plaintiff claims only that he experiences 'pain and suffering,' 'moderate to severe depression,' and 'mood swings.' This is insufficient to establish 'physical injury' under the PLRA." (citation omitted)).

[53] *See* Boston, *supra* note 16, at 150.

[54] *See, e.g.*, Pearson v. Wellborn, 471 F.3d 732, 744 (7th Cir. 2006); Herman v. Holiday, 238 F.3d 660, 665–66 (5th Cir. 2001).

[55] Although there is no indication in the PLRA's legislative history that Congress considered the implications of the particular phrase used, the failure to use an established term such as "emotional distress," *see* BLACK'S LAW DICTIONARY 563 (8th ed. 2004), suggests that the statute's prohibition should not be limited to the tort system's conception of mental sequelae.

[56] *Cf.* Royal v. Kautzky, 375 F.3d 720, 730 n.5 (8th Cir. 2004) (Heaney, J., dissenting) ("[T]here is almost nothing in the legislative history as to § 1997e(e) at all.")

[57] The Eighth Amendment imposes upon prison officials a duty to ensure, among other things, "that inmates receive adequate . . medical care," Farmer v. Brennan, 511 U.S. 825, 832 (1994), and to "take reasonable measures to guarantee the safety of

courts have held that Congress did not intend § 1997e(e) to bar constitutional claims.[58] Although this contention is usually raised in support of constitutional claims such as First Amendment violations — claims in which the core harms are less tangible than those in the infliction or exacerbation of mental suffering — it is likely *stronger* with regard to substantial Eighth Amendment claims. Congress unquestionably *did* intend to prohibit some intangible rights claims; the litany of litigious excesses cited by supporters of the PLRA frequently included First Amendment claims.[59] By contrast, no legislator expressed an intent to exclude claims involving serious mental illness. Given the Supreme Court's dictum that "the integrity of the criminal justice system depends on full compliance with the Eighth Amendment,"[60] courts should preserve remedies for Eighth Amendment violations until Congress clearly expresses its intent to limit them.

C. Volume Reduction and the Elaboration of Constitutional Standards

1. *The Importance of Clear Precedent to Correctional Litigation.* — Another consequence of the PLRA's effort to reduce the volume of inmate litigation is a reduction in the number of reported decisions. Along with adding the substantive hurdles described above, Congress streamlined dismissal of prisoners' suits[61] and made filing more financially burdensome;[62] at the tail end of litigation, the PLRA made it more difficult to enter or maintain court orders for prospective relief,[63] although it exempted

the inmates," *id.* (quoting Hudson v. Palmer, 468 U.S. 517, 526–27 (1984)) (internal quotation marks omitted). This obligation extends to mental health care, *see, e.g.*, Gates v. Cook, 376 F.3d 323, 332 (5th Cir. 2004). Pretrial detainees' rights are protected under the Due Process Clause of the Fourteenth Amendment, rather than the Eighth Amendment, and are "at least as great as the Eighth Amendment protections available to a convicted prisoner." City of Revere v. Mass. Gen. Hosp., 463 U.S. 239, 244 (1983).

[58] *See* Boston, *supra* note 16, at 141 n.568 (compiling cases); id. at 142 ("[C]haracterizing [a First Amendment violation] as a mental or emotional injury seems to miss the point of constitutional protection . . . ."); *see also* Nguyen, *supra* note 14, at 164 ("To treat a constitutional rights claim as a mental or emotional injury claim is to ignore the true meaning of constitutional protection . . . .").

[59] *See, e.g.*, 141 CONG. REC. 20,991–92 (1995) (statement of Sen. Reid); *id.* at 14,572 (statement of Sen. Kyl).

[60] Johnson v. California, 543 U.S. 499, 511 (2005).

[61] The PLRA empowered courts to dismiss claims sua sponte "if the court is satisfied that the action is frivolous, malicious, fails to state a claim upon which relief can be granted, or seeks monetary relief from a defendant who is immune from such relief," 42 U.S.C. § 1997e(c)(1) (2000), and instructed courts to do so as early as possible — "before docketing, if feasible or, in any event, as soon as practicable after docketing," 28 U.S.C. § 1915A(a).

[62] *See* 28 U.S.C. § 1915(b), (f). The PLRA also limited attorneys' fees awards. *See* 42 U.S.C. § 1997e(d); *see also* Margo Schlanger, *Civil Rights Injunctions over Time: A Case Study of Jail and Prison Court Orders*, 81 N.Y.U. L. REV. 550, 593–94 (2006).

[63] *See* 18 U.S.C. § 3626. Courts may only grant prospective relief if "the court finds that such relief is narrowly drawn, extends no further than necessary to correct the violation of the Federal right, and is the least intrusive means necessary to correct the violation of the Federal right." *Id.*

private settlement agreements from its restrictions.[64] These provisions correlate with an unmistakable decrease in both inmate filings[65] and in ongoing court-order regulation of correctional facilities.[66]

This reduction in the volume of decisions has had the perhaps unintended effect of limiting judicial elaboration of standards for future cases. The clarity of such standards is especially important for plaintiffs' attempts to sue prison officials acting in their individual capacities, which are the only kind of Eighth Amendment suits in which plaintiffs can receive monetary damages from federal or state officials. Such defendants possess "qualified immunity" from suit; they may be held liable only if their conduct violated a statutory or constitutional right that was "clearly established" at the time of the violation.[67] By eliminating opportunities for judicial elaboration, the PLRA has stunted the establishment of clear constitutional standards.[68]

This effect is aptly illustrated by recent case law on the total isolation and understimulation found in supermax prisons and Security Housing Units (SHUs).[69] Although only one court has found supermax conditions unconstitutional as applied to all prisoners,[70] a line of cases since 1995 has held that such confinement

§ 3626(a)(1). Parties have several mechanisms by which they can seek termination of ongoing relief. *See id.* § 3626(b); *see also* Schlanger, *supra* note 62, at 590–92.

[64] 18 U.S.C. § 3626(c)(2).

[65] *See* Woodford v. Ngo, 126 S. Ct. 2378, 2400 (2006) (Stevens, J., dissenting) ("[T]he number of civil rights suits filed by prisoners in federal court dropped from 41,679 in 1995 to 25,504 in 2000, and the rate of prisoner filing dropped even more dramatically during that period, from 37 prisoner suits per 1,000 inmates to 19 suits per 1,000 inmates."); Schlanger, *supra* note 19, at 1578–90.

[66] *See* Schlanger, *supra* note 62, at 573–89. Judicial oversight of prisons may have been waning even before passage of the PLRA. *Compare* MALCOLM M. FEELEY & EDWARD L. RUBIN, JUDICIAL POLICY MAKING AND THE MODERN STATE: HOW THE COURTS REFORMED AMERICA'S PRISONS 46 (1998) ("Since the late 1980s, the decline of momentum in prison condi- tions litigation has been abundantly evident."), *with* Schlanger, *supra* note 62, at 554 ("[A]t least as to correctional court orders, the claim that there was a decline in the reach of court-order regulation in the 1980s and 1990s is simply wrong.").

[67] *See* Harlow v. Fitzgerald, 457 U.S. 800, 818 (1982).

[68] This effect may not be entirely to plaintiffs' detriment, as the two types of provisions likely militate in opposite directions. By eliminating weak claims before courts determine their merits, the provisions impeding filing may prevent courts from developing standards in cases with unsympathetic plaintiffs. This development is counterbalanced by the PLRA's preference for pri- vate settlement agreements over judicial oversight, which removes cases from the courts' purview when they are most likely to result in judicially enforced standards of mental health treatment.

[69] *Ruiz v. Johnson,* 37 F. Supp. 2d 855 (S.D. Tex. 1999), *rev'd and remanded for further findings sub nom.* Ruiz v. United States, 243 F.3d 941 (5th Cir. 2001), provides a vivid description of the effect of segregation on mentally ill inmates. *See id.* at 908–10; *see also* KUPERS, *supra* note 1, at 53–64 (describing SHUs and their effects on prisoners). *See generally* Peter Scharff Smith, *The Effect of Solitary Confinement on Prison Inmates: A Brief History and Review of the Literature,* 34 CRIME & JUST. 441, 471–500 (2006).

[70] *See* Ruiz, 37 F. Supp. 2d at 861; *see also* Smith, *supra* note 69, at 444 ("There has been a 'general refusal of courts to find isolated confinement unconstitutional absent aggravating circumstances,' although specific conditions in specific facilities

unconstitutionally risks serious harm to mentally ill inmates.[71] But despite this "increasingly clear judicial consensus that the Eighth Amendment is violated when the seriously mentally ill or developmentally disabled are held in supermax confinement,"[72] the lack of an unambiguous rule allows prison officials to win on qualified immunity.[73] One district judge described the relevant case law as "fuzzy" between 2000 and 2003,[74] even though she herself had concluded in 2001 that the conditions encountered by the plaintiff were likely unconstitutional.[75]

2. DOJ Investigations as an Entrenchment of Precedent. — Given the PLRA's throttling effect on already underelaborated judicial standards, plaintiffs' advocates might do well to look outside the courts for sources of clearly established law. DOJ investigations of jails and prisons under the Civil Rights of Institutionalized Persons Act[76] (CRIPA) could provide one such source of guidance. These investigations[77] consistently define a set of minimum constitutional standards for correctional mental health care and treatment of mentally ill inmates.[78] At times, the DOJ has even defined as "minimum remedial measures" such specific practices as "follow-up evaluations of [suicidal]

have been found to violate the Eighth Amendment." (citation omitted)).

71 *See, e.g.*, Jones'El v. Berge, 164 F. Supp. 2d 1096, 1116–17 (W.D. Wis. 2001); Madrid v. Gomez, 889 F. Supp. 1146 (N.D. Cal. 1995); *see also* David C. Fathi, *The Common Law of Supermax Litigation*, 24 PACE L. REV. 675, 681 n.33 (2004) (collecting cases).

72 Fathi, *supra* note 71, at 681.

73 *See, e.g.*, Scarver v. Litscher, 371 F. Supp. 2d 986, 1003–05 (W.D. Wis. 2005), *aff'd on other grounds*, 434 F.3d 972 (7th Cir. 2006).

74 *See id.* at 1004.

75 *See Jones'El*, 164 F. Supp. 2d at 1117–21; *cf.* Scarver, 371 F. Supp. 2d at 1005 (noting that district court opinions "have no precedential weight").

76 42 U.S.C. §§ 1997–1997j (2000).

77 For a partial list of CRIPA investigations, complaints, and settlements, *see* DOJ Civil Rights Div., Special Litigation Section, Documents and Publications (Dec. 7, 2007), http://www.usdoj. gov/crt/split/findsettle.htm.

78 The DOJ requires that prisons have:

> (1) a systematic program for screening and evaluating inmates to identify those in need of mental health care; (2) a treatment program that involves more than segregation and close supervision of mentally ill inmates; (3) employment of a sufficient number of trained mental health professionals; (4) maintenance of accurate, complete and confidential mental health treatment records; (5) administration of psychotropic medication only with appropriate supervision and periodic evaluation; and (6) a basic program to identify, treat, and supervise inmates at risk for suicide.

Letter from Wan J. Kim, Assistant Att'y Gen., DOJ Civil Rights Div., to Linda Lingle, Governor of Haw. 4 (Mar. 14, 2007), *available at* http://www.usdoj.gov/crt/split/documents/oahu_center_ findlet_3-14-07.pdf (quoting Coleman v. Wilson, 912 F. Supp. 1282, 1298 n.10 (E.D. Cal. 1995)); *see also* Letter from Wan J. Kim, Assistant Att'y Gen., DOJ Civil Rights Div., to Robert Dedman, Mayor of Lebanon, Tenn. 18–22 (Aug. 30, 2007), *available at* http://www.usdoj.gov/crt/split/ documents/ wilson_county_findlet_8-30-07.pdf; Doyle Letter, *supra* note 6, at 3–19.

new inmates within 14 days of intake,"[79] "15- and 30-minute checks of inmates under observation for risk of suicide,"[80] and no less than one "full-time master's level psychologist" and eight hours a week of psychiatric services for a jail population of 325.[81]

Although these investigations are rarely discussed in the literature, they could be taken as a significant interpretation of the floor required by the Eighth Amendment. The standards used by the DOJ are drawn from pre-PLRA case law,[82] but they have never been validated by an appellate court. Executive endorsement of these standards responds to a frequent concern of courts: that they are institutionally ill-suited to pass judgment on correctional systems.[83] To the extent that both deferential judges and Congress are leery of imposing judicially created requirements on prisons for reasons of institutional capacity, the measured opinions of the branch tasked with administrating federal prisons should provide assurance that such policies are both feasible and justified, thus making the CRIPA investigations as useful a source of precedent as the rare published opinions that they cite.

D. Conclusion

The PLRA was not meant to immunize the mistreatment of the mentally ill in prisons and jails, nor was it meant to disfavor mentally ill litigants in particular. Nevertheless, the Act has the potential to severely disadvantage their claims. Its most significant provisions, however, lend themselves to less disabling constructions, which courts should keep in mind when applying the PLRA.

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79 Letter from Wan J. Kim, Assistant Att'y Gen., DOJ Civil Rights Div., to Ruth Ann Minner, Governor of Del. 16, 18 (Dec. 29, 2006), *available at* http://www.usdoj.gov/crt/split/documents/ delaware_prisons_findlet_12-29-06.pdf.

80 Id. at 18.

81 Letter from Wan J. Kim, Assistant Att'y Gen., DOJ Civil Rights Div., to David Hudson, Judge, Sebastian County, Ark. 2, 15 (May 9, 2006), available at http://www.usdoj.gov/crt/split/documents/sebastian_findlet_5-9-06.pdf.

82 The formulation commonly used by the DOJ was first set forth by the District Court for the Southern District of Texas in *Ruiz v. Estelle* in 1980. 503 F. Supp. 1265, 1339 (S.D. Tex 1980), *aff'd in part and rev'd in part,* 679 F.2d 1115 (5th Cir. 1982), *amended in part and vacated in part,* 688 F.2d 266 (5th Cir. 1982) (per curiam).

83 *See, e.g.*, Pell v. Procunier, 417 U.S. 817, 827 (1974) ("Such considerations are peculiarly within the province and professional expertise of corrections officials, and . . . courts should ordinarily defer to their expert judgment in such matters."); Shook v. Bd. of County Comm'rs, No. 02-CV-00651-RPM, 2006 U.S. Dist. LEXIS 43882, at *33 (D. Colo. June 28, 2006) ("This court is not the appropriate decision maker to determine what constitutes 'adequate' training for Jail staff, or what medications should be on the Jail's list of approved medications, or how many employees are needed for 'sufficient' Jail staffing. This court must respect its constitutional boundaries . . . .").

V. THE SUPREME COURT'S PURSUIT OF PROCEDURAL MAXIMA OVER SUBSTANTIVE MINIMA IN MENTAL CAPACITY DETERMINATIONS

In the course of a mentally ill defendant's journey through the criminal justice process, there are three main instances in which the defendant's mental capacity comes into play: the element of mens rea, the insanity defense, and the determination of competency. Traditionally, these three concepts exist in distinct doctrinal boxes. They are analytically differentiated. Courts define them in different ways. And lawyers rarely, if ever, cite them together.

Nevertheless, the three are closely related. Insanity and competency are related to each other in time — they both concern a defendant's ability to understand the nature of his act or circumstances, but the inquiry into this understanding is made at different times for different purposes. This pair is related to mens rea in scope — instead of looking at a macro level situational understanding and awareness, the mens rea inquiry homes in on the moment of the causal act and asks about the actor's intentionality. Together, these three doctrines are paradigmatic instances of the courts assessing mental capacity. They provide the key doctrinal means by which mentally ill defendants escape punishment. And constitutional law bears on all three concepts.[1]

In the past few years, the U.S. Supreme Court has developed a renewed interest in these doctrines. This heightened attention has manifested itself through intense focus on procedural justice rather than on the contours of substantive regulation.[2] This preoccupation with procedures is misplaced. The Court should invoke both substantive and procedural frameworks, despite the difficulties that doing so entails, to ensure that the rights of mentally ill defendants are adequately protected.

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[1] *See, e.g.*, Montana v. Egelhoff, 518 U.S. 37 (1996) (mens rea); Leland v. Oregon, 343 U.S. 790 (1952) (insanity defense); Godinez v. Moran, 509 U.S. 389 (1993) (competencies to stand trial, plead guilty, and waive the right to counsel); Ford v. Wainwright, 477 U.S. 399 (1986) (competency to be executed).

[2] For definitions of "substantive" and "procedural" criminal law, see WILLIAM R. LAFAVE & AUSTIN W. SCOTT, JR., CRIMINAL LAW (2d ed. 1986) § 1.1, at 2 ("The substantive criminal law . . . is mostly concerned with what act and mental state, together with what attendant cir- cumstances or consequences, are necessary ingredients of the various crimes. Criminal procedure . . . is concerned with the legal steps through which a criminal proceeding passes, from the initial investigation of a crime through the termination of punishment."). For a normative description of what distinguishes substance from procedure more generally, see Frank I. Michelman, Commentary, *Process and Property in Constitutional Theory,* 30 CLEV. ST. L. REV. 577, 577 (1981) ("Substantive values are values deemed 'so important that they must be insulated from whatever inhibition the political process might impose, whereas a participational [or process goal is concerned] with how decisions effecting [substantive] value choices are made.'" (alterations in original) (quoting JOHN HART ELY, DEMOCRACY AND DISTRUST 75 n.* (1980)).

A. The Three Instances of Capacity Defined

Mens rea ("guilty mind") is "[t]he state of mind that the prosecution . . . must prove that a defendant had when committing a crime."[3] It is an "essential element[] of every crime at common law,"[4] and is thus a part of almost every criminal prosecution. The inquiry into mens rea is a much narrower inquiry than that into culpability as a whole. For example, a mentally ill defendant who perceives his attacker to be a bear and kills it, only to discover later that he killed a person, would lack the requisite mens rea for homicide (intent to kill a human being). By contrast, a mentally ill defendant who believes that God commanded him to kill the person would not have a mens rea defense (he still had intent to kill a human being) but might be excused for reasons of insanity.[5] It is a rare case when a defendant is found to have lacked the ability to form the requisite mens rea.[6]

The insanity defense is an "affirmative defense alleging that a mental disorder caused the accused to commit the crime."[7] The defense has a long history, from its roots in the common law,[8] to its transformation in M'Naghten's Case,[9] to its decline after United States v. Hinckley.[10] Today, the defense takes a number of forms in forty-six states,[11] and four states have abolished it altogether.[12] Findings of insanity are more common than findings of inadequate mens rea, but less common than findings of incompetency.

In contrast to the insanity defense, which focuses on the defendant's mental state at the time of the offense, competency determinations assess a defendant's "present insanity"[13]

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[3] BLACK'S LAW DICTIONARY 1006 (8th ed. 2004).

[4] *Id.*

[5] These examples are taken from Susan F. Mandiberg, *Protecting Society and Defendants Too: The Constitutional Dilemma of Mental Abnormality and Intoxication Defenses*, 53 FORD- HAM L. REV. 221, 226–27 (1984).

[6] *See* United States v. Pohlot, 827 F.2d 889, 900 (3d Cir. 1987).

[7] BLACK'S LAW DICTIONARY 810 (8th ed. 2004) (defining "insanity defense").

[8] 4 WILLIAM BLACKSTONE, COMMENTARIES *24–25.

[9] (1843) 8 Eng. Rep. 718 (H.L.) (setting forth the classical two-prong test). 10 525 F. Supp. 1342 (D.D.C. 1981), *clarified on denial of reconsideration*, 529 F. Supp. 520 (D.D.C. 1982), aff'd, 672 F.2d 115 (D.C. Cir. 1982); *see* Henry F. Fradella, *From Insanity to Beyond Diminished Capacity: Mental Illness and Criminal Excuse in the Post-Clark Era,* 18 U FLA. J.L. & PUB. POL'Y 7, 13–28 (2007).

[11] Those forms include various versions of cognitive incapacity, moral incapacity, volitional incapacity, and product-of-mental-illness tests. Clark v. Arizona, 126 S. Ct. 2709, 2720–22 (2006).

[12] Those four states are Idaho, Kansas, Montana, and Utah. Stephen M. LeBlanc, *Comment, Cruelty to the Mentally Ill: An Eighth Amendment Challenge to the Abolition of the Insanity Defense*, 56 AM. U. L. REV. 1281, 1288–93 (2007).

[13] *E.g.*, Hopkins v. State, 429 So. 2d 1146, 1155 (Ala. Crim. App. 1983). Mens rea and insanity both concern the defendant's responsibility for the crime, whereas competency implicates the defendant's Fifth, Sixth, and Fourteenth Amendment rights to confrontation and a fair trial. *See* DONALD PAULL, FITNESS TO STAND TRIAL 8–9 (1993).

or present mental fitness.[14] The idea of competency is also firmly rooted in common law tradition.[15] Competency determinations can take place at various phases of a prosecution, from arraignment to trial to execution, at the suggestion of either the defendant or the court. Findings of incompetency are by far the most common of the three mental capacity deficiencies.[16]

B. The Court's Proceduralism

The federal constitutional limits on the three doctrines just defined share an important characteristic: they are virtually all procedural. That proposition is clearer today than it was even a few years ago. Since 2003, the Supreme Court has taken more substantive criminal mental health law cases than it had averaged in each of the prior four decades.[17] Two of these recent cases — Clark v. Arizona[18] and Panetti v. Quarterman[19] — dealt with the capacity of mentally ill defendants.[20] Although both cases had the potential for significant substantive innovations, in each the Court more eagerly analyzed and engaged with the procedural issues of the case, passing on important opportunities to lay down even minimal substantive standards.

In Clark, the Court left unanswered the question whether the Constitution requires some minimum diminished capacity defense.[21] Faced with the issue of whether Arizona's Mott[22] rule — a rule that barred psychiatric testimony about a defendant's mental incapacity from being considered on the element of mens rea — violated due process, the Court could have approached the issue by focusing on "the substantive question of how states may define mens rea and defenses to it."[23] Indeed, this was the approach the Court had previously taken in Montana v. Egelhoff[24] when faced with a similar evidence channeling question. In that case, the Court decided

[14] It should be noted that there are many people who may be incompetent but who are not mentally ill, and there are many people with mental illnesses who are perfectly competent.

[15] 4 BLACKSTONE, *supra* note 8, at *24–25.

[16] PAULL, *supra* note 13, at 5–6 (noting that one hundred defendants are found to be incompetent for every one found to be insane); *see also* United States v. Pohlot, 827 F.2d 889, 900 (3d Cir. 1987).

[17] Christopher Slobogin, *The Supreme Court's Recent Criminal Mental Health Cases*, CRIM. JUST., Fall 2007, at 8, 8.

[18] 26 S. Ct. 2709 (2006).

[19] 127 S. Ct. 2842 (2007).

[20] The third case, *Sell v. United States,* 539 U.S. 166 (2003), is discussed in Part II, *supra* pp.1121–33, and the fourth case, *Atkins v. Virginia*, 536 U.S. 304 (2002), which deals with mental retardation, is outside the scope of this Development.

[21] A diminished capacity defense is essentially "a recognition that mental illness . . . can negatethe requisite mens rea for the crime." Christopher Slobogin, *An End to Insanity: Recasting theRole of Mental Disability in Criminal Cases*, 86 VA. L. REV. 1199, 1218 (2000).

[22] *See* State v. Mott, 931 P.2d 1046 (Ariz. 1997).

[23] *See* Slobogin, *supra* note 17, at 12.

[24] 518 U.S. 37 (1996).

that the voluntary intoxication defense is not a fundamental principle of justice protected by the Due Process Clause, thus rendering evidence channeling unproblematic.[25] By contrast, in Clark, the Court wrangled with the matter as one involving evidentiary rules, and chose to comment upon the ability of states to channel testimony of mental illness toward the insanity defense and away from mens rea.[26] (This channeling question would be moot if the underlying substantive question — whether or not the Constitution requires a diminished capacity defense — were resolved.) Not only did the Court embark on this procedural tack from the outset, it went forth aggressively, contriving an elaborate (and arguably unnecessary[27]) construct to categorize the relevant evidence into three domains.[28] In all its procedural zeal, the Court failed to answer the underlying substantive question.

The *Clark* Court also avoided answering the question whether the Constitution requires states to maintain some minimum insanity defense. At issue in *Clark* was Arizona's formulation of the insanity defense, which asked only whether the defendant "was afflicted with a mental disease or defect of such severity that [he] did not know the criminal act was wrong."[29] This formulation eliminated the traditional first prong of *M'Naghten*: that the defendant not know the nature and quality of his act.[30] In determining the constitutionality of the Arizona standard, the *Clark* majority went so far as to declare, "History shows no deference to *M'Naghten* that could elevate its formula to the level of [a] fundamental principle" that limits the states' ability to define crimes and defenses.[31] But the Court went no further, leaving open the question what sort of standard *does* constitute a fundamental principle limiting the states. To be sure, this sort of evasion is not the same as the evasion engaged in by the Court with respect to mens rea. The mens rea issue was squarely before the Court, whereas judicial minimalists might argue that the Court would have had to go out of its way to answer the question whether the Constitution requires the states to provide some minimum insanity defense. But this is true only if one assumes that the constitutional minimum does not lie somewhere between *M'Naghte*n and the Arizona standard, which it very well may. Consider this example: a mentally ill man shoots a row of apples in a fruit stant. Only, the fruit

25 *Id.* at 51, 56 (plurality opinion).

26 *See* Clark v. Arizona, 126 S. Ct. 2709, 2724–26, 2731–36 (2006).

27 *Id.* at 2738 (Kennedy, J., dissenting).

28 *Id.* at 2724–25 (majority opinion) (describing categories of "observation evidence," "mental-disease evidence," and "capacity evidence").

29 *Id.* at 2719 (alteration in original) (quoting ARIZ. REV. STAT. ANN. § 13-502(a) (West Supp. 2005)).

30 (1843) 8 Eng. Rep. 718, 722 (H.L.).

31 *Clark,* 126 S. Ct. at 2719.

stand is a hallucination, and he is really shooting into a group of people. The man does not know the nature of his act (that he is shooting people), but does know that what he is doing is wrong (it is destruction of property). Under the Arizona standard, this man would be considered sane for the purposes of a homicide prosecution. However, the factual scenario presents clear doubts about the man's culpability and the proportionality of his punishment — misgivings that might implicate the Eighth Amendment.

In *Panetti*, the Court left unanswered the question of the proper standard for competency to be executed. The Court, in large part, engaged with the procedural matters of the case: it interpreted restrictions on "second or successive" petitions for habeas corpus[32] as containing an exception for certain competency claims,[33] and it held unconstitutional the trial court's failure to provide the defendant with a hearing and an independent psychiatric evaluation upon a "substantial threshold showing of insanity."[34] The Court then issued what Justice Thomas termed "a half-baked holding"[35] on the substantive matter of the proper competency standard, asserting that an individual who "cannot reach a rational understanding of the reason for the execution" cannot be competent to be executed.[36] As for a controlling definition of the competency standard, the Court left this to the states, saying: "[W]e do not attempt to set down a rule governing all competency determinations."[37] To be sure, this step in the substantive direction deserves some recognition, considering the Court could have resolved the case on procedural grounds alone. However, since it was just a small step (merely letting states know what was unacceptable), it did little in the way of demarcating the limits of what might be acceptable.

In the end, in its consideration of the capacities of mentally ill defendants, the Court is most proceduralist in the most substantive areas. On mens rea and the insanity defense — concepts that define criminal liability — the Court hesitates to provide definitive substantive minima. On competency — an inquiry made during the litigation process — the Court nears substantive innovation but ultimately shies away.

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[32] 28 U.S.C. § 2244(b) (2000).

[33] Panetti v. Quarterman, 127 S. Ct. 2842, 2852–54 (2007) (excepting competency claims made pursuant to *Ford v. Wainright,* 477 U.S. 399 (1985), that are filed as soon as they are ripe). Ford held that the Eighth Amendment "prohibits a State from carrying out a sentence of death upon a prisoner who is insane." 477 U.S. at 410.

[34] *Panetti*, 127 S. Ct. at 2856–57 (quoting Ford, 477 U.S. at 426 (Powell, J., concurring in part and concurring in the judgment)).

[35] *Id.* at 2873 (Thomas, J., dissenting). Justice Thomas chided the Court for undertaking the substantive inquiry in the first place. *See id.*

[36] *Id.* at 2861 (majority opinion).

[37] *Id.* at 2862.

C. The Problem with a Primarily Procedural Approach

Procedural jurisprudence alone cannot properly protect the rights of mentally ill defendants. Substantive and procedural values or goals are "strictly relative to one another."[38] Procedures only work if they act to enforce or ensure enforcement of some background norm. Even the most thorough procedural constructs employed by the Court are empty without strong substantive guides for states to follow.[39] For this reason, the Court should not shy away from greater substantive engagement, or else the rights themselves may be rendered meaningless.

Excessive focus on procedural solutions can have the effect of preventing alignment between the law and prevailing notions of justice. To be sure, procedure is important to perceptions of fairness and compliance with the law.[40] But a fair procedure, by itself, cannot guarantee public satisfaction with an ultimate outcome. Indeed, people are less concerned about process when outcomes implicate and threaten "moral mandates," like those concerning innocence and guilt.[41] No amount of evidentiary rules, avenues of appeal, and rounds of review can make a guilty verdict right if, in fact, the defendant is innocent. Errors will occur, in part because total accuracy is both unattainable and unaffordable in procedural systems,[42] and in part because some of the error lies beyond procedure — undetected and undetectable by procedural mechanisms and lurking within the background substantive norm to which those mechanisms are tethered. That is why, despite rigorous litigation and appeal, the outcome "must in the end be submitted to a moral scrutiny."[43] Scrutiny is particularly warranted with respect to jurisprudence in the realm of mental illness, where a lack of substantive regulation of state-led determinations results in outcomes that fall short of nationally accepted moral sensibilities.[44]

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[38] Michelman, *supra* note 2, at 577.

[39] *See* Parratt v. Taylor, 451 U.S. 527, 545 (1981) (Blackmun, J., concurring) ("I continue to believe that there are certain governmental actions that, even if undertaken with a full panoply of procedural protection, are, in and of themselves, antithetical to fundamental notions of due process."), *overruled on other grounds* by Daniels v. Williams, 474 U.S. 327 (1986); William J. Stuntz, *Substance, Process, and the Civil-Criminal Line,* 7 J. CONTEMP. LEGAL ISSUES 1, 7–19 (1996) (arguing that procedural rules need substantive limits to work).

[40] *See* TOM R. TYLER ET AL., SOCIAL JUSTICE IN A DIVERSE SOCIETY 176 (1997) (noting that "people who experience procedural justice when they deal with authorities are more likely to view those authorities as legitimate, to accept their decisions, and to obey social rules").

[41] *See* Linda J. Skitka & David A. Houston, *When Due Process Is of No Consequence: Moral Mandates and Presumed Defendant Guilt or Innocence,* 14 SOC. JUST. RESEARCH 305, 315–16 (2001).

[42] Lawrence B. Solum, *Procedural Justice*, 78 S. CAL. L. REV. 181, 185–86 (2004).

[43] H.L.A. HART, THE CONCEPT OF LAW 210 (2d ed. 1994).

[44] *See* Ford v. Wainwright, 477 U.S. 399, 409 (1986) ("[T]he natural abhorrence civilized societies feel at killing one who has no capacity to come to grips with his own conscience or deity is still vivid today. And the intuition that such an execution simply offends humanity is evidently shared across this Nation."). *See generally* Lynnette S. Cobun, Note, *The Insanity Defense:*

Procedural guidelines, unaccompanied by substantive ones, also create perverse incentives for states to formulate minimal substantive standards. State courts are, to a significant extent, motivated by a desire not to have their decisions overturned. In order to achieve this goal, lower courts implement weak substantive protections — standards that are narrowly defined and easily met — such that officials can easily comply with the procedural requirements set by the Court above. The phenomenon is well illustrated by guilty pleas. For a defendant to plead guilty, he must voluntarily, knowingly, and intelligently waive his right to trial.[45] This inquiry *should* delve into the mental and emotional health of the defendant,[46] and his ability to understand and assimilate to a set of legal warnings. Instead, in practice, the guilty plea colloquy consists of a series of "yes" or "no" questions.[47] Defendants often nod away their rights with the judge's goading and their lawyer's coaching.[48] Courts thus proceduralize a substantive inquiry: instead of actually evaluating the defendant's mental state, the standard requires only that officials jump through a few hoops. If anything, the procedure is a mask — it does not identify incompetency so much as hide it.

Indeed, this race to the bottom occurs even when the Court *does* set forth some substantive constitutional minimum. Consider the nature of lower court decisions interpreting *Ford v. Wainwright*[49] prior to *Panetti.* Justice Marshall's opinion in *Ford* banned execution of the incompetent, but declined to provide the relevant definition of competency.[50] Only Justice Powell, in a concurring opinion, provided some substantive guidance, arguing that the state should not execute offenders who "are unaware of the punishment they are about to suffer and why they are to suffer it."[51] Equipped with this substantive morsel, lower courts addressing the issue after *Ford* have applied and

Effects of Abolition Unsupported by a Moral Consensus, 9 AM. J.L. & MED. 471, 475, 478 (1984) ("[T]he insanity defense reflects society's moral judgment that certain persons, due to mental disability, have not inflicted the same harm upon society as have others who have committed the same offense. . . . [The defense] illustrate[s] society's willingness to consider mental illness in determining culpability . . . .").

[45] *See* Johnson v. Zerbst, 304 U.S. 458, 464–65 (1938).

[46] *Cf.* Michael Mello, *Executing the Mentally Ill: When Is Someone Sane Enough to Die?,* CRIM. JUST., Fall 2007, at 30, 30 (noting that mental illness is relevant to plea negotiations).

[47] Alexandra Natapoff, *Speechless: The Silencing of Criminal Defendants*, 80 N.Y.U. L. REV. 1449, 1463 (2005).

[48] *See id.* at 1463–64.

[49] 477 U.S. 399.

[50] *See id.* at 405–10; id. at 410–18 (plurality opinion).

[51] *Id.* at 422 (Powell, J., concurring in part and concurring in the judgment).

interpreted Justice Powell's language very narrowly.[52] The same has happened with standards for competency generally. In *Godinez v. Moran*,[53] the Court held that the standards for competency to plead guilty and competency to waive the right to counsel are no higher than the standard for competency to stand trial.[54] In addition to reaching this holding, the Court mentioned that "[s]tates are free to adopt competency standards that are more elaborate than [this] formulation."[55] Despite this explicit allowance for — and perhaps encouragement of — trial court–level formulation of higher standards, lower courts have largely followed the Supreme Court's lead, parroting the minimum.[56] At least one state has interpreted *Godinez's* seemingly permissive equivocation of standards as a ceiling, not a floor, describing the Court as having held that the standard for competency to waive counsel "*may not* be higher than" the standard for competency to stand trial.[57] This interpretation exemplifies why the Court not only must prescribe constitutional minima that are substantive, but also must ensure that those minima are meaningful constitutional floors.

D. Toward Increased Substantive Engagement

The Supreme Court should grapple with substantive standards and establish constitutional minima, not simply leave this task to the states. A substantive approach is preferable because it can better ensure an acceptable set of outcomes by addressing those outcomes directly;[58] that is, it can better ensure that people whose mental capacities make them undeserving of punishment do not receive punishments that they do not deserve. While there are a number of reasons why substantive lawmaking may prove difficult, the Court still should consider this approach.

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[52] Slobogin, *supra* note 17, at 14. Examples of courts to have addressed the language are *Billiot v. State,* 655 So. 2d 1, 6 (Miss. 1995); and *Barnard v. Collins,* 13 F.3d 871, 876–77 (5th Cir. 1994).

[53] 509 U.S. 389 (1993).

[54] *Id.* at 391. The Court adopted a standard requiring that a defendant need only have "sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding" and a "rational as well as factual understanding of the proceedings against him." *Id.* at 396 (quoting Dusky v. United States, 362 U.S. 402, 402 (1960) (per curiam)) (internal quotation marks omitted).

[55] *Id.* at 402.

[56] *See, e.g.*, Sims v. State, 438 S.E.2d 253, 254–55 (S.C. 1993).

[57] Edwards v. State, 854 N.E.2d 42, 48 (Ind. Ct. App. 2006) (emphasis added), *aff'd,* 866 N.E.2d 252 (Ind. 2007), *cert. granted,* 128 S. Ct. 741 (2007).

[58] *See* Carol S. Steiker & Jordan M. Steiker, *Sober Second Thoughts: Reflections on Two Decades of Constitutional Regulation of Capital Punishment,* 109 HARV. L. REV. 355, 412–26 (1995); William J. Stuntz, *The Uneasy Relationship Between Criminal Procedure and Criminal Justice*, 107 YALE L.J. 1, 66–74 (1997).

Substantive standards can be hard to formulate because mental illness is difficult to define and categorize.[59] This difficulty may incline the Court to avoid them altogether. But substantive approximations are not impossible to formulate. The Court is in a position to create a functional and moral — if not purely scientific — definition.[60] This is precisely what the Court did in Dusky v. United States,[61] where it defined the test for competency to stand trial as "whether [the defendant] has sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding — and whether he has a rational as well as factual understanding of the proceedings against him."[62] The Dusky test was formulated in functional terms. The Court might take a similar approach with other mental capacity doctrines.

Indeed, a number of administrable standards exist and have been proposed in the courts and in the literature.[63] These include a diminished capacity defense only for specific intent crimes,[64] an insanity defense that includes cognitive, moral, and volitional prongs,[65] and a competency to be executed standard that requires that the defendant understand the nature and purpose of the punishment and appreciate the reason for its application in his case.[66] To be sure, such definitions inevitably involve some arbitrary line drawing. But, as the Court's jurisprudence has already evidenced in other areas,[67] with some substantive matters, this risk is worth taking.[68]

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[59] *See* Andrew E. Taslitz, *Mental Health and Criminal Justice: An Overview,* 22 CRIM. JUST., Fall 2007, at 4, 4.

[60] *See id.* ("[B]ecause 'normalcy' unquestionably involves moral and social judgments, no definitions of mental health or illness can be purely 'scientific' ones.").

[61] 362 U.S. 402 (1960) (per curiam).

[62] *Id.* at 402 (quoting the Solicitor General's brief) (internal quotation mark omitted).

[63] *See, e.g.,* Richard J. Bonnie, *The Competence of Criminal Defendants: A Theoretical Reformulation,* 10 BEHAV. SCI. & L. 291, 294 (1992) (advocating multifaceted evaluation of competence, including competence to assist counsel and decisional competence); Joshua Dressler, *Commentary, Reaffirming the Moral Legitimacy of the Doctrine of Diminished Capacity: A Brief Reply to Professor Morse*, 75 J. CRIM. L. & CRIMINOLOGY 953 (1984) (arguing that diminished capacity, in the form of partial responsibility, should be recognized as a legitimate excuse); Jodie English, *The Light Between Twilight and Dusk: Federal Criminal Law and the Volitional Insanity Defense*, 40 HASTINGS L.J. 1 (1988) (advocating a volitional insanity defense as a constitutional floor).

[64] *E.g.*, State v. Holcomb, 643 S.W.2d 336, 341–42 (Tenn. Crim. App. 1982).

[65] *E.g.*, State v. Hartley, 565 P.2d 658, 660–61 (N.M. 1977).

[66] AM. BAR ASS'N, COMM'N ON MENTAL AND PHYSICAL DISABILITY LAW, REPORT NO. 122(A), Recommendation § 3(d) (2006), *available at* http://www.abanet.org/disability/docs/DP122A. pdf.

[67] The Court's categorical exclusion of juvenile defendants, Roper v. Simmons, 543 U.S. 551 (2005), and mentally retarded defendants, Atkins v. Virginia, 536 U.S. 304 (2002), from death penalty eligibility drew lines that may have a less-than-perfect correlation with culpability.

[68] *See* Steiker & Steiker, *supra* note 58, at 418 (noting that the risk of underinclusion incurred by arbitrary line-drawing is preferable to the risk of overinclusion — that is, the risk that criminal punishment will be imposed on the undeserving — when no lines are drawn).

Though courts can formulate substantive standards, such standards, once formulated, may prove difficult in their application. Psychiatric evidence is often tough to interpret, and courts tend to lack the institutional competence to make such determinations. Instead, their comparative advantage lies in judging the adequacy and design of procedural protections.[69] Courts' familiarity with procedural decisionmaking may explain why they prefer to analyze cases using procedural formulations rather than substantive ones. Nevertheless, courts can still forge ahead on the substantive front with the help of experts.[70] Indeed, this is the precise purpose of expert testimony.[71] To be sure, there are many instances in which even the experts disagree.[72] But such disagreement does not occur with great frequency[73] or consequence,[74] and to the extent that it does occur, it is somewhat inevitable.[75] If the courts were to surrender to this inevitability, they would undermine the entire well-established practice of using psychiatric expert testimony — a practice the Court has repeatedly endorsed.[76]

Even if the Court, through the use of expert testimony, is well-equipped to engage in substantive formulation, the principle of federalism would rightly give it pause. Substantive criminal law standards are traditionally the domain of the states,[77] and for good reason. In a world in which large majorities of people in one place find a particular behavior offensive and wrong, and large majorities of people in another place find that same behavior trivial or acceptable, or even good, the best way to maximize individuals' satisfaction with the laws they live under is to devolve

69 *See* Bus. Guides, Inc. v. Chromatic Commc'ns Enters., Inc., 498 U.S. 533, 565 (1991) (Kennedy, J., dissenting) (noting that courts have "expertise and some degree of inherent authority" in the area of "practice and procedure").

70 Mental health professionals can assist courts, but ultimately it is the role of judges to balance the legal, moral, and social interests at stake. *Cf.* Donald N. Bersoff, *Judicial Deference to Nonlegal Decisionmakers: Imposing Simplistic Solutions on Problems of Cognitive Complexity in Mental Disability Law*, 46 SMU L. REV. 329, 371 (1992).

71 *See* FED. R. EVID. 702 (allowing expert testimony only when it will "assist the trier of fact to understand the evidence"); Learned Hand, *Historical and Practical Considerations Regarding Expert Testimony,* 15 HARV. L. REV. 40, 52 (1901) (noting that the role of an expert witness is to furnish "general propositions" that are outside of the common knowledge of the factfinder). Indeed, expert testimony is particularly valuable with respect to adjudications of mental states. *See generally* CHRISTOPHER SLOBOGIN, PROVING THE UNPROVABLE: THE ROLE OF LAW, SCIENCE, AND SPECULATION IN ADJUDICATING CULPABILITY AND DANGEROUSNESS (2007).

72 *See, e.g.*, Mello, *supra* note 46, at 32 (noting the varied diagnoses of the defendant in Ford).

73 Park Elliott Dietz, *Why the Experts Disagree: Variations in the Psychiatric Evaluation of Criminal Insanity,* 477 ANNALS AM. ACAD. POL. & SOC. SCI. 84, 85 (1985) (noting agreement in 92% of cases).

74 Gerald E. Nora, Prosecutor as "Nurse Ratched"?: Misusing Criminal Justice as Alternative Medicine, CRIM. JUST., Fall 2007, at 18, 20 (noting that the "[mental] illnesses that are most relevant to public safety and criminal justice" are "subject to objective diagnoses").

75 *See* Dietz, *supra* note 73, at 86.

76 *See,* e.g., Barefoot v. Estelle, 463 U.S. 880, 896 (1983).

77 *See* United States v. Lopez, 514 U.S. 549, 561 n.3 (1995).

decisionmaking to the local level.[78] Federal guidance that is merely procedural is more respectful of state-level substantive standards than federal substantive mandates to the states. But all behaviors do not fit under this rubric. In fact, the federal system has already incorporated at least some areas of criminal law into its own domain.[79] Mental capacity determinations should be next.[80]

Mentally ill defendants cannot rely on local democracy to enforce the proper moral outcome or to protect them. For there is a political process problem[81]: mentally ill defendants systematically lack access to local legislatures that could advocate for their interests.[82] And given that most state judges are elected, they too are too vulnerable to majoritarian pressures to protect the insular rights at issue. These factors justify the Court's stepping in[83:]

> Those whom we would banish from society or from the human community itself often speak in too faint a voice to be heard above society's demand for punishment. It is the particular role of courts to hear these voices, for the Constitution declares that the majoritarian chorus may not alone dictate the conditions of social life.[84]

Given the perversities of pure proceduralism in this area, the Court can only fully perform its role as buffer against majoritarian politics if it agrees to engage in meaningful

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[78] *See* Michael W. McConnell, *Federalism: Evaluating the Founders' Design*, 54 U. CHI. L. REV. 1484, 1492–1511 (1987) (book review) (explaining how federalism "secure[s] the public good," "protect[s] private rights," and "preserve[s] the spirit and form of popular government" (quoting THE FEDERALIST NO. 10 (James Madison)) (internal quotation marks omitted)).

[79] *See* Curtis A. Bradley, *The Treaty Power and American Federalism*, 97 MICH. L. REV. 390, 403–06 (1998) (noting that traditionally state-based American criminal law is subject to international treaty-making and related federal regulation). Criminal trial rules and procedures are also a traditional domain of the states, Chambers v. Mississippi, 410 U.S. 284, 302–03 (1973), but the Court has federalized that arena nevertheless, *see* Stuntz, *supra* note 58, at 16–19.

[80] Even staunch advocates of federalism acknowledge the need for exceptions. Federalism's ends of diversity and creative energy must be balanced against the goal of "achiev[ing] a unity sufficient to resist [a people's] common perils and advance their common welfare." Herbert Wechlser, *The Political Safeguards of Federalism: The Role of the States in the Composition and Selection of the National Government*, 54 COLUM. L. REV. 543, 543 (1954). Protection of the mentally ill fits into this caveat, given that prosecution and execution of mentally ill defendants are unacceptable as a moral matter.

[81] ELY, *supra* note 2, at 135. The political process argument applies as forcefully to substantive protections as to procedural ones. *See* Stuntz, *supra* note 39, at 21.

[82] *See* Stephen B. Bright, *Can Judicial Independence Be Attained in the South? Overcoming History, Elections, and Misperceptions About the Role of the Judiciary,* 14 GA. ST. U. L. REV. 817, 843 (1998) (noting that the mentally ill "have no political action committee or access to legislators or governors"); Laura B. Chisolm, *Exempt Organization Advocacy: Matching the Rules to the Rationales*, 63 IND. L.J. 201, 269 (1987) (noting that the mentally ill lack "effective direct access to decisionmaking processes" and that "it is likely that their interests will not routinely be of much importance to those who do have access").

[83] *See* Alan M. Dershowitz, *John Hart Ely:* Constitutional Scholar (A Skeptic's Perspective on Original Intent as Reinforced by the Writings of John Hart Ely), 40 STAN. L. REV. 360, 369 (1988).

[84] McCleskey v. Kemp, 481 U.S. 279, 343 (1987) (Brennan, J., dissenting).

substantive analysis of the issues that affect mentally ill defendants.

E. Conclusion

The judicial values of minimalism and restraint undoubtedly suggest that, even given the benefits of judicial engagement in the substantive arena, the Court should proceed cautiously into this area.[85] But it is a mistake to assume that proceduralism is the most minimalist route. The reality of the Court's procedural jurisprudence suggests otherwise. In the realm of criminal procedure, the Court has meddled in the minutiae of even day-to-day investigative activities. With each decision, the Court defines the required processes in ever more detail.[86] A substantive turn in this area might in fact enable less activism in Supreme Court decisionmaking on the whole.

Moreover, substantive regulation of mental capacity determinations readily finds a place within the Constitution's provisions. To be sure, due process does say "process," and most of the Bill of Rights' provisions pertain only to process,[87] so, at first glance, it may appear difficult to give such regulation a constitutional home. Nevertheless, there are several plausible options. These include the Eighth Amendment's bar against cruel and unusual punishment,[88] an Eighth Amendment proportionality principle,[89] and Fourteenth Amendment substantive due process as applied to criminal law.[90]

Whichever path it chooses, the Court need not define the ultimate, optimal doctrine — it need only define a meaningful substantive floor. Only such an approach both respects state power and protects those whose voices are drowned out by the majoritarian chorus.

85 *See generally* ALEXANDER M. BICKEL, THE LEAST DANGEROUS BRANCH: THE SU- PREME COURT AT THE BAR OF POLITICS (2d ed. 1986); CASS R. SUNSTEIN, ONE CASE AT A TIME: JUDICIAL MINIMALISM ON THE SUPREME COURT (1999).

86 *See* Stuntz, *supr*a note 58, at 16–19 & nn.61–69.

87 *See* Anti-Fascist Comm. v. McGrath, 341 U.S. 123, 164 (1951) (Frankfurter, J., concurring).

88 *See generally* Note, *The Cruel and Unusual Punishment Clause and the Substantive Criminal Law*, 79 HARV. L. REV. 635 (1966). In this vein, the Court's stance in *Robinson v. California*, 370 U.S. 660 (1962), provides an apposite starting point. *But see* Powell v. Texas, 392 U.S. 514, 532–33 (1968) (distinguishing *Robinson* and limiting its logic). At the very least, *Robinson* provides precedent for the Court's limiting the government's penal powers by assessing the constitutionality of the definition of the crime, not simply the length of the punishment. *See Robinson,* 370 U.S. at 667.

89 *See, e.g.*, Steiker & Steiker, *supra* note 58, at 415; Stuntz, *supra* note 58, at 72; see also Richard S. Frase, *Excessive Prison Sentences, Punishment Goals, and the Eighth Amendment: "Proportionality" Relative to What?*, 89 MINN. L. REV. 571, 600–06 (2005).

90 *See* Stuntz, *supra* note 58, at 68. See generally Herbert L. Packer, *The Aims of the Criminal Law Revisited: A Plea for a New Look at "Substantive Due Process,"* 44 S. CAL. L. REV. 490 (1971).

VI. MENTAL HEALTH COURTS AND THE TREND TOWARD A REHABILITATIVE JUSTICE SYSTEM

In the last decade, diversionary programs known as mental health courts (MHCs) have been created all over the country. These programs work at the local level to divert mentally ill chronic reoffenders away from the traditional criminal justice system and into treatment. As MHCs become more widespread and their effectiveness becomes broadly recognized, their sources of support and funding have grown. Recently, MHCs have been increasingly promoted (and funded) by the U.S. Department of Justice as part of a bipartisan effort jointly sponsored by the President and Congress to increase access to mental health services.[1] No longer simply a few scattered programs, MHCs have now become a national project providing mentally ill individuals a way out of repeated imprisonment.

Because of their unconventional nature, MHCs may also prove to be a window into the evolution of America's criminal justice system. Historically, the prevailing theory of punishment has moved from rehabilitation to retribution and back again.[2] Since the mid-1970s, retribution has been the norm. Along with it have come overflowing prisons and an incarceration level higher than that of nearly all other developed countries.[3] The recent popularity, success, and widespread acceptance of MHCs (and other problem-solving courts[4]), with their focus on treatment and probation instead of incarceration and punishment, indicate that an important step has been taken toward a more rehabilitation-focused justice system as a whole.

Section A chronicles the rise of the MHC system and provides an overview of MHC mechanics. This section also discusses the social and fiscal costs and benefits of MHCs, as well as the effect of federal funding on the development of MHCs. Section B examines historical theories of punishment — particularly the divide between retributive

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1 In 2000, Congress enacted the America's Law Enforcement and Mental Health Project (ALEMHP) Act, Pub. L. No. 106-515, 114 Stat. 2399 (codified at 42 U.S.C. §§ 3796ii to 3796ii-7 (2000)). The ALEMHP Act would have created up to 100 new MHCs by 2004. However, funding was not immediately appropriated. Henry J. Steadman et al., *Mental Health Courts: Their Promise and Unanswered Questions*, 52 PSYCHIATRIC SERVICES 457, 457 (2001). Little progress was made on federal funding until President George W. Bush's 2003 New Freedom Commission, discussed *infra* pp. 1173–74.

2 *See infra* pp. 1174–75.

3 JUSTICE KENNEDY COMM'N, AMERICAN BAR ASS'N, REPORT TO THE HOUSE OF DELEGATES 4 (2004) [hereinafter KENNEDY COMM'N], *available at* http://www.abanet.org/ media/kencomm/rep121a.pdf.

4 Problem-solving courts, the group of courts to which MHCs belong, are criminal judicial proceedings that attempt to address defendants' actions at a causal level by imposing remedial discipline rather than retributive punishment. Such courts include drug courts, domestic violence courts, MHCs, and others. *See* Bruce Winick & David Wexler, *Introduction* to JUDGING IN A THERAPEUTIC KEY 3–5 (Bruce Winick & David Wexler eds., 2003).

and rehabilitative theories — and how they have affected the development of MHCs. Section C analyzes the current state of the retributive-rehabilitative divide, concluding that MHCs may provide a useful insight into the future direction of the criminal justice system as a whole.

A. Mental Health Courts: An Overview

America's court system has long struggled with the question of how to provide justice for mentally ill defendants. Are they to be treated like the rest of the population, tried, convicted, and confined without regard to their mental status? Or does their mental illness place them in a separate category? Are they more treatable than their "normal" fellow inmates — is their recidivism more preventable? One MHC-sponsoring judge states, "We've learned that [mentally ill] offenders do not do well in prison. . . . [T]heir illnesses just get worse. And what happens when they are released without having received effective treatment? They get recycled right back into the system. Everyone loses."[5] Mentally ill defendants whose offenses are linked to their conditions are unlikely to receive treatment in prison, and very likely to reoffend quickly after their sentences are over.[6] This situation presents a challenge to judges, prosecutors, and legislators alike: if there is a treatable mental condition at the root of a series of recidivist offenses, does the criminal justice system have the right, or perhaps the responsibility, to attempt to intervene at that root level?

In the last ten years, a new type of court has arisen to take on this challenge: the mental health court. Combining aspects of adversarial courts and other diversionary programs under the supervision of criminal court judges, MHCs actively seek out and divert from the normal criminal process repeat offenders whose offenses are linked to mental illness. Flagged for the program by the arresting officer, defense counsel, the judge, or even the prosecution, these individuals' cases are adjudicated in an MHC in hopes of granting offenders a way out of the cycle of recidivism. When identified as possible candidates for an MHC, defendants are given psychiatric evaluations and, if

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5 Jonathan Lippman, *Achieving Better Outcomes for Litigants in the New York State Courts,* 34 FORDHAM URB. L.J. 813, 826 (2007).

6 By some estimates, 16% of inmates in prisons nationwide are mentally ill. Only 17% of these inmates receive any sort of treatment during their incarceration, which leaves thousands of untreated individuals, their diseases possibly worsened by their jail experience, to be released onto the streets — and often rearrested within months. *See* DEREK DENCKLA & GREG BERMAN, CTR. FOR CT. INNOVATION, RETHINKING THE REVOLVING DOOR: A LOOK AT MENTAL ILLNESS IN THE COURTS 3–4 (2003), *available at* http://www.courtinnovation.org/_uploads/ documents/rethinkingtherevolvingdoor.pdf. Forty-nine percent of mentally ill inmates have three or more prior arrests, as opposed to only 28% of non–mentally ill inmates. *Id.* at 4

diagnosed with a mental illness that contributed to their offense, are offered "long-term treatment as an alternative to incarceration."[7]

1. *The Rise of the Mental Health Court.* — Since 1997, when the first MHC was set up in Broward County, Florida, MHCs have rapidly increased in number and size. Founded in order to "focus mental health services and resources on defendants whose mental illness was the primary reason for their recidivism," early MHCs accepted primarily inmates who had repeatedly committed misdemeanors.[8] In 1999, Anchorage, Alaska, set up a court to divert its own mentally ill recidivists.[9] By 2005, some 125 MHCs had been established in states across the nation.[10]

MHCs typically have dedicated personnel, including a judge, a prosecutor, and a public defender, each of whose entire docket consists of MHC participants.[11] Also present are various mental health professionals whose primary responsibility is their designated MHC. All personnel in an MHC, from judge to case worker, are thoroughly trained in mental illness and its treatment, as well as in the psychology underlying criminal behavior of the mentally ill. Because the administrative personnel of an MHC are so stable,

7 Lippman, *supra* note 5, at 826. Some defense practitioners and advocates for the mentally ill have questioned whether MHCs and other forms of problem-solving courts are truly voluntary. A choice between jail and treatment, they say, is no choice at all. Furthermore, because a defen- dant must often plead guilty to the underlying offense in order to participate in some MHCs, some defense attorneys have expressed ethical and professional reservations at the dual role they must play — they must defend, but also must inform their client that the only way to obtain potentially life-saving mental health services is to surrender without a fight. For a detailed exchange on the problem of voluntariness and the dilemmas of the defense attorney in problem-solving courts, *see* David B. Wexler, *Therapeutic Jurisprudence and the Rehabilitative Role of the Criminal Defense Lawyer,* 17 ST. THOMAS L. REV. 743 (2005); and Mae C. Quinn, An RSVP to Profes sor Wexler's *Warm Therapeutic Jurisprudence Invitation to the Criminal Defense Bar: Unable To Join You, Already (Somewhat Similarly) Engaged*, 48 B.C. L. REV. 539 (2007).

8 Tamar M. Meekins, *"Specialized Justice": The Over-Emergence of Specialty Courts and the Threat of a New Criminal Defense Paradigm*, 40 SUFFOLK U. L. REV. 1, 24–25 (2006).

9 University of Alaska Anchorage Justice Ctr.: Mental Health Courts (2002) [hereinafter An- chorage MHCs], http://justice.uaa.alaska.edu/rlinks/courts/mentalhealth.html.

10 *See* COUNCIL OF STATE GOV'TS, MENTAL HEALTH COURTS: A NATIONAL SNAPSHOT (2005) [hereinafter NAT'L SNAPSHOT], http://www.consensusproject.org/mhcp/national-snapshot. pdf.

11 The stability of these three individuals is important because many legal professionals will have little or no background in psychology. Stability keeps training costs down and allows court personnel to reap the benefits of consistent and broad exposure to the mentally ill and their various symptoms and needs. *See* DENCKLA & BERMAN, *supra* note 6, at 15–16 (comparing the roles of traditional and problem-solving judges).

the court takes on a unique character[12] as a place where therapy can actually begin, not merely be prescribed.[13]

The relationship between MHCs and standard criminal courts is similar across jurisdictions, but can differ in the details. MHCs, like standard courts, derive their coercive power from the authority of the judge. Though MHCs vary in their use of jail as a sanction for noncompliance with the therapeutic requirements,[14] they all have in common the goal of transitioning the mentally ill defendants out of the prison system and into a treatment-oriented probationary period. MHCs vary as to whether they accept individuals who have already been convicted of or charged with a crime or those who have merely been arrested.[15] Regardless, nearly all MHCs use the promise of a cleared criminal record as an incentive for treatment compliance.[16] During their enrollment in an MHC, individuals receive outpatient treatment at local clinics, have regular meetings with court or probation officers, make appearances in court to confer with the judge over their treatment progress, and participate in group counseling programs. Though the initial MHC proceeding is usually still formulated as an adversarial process, it is certainly less so than a typical criminal court proceeding, and a defendant's subsequent court appearances often bear a strong resemblance to therapeutic appointments.[17]

2. *The Expansion of the MHC System*. — The types of defendants accepted by MHCs have evolved over the decade since the Broward County court was founded. Early MHCs refused to accept defendants charged with felonies, preferring instead to focus their efforts on misdemeanants who committed "quality of life crimes."[18] No violent

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[12] One unique aspect is the cooperation between the defense attorney and prosecutor — as one scholar puts it, "the attorneys for both sides work on the same team and share information." Stacey M. Faraci, Slip Slidin' Away? *Will Our Nation's Mental Health Court Experiment Diminish the Rights of the Mentally Ill?*, 22 QUINNIPIAC L. REV. 811, 825 (2004).

[13] *See, e.g.*, LISA CONTOS SHOAF, OHIO OFFICE OF CRIMINAL JUSTICE SERVS., A CASE STUDY OF THE AKRON MENTAL HEALTH COURT 3 (2004), http://www.ocjs.ohio.gov/research/ Akron%20MHC%20case%20study.pdf (describing the atmosphere of the Akron, Ohio, MHC as "less adversarial and more relaxed than what is seen in a traditional court session"). For a practical example of how this atmosphere is created, *see* Eliza Strickland, *Breaking the Cycle*, SFWEEKLY.COM, Aug. 8, 2007, http://www.sfweekly.com/2007-08-08/news/breaking-the-cycle (describing a typical day in a California MHC).

[14] *See, e.g.*, DENCKLA & BERMAN, supra note 6, at 13.

[15] *See* Meekins, *supra* note 8, at 16–17.

[16] *See* Faraci, *supra* note 12, at 829–30.

[17] For a thorough discussion on MHCs and their inner workings, see generally GREG BERMAN & JOHN FEINBLATT, CTR. FOR CT. INNOVATION, PROBLEM-SOLVING COURTS: A BRIEF PRIMER (2001) [hereinafter BRIEF PRIMER], *available at* http:// www.courtinnovation.org/ pdf/prob_solv_courts.pdf.

[18] Meekins, *supra* note 8, at 25. Such crimes include public urination, disruptive or verbally assaultive behavior, and the like.

criminals or sexual offenders were permitted into the programs,[19] although this restriction has changed in the last few years as MHCs have become more willing to accept individuals charged with minor felonies.[20] One of the natural concerns in a society contemplating the creation of an MHC is the safety of the surrounding population, as such courts frequently release into the community individuals who would likely otherwise have been incarcerated. However, participants in MHCs often have much lower rates of reoffense while on probation than do mentally ill individuals with similar backgrounds who are sentenced to jail or prison.[21]

MHCs, as might be expected, are highly treatment-oriented. Many of their entrance criteria deal, either directly or indirectly, with treatability, as do their retention criteria and their requirements for "graduating" the program.[22] This treatment focus has led to some interesting effects — the courtroom becomes less of a place where impersonal justice is given, and more like a group therapy room.[23] Treatment may be emphasized to the exclusion of all else: at times, even the "stick" of a potential jail sentence for noncompliance with treatment and probation requirements is off limits to the MHC because of the contrary effects that a stint in jail might have on a participant.[24]

3. *The Long-Term Benefits of MHCs Outweigh Their Startup Costs.* — Because MHCs require the active, dedicated participation of many trained professionals, administrative costs can mount quickly. Judges and prosecutors are often in short supply already;[25] public defender offices are busy and understaffed; mental health professionals are expensive. Some cities have been forced to cut back or eliminate their problem-solving courts because of their high cost. Other states and municipalities have begun imposing blanket fines on participation in their criminal justice systems — Illinois, for example, includes a uniform ten dollar "mental health court charge" in its court costs.[26] Nevertheless, counties acting on their own are often hard-pressed to provide what has

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19 Faraci, *supra* note 12, at 826.

20 *See* NAT'L SNAPSHOT, *supra* note 10.

21 *See infra* p. 1173.

22 *See* HENRY J. STEADMAN & ALLISON D. REDLICH, NAT'L INST. OF JUSTICE, AN EVALUATION OF THE BUREAU OF JUSTICE ASSISTANCE MENTAL HEALTH COURT INITIATIVE 14–15 (2006), *available at* http://www.ncjrs.gov/pdffiles1/nij/grants/213136.pdf.

23 *See id.* at 15–16; *see also* Strickland, *supra* note 13 (describing participation in MHCs as a group-oriented therapeutic endeavor).

24 *See* Meekins, *supra* note 8, at 25.

25 *See In re* Certification of Need for Additional Judges, 842 So. 2d 100, 103 (Fla. 2003) (per curiam) ("Existing judicial resources are strained by . . . the creation and expansion of effective, but labor-intensive, specialized case processing techniques (e.g., juvenile and adult drug courts, mental health courts, elder courts, and domestic violence courts)." (emphasis added)).

26 *See* People v. Price, 873 N.E.2d 453, 468–69 (Ill. App. Ct. 2007) (upholding the constitutionality of a $10 "fee" upon criminal conviction, even for nonparticipants in MHCs).

become an important part of their efforts at crime reduction and quality of life improvement.

Though the cost of starting an MHC is daunting, the potential social payout may be very high. In one drug court, recidivism has been reduced by over 40%, and employment rates exceed 90%.[27] Early data indicate that MHCs may similarly improve outcomes.[28] A study of one MHC program indicates that, within twelve months, MHC graduates are over 75% less likely to reoffend. Those graduates who do reoffend are almost 88% less likely to do so in a violent manner.[29] Another court saw its recidivism rates drop from 78% to 16%.[30] Of course, once a court is successfully established, reduced recidivism has its own financial rewards, not the least of which is an influx of stable, working individuals to a locality's tax base.[31]

In the first years of the MHC experiment, the initial startup costs were so high that they may have prevented rural communities, often poor, from starting an MHC.[32] The impact of high startup costs has dwindled with President George W. Bush's establishment of the New Freedom Commission on Mental Health.[33] The order established an investigative Commission "to conduct a comprehensive study of the United States mental health service delivery system, including public and private sector providers, and to advise the President on methods of improving the system."[34] The study was completed a year later.[35]

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27 *See* KENNEDY COMM'N, *supra* note 3, at 33.

28 Because MHCs are so new, there has not been enough time to conduct a thorough, system- wide analysis of their effectiveness. However, some MHCs have conducted internal efficacy studies, many of which are catalogued at BJA Ctr. for Program Evaluation: Mental Health Courts, http://www.ojp.usdoj.gov/BJA/evaluation/psi_courts/mh6.htm (last visited Jan. 12, 2008). MHCs receiving DOJ money are required to collect statistics on the results of their programs, thus providing at least a minimal source of information. For an example of such a report, *see* SHOAF, *supra* note 13, at 1 (noting partial sponsorship of Akron MHC study by the DOJ Bureau of Justice Statistics).

29 JOHN R. NEISWENDER, EXECUTIVE SUMMARY OF EVALUATION OF OUTCOMES FOR KING COUNTY MENTAL HEALTH COURT 4 (2004), *available at* http://www.metrokc.gov/ KCDC/mhcsum32.pdf.

30 KELLY O'KEEFE, CTR. FOR CT. INNOVATION, THE BROOKLYN MENTAL HEALTH COURT EVALUATION 53 (2006) [hereinafter BROOKLYN EVALUATION], http://www. courtinnovation.org/_uploads/documents/BMHCevaluation.pdf.

31 DENCKLA & BERMAN, *supra* note 6, at 11 (noting that one established MHC had, with only 56 graduates, saved its locality nearly $400,000). Of course, as another commentator wryly noted, a "carrot-and-stick approach has successfully motivated thousands of offenders to get clean and lead productive *(and tax-paying)* lives." GREG BERMAN & JOHN FEINBLATT, GOOD COURTS: THE CASE FOR PROBLEM-SOLVING JUSTICE 9 (2005) (emphasis added).

32 One-fourth of MHC-employing communities are rural. *See* NAT'L SNAPSHOT, *supra* note 10.

33 Exec. Order No. 13,263, 3 C.F.R. 233 (2003) (superseded 2003).

34 *Id.* § 3, 3 C.F.R. at 233.

35 PRESIDENT'S NEW FREEDOM COMM'N ON MENTAL HEALTH, ACHIEVING THE PROMISE: TRANSFORMING MENTAL HEALTH CARE IN AMERICA (2003) [hereinafter NEW FREEDOM COMM'N], *available at* http://www.mentalhealth

With the encouraging recognition that "recovery from mental illness is now a real possibility,"[36] the Commission recommended an increase in federal funding to mental health facilities, and in particular to facilities dealing with mental illness in the criminal justice system.[37]

In 2004, Congress responded to the Commission's findings by reviving and passing bills to create and fund MHC programs.[38] The Department of Justice (DOJ), which administers the grant program, has taken up Congress's call with enthusiasm, and now has an active sponsorship program.[39] Since the inception of DOJ sponsorship the number of MHCs has grown steadily, from 70 in January 2004 to over 125 in December 2005.[40]

As federal funding to MHCs has increased, the national judicial and legislative support for these courts has become more apparent. Though they started as local initiatives and are still conducted at the local level (the federal government does not yet have a problem-solving court program), MHCs are gaining a national character as well. The use of federal tax dollars to provide startup money to MHCs, situated as these appropriations are within the increasing nationwide use of problem-solving courts, may indicate the country's willingness to accept a shift of focus from a punishment model of justice to a rehabilitative model.

B. The Criminal Justice System: Retribution or Rehabilitation?

The difference between the new theory of problem-solving courts and the jurisprudence of punishment that has dominated the criminal justice system during the last twenty-five years is striking. Throughout American history, the purpose of punishment has been a source of great debate. The pendulum of criminal theory has swung between the poles of retribution and rehabilitation for longer than America has been a nation.[41]

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commission.gov/reports/FinalReport/ downloads/FinalReport.pdf.

36 *Id.* at 1. The Commission "recommend[ed] a fundamental transformation of the Nation's approach to mental health care . . . ensur[ing] that mental health services . . . actively facilitate recovery, and build resilience to face life's challenges." *Id.* 37 *Id.* at 43–44.

38 In 2004, Congress appropriated funding for the ALEMHP Act and also passed the Mentally Ill Offender Treatment and Crime Reduction Act of 2004, Pub. L. No. 108-414, 118 Stat. 2327 (codified at 42 U.S.C. § 3797aa (Supp. IV 2004)).

39 For further information on the DOJ sponsorship program, *see* Bureau of Justice Assistance Programs: Mental Health Courts, http://www.ojp.usdoj.gov/BJA/grant/mentalhealth.html (last visited Jan. 12, 2008).

40 NAT'L SNAPSHOT, *supra* note 10.

41 *See, e.g.*, Stephen P. Garvey, *Freeing Prisoners' Labor,* 50 STAN. L. REV. 339, 341 (1998) ("[T]he early penitentiary was founded on the hope of moral reform . . . . In contrast, [in] today's prison[s] . . . moral decay is more likely than moral reform."); Melvin Gutterman, *Prison Objectives and Human Dignity: Reaching a Mutual Accommodation, 1992 BYU L. REV 857, 860--*

By the middle of the twentieth century, theories of rehabilitation were the norm. Prisons were a place where treatment could be obtained, education could be had, and — hopefully — the groundwork for a normal life could be laid.[42] In the last few decades, however, the focus of the criminal justice system has swung with a vengeance to- ward a more standardized, punitive vision of punishment.[43] By the time the Sentencing Reform Act established the Federal Sentencing Guidelines in 1984, "the previously dominant rehabilitative ideal in criminal law had been called into question and replaced by a just desert theory of punishment."[44] Rehabilitation fell by the wayside, and with the introduction of mandatory minimums and high statutory maximums the "lock 'em up and throw away the key" perspective became the norm.[45]

Despite the general shift toward a more punitive theory of punishment, one academic theory continues to espouse rehabilitation and community-based remedies: Therapeutic Jurisprudence (TJ). TJ was developed by Professors Bruce Winick and David Wexler in the early 1980s in response to what they perceived as a harmful drift of the criminal justice system toward longer, harsher sentences and away from the rehabilitation of offenders. The basic assumption of TJ is that the purpose of the criminal justice system is treatment.[46] Thus, TJ theorists focus on incarceration's effect on defendants' mental and physical status. They consider "emotions, empathy, healing, and the psychological well-being of individuals" to be an important emphasis of the criminal justice system, a focus that leads naturally to a problem-solving approach.[47] Although TJ has never been a dominant theory in legal academia, the principles it espouses have become more accepted as problem-solving courts have risen in prominence. With the advent of problem-solving courts, TJ has found its place as the idea upon which drug

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72 (1993) (providing detailed history of the development of the American prison system and chronicling its repeated swings from rehabilitation to harsh punishment and back again).

[42] *See* Gutterman, *supra* note 41.

[43] *See generally* Austin Sarat, *Putting a Square Peg in a Round Hole: Victims, Retribution, and George Ryan's Clemency*, 82 N.C. L. REV. 1345 (2004) (depicting the retributionist nature of the modern criminal justice system).

[44] James L. Nolan, Jr., Commentary, *Redefining Criminal Courts: Problem-Solving and the Meaning of Justice,* 40 AM. CRIM. L. REV. 1541, 1548 (2003).

[45] The United States now incarcerates over two million of its inhabitants, or approximately 1 in every 143 persons. In contrast, England, Italy, France, and Germany have rates of approximately 1 in every 1000. *See* KENNEDY COMM'N, *supra* note 3, at 4; *see also* Jennifer Gonnerman, *Two Million and Counting,* VILLAGE VOICE, Feb. 29, 2000, at 56 (noting that "the U.S. has 5 percent of the world's population . . . [but] 25 percent of its prisoners").

[46] Meekins, *supra* note 8, at 15.

[47] *See* Nolan, *supra* note 44, at 1546.

courts, MHCs, and other such courts were strucured.[48] As such, the academic theories underlying TJ are now codified in the criminal justice systems of cities and towns nationwide.[49]

C. Mental Health Courts: The Herald of a Fundamental Shift in the Criminal Justice System?

The recent growth of MHCs is illustrative of a broader trend — or, perhaps, the reversal of a trend. In a 2003 speech to the American Bar Association (ABA), Justice Kennedy issued a charge to legal practitioners not to forget that the criminal justice system is more than "the process for determining guilt or innocence."[50] Instead, "[a]s a profession, and as a people, [lawyers] should know what happens after the prisoner is taken away."[51] He went on to note that, though "[p]revention and incapacitation are often legitimate goals," it is nevertheless important "to bridge the gap between proper skepticism about rehabilitation on the one hand and the improper refusal to acknowledge that the more than two million inmates in the United States are human beings whose minds and spirits we must try to reach."[52] An ABA committee undertook this charge and presented its recommendations in a 2004 report urging the bar to adopt a greater emphasis on rehabilitation in sentencing.[53] The ABA report did not specifically focus on the situation of mentally ill defendants; its target was general rehabilitation for all offenders for whom such rehabilitation would be effective.[54] This report gave rise to the ABA Commission on Effective Criminal Sanctions, testimony before various state legislatures, and national conferences geared toward developing a more reentry-focused criminal justice system.[55]

Given the positions of such influential legal actors as Justice Kennedy, the ABA, and the scholars and judges cited in this and other pieces, a growing shift in the American criminal justice system is evident — a swing of the pendulum back toward rehabilitation and away from retribution. From an unquestionably retributive system that relies upon

[48] *See id.* at 1545–46; *see also* Peggy Fulton Hora, William G. Schma & John T.A. Rosenthal, *Therapeutic Jurisprudence and the Drug Treatment Court Movement: Revolutionizing the Criminal Justice System's Response to Drug Abuse and Crime in America,* 74 NOTRE DAME L. REV. 439 (1999) (noting drug courts' reliance on TJ principles).

[49] *But cf.* Samuel J. Brakel, *Searching for the Therapy in Therapeutic Jurisprudence,* 33 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT 455, 461 (2007) (chastising mental health professionals for having "bought into" TJ).

[50] KENNEDY COMM'N, supra note 3, at 3.

[51] *Id.*

[52] *Id.* at 5–6.

[53] *Id.* at 24, 32–33.

[54] *See id.* at 9.

[55] *See generally* Criminal Justice Section: ABA Comm'n on Effective Criminal Sanctions (2007), http://www.abanet.org/dch/committee.cfm?com=CR209800 (cataloguing the many new ABA committees and working groups on criminal punishment).

mandatory minimums and restriction of judicial discretion, jail diversion programs and reduced sentences are emerging.[56] Though the dominant retributive regime is clearly still strong,[57] these rehabilitative innovations mark a notable and growing counterpoint.

Even the language of MHCs is fundamentally different from the rhetoric of standard retributive and incapacitative imprisonment justifications. For example, the Anchorage court was set up "to address the needs of mentally disabled misdemeanants."[58] The Brooklyn court exists to "link[] defendants with serious and persistent mental illnesses . . . to long-term treatment as an alternative to incarceration."[59] The federal impetus for expanding the MHC system came from the New Freedom Commission's finding that "[r]elevant Federal programs . . . must . . . better align their programs to meet the needs of adults and children with mental illnesses."[60] An individual involved in an MHC is not a defendant, but a "client" or a "court customer."[61] A problem-solving court judge describes his job not as "imposing punishment but as providing help."[62] In these and other ways, the criminal justice system, through its problem-solving courts, has incorporated the language of psychology — and, quite possibly, its therapeutic goals as well.

MHCs' emphasis on defendant rehabilitation has not been without criticism, both from rights advocates and from scholars. The intimate involvement that MHC judges and prosecutors have with defendants, and the coercive power of the choice between an MHC proceeding and a full trial that might lead to prison, have raised fears about MHCs' neutrality, detachment, and fairness, as well as concerns about due process and individual autonomy.[63] One commentator, concerned that "judicial activists" were using their "new position and influence in government . . . [to] become increasingly powerful

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[56] JON WOOL & DON STEMEN, VERA INST. OF JUSTICE, CHANGING FORTUNES OR CHANGING ATTITUDES? SENTENCING AND CORRECTIONS REFORMS IN 2003, at 1 (2004), http://www.vera.org/publication_pdf/226_431.pdf ("[In 2003,] more than 25 states took steps to lessen sentences and otherwise modify sentencing and corrections policy."). Though the Vera Institute attributes this trend at least in part to concerns about the expense of incarceration, it is likely that the trend also has something to do with rehabilitative justice concerns.

[57] For example, California, which is known for its massive prison population and harsh three-strikes law, also has some of the best-functioning MHCs and other problem-solving courts in the country. This correlation may indicate a difficult internal conflict, as the instinct to punish harshly coexists with the instinct to divert those seen as having less culpability for their actions.

[58] Anchorage MHCs, *supra* note 9 (emphasis added).

[59] Lippman, *supra* note 5, at 826.

[60] NEW FREEDOM COMM'N, *supra* note 35, at 37 (emphasis added).

[61] *See, e.g.*, Randal B. Fritzler, *Ten Key Components of a Criminal Mental Health Court, in JUDGING IN A THERAPEUTIC KEY, supra* note 4, at 118, 118.

[62] Nolan, *supra* note 44, at 1556 (internal quotation marks omitted).

[63] *See supra* note 7; *see also* BRIEF PRIMER, *supra* note 17, at 10–15.

social engineers,"expresses worry that therapeutic courts open the door to judicial "manipulat[ion]," bringing about social change at the expense of individual rights.[64] Another notes that, because of their arguably less rigorous due process safeguards, MHCs risk "de-legitimiz[ing] the justice system" by undermining the protections present in a traditional court.[65]

The questions raised by advocates for the mentally ill and for criminal defendants are extremely important, and will likely structure this debate for years to come. Nevertheless, even in the early stages of the MHC movement, these questions seem to be finding answers. Perhaps most importantly, graduates of MHC programs nationwide have reported their satisfaction with the fairness of the process.[66] The reduction in recidivism rates reported in early studies,[67] an empirical indication that MHCs positively affect their clients' lives, is also telling of MHCs' legitimacy. Thus, despite the potential pitfalls of MHCs, their initial success seems to indicate that the benefits will justify the risks — especially if proper care is taken to ensure that a concern for defendants' rights and well-being remains at the fore.

Furthermore, if society is truly reentering an era of rehabilitative justice, MHCs and other problem-solving courts may only be the beginning. As medical and psychological knowledge progress, the "treatability" standard may broaden as well. If that occurs, there may eventually be substantially fewer limits on the types of disorders the justice system can address. A rehabilitative theory might be precisely what our overburdened system needs.[68] For those who object to the expense of providing such diversionary services to defendants, it is worth noting that, as therapeutic programs and focuses grow, a corresponding drop in the cost of imprisonment due to reduced recidivism will also result.[69] Thus, the idea of MHCs, and of problem-solving courts in general, is one that can appeal to many ideological perspectives.

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[64] Frank V. Williams, III, *Reinventing the Courts: The Frontiers of Judicial Activism in the State Courts,* 29 CAMPBELL L. REV. 591, 592–96 (2007).

[65] Faraci, *supra* note 12, at 838–39. *But see* Greg Berman, Comment, *Redefining Criminal Courts: Problem-Solving and the Meaning of Justice*, 41 AM. CRIM. L. REV. 1313, 1314 (2004) (theorizing that inattention to due process in MHCs and other problem-solving courts may instead be endemic to the broader criminal justice system, and could in fact be lessened in the MHCs by the increased scrutiny brought about by their experimental natures).

[66] *See* BROOKLYN EVALUATION, *supra* note 30, at 39–42; NEISWENDER, *supra* note 29, at 9–10.

[67] *See supra* p. 1173.

[68] For a discussion on MHCs' potential to ease judicial strain, *see* sources cited *supra* note 31.

[69] *See, e.g.*, M. SUSAN RIDGELY ET AL., RAND, JUSTICE, TREATMENT, AND COST: AN EVALUATION OF THE FISCAL IMPACT OF ALLEGHENY COUNTY MENTAL HEALTH COURT 33 (2007) (noting that "over the longer term, the MHC program may actually result in net savings to government, to the extent that MHC participation . . . [reduces] criminal recidivism"), *available at* http://www.rand.org/pubs/technical_reports/2007/RAND_TR439.pdf.

Both opponents and proponents of a therapeutic approach to criminal justice agree: for good or ill, the trend toward problemsolving courts is increasing, and is fundamentally changing the way we think about justice.[70] No longer are courts solely places where punishment is meted out. Instead, some now employ holistic solutions aimed at solving the problem of the mentally ill misdemeanant recidivist before it truly begins. Far from punishing people who commit crimes because of their illness, MHCs provide treatment for mentally ill individuals who otherwise would not have access to (or realize their need for) therapy. MHCs also decrease the overall amount of money being spent on imprisonment, thus allaying taxpayers' concerns. Furthermore, the statistics show dramatic drops in recidivism for those who complete the programs, indicating that MHCs are achieving positive results both for the criminal justice system and for the mentally ill individuals they endeavor to help.

Many problems with MHCs remain to be solved, such as the disposition of violent but untreatable mentally ill offenders and others for whom rehabilitation would not be effective. However, it seems reasonable that the criminal justice system is beginning to trend toward a more rehabilitative focus for misdemeanants, and possibly for felons as well. If the problem-solving court experiment succeeds and becomes widely accepted, what might the next step be? If the emphasis is truly on rehabilitation, evidence suggests the potential usefulness of educational courts for young adult offenders, lifestyle-altering programs for interested inmates,[71] or other (even more controversial) programs[72] targeting specified communities that might be effectively rehabilitated. As medical and psychological understanding increases, the boundaries of realistic rehabilitation are pushed ever outward. Such considerations will continue to drive judges, legislatures, attorneys, and voters as the struggle to define the modern criminal justice system continues.

VII. VOTING RIGHTS AND THE MENTALLY INCAPACITATED

During a 1988 subcommittee hearing in the House of Representatives on the Americans with Disabilities Act, the chairwoman of the Rhode Island Governor's Commission on the Handicapped testified:

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70 *See, e.g.*, Williams, *supra* note 64, at 642 ("[T]he goal is to extend therapeutic techniques to the entire judicial system based upon the belief that the role of judges has changed from that of a dispassionate, disinterested magistrate to the role of a sensitive, caring counselor.").

71 *See, e.g.*, Glenn D. Walters, *Recidivism in Released Lifestyle Change Program Participants,* 32 CRIM. JUST. & BEHAV. 50, 58 (2005) (noting a fifteen-percent recidivism reduction for program participants).

72 For example, faith-based prisons such as Prison Fellowship's Carol Vance Unit in Texas. *See* The InnerChange Freedom Initiative, Program Details: Texas, http://www.ifiprison.org/generic.asp?ID=977 (last visited Jan. 12, 2008).

> I spoke to one of the social workers who came to me and explained to me that in the group homes, the people who were running the group homes . . . were deciding who they deemed competent to vote and who they deemed not competent. They were not telling all the people about this opportunity to be registered.[1]

Such arbitrary methods for deciding who gets to vote seem antithetical to the idea of a democracy, where all who are able should have a voice in the election of their leaders. However, the legitimacy of excluding certain citizens from voting because of their mental status has rarely been discussed or debated with any rigor. Federal law leaves the whole practice of disenfranchisement of the mentally incapacitated to the states, simply stating, "[T]he name of a registrant may not be removed from the official list of eligible voters except . . . as provided by State law, by reason of criminal conviction or mental incapacity."[2] Pursuant to this law, over forty states have constitutional or statutory provisions that disenfranchise the mentally disabled. In defining which people with mental disabilities lose their right to vote, most states use terminology that is vague, inconsistent, or outdated, and most do not directly address the capacity to vote. Instead, they use some proxy classification for disenfranchisement.

Fortunately, developments in the law of elections and of disability rights suggest that states may be reversing course on the arbitrary disenfranchisement of mentally incapacitated persons. Several states have reformed their disenfranchisement provisions, although these reforms are inconsistent and often not sufficiently comprehensive. A couple of federal cases have held that governments must provide fair access to voting or other "fundamental rights" of the disabled, and if there is not fair access, that individuals have a cause of action against the state. By capitalizing on the reasoning of these decisions, advocates for the disabled may be able to gain even more ground for the enfranchisement of the mentally incapacitated.

1 *Oversight Hearing on H.R. 4498, Americans with Disabilities Act of 1988: Hearing of the Subcomm. on Select Educ. of the Comm. on Educ. and Labor,* H.R., 100th Cong. 189 (1989) (statement of Nancy Husted-Jensen, Chairwoman, Governor's Comm'n on the Handicapped, Providence, R.I.).

2 National Voter Registration Act of 1993, 42 U.S.C. § 1973gg-6(a)(3), (a)(3)(B) (2000). This Part will use the term "mentally incapacitated" to refer to those with such severe mental disorders that they may be subject to some form of civil rights limitation, such as being placed under guardianship. This reference includes both the mentally ill and those incapacitated for other reasons, such as mental retardation.

A. The State of States' Laws

As of 2000, forty-four states disenfranchised the mentally incompetent, most often through their state constitutions.[3] Only a few of them did this through narrow statutory provisions tailored directly to voting capacity. Instead, nine states simply disenfranchised those under guardianship.[4] Fifteen used outdated language that "restrict[ed] voting by 'idiots,' the 'insane,' or 'lunatics.'"[5] Even those few that dealt directly with the capacity to vote did not generally identify any standard by which that capacity should be measured before the franchise is revoked.[6]

Granted, states have a compelling interest in ensuring that voters understand the election process at least well enough to make an independent choice about whom to vote for.[7] States also have an interest in minimizing abuses of the system that arise through voter fraud from caregivers and absentee ballot systems

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3 Kay Schriner et al., *Democratic Dilemmas: Notes on the ADA and Voting Rights of People with Cognitive and Emotional Impairments*, 21 BERKELEY J. EMP. & LAB. L. 437, 439, 456 tbl.2 (2000).

4 *See* Kingshuk K. Roy, Note, *Sleeping Watchdogs of Personal Liberty: State Laws Disenfranchising the Elderly,* 11 ELDER L.J. 109, 116 n.46 (2003) (listing ten statutes). An opinion of the Attorney General of Alaska, which states that disenfranchisement must be determined in a separate proceeding, qualifies as a narrowly tailored provision that limited the state's broad stat-te. *See* infra note 19. Guardianship is an involuntary procedure by which a person is deemed incapable of making day-to-day decisions and is either put into a group home run by the state or put under the authority of another person who "assumes the power to make decisions about the ward's person or property." BLACK'S LAW DICTIONARY 726 (8th ed. 2004) (defining "guardianship").

5 Paul S. Appelbaum, "*I Vote. I Count": Mental Disability and the Right to Vote,* 51 PSYCHIATRIC SERVICES 849, 849 (2000).

6 Jason H. Karlawish et al., *Addressing the Ethical, Legal, and Social Issues Raised by Voting by Persons with Dementia,* 292 J. AM. MED. ASS'N 1345, 1346 (2004). By 2004, ten states had statutes that specifically addressed voting capacity: California, Connecticut, Florida, Hawaii, Iowa, Massachusetts, New Mexico, Ohio, Oregon, and Wisconsin. *See id.*; Kay Schriner & Lisa A. Ochs, *Creating the Disabled Citizen: How Massachusetts Disenfranchised People Under Guardianship,* 62 OHIO ST. L.J. 481, 485 (2001).

7 That this is a compelling state interest with respect to strict scrutiny review seems to be al- most universally accepted by disability rights advocates and other interested parties. *See, e.g.*, Henry G. Watkins, *The Right To Vote of Persons Under Guardianship — Limited and Otherwise* (Ariz. Ctr. for Disability Law, Oct. 11, 2006), *available at* http://acdl.com/GUARDIANSHIP%20 AND%20 VOTING.htm (noting without comment that "those incapable of exercising the right to vote may be declared ineligible"); *see also* Doe v. Rowe, 156 F. Supp. 2d 35, 51 (D. Me. 2001) ("Additionally, for purposes of summary judgment, the parties agree that Maine has a compelling state interest in ensuring that 'those who cast a vote have the mental capacity to make their own decision by being able to understand the nature and effect of the voting act itself.'"). *But see* Roy, *supra* note 4, at 117–18 (noting that "there are many uninformed voters who will vote . . . without exercising what most people would consider amounts to reasonable judgment" and claiming therefore that laws that discriminate against the mentally incapacitated are "either grossly underinclusive or simply discriminatory").

used by the mentally incapacitated.[8] However, those state interests do not overcome the fact that not all those who are deemed mentally incapacitated in general are specifically incompetent to vote.

Equal access to voting is a fundamental constitutional right,[9] and therefore voting rights of an otherwise qualified adult should not be denied except as the narrowly tailored consequence of a compelling state interest.[10] It seems almost a tautology, but those who can vote should be allowed to, and those who cannot should not. However, the prevalent methods of removing voting rights do not determine effectively or fairly the capacity to vote — the only capacity relevant either to the individual's fundamental right or the state's interest in fair elections. Rather, most states make disenfranchisement decisions by proxy variables, such as guardianship or being deemed generally incompetent. Their current procedures have been severely criticized in both the legal and medical communities.[11] The main point these advocates make is that the right to vote should not be denied categorically on the basis of some general classification of mental disability, such as a defi- nition of "mental incapacity" adopted by a probate court.[12] If a person has opinions about and can understand voting, that person should be allowed to vote, even if he does not have the capacity to carry out other parts of his life independently.[13]

In response to this advocacy, states slowly have begun to tailor disenfranchisement more narrowly to the real capacities of their citizens. One broad innovation distinguishes between different levels of mental capacity in the context of guardianship by creating a lesser classification called limited guardianship, whereby a person is deemed

8 *See* Karlawish et al., *supra* note 6, at 1347–48.

9 *See*, e.g., Wesberry v. Sanders, 376 U.S. 1, 17 (1964) ("No right is more precious in a free country than that of having a voice in the election of those who make the laws under which, as good citizens, we must live.").

10 *See* Dunn v. Blumstein, 405 U.S. 330, 336–37 (1972).

11 *See*, e.g., ROBERT M. LEVY & LEONARD S. RUBENSTEIN, THE RIGHTS OF PEOPLE WITH MENTAL DISABILITIES 293 & 324 nn.50–51 (1996) (arguing that the constitutional right to vote should apply to institutionalized persons); Appelbaum, *supra* note 5, at 849 (describing criticism of state disenfranchisement laws); Karlawish et al., *supra* note 6, at 1346–47 (advocating voting procedures that assess decisionmaking ability on a "specific functional capacit[y]" basis); Watkins, *supra* note 7 ("[S]uch a determination [of ineligibility to vote] must be based on an individualized assessment. Any process that denies the right to vote must . . . not extend[] this bar to those who may be capable of voting.").

12 Professor Karlawish and his coauthors also advocate for a specific determination of voting capacity that is defined by whether the individual understands what voting is and what a vote will mean in that process. *See* Karlawish et al., *supra* note 6, at 1346–47.

13 Instead, several states lump voting capacity with other mental abilities and treat capacity as an all-or-nothing proposition. *See, e.g.*, Doe v. Rowe, 156 F. Supp. 2d 35, 39 (D. Me. 2001) ("Although [the plaintiff] understood the nature and effect of voting such that she could make an individual decision regarding the candidates and questions on the ballot, the Maine Constitution prohibited Jane Doe from voting because she was under guardianship by reason of mental illness."); *id.* at 39–41 (describing similar mental capacities for the other plaintiffs).

incapacitated and put under guardianship with respect to some rights but not others. Almost all states offer this type of guardianship,[14] though many older state disenfranchisement provisions do not directly deal with the distinction between full and limited guardianship.[15] In response to this discrepancy, state courts have attempted to use the notion of limited guardianship to cabin disenfranchisement provisions, finding that rules removing voting rights from individuals under guardianship refer only to those under full guardianship.

But the introduction of limited guardianship does not completely remove the problem of overbroad denials of the right to vote. Courts still impose full guardianships for a myriad of reasons, which means that some people who understand voting and have opinions on which to base a vote might be denied the right to vote for simply falling on the wrong side of the line between limited and full guardianship. As noted by the federal district court in *Doe v. Rowe*,[16] denying voting rights to all mentally incapacitated people under full guardianship could still result in unjustified removals of voting rights: "For example, a person placed under guardianship for an eating disorder could be disenfranchised because they are, in fact, considered to be suffering from a form of mental illness."[17]

More substantial reform has occurred in the context of laws specifically dealing with voting incapacity, as some states have worked to remove over and under inclusive terminology from their laws.[18] In the 1990s, Alaska and California determined that courts must make individual determinations about voting capacity before disenfranchising anyone.[19] In 2003, Minnesota changed its law from one automatically

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[14] John W. Parry & Sally Balch Hurme, *Guardianship Monitoring and Enforcement Nationwide,* 15 MENTAL & PHYSICAL DISABILITY L. REP. 304, 304 (1991).

[15] Watkins, *supra* note 7.

[16] 156 F. Supp. 2d 35.

[17] *Id.* at 55. Even when a probate court tries to prevent improper disenfranchisement, broad statutes or constitutional provisions can still cause problems. In *Missouri Protection & Advocacy Services, Inc. v. Carnahan*, 499 F.3d 803 (8th Cir. 2007), a man under full guardianship was mistakenly prevented from voting because of Missouri's constitutional provision even though his guardianship order expressly allowed him to vote. *Id.* at 811.

[18] *See* TRANSITION ELECTION WORK GROUP, OFFICE OF THE MARYLAND GOVERNOR,ELECTION WORK GROUP REPORT 14 (2007), *available at* http://www.governor.maryland.gov documents/transition/Elections.pdf. Indeed, in *Doe v. Rowe*, the court noted that the very election in which the plaintiffs had been barred from voting included a ballot question asking, "Do you favor amending the Constitution of Maine to end discrimination against persons under guardian- ship for mental illness for the purpose of voting?," which failed. 156 F. Supp. 2d at 38 n.3.

[19] These two states' reforms occurred in 1992 and 1990, respectively. *See* 1992 Alaska Op. Att'y Gen. No. 123, 1992 Alaska AG LEXIS 74, at *3 (Aug. 28, 1992); Act of May 1, 1990, ch. 79, sec. 14, § 1910, 1990 Cal. Stat. 458, 549 (codified as amended at CAL. PROB. CODE § 1910 (West 2002)). These states' processes are still imperfect; Alaska's does not outline how that

disenfranchising those under guardianship to one disenfranchising them only after judicial proceedings that specifically revoke their right to vote.[20] In November 2007, New Jersey voters approved amending the state constitution's provision that restricts the right to vote "by deleting the phrase 'idiot or insane person' and providing instead that a 'person who has been adjudicated by a court of competent jurisdiction to lack the capacity to understand the act of voting' shall not enjoy the right of suffrage."[21]

Other states have not fully moved to a narrowly tailored system that assesses a person's capacity to vote, but have at least moved toward less egregious disenfranchisement processes. In 2001, Delaware removed a reference to "idiot[s] and insane person[s]" from its constitution, making the right to vote contingent instead on being "adjudged mentally incompetent."[22] Nevada's voters approved a similar amendment in 2004.[23] These changes may not significantly alter the number of disenfranchised persons, but they signal that those states recognize that the old terminology is vague, offensive, and not narrowly tailored to an individual assessment of competence. Also in 2004, Louisiana made it clear that only those under full guardianship would have their voting rights revoked automatically, rather than anyone under any kind of guardianship,[24] and in 2006, Wisconsin changed its law to give courts the discretion to declare even persons under full guardianship competent to vote.[25]

However, those changes do not do enough, and several other states have yet to change their disenfranchisement clauses and statutes at all. The constitutions of Iowa, Mississippi, and New Mexico still exclude "idiots and insane" persons from

capacity should be measured, and California's standard measures the ability to fill out a voter registration form, rather than determining a person's true capacity to vote.

[20] Uniform Guardianship and Protective Proceedings Act, ch. 12, art. 1, § 37(c)(8), art. 2, § 2, 2003 Minn. Laws. 116, 140, 166 (codified as amended at MINN. STAT. §§ 524.5-313(c)(8), 201.014(2)(b) (2006)).

[21] S. Con. Res. 134, 212th Leg., 2d Reg. Sess., at 3 (N.J. 2007) (enacted), *available at* http://www.njleg.state.nj.us/2006/Bills/SCR/134_I1.pdf (amending N.J. CONST. art. II, § 1(6)). The ballot measure passed with almost sixty percent of the vote. See N.J. Office of the Att'y Gen., Ballot Questions Tally for November 2007 Election, at 4 (Dec. 3, 2007), http://www.nj.gov/oag/elections/2007results/07general-election/07-official-general-election-tallies(pub-ques)-12.3.07. pdf.

[22] Act of May 8, 2001, ch. 99, 73 Del. Laws 591 (amending DEL. CONST. art. V, § 2).

[23] Assemb. J. Res. 3, 2003 Leg., 72nd Sess. (Nev. 2003), 2003 Nev. Stat. 3726 (amending NEV. CONST. art. II, § 1); Nev. Sec'y of State, 2004 Official General Election Results: State Question 7 (Nov. 2, 2004), http://sos.state.nv.us/elections/results/2004General/ElectionSummary.asp (54.3% of voters approved the amendment).

[24] Act of June 25, 2004, No. 575, § 1, 2004 La. Acts 1955, 1955–56 (codified at LA. REV. STAT. ANN. § 18:102 (2004 & Supp. 2007)).

[25] Act of May 10, 2006, No. 387, § 1, 2005 Wis. Sess. Laws 1332, 1333 (codified as amended at WIS. STAT. ANN. § 6.03(1)(a) (West 2004 & Supp. 2007)). Under prior Wisconsin law, courts could preserve the right to vote only for persons under limited guardianships.

voting.[26] The Maryland and Massachusetts constitutions refer to guardianship as the only criterion necessary to disenfranchise the mentally disabled.[27] Arkansas even seems to have gone backwards: prior to 2001, voting rights could be denied only with express court approval; since 2001, an incapacitated person under guardianship must receive express court approval to be authorized to vote.[28] In sum, most states still do not recognize the right to vote for those who are mentally incapacitated but who retain the mental ability to vote.

B. Judgments Facilitating Advocacy

With so many states still disenfranchising mentally incompetent or mentally incapacitated people through arbitrary and imprecise methods, advocates are turning to courts to help change state laws. In 2001, the U.S. District Court for the District of Maine ruled that the Maine Constitution violated the Fourteenth Amendment of the U.S. Constitution by "prohibiting voting by persons under guardianship for mental illness."[29] Three years later, the Supreme Court set the stage for further litigation over disenfranchisement provisions by upholding Title II of the Americans with Disabilities Act of 1990[30] (ADA) as a valid exercise of Congress's power to provide a right of action against states (and thereby abrogate state sovereign immunity) when state laws fail to protect "fundamental rights" — a category that may include the right to vote.[31] Analyzed together, these cases form a foundation for constructing new state law that reflects more accurately the protection of voting rights demanded by the Constitution and the ADA.

Leading up to the 2000 elections, three mentally ill Maine women under full guardianship were denied the right to vote.[32] The probate courts that put the women under guardianship did not specifically consider the right to vote as a distinct inquiry in their decision, nor did they notify the women that their right to vote would be automatically suspended when they were put under full guardianship.[33] One of the three women,

[26] IOWA CONST. art. II, § 5; MISS. CONST. art. 12, § 241; N.M. CONST. art. VII, § 1.

[27] *See* MD. CONST. art. I, § 4 ("The General Assembly by law may regulate or prohibit the right to vote of a person . . . under care or guardianship for mental disability."); *see also* MASS. CONST. amend. III (outlining a similar disenfranchisement provision).

[28] *Compare* ARK. CODE ANN. § 28-65-302(a)(1)(E) (2007) (provisions applying before October 2001), *with id.* at (a)(2)(E) (provisions applying after that date).

[29] Doe v. Rowe, 156 F. Supp. 2d 35, 37 (D. Me. 2001).

[30] 42 U.S.C. §§ 12131–12165 (2000).

[31] Tennessee v. Lane, 541 U.S. 509 (2004); *see also* Michael E. Waterstone, Lane, *Fundamental Rights, and Voting*, 56 ALA. L. REV 793, 807 (2005).

[32] *See* Doe, 156 F. Supp. 2d at 39–40.

[33] *See id.* at 39–41.

a thirty-three-year-old with bipolar disorder,[34] sought to regain her right to vote before the election and was granted a modification to her guardianship giving her back that right.[35] The other women were not able to obtain such modifications before the 2000 elections, even though their psychiatrists concluded that they had the mental capacity to vote.[36] After being prohibited from voting, they sued, claiming that the state constitution's disenfranchisement provision violated the Fourteenth Amendment of the U.S. Constitution.[37]

Maine's constitution states that only "persons who are 'under guardianship for reasons of *mental illness*' are prohibited from registering to vote or voting in any election."[38] By the time of litigation, both the plaintiffs and the State realized that much of the case turned on who qualified as mentally ill, since this classification was narrower than that of all the people who are sufficiently incapacitated for whatever reason to be under guardianship. The term "mentally ill" generally includes only people with mental disorders,[39] while incapacitated persons under guardianship in Maine can include anyone "who is impaired by reason of mental illness, mental deficiency, physical illness or disability, chronic use of drugs, chronic intoxication or other cause except minority to the extent he lacks sufficient understanding or capacity to make or communicate responsible decisions concerning his person."[40] Realizing that simultaneously prohibiting mentally ill persons under guardianship from voting and allowing persons under guardianship for other reasons (such as mental retardation) to vote was discriminatory, the State posited that "mentally ill" in the Maine Constitution was meant to include all sorts of mental disabilities.[41] The State argued that this broad definition was

[34] "Bipolar disorder is a recurrent mood disorder featuring one or more episodes of mania or mixed episodes of mania and depression." U.S. DEP'T OF HEALTH & HUMAN SERVS., MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL 246 (1999) [hereinafter SURGEON GENERAL'S REPORT], *available at* http://www.surgeongeneral.gov/library/mentalhealth/pdfs/c4. pdf.

[35] Doe, 156 F. Supp. 2d at 39.

[36] *Id.* at 40–41.

[37] *Id.* at 39.

[38] *Id.* (emphasis added) (quoting ME. CONST. art. 2, § 1). This terminology only entered the Maine Constitution in 1965; prior to that amendment, the Constitution had disenfranchised "paupers and persons under guardianship." *Id.* at 38–39 (internal quotation marks omitted).

[39] According to the Surgeon General, "Mental illness is the term that refers collectively to all diagnosable mental disorders. Mental disorders are health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning." SURGEON GENERAL'S REPORT, *supra* note 34, at 5.

[40] *Doe,* 156 F. Supp. 2d at 42 (quoting ME. REV. STAT. ANN. tit. 18-A, § 5-101(1) (1997)) (in- ternal quotation marks omitted).

[41] This argument rested at least partly on the fact that in the 1950s, the Maine legislature had defined "insane person" to "include idiotic, non compos, lunatic or distracted persons," and in 1959 had passed legislation changing the words "insane" and "insanity" to "mentally ill" and "mental illness" throughout Maine's statutes. The State asserted that the 1959 meaning of

incorporated into the Maine Constitution, even though the 1999 Maine Secretary of State's "Guide to Voter Registration Laws and Procedures" stated that "[t]he law does not restrict people under guardianship for reasons other than mental illness from voting."[42] The court admonished the State for trying to define "mental illness" broadly even though there was no indication that the broad definition had ever been the one followed by the State,[43] and proceeded to reject the disenfranchisement provision on two grounds.

First, the court held that the provision violated procedural due process under the Fourteenth Amendment because the practice of probate courts failed to "ensure[] uniformly adequate notice regarding the potential disenfranchising effect of being placed under guardianship."[44] Second, the court held that the provision violated the Equal Protection Clause because guardianship for reasons of mental illness was an inadequate proxy for the capacity to vote.[45] Since voting is a fundamental right, the provision was analyzed under strict scrutiny,[46] and the Court could find no definition of "mentally ill" that would correlate closely enough to the state's interests in fair elections to pass the requirements of the Equal Protection Clause.[47]

While *Doe v. Rowe* outlined the policy and constitutional reasons why a state should disenfranchise a person only after a specific determination of that person's incapacity to vote, most other states' provisions do not have the same problems of inadequate notice or the direct discrimination against the "mentally ill" that gave rise to the constitutional issues in that case. As a result, *Doe v. Rowe* provides only a few states with a strong reason to change their laws. However, in 2004, the Supreme Court's decision in *Tennessee v. Lane*[48] opened the door for litigation in other states by ruling that the abrogation of state sovereign immunity under Title II of the ADA was valid insofar as it applied to cases implicating a fundamental right.[49]

"mentally ill" included a broad assortment of mental disabilities, and that the same definition would have applied in 1965 when the Maine Constitution was amended to disenfranchise those under guardianship for mental illness. *Id.* at 53.

42 *Id.* at 44.

43 *Id.* at 46.

44 *Id.* at 50.

45 *Id.* at 54. The class of people "under guardianship for reasons of mental illness" includes plenty of people who have the capacity to vote, and excludes people who are clearly incapable of voting but not under guardianship for reasons of *mental illness. Id* at 55; *see also id.* ("For example, it would be illogical to say that a person who slips into a coma or persistent vegetative state as a result of a physical injury or ailment was 'mentally ill' . . . .").

46 *Id* at 51.

47 *Id* at 56.

48 541 U.S. 509 (2004).

49 *Id.* at 533–34.

Lane involved two paraplegic individuals who were unable to reach courtrooms above the ground floor. George Lane was a criminal defendant who was compelled to appear before the court on the second floor of a county courthouse with no elevator.[50] "At his first appearance, Lane crawled up two flights of stairs to get to the courtroom," but when he returned for a hearing, he refused to crawl or be carried up.[51] He was arrested and jailed for failure to appear.[52] The other plaintiff, Beverly Jones, was a court reporter who had lost work for not being able to access upstairs courtrooms.[53] Both sued under Title II of the ADA, "claim[ing] that they were denied access to, and the services of, the state court system by reason of their disabilities."[54]

From this description, Lane seems to have very little to do with voting rights and the mentally incapacitated. However, the case applies to this topic because the Court decided that states' sovereign immunity was properly abrogated by Title II of the ADA,[55] which prohibits discrimination against otherwise qualified persons with disabilities with respect to public works, including any department or instrumentality of a state or local government.[56] The Court ruled that the abrogation was appropriate under the ADA "as applied to the class of cases implicating the fundamental right of access to the courts,"[57] which suggests that Title II actions can now be brought against other discriminatory laws, such as state disenfranchisement provisions, that affect fundamental rights.[58]

Lane is also relevant because for "a case not about voting, it is striking that it mentions voting as an example of a fundamental right covered by the ADA no less than five times."[59] Future litigators can point to the Court's concern about several categories of discrimination other than courtroom access that it weighed in its analysis, including

50 *Id.* at 513–14.

51 *Id.* at 514.

52 *Id.*

53 *Id.*

54 *Id* at 513.

55 *See id.* at 533–34.

56 42 U.S.C. §§ 12131–12132 (2000).

57 *See* Lane, 541 U.S. at 533–34.

58 Indeed, this issue was also litigated in *Doe v. Rowe*, as it was then an open question. The ADA's definition of "qualified individual" requires that the person "meet[] the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by a public entity," 42 U.S.C. § 12131, and in noting that the plaintiffs would have to be qualified individuals under the Act for their claim to succeed, the *Doe* court tacitly conceded that some mentally incapacitated persons would not be eligible to vote. Doe v. Rowe, 156 F. Supp. 2d 35, 58–59 (D. Me. 2001). However, the court declined to define "what level of mental capacity may be considered an 'essential eligibility criteri[on],'" saying instead that whatever that level might be, the past application of the provision by the State had been discriminatory and in violation of the ADA. Id. at 59.

59 Waterstone, *supra* note 31, at 796 & n.15.

a "pattern of unequal treatment in the administration of a wide range of public services, programs, and activities, including the penal system, public education, and voting."[60] Though *Lane* focused on the fundamental right to courtroom access, the Court's reasons for protecting that right also apply to voting; as the Court previously determined in *Wesberry v Sanders*,[61] the right to vote is a fundamental right[62] and therefore deserves a heightened level of protection.

The *Lane* Court also provided powerful historical policy arguments for why such protections are necessary, analyzing disability discrimination in general and pointing out a history of discrimination against the mentally incapacitated. Though *Lane* was a case about physical disabilities, the Court's accounts of state-induced discrimination and unequal treatment included discussion of unjustified commitment and the abuse and neglect of persons committed to state mental health facilities, as well as state laws that "categorically disqualify[] 'idiots' from voting" or marrying.[63] The Court found that the "sheer volume of evidence demonstrating the nature and extent of unconstitutional discrimination against persons with disabilities in the provision of public services"[64] justified the ADA's requirements. Such reasoning implies that when dealing with a fundamental right, states should be particularly sensitive to the full history of discrimination against the disabled before broadly disenfranchising whole classes of people.

C. What's Next?

As described above, many states still have vague, confusing, or downright discriminatory provisions when providing for the disenfranchisement of the mentally incapacitated. Those statutes and constitutional provisions are unclear about the definitions of "disability," "mental illness," "mental incapacity," and "incapacity to vote." These ideas are all distinct, but are rarely distinguished. Instead, most states simply choose one term or another without definition or explanation. Current state constitutions disenfranchise citizens based on categories ranging from "idiots" and "insane persons,"[65] to those who are not "of a quiet and peaceable behavior,"[66] to those under guardianship,[67] to those who are mentally incompetent[68] or under guardianship because

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[60] *Lane*, 541 U.S. at 525 (footnotes omitted).

[61] 376 U.S. 1 (1964).

[62] *See id.* at 17.

[63] Waterstone, *supra* note 31, at 821 (citing Lane, 541 U.S. at 524).

[64] *Lane*, 541 U.S. at 528.

[65] *See, e.g.*, IOWA CONST. art. II, § 5; MISS. CONST. art. 12, § 241; N.M. CONST. art. VII, § 1.

[66] VT. CONST. ch. II, § 42.

[67] *E.g.,* MD. CONST. art. I, § 4; MASS. CONST. amend. III.

[68] *See, e.g.*, ALA. CONST. art. VIII, § 177(b); N.D. CONST. art. II, § 2; S.C. CONST. art. II, § 7; UTAH CONST. art. IV, § 6; WYO. CONST. art. 6, § 6.

of mental incapacity[69] or adjudicated to be "incapacitated."[70] Even federal law switches back and forth between separating mental and physical disabilities and incapacities and lumping them together.[71] This ambiguity can be discouraging for advocates of voting rights for mentally incapacitated people who nonetheless have the capacity to vote; so many varying definitions mean that states and courts can pick and choose which definitions to use.[72]

After *Doe* and *Lane*, litigation is one possible avenue for changing these laws. The *Lane* decision can extend *Doe* beyond Maine's peculiar constitutional provision by allowing a private right of action for money damages under Title II of the ADA with respect to state violations of fundamental rights.[73] As a result, there is much promise for litigation in other districts in states that still constitutionally or statutorily endorse discrimination against the mentally incapacitated.

Doe's and *Lane's* reasoning can also be used in legislative, rather than litigious, advocacy. In addition to the medical arguments about why general incapacity does not equal the incapacity to vote, *Doe* provides persuasive arguments about why disenfranchisement should be done on an individual basis. Both cases review the long histories of voting discrimination and discrimination against the disabled, which indicate just how important it is for disenfranchisement provisions to be clearly written and fairly applied in order to prevent further discrimination. In addition, the specter of adverse court rulings may loom large enough to impel some change from state legislatures; as noted above, one could infer from *Lane* that voting is fundamental enough, and past history discriminatory enough, to *require* specific and narrowly tailored procedures for disenfranchising the mentally incapacitated.

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[69] *See, e.g.*, MO. CONST. art. VIII, § 2.

[70] *E.g.*, ARIZ. CONST. art. VII, § 2(C).

[71] *Compare* National Voter Registration Act of 1993, 42 U.S.C. § 1973gg-6(a)(3)(B) (2000), *with* Help America Vote Act of 2002, 42 U.S.C. § 15461 (Supp. IV 2004) (directing the Secretary of Health and Human Services to "ensure full participation in the electoral process for individuals with disabilities," a category that presumably includes both physical and mental disabilities).

[72] *Cf.* Christina J. Weis, Note, *Why the Help America Vote Act Fails To Help Disabled Americans Vote, 8* N.Y.U. J. LEGIS. & PUB. POL'Y 421, 447–50 (2005) (arguing that the Act's vague (or nonexistent) definition of the disabled voter could lead to underinclusive state protections).

[73] Before *Lane*, courts were divided as to whether Title II claims properly abrogated state sovereign immunity. *Compare* Alsbrook v. Maumelle, 184 F.3d 999, 1007–10 (8th Cir. 1999) (en banc) (prohibiting a Title II claim for money damages because of the state's sovereign immunity), *and* Reickenbacker v. Foster, 274 F.3d 974, 985 (5th Cir. 2001) (same), *with* Garcia v. SUNY Health Scis. Ctr. of Brooklyn, 280 F.3d 98, 112 (2d Cir. 2001) (allowing a claim for money damages, albeit only in cases of "discriminatory animus or ill will due to disability"). *Lane* resolved this debate, at least to the extent that the Title II claims implicate fundamental rights. *See, e.g.*, Pace v. Bogalusa City Sch. Bd., 403 F.3d 272, 277 n.14 (5th Cir. 2005).

Finally, while the varying definitions and justifications for disenfranchisement may at first seem frustrating, that variation suggests that courts' and state legislatures' ideas about disenfranchisement of the mentally disabled are vague and unexplored, and therefore ripe for change. Diligent advocates may be able to convince lawmakers to take lessons learned from the civil rights struggles of one type of disability discrimination and apply them to another. For example, recently realized rights of the physically disabled might be translated into furthering the rights of the mentally disabled. Some states already evaluate both mental and physical disabilities together when informing the public about the right to vote by persons with disabilities.[74] Indeed, Lane also lumped mental and physical disabilities together in explaining why the ADA's abrogation of state sovereign immunity was appropriate, suggesting that accommodations and special procedures afforded to the physically disabled were justified partly because of the historical injustices against the mentally disabled.[75] It seems only fair that if past injustices against the mentally disabled should result in accommodations for the physically disabled, they should also translate into similar accommodations for the mentally disabled. By stressing the importance of making determinations based on capacity to vote rather than general mental capacity or some other proxy for capacity (such as guardianship), advocates may be able to remove the "uncertainty, inconsistency, and apparent confusion"[76] in the interpretation of states' voting laws, allowing states to disenfranchise those who truly lack the mental capacity to vote while ensuring that those who understand voting can vote.

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[74] *See, e.g.*, Conn. Office of Prot. & Advocacy for Pers. with Disabilities, Your Rights as a Voter with a Disability (Oct. 31, 2004), http://www.ct.gov/opapd/cwp/view.asp?a=1759&q=284882.

[75] *See* Tennessee v. Lane, 541 U.S. 509, 524–25 (2004).

[76] Mo. Prot. & Advocacy Servs., Inc. v. Carnahan, 499 F.3d 803, 807 (8th Cir. 2007).

INITIATION OF INVOLUNTARY COMMITTMENT PROCEDURES
EMERGENCY (Out of Court)

Relevant Statues/Rules/Cases/Forms

AS 47.30.705 EMERGENCY DETENTION FOR EVALUATION
AS 47.30.710 EXAMINATION
AS 47.30.720 RELEASE BEFORE EXPIRATION OF 72 HOUR PERIOD
AS 47.30.725 COMMITMENT PROCEDING RIGHTS: NOTIFICATION
AS 47.30.915 GRAVELY DISABLED
Wetherhorn v. API, 156 P.3d 371 (Alaska 2007) (requirements for "gravely disabled")
Wayne B. v. API, Supreme Court, S-12677, August 29, 2008
AK Rule of Probate 2 Appointment and Authority of Masters

FORMS
MC-100 Petition for Initiation of Involuntary Commitment
MC-105 Peace Officer's/Mental Health Professional's Application for Examination (POA)
MC-400 Notice of Respondent's Arrival at Evaluation Facility
MC-405 Notice of Rights Upon Detention for Evaluation
MC-300 Order for Screening Investigation.
MC-305 Temporary Order for Emergency Examination/Treatment (ex parte)
MC-405 Notice of Rights Upon Detention for Evaluation

EMERGENCY (out of court) DETENTION FOR EVALUATION

- a peace officer, an Alaska licensed psychiatrist, physician, or clinical psychologist or a federal employee psychiatrist or physician who has **probable cause** to believe that a person is gravely disabled or is suffering from mental illness **and** is likely to cause serious harm to self or others of such an immediate nature that considerations of safety do not allow initiation of involuntary commitment procedures set out in AS 47.30.700 may cause the person to be taken into protective custody and delivered to the nearest evaluation facility for an emergency evaluation. AS 47.30.705(a). (See Appendix 1 Mentally Ill)
- a peace officer, licensed psychiatrist, physician or clinical psychologist may fill out an Application for Examination (MC-105)
- If the mental health professional who performs the emergency examination has reason to believe that the respondent meets the criteria set out in AS 47.30.700 and is in need of care or treatment, the mental health professional may hospitalize the respondent, or arrange for hospitalization, on an emergency basis. AS 47.30.710 (b).
- If a judicial order has not been obtained under AS 47.30.700, the mental health professional shall apply for an ex parte order authorizing hospitalization for evaluation. AS 47.30.710(b).
- Once an ex parte order has been granted, the mental health facility may hold the person no longer than 72 hours for evaluation. An examination by a physician must occur within the first 24 hours of arrival. AS 47. 30.710(a).

PROCEDURE/PETITION

- No **petition is** initially filed, due to circumstances of such immediate nature that considerations of safety do not allow initiation of involuntary commitment procedures set out in AS 47.40.700.
- Peace Officer, psychiatrist, or physician with probable cause to believe person is gravely disabled or is suffering from mental illness **and** is likely to cause serious harm to self or others and is in need of care or treatment, initiates a peace officer's hold and take respondent to nearest evaluation facility. AS 47.30.705 & MC -105 Peace Officer/Mental Health Professional Application For Examination.
- Mental health professional contacts judicial officer and requests an ex-parte order. AS 47.30.710 (b) & .700.
- Within 48 hours after the completion of the screening investigation, a judge may issue an ex parte order orally or in writing, stating that there is probable cause to believe the respondent to be gravely disabled or presents the likelihood of serious harm to self or others. The order shall be provided to respondent and made part of the respondent's clinical record. AS 47.30.700(a).
- The court must confirm an oral order in writing within 24 hours after it is issued. AS 47.30.700(a).
- The court must provide findings on which the conclusion is based, appoint an attorney, and may direct that a peace officer take respondent into custody and deliver respondent to the nearest appropriate facility for emergency examination or treatment (if that has not already occurred). AS 47.30.700(a).
- MC-105 is signed by Peace Officer or Mental Health Professional. AS 47.30.705(a).
- The evaluation facility completes a Notice of Respondents Arrival at Evaluation Facility (MC-400). The person completing the form must note the name of the judicial officer who issued the telephonic ex parte order along with the time and date on the form.
- The Petition for Initiation of Involuntary Commitment MC-100, AS 47.30.700, & .710 requests that the court or mental health professional conduct a screening investigation and if determined that respondent is mentally ill and that condition causes respondent to be gravely disabled or to present a likelihood of serious harm to self or others, and that the court issue an ex parte order for the temporary custody and detention for emergency examination.
- The Petition must state name and address of respondent and the facts which make the respondent a person in need of screening investigation or hospitalization for evaluation and specify the factual information on which that belief is based including the names and addresses of all persons

known to the petitioner who have knowledge of those facts through personal observation. MC-100, AS 47.30.700.

- The treatment facility is required to fax the following documents to AG's office and original copy to Court: MC-100, 105, 400 and 405.
- Ex Parte Order (Temporary Custody for Emergency Exam/Treatment MC-305) is assigned to a superior court judge for signature, along with an appointment of counsel for respondent, and written authority for treatment facility to take respondent into custody.
- Notice of 30-Day Commitment Hearing (MC-200) that includes date, time, and location for the 30-day commitment hearing if needed is prepared by the court and forwarded to the AG, treatment facility, and counsel for respondent.

NOTICE

See Appendix 2 NOTICE

RIGHTS

See Appendix 3 RIGHTS
MC-405 Notice of Rights Upon Detention for Evaluation

TIMEFRAMES

- A respondent who is delivered under AS 47.30.700 - 47.30.705 to an evaluation facility for emergency examination and treatment shall be examined and evaluated as to mental and physical condition by a mental health professional and by a physician within **24 hours** after arrival at the facility. AS 47.10.710(a).
- Unless a respondent is released or voluntarily admitted for treatment within **72 hours** of arrival at the facility or, if the respondent is evaluated by evaluation personnel, within **72 hours** from the beginning of the respondent's meeting with evaluation personnel, the **respondent is entitled to a court hearing to be set for not later than the end of that 72-hour** period to determine whether there is cause for detention after the **72 hours** have expired for up to an additional 30 days on the grounds that the respondent is mentally ill, and as a result presents a likelihood of serious harm to the respondent or others, or is gravely disabled. The facility or evaluation personnel shall give notice to the court of the releases and voluntary admissions under AS 47.30.700 - 47.30.815. AS 47.30.725(b).
- Respondent, if represented by counsel, may waive, orally or in writing, the **72-hour** time limit on the 30-day commitment hearing and have the hearing set for a date no more than **seven calendar days after arrival** at the facility.

The respondent's counsel shall immediately notify the court of the waiver. AS 47.30.725(f).

- **Within 48 hours** after the completion of the screening investigation, a judge may issue an ex parte order orally or in writing, stating that there is probable cause to believe the respondent is mentally ill and that condition causes the respondent to be gravely disabled or to present a likelihood of serious harm to self or others. AS 47.30.700(a).
- When a facility receives a proper order for evaluation, it must accept the order and the respondent for an evaluation period not to exceed 72 hours. The facility must promptly notify the court of the date and time of the respondent's arrival. The court sets a date, time and place for a 30-day commitment hearing, to be held if needed within 72 hours after the respondent's arrival, and the court notifies the facility, the respondent, the respondent's attorney, and the prosecuting attorney of the hearing arrangements. Evaluation personnel, when used, shall similarly notify the court of the date and time when they first met with the respondent. AS 47.30.715.
- **Computing Periods of Time. Except when respondent is voluntarily absent or fails to appear in violation of an order under AS 47.30.66, computations of a 72-hour evaluation period under AS 47.30.715 or a 48-hour detention period under AS 47.30.685 do not include Saturdays, Sundays, legal holidays, or any period of time necessary to transport the respondent to the treatment facility. AS 47.30.805.**

EVIDENTIARY STANDARD

- A peace officer, psychiatrist, or physician who is licensed to practice in this state or employed by the federal government, or a clinical psychologist licensed by the state who has **probable cause** to believe that a person is gravely disabled or is suffering from mental illness **and** is likely to cause serious harm to self or others of such immediate nature that considerations of safety do not allow initiation of involuntary commitment procedures set out in AS 47.30.700 , may cause the person to be taken into custody and delivered to the nearest evaluation facility. AS 47.30.705(a).
- When there has been no judicial order, the mental health professional must apply for an ex parte authorizing hospitalization for evaluation. AS 47.30.710(b). The judicial officer must determine whether there is probable cause to believe that respondent is mentally ill and that condition causes the respondent to be gravely disabled or to present a likelihood of serious harm to self or others **and** is in need of care or treatment that resulted in respondent's emergency hospitalization. The judicial officer examines the mental health professionals reasons set out in the application and may take testimony if necessary. AS 47.30.710.

FINDINGS

- Within 48 hours after the completion of the screening investigation, a judge may issue Ex Parte Order-Temporary Custody For Emergency Examination/ Treatment MC-305, orally or in writing authorizing hospitalization for evaluation based on **probable cause** that respondent is **mentally ill** and that condition causes the respondent to be **gravely disabled** or to present a likelihood of serious harm to self or other, and is in need of care or treatment that resulted in respondent's emergency hospitalization. AS 47.30.710(b); AS 47.30.700, .710 & .715. The judge must enter findings of fact supporting the decision.
- If "gravely disabled" is alleged, the court must include findings that there is probable cause to believe respondent's mental condition could be improved by the course of treatment sought and there is no less viable alternative available. ***Wetherhorn,*** **156 P.3d at 368.**
- The court shall confirm an oral order in writing within 24 hours after it is issued. AS 47.30.700(a).

ORDERS

- Order for Screening Investigation (MC-300). Upon petition of any adult alleging respondent is mentally ill and, as a result of that condition, alleged to be gravely disabled or to present a likelihood of serious harm to self or others, a judge must immediately conduct a screening investigation or designate a mental health professional to conduct such an investigation. AS 47.30.700.
- Ex Parte Order (Temporary Custody For Emergency Examination/Treatment) a judge may authorizing examination at an evaluation facility after application by a mental health professional. AS 47.30.700,.710(b),.& .715
- When a facility receives a proper order for evaluation, it must accept the order and the respondent for an evaluation period not to exceed 72 hours. The facility must promptly notify the court of the date and time of the respondent's arrival. The court must then set a date, time and place for a 30-day commitment hearing to be held, if needed, within 72 hours after the respondent's arrival, and the court shall notify the facility, the respondent, the respondent's attorney, and the prosecuting attorney of the hearing arrangements. AS 47.30.715.

APPEAL

- Nothing in AS 47.30.660 - .915 may be construed as limiting a person's right to a writ of habeas corpus. AS 47.30.810.

INITIATION OF INVOLUNTARY COMMITMENT PROCEDURES
NON-EMERGENCY (In Court)

Relevant Statues/Rules/Forms

AS 47.30.700 INITIATION of INVOLUNTARY COMMITMENT PROCEDURES
AS 47.30.705 EMERGENCY DETENTION FOR EVALUATION
AS 47.30.710 EXAMINATION
AS 47.30.720 RELEASE BEFORE EXPIRATION OF 72 HOUR PERIOD
AS 47.30.725 COMMITMENT PROCEDING RIGHTS: NOTIFICATION
AS 47.30.915 GRAVELY DISABLED
Wetherhorn v. API, 156 P.3d 371 (Alaska 2007).
Wayne B. v. API, Supreme Court, S-12677, August 29, 2008
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FORMS
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MC-405 Notice of Rights Upon Detention for Evaluation

PETITION FOR SCREENING AS 47.30.700

- **Any adult** may file a non emergency petition for involuntary commitment and request the court conduct or arrange for a screening investigation AS 47.30.700
- Petition must allege **specific facts** and **specific behavior** that supports a conclusion that respondent is alleged to be mentally ill and, as a result of that condition, alleged to be gravely disabled or to present a likelihood of serious harm to self or others. AS 47.30.700(a) (See Appendix-1)
- Petition must specify the factual information on which that belief is based including the names and addresses of all persons known to the petitioner who have knowledge of those facts through personal observation. AS 47.30.700(b).

NOTICE

See Appendix 2 NOTICE

RIGHTS

See Appendix 3 RIGHTS

TIMEFRAMES

- **Within 48 hours** after the completion of the screening investigation**,** a judge may issue an ex parte order orally or in writing, stating that there is probable cause to believe the respondent is mentally ill and that condition causes the respondent to be gravely disabled or to present a likelihood of serious harm to self or others. The judge may direct a peace officer to take the respondent to the nearest appropriate facility for emergency examination or treatment. If the order is oral, the judge must issue a confirming written order within 24 hours after the oral order. AS 47.30.700(a).
- A respondent who is delivered to an evaluation facility for emergency examination and treatment under a court order after ex parte review shall be examined and evaluated as to mental and physical condition by a mental health professional and by a physician within **24 hours** after arrival at the facility. AS 47.10.710(a) & .700.
- Unless a respondent is released or voluntarily admitted for treatment within **72 hours** of arrival at the facility or, if the respondent is evaluated by evaluation personnel, within **72 hours** from the beginning of the respondent's meeting with evaluation personnel, the **respondent is entitled to a court hearing to be held not later than the end of that 72-hour** period to determine whether there is cause for detention after the **72 hours** have expired for up to an additional 30 days on the grounds that the respondent is mentally ill, and as a result presents a likelihood of serious harm to the respondent or others, or is gravely disabled. The facility or evaluation personnel must give notice to the court of any releases and voluntary admissions under AS 47.30.700 - 47.30.815. AS 47.30.725(b).
- Respondent, if represented by counsel, may waive, orally or in writing, the **72-hour** time limit on the 30-day commitment hearing and have the hearing set for a date no more than **seven calendar days after arrival** at the facility. The respondent's counsel shall immediately notify the court of the waiver. AS 47.30.725(f)
- When a facility receives a proper order for evaluation, it shall accept the order and the respondent for an evaluation period not to exceed 72 hours. The facility shall promptly notify the court of the date and time of the respondent's arrival. The court must set a date, time, and place for a 30-day commitment hearing to be held, if needed, within 72 hours after the respondent's arrival, and the court shall notify the facility, the respondent, the respondent's attorney, and the prosecuting attorney of the hearing arrangements. Evaluation personnel, when used, shall similarly notify the court of the date and time when they first met with the respondent. AS 47.30.715
- Computing Periods of Time Except when respondent is voluntarily absent or fails to appear, computations of a 72-hour evaluation period under AS 47.30.715 or a 48-hour detention period under AS 47.30.685 do not include Saturdays, Sundays, legal holidays, or any period of time necessary to transport the respondent to the treatment facility. AS 47.30.805.

EVIDENCE

- Within 48 hours after the completion of the screening investigation a judge may issue Ex Parte Order-Temporary Custody For Emergency Examination/Treatment, Form MC-305 orally or in writing authorizing hospitalization for evaluation AS 47.30.710(b) based on **probable cause** that respondent is mentally ill and that condition causes the respondent to be gravely disabled or to present a likelihood of serious harm to self or others. AS 47.30.700, .710 & .715

FINDINGS

- Within 48 hours after completion of the screening investigation, a judge may issue an ex parte order orally or in writing, stating there is probable cause to believe respondent is mentally ill and that condition causes the respondent to be gravely disabled or to present a likelihood of serious harm to self or others. AS 47.30.700(a)
- If the allegations include "gravely disabled," the court must include findings that there is reason to believe respondent's mental condition could be improved by the course of treatment sought and there is no less viable alternative available. *Wetherhorn v. API*, 156 P.3d at 378.
- The court shall confirm an oral order in writing within 24 hours after it is issued. AS 47.30.700(a)
- The court shall provide findings on which the probable cause determination is based.

ORDERS

- An Order for Screening Investigation (MC-300) directs a local mental health professional employed by the department or by a local mental health program that receives money from the department or another mental health professional designated by the judge, to conduct a screening investigation of the person within 48 hours and report to court findings as to the mental condition of respondent. AS 47.30.700(a).
- Within 48 hours after completion of the screening investigation, a judge may issue an ex parte order orally or in writing, stating there is probable cause to believe respondent is mentally ill and that condition causes the respondent to be gravely disabled or to present a likelihood of serious harm to self or others. AS 47.30.700(a)
- In an ex parte order, the court must appoint an attorney to represent the respondent, and may direct that a peace officer take the respondent into custody and deliver the respondent to the nearest appropriate facility for **emergency examination** or **treatment**. AS 47.30.700(a).
- The court shall confirm an oral Ex Parte Order for Evaluation in writing within 24 hours after it is issued. AS 47.30.700(a)
- When a facility receives a proper order for evaluation, it shall accept the order and

the respondent for an evaluation period not to exceed 72 hours. The facility shall promptly notify the court of the date and time of the respondent's arrival. **The court must set a date, time, and place for a 30-day commitment hearing to be held, if needed, within 72 hours after the respondent's arrival,** and the court shall notify the facility, the respondent, the respondent's attorney, and the prosecuting attorney of the hearing arrangements. AS 47.30.715.

APPEAL

Habeas Corpus Not Limited. Nothing in AS 47.30.660 - 47.30.915 may be construed as limiting a person's right to a writ of habeas corpus. AS 47.30.810.

HEARING FOR PETITION ON 30-DAY INVOLUNTARY COMMITMENT

Pursuant to AS 47.30.735(c),(d) and (e), the court must determine by clear and convincing evidence if: (1) that the respondent is mentally ill; and (2) that as a result of that mental illness is likely to cause harm to the respondent or others [(AS 47.30.915(10)(A)] or is gravely disabled AS 47.30.915(B) and with respect to a gravely disabled respondent that there is reason to believe that the respondent's mental condition could be improved by the course of treatment sought and there is no viable less restrictive alternative available. AS 47.30.735(d)

Relevant Statues/Rules/Cases/Forms

AS 47.30.725-.735
Wetherhorn v. API, 156 P.3d 371 (Alaska 2007)
Humphrey v. Cady, 405 U.S. 504 (1972)
*Addington v.. Texas***,** 441 U.S. 418, 425 (1979)
O'Connor v. Donaldson, 422 U.S. 563 (1975)
DeNuptiis v. Unocal, 63 P.3d 272, 278(Alaska 2003)
Evidence Rule 702. Testimony by Experts
Evidence Rule 703. Basis of Opinion Testimony Experts
Wayne B. v. API, Supreme Court, S-12677, August 29, 2008
AK Rule of Probate 2 Appointment and Authority of Masters

FORMS

MC-200 Notice of 30-Day Commitment Hearing
MC-310 Order for 30-DayCommitment
MC-325 Order of Dismissal of Petition for Commitment
MC-505 Motion for Dismissal of Petition
MC-506 Affidavit in Support of Motion to Dismiss Petition

PETITION AS 47.30.730

- Must be signed by ***2*** mental health professionals who have examined the petitioner (1 must be a physician.) AS 47.30.730 (a).
- The petition must allege ***specific facts*** *and* ***specific behavior*** *that supports a conclusion that the respondent is mentally ill and as a result is likely to cause* ***harm to self or others*** or is ***gravely disabled*** AS 47.30.730(a) (1) & (7).
- The petition must allege that the evaluation staff has considered but has not found that there are **any** less restrictive alternatives available, or, if a less restrictive involuntary form of treatment, is sought, specify the treatment and the basis for supporting it. AS 47.30.730(a)(2) *Wetherhorn,* 156 P.3d at 378.
- The petition must allege with respect to a **gravely disabled** respondent that there is reason to believe that the respondent's mental condition could be improved by the course of treatment sought; AS 47.30.730(a)(3) *Wetherhorn*, 156 P.3d at 378.

- The petition must specify a **treatment facility** or **less restrictive alternative** that is **appropriate** to the respondent's condition has agreed to accept the respondent. AS 47.30.730(a)(4).
- The petition must indicate respondent has been **advised** of the need but **not accepted, voluntary treatment**. AS 47.30.730(a)(5). and
- The petition must request that the court **commit the respondent to the treatment facility** or **less restrictive alternative** for a period not to exceed **30 days**. AS 47.30.730(a)(5)
- The petition must list the prospective **witnesses** who will testify in support of commitment or involuntary treatment, but the petition **need not** summarize **all the evidence** or be **sufficient in itself** to entitle **granting the petition** as a **matter of law**. *Wetherhorn,* 156 P.3d at.380.

NOTICE

See Appendix 2 NOTICE

RIGHTS

See Appendix 3 RIGHTS

TIMEFRAMES

- Computing Periods of Time see AS 47.30.805
- Hearing within **72 hrs** of either admission or time the patient files notice no longer a voluntary patient. AS 47.30.805(e)
- Court can continue hearing past **72 hrs only** if respondent and attorney **waive.** Then hearing must be held within **7 days** after admission. AS 47.30.725**.**
- **30 day commitment** period **expires** at **end of the 30th** day **after the 72 hrs** following initial acceptance unless the respondent has failed to appear or been voluntarily absent. AS 47.30.805.
- If respondent is refusing medication a Petition for Court Approval is usually filed at same time (**NOTE**: Such non-emergency motions allow for continuance. Medication petition **may be held within 72 hours after filing,** rather than 72 hours after admission. AS 47.30.829(e). If the visitor is unable to complete the report timely, the hearing must be continued. *Wetherhorn,* 156 P.3d at 381-82.)
- A 30-day commitment period expires at the end of the 30th day after the 72 hours following initial acceptance. AS 47.30.805.

EVIDENCE

- Rules of evidence and procedure are applied to provide for the informal but efficient presentation of evidence. AS 47.30.735(b)(4).
- Expert Witness – Evidence Rule 702 and 703.

BURDEN of PROOF

- **Clear and Convincing** AS 47.30.735 (c) and .740 (c). (Highly probable but not beyond a reasonable doubt or a certainty or conclusive.)
  - o **Mental illness** as defined in AS 47.30.915(12);
  - o **As a result** of mental illness patient is **likely to cause serious harm** to **self** or **others** ***and/or*** is **gravely disabled.** (See Appendix 1)
    - No viable less restrictive alternative available AS 47.30.735 (d) and AS 47.30.915 (9), *Wetherhorn*, 156 P.3d at.378.
    - If petition alleges that respondent is gravely disabled then it must allege that the respondent's mental condition could be improved by the course of treatment sought. AS 47.30.730(a)(3); *Wetherhorn*, 156 P.3d at 378.

FINDINGS

Form MC-310
Having considered the allegations of the petition, the evidence presented and the arguments of counsel, the court finds:

- **Clear and convincing evidence** respondent is **mentally ill** and as a result, is **likely to cause harm** to **self** or **others and/or** is **gravely disabled**
- ▪ If petition alleges respondent is **gravely disabled** then finding by clear and convincing evidence that the respondent's mental condition could be improved by the course of treatment sought. AS 47.30.730(a)(3). *Wetherhorn*, 156 P.3d at 378.
- ▪ If gravely disabled, the "distress" that justifies commitment refers to the level of incapacity that prevents the person from being able to live safely outside of a controlled environment. *Wetherhorn,* 156 P.3d at.378.
- Respondent has been advised of and refused voluntary treatment.
- Respondent is resident of the State of _________.
- Respondent has been given proper written Notice of Rights and those rights have been explained orally.
- Respondent is committed for up to 30 days.
- Respondent was given verbal notice that if commitment or other involuntary treatment beyond 30 days is sought, respondent will have the right to a full hearing or jury trial.
- If commitment is extended, respondent has a right to an independent second opinion and is the respondent is indigent, the court will appoint an independent physician or mental health professional to examine respondent and to testify. AS 47.30.745(e).
- _______is an appropriate treatment facility and has agreed to accept respondent.
- Clear and Convincing evidence that the evaluation staff has considered and not found that there are any less restrictive alternatives available**.** *Wetherhorn,* 156 P.3d at.378.

- There is a preference for facility closer to home unless court orders otherwise. (See Appendix 5 Placement at Closest Facility)
- If respondent is accepted but refuses a less restrictive alternative then court may order the less restrictive alternative. AS 47.30.735(d).

The facts which support the above conclusion are:

See also:
Appendix 1 Mentally Ill
Appendix 4 No less restrictive alternative available

ORDER

- It is ordered that respondent ______is committed to ______for a period of time not to exceed 30 days.

POST FINDING NOTICE REQUIREMENT

- The court is required to specifically notify the respondent **in writing** that if the treatment facility seeks a commitment past 30 days the respondent has the **right to a full hearing or jury trial**. AS 47.30.735 (e).
- The court must inform respondent of the right to appeal an involuntary commitment order. AS 47.30.765.
- Respondent has 10 days to file objections (frequently reduced to 3 days) to the Masters recommendations. Civil Rule 53(d)(2); Probate Rule 2(f).
- The court is required to specifically notify the respondent that if the treatment facility seeks a commitment past 30 days the respondent has the **right to a full hearing or jury trial.** AS 47.30.745(c).

Court May Advise:

- That hospital has the **authority to discharge** before the end of the commitment period.
    - If commitment is extended, respondent has a right to an independent second opinion and if the respondent is indigent, the court would appoint someone. AS 47.30.745(e).

APPEAL

- Respondent has right to appeal an involuntary commitment order. AS 47.30.765.
- Respondent may file objections to Master's Recommendations (usually within 3 days).
- **Habeas Corpus Not Limited.** Nothing in AS 47.30.660 - 47.30.915 may be construed as limiting a person's right to a writ of habeas corpus. AS 47.30.810

HEARING FOR PETITION ON 90-DAY INVOLUNTARY COMMITMENT

Pursuant to AS 47.30.735(c),(d) and (e), the court must determine by clear and convincing evidence if: (1) that the respondent is mentally ill; and (2) that as a result of that mental illness is likely to cause harm to the respondent or others [(AS 47.30.915(10)(A)] or is gravely disabled AS 47.30.915(B) and (with respect to a gravely disabled) there is reason to believe that the respondent's mental condition could be improved by the course of treatment sought and there is no viable less restrictive alternative available. AS 47.30.735(d), and AS 47.30.915(9). The court must decide whether the respondent's commitment be extended for up to 90 days. (See additional FINDINGS required at 90-Day Commitment.)

RELEVANT STATUTES/RULES/CASES/FORMS

AS 47.30.700
AS 47. 30.730(a)
AS 47.30.735 30-day commitment
AS 47.30.740 Procedure for 90-day commitment
AS 47.30.745 90-day commitment hearing rights
AS 47.30.755 Court order.
AS 47.30.760 Placement at closest facility.
AS 47.30.805 Computing periods of time
Wetherhorn v. API, 156 P.3d 371 (Alaska 2007)
Addington v. Texas, 441 U.S. 418 (1979)
O'Connor v. Donaldson, 422 U.S. 563 (1975)
DeNuptiis v. Unocal, 63 P.3d 272, 278(Alaska 2003)
Evidence Rule 702 testimony of experts
Evidence Rule 703. Basis of Opinion Testimony Experts.
Wayne B. v. API, Supreme Court, S-12677, August 29, 2008
AK Rule of Probate 2 Appointment and Authority of Masters

FORMS

MC-115 Petition for 90-day Commitment
MC-205 Notice of 90-day Commitment HEaring
MC-315 Order for 90-Day Commitment
MC-505 Motion for Dismissal of Petition
MC-506 Affidavit in Support of Motion to Dismiss Petition

PETITION

Must include all material required under AS 47.30.730 (a) except "30" read as "90" days. AS 47.30.740(a).

- Must be verified by the professional person in charge, or that person's professional designee, during the 30 day commitment. AS 47.30.740(a)(3).

Petition must allege that respondent is mentally ill and as a result is:

- likely to cause harm to self or others, and/or
- gravely disabled as previously alleged in the Petition for 30-day petition AS 47.30.740(a) and AS 47.30.730(a)(1).

90-day petition must also:

- allege that the respondent (1) continues to be **gravely disabled**, or (2) that the respondent has attempted to inflict or has inflicted **serious bodily harm** upon the respondent or another since the respondent's acceptance for evaluation, or (3) that the respondent was committed initially as a result of conduct in which the respondent attempted or **inflicted serious bodily harm** upon the respondent or another, or (4) that the respondent demonstrates a **current intent** to carry out plans of **serious harm** to the respondent or another. AS 47.30.740(a)(1).
- allege that the respondent has received appropriate and adequate care and treatment during the respondent's 30-day commitment. AS 47.30.740(a)(2).
- allege that the evaluation staff has considered, but not found, any less restrictive alternative available that would adequately protect the respondents or others. AS 47.30.730(a)(2).
- specify a **treatment facility** or **less restrictive alternative** that is **appropriate** to the respondent's condition has agreed to accept the respondent. AS 47.30.730(a)(4).
- allege ***specific facts** and **specific behavior** that supports a conclusion of **harm to self/others*** or that respondent is ***gravely disabled***: allege that the treatment staff has considered but has not found that there are **any less restrictive alternatives available;** AS 47.30.730(a)(2); *Wetherhorn*, 156 P.3d at.378.
- if respondent is alleged to be gravely disabled, allege there is reason to believe that the respondent's mental condition could be improved by the course of treatment sought. AS 47.30.730(a)(3); *Wetherhorn,* 156 P.3d at.378.
- indicate that respondent has been **advised** of the need but **not accepted, voluntary treatment**. AS 47.30.730(a) (5).
- request that the court **commit the respondent to the treatment facility** or **less restrictive alternative** for a period not to exceed **90 days**. AS 47.30.730(a)(5).
- list the prospective **witnesses** who will testify in support of commitment for involuntary treatment: AS 47.30.740(a); AS 47.30.730(a)(6).
- list facts and specific behavior of the respondent supporting allegation respondent is **mentally ill** and as a result is likely to cause **harm to self or others** or is **gravely disabled**, but the petition need **not** summarize **all the evidence** or be **sufficient in itself** to entitle **grant of the petition** as a **matter of law**. AS 47.30.740(a); AS 47.30.730(a)(7); *Wetherhorn*, 156 P.3d at.379.

NOTICE

See Appendix 2 NOTICE

RIGHTS

See Appendix 3 RIGHTS

TIMEFRAMES

- Computing Periods of Time see **AS 47.30.805**.
- A 90-day commitment period expires at the end of the 90th day after the expiration of a 30-day period of treatment. AS 47.30.805(a)(3).
- The petition for 90-day commitment and proofs of service shall be filed with the clerk of court, and a date for the hearing shall be set by the end of the next judicial day for not later than five judicial days from the date of the filing of the petition. AS 47.30.740(b).
- The clerk shall notify the respondent and attorney, and the petitioner of the hearing date at least 3 judicial days in advance of the hearing. AS 47.30.740(b).
- Respondent is entitled to a jury trial upon request filed with the court, if the request is made at least **2 days** before the hearing. If respondent requests a jury trial, the hearing may be continued for no more than **10 calendar days**. AS 47.30.745(c).
- If a jury trial IS NOT requested, the court may still continue the hearing at the respondent's request for **no more than 10 calendar days**. AS 47.30.745(d)
- If at any time during the respondent's voluntary admission under this subsection, the respondent submits to the facility a written request to leave, the professional person in charge may file with the court a petition for a 180-day commitment of the respondent under AS 47.30.770. The 180-day commitment hearing shall be scheduled for a date **not later than 90 days after respondent's voluntary admission.** AS 47.30.745(b).
- **90 day commitment** period **expires** at **end of the 90th** day **after the 72 hrs** following initial acceptance, unless the respondent is voluntarily absent or has failed to appear. AS 47.30.805.
- Until the court issues a final decision, the respondent shall continue to be treated at the treatment facility unless the petition for 90-day commitment is withdrawn. If a decision has not been made within **20 days** of filing of the petition, not including extensions of time due to jury trial or other requests by the respondent, the **respondent shall be released**. AS 47.30.745(g).

EVIDENCE

- Rules of evidence and civil procedure are applied so as to provide for the informal but efficient presentation of evidence; AS 47.30.735(b), .745, and .750.
- Expert Witness – Evidence Rules 702 and 703.

BURDEN OF PROOF

- **Clear and Convincing** AS 47.30.735 (c) and .740(c). (Highly probable but not beyond a reasonable doubt or a certainty or conclusive.)
- Clear and convincing evidence of
  - **mental illness** as defined in AS 47.30.915(12) **as a result** of mental illness patient is **likely to cause serious harm** to **self** or **others** ***and/or*** is **gravely disabled**. (See Appendix 1 for checklist)
  - if allegation of "gravely disabled," then proof that the respondent's mental condition could be improved by the course of treatment sought. AS 47.30.730(a)(3); *Wetherhorn*, 156 P.3d at.378.
  - no viable less restrictive alternative available. AS 47.30.735 (d), AS 47.30.915(9), and *Wetherhorn, Id*. at 378.
- Findings of fact relating to the respondent's behavior made at a 30-day commitment hearing under AS 47.30.735 shall be admitted as evidence and may not be rebutted except that newly discovered evidence may be used for the purpose of rebutting the findings. AS 47.30.740(c). Note: Finding made at previous hearing does not mean respondent is currently gravely disabled or a danger to self or others.

FINDINGS

Form MC 315

- Findings of fact relating to the respondent's behavior made at a 30-day commitment hearing under AS 47.30.735 shall be admitted as evidence and may not be rebutted except that newly discovered evidence may be used for the purpose of rebutting the findings. AS 47.30.7740(c)
- A petition for 90-day commitment was filed on __________, 20 __
- A hearing was held on ________, 20__, to inquire into the mental condition of the respondent. Respondent ___ was ____ was not personally present at the hearing and was represented by ______________, attorney. Representing the State was ________________.
- Having considered the allegations of the petition, the evidence presented and the arguments of counsel, the court finds:
  - Clear and convincing evidence:
  - Respondent is **mentally ill** and, as a result , is
  - **likely to cause harm to____ self** or **____others**, **___gravely disabled***
    - With respect to **gravely disabled respondent**, reason to believe that the mental condition could be improved by the course of treatment sought. AS 47.30.730(a)(3); *Wetherhorn*, 156 P.3d at.378.
    - If gravely disabled, the level of incapacity prevents the respondent from being able to live safely outside of a controlled environment. *Wetherhorn, Id*. at. 378.
  - **No less restrictive treatment alternative** has been found which would adequately protect the respondent or others.

- o **API** (or designated treatment facility closer to respondent's home) **is an appropriate treatment facility**.
- o Respondent has received proper Notice of Rights. AS 47.30.745(a).

- If the court finds that there is a less restrictive alternative available and that the respondent has been advised of and refused voluntary treatment through the alternative, the court may order the less restrictive alternative treatment after acceptance by the program of the respondent for a period not to exceed 90 days. See AS 47.30.755 and .760.
- Respondent :
  - o has been advised of and refused voluntary treatment.
  - o is a resident of the State of ___________.
  - o was given verbal notice that if commitment or other involuntary treatment beyond the 90 days is sought, respondent will have the right to full hearing or jury trial.
  - o has received appropriate and adequate care and treatment during the 30-day commitment. AS 47.30.740(2)

Additional findings at 90-day commitment hearing include, clear and convincing evidence that:

- Respondent attempted to inflict or has inflicted **serious bodily harm** upon the respondent or another **since acceptance for evaluation,** based on the testimony of ______ that respondent ____or
- the respondent **was committed initially** as a result of conduct in which the respondent attempted or **inflicted serious bodily harm** upon the respondent or another, based on the testimony of _____________ that respondent __________ ____ or
- the respondent is gravely disabled based on the evidence/testimony of ________ and the respondent's mental condition could be improved by the course of treatment sought. [AS 47.30.730(a)(3); AS 47.30.740(a)(1); *Wetherhorn*, 156 P.3d at 378.] or
- the respondent demonstrates a **current intent** to carry out plans of **serious harm** to the respondent or another, based on the testimony of ______ that respondent ____

The facts with support the above conclusion are: ___________________________ ____

See: Appendix 1 Mentally Ill and as result danger self/others or gravely disabled
Appendix 4 No less restrictive alternative available

ORDER

- It is ordered that respondent ______is committed to ______for a period of time not to exceed 90 days.

POST FINDING NOTICE REQUIREMENT

- Respondent has right to decision by the court within 20 days after the petition was filed. AS 47.30.745(g).
- The court must inform respondent of the right to appeal an involuntary commitment order. AS 47.30.765.
- The court is required to specifically notify the respondent that if the treatment facility seeks a commitment past 90 days the respondent has the **right to a full hearing or jury trial.** AS 47.30.745(c).

Court May Advise:

- That the facility has the authority to discharge prior to end of the commitment period. AS 47.30.780.
- If commitment is extended respondent has a right to an independent second opinion and the court will appoint someone if the respondent is indigent. AS 47.30.745(e)

APPEAL

- Respondent has right to appeal an involuntary commitment order. AS 47.30.765.
- Respondent may file objections to Master's Recommendations (usually within 3 days).
- Nothing in AS 47.30.660 - 47.30.915 may be construed as limiting a person's right to a writ of habeas corpus. AS 47.30.810.

HEARING FOR PETITION ON 180-DAY INVOLUNTARY COMMITMENT

PURPOSE OF HEARING or JURY TRIAL: To determine whether cause to continue the respondent's treatment after the 90-day commitment has expired for an additional 180 days. If the court or jury finds by clear and convincing evidence that the grounds for 180-day commitment as set out in AS 47.30.755 are present, the court may order the respondent committed for an additional treatment period not to exceed 180 days from the date on which the 90-day treatment period would have expired. AS 47.30.700(b). Successive 180-day commitments are permissible on the same ground and under the smae procedures as the original 180-day commitments. Any order of commitment may not exceed 180 days. AS 47.30.770(c).

Relevant Statues/Cases/Rules/Cases

AS 47.30.735 30-day commitment
AS 47.30.740-.750
AS 47.30.770. Additional 180-Day Commitment.
Myers v. API, 138 P.3d 238 (Alaska 2006)
Wetherhorn v. API, 156 P.3d 371 (Alaska 2007)
Addington v. Texas, 441 U.S. 418 (1979)
O'Connor v. Donaldson, 422 U.S. 563 (1975)
DeNuptiis v. Unocal, 63 P.3d 272,278(Alaska 2003)
Evidence Rule 702 Testimony of Experts
Evidence Rule 703 Basis of Opinion Testimony Experts.
Wayne B. v. API, Supreme Court, S-12677, August 29, 2008
AK Rule of Probate 2 Appointment and Authority of Masters

FORMS
MC-120 Petition for 180 –Day Commitment
MC-210 Notice of 180-Day Commitment Hearing
MC-320 Order for 180-Day Commitment
MC-505 Motion for Dismissal of Petition
MC-506 Affidavit in Support of Motion to Dismiss Petition

PETITION

- At any time during the respondent's 90-day commitment, the professional person in charge, or that person's professional designee, may file with the court a petition for a 180-day commitment of that respondent. The professional person or designee must verify the petition, AS 47.30.770(a).
- The petition must include all material required under AS 47.30.730 (a) except that references to "30 days" is read as "90 days" and "90 days" is read as "180 days". AS 47.30.770(a).

Petition must allege that respondent is mentally ill and as a result is:

- likely to cause harm to self or others, and/or
- gravely disabled as previously alleged in the Petition for 90-day petition AS 47.30.740(a) and AS 47.30.730(a)(1)

180-day petition must also:

- allege that the respondent (1) continues to be **gravely disabled**, or (2) that the respondent has attempted to inflict or has inflicted **serious bodily harm** upon the respondent or another since the respondent's acceptance for evaluation, or (3) that the respondent was committed initially as a result of conduct in which the respondent attempted or **inflicted serious bodily harm** upon the respondent or another, or (4) that the respondent demonstrates a **current intent** to carry out plans of **serious harm** to the respondent or another. AS 47.30.740(a)(1).
- allege that the respondent has received appropriate and adequate care and treatment during the respondent's 90-day commitment. AS 47.30.740(a)(2).
- allege that the evaluation staff has considered, but not found, any less restrictive alternative available that would adequately protect the respondents or others. AS 47.30.730(a)(2)
- specify a **treatment facility** or **less restrictive alternative** that is **appropriate** to the respondent's condition has agreed to accept the respondent. AS 47.30.730(a)(4)
- allege ***specific facts*** *and* ***specific behavior*** *that supports a conclusion of* ***harm to self/others*** or that respondent is ***gravely disabled***: allege that the treatment staff has considered but has not found that there are **any less restrictive alternatives available;** AS 47.30.730(a)(2); *Wetherhorn*, 156 P.3d at.378.
- if respondent is alleged to be gravely disabled, allege there is reason to believe that the respondent's mental condition could be improved by the course of treatment sought. AS 47.30.730(a)(3); *Wetherhorn,* 156 P.3d at.378.
- indicate that respondent has been **advised** of the need but **not accepted, voluntary treatment**. AS 47.30.730(a) (5).
- request that the court **commit the respondent to the treatment facility** or **less restrictive alternative** for a period not to exceed **180 days**. AS 47.30.730(a)(5).
- list the prospective **witnesses** who will testify in support of commitment for involuntary treatment: AS 47.30.740(a); AS 47.30.730(a)(6).
- list facts and specific behavior of the respondent supporting allegation respondent is **mentally ill** and as a result is likely to cause **harm to self or others** or is **gravely disabled**, but the petition need **not** summarize **all the evidence** or be **sufficient in itself** to entitle **grant of the petition** as a **matter of law**. AS 47.30.740(a); AS 47.30.730(a)(7); *Wetherhorn*, 156 P.3d at.379.
- indicate respondent has been **advised** of the need for, but has **not accepted, voluntary treatment** AS 47.30.730(a)(5), AS 47.30.740(a) and AS 47.30.770(a)
- request that the court **commit the respondent to 180 days** AS 47.30.730(a)(5), AS 47.30.740(a), and AS 47.30.770(a).

NOTICE

See Appendix 2 NOTICE

- The court shall specifically state to the respondent, and give the respondent written notice, that if commitment or other involuntary treatment beyond the 180 days is to be sought, the respondent has the right to a full hearing or jury trial. AS 47.30.735(e).

Rights

See Appendix 3 RIGHTS

TIMEFRAMES AS 47.30.770

- Computing Periods of Time see **AS 47.30.805**.
- 180-day commitment period expires at the end of the 180th day, after the expiration of a 90-day period of treatment or previous 180-day period, whichever is applicable.
- The respondent shall be released from involuntary treatment at the expiration of 90/180 days unless the professional person in charge files a petition for a 180-day commitment conforming to the requirements of AS 47.30.740(a). AS 47.30.770(a).
- Successive 180-day commitments are permissible on the same grounds and under the same procedures as the original 180-day commitment. An order of commitment may not exceed 180 days. AS 47.30.770(c).

EVIDENCE

- Rules of evidence and civil procedure are applied so as to provide for the informal but efficient presentation of evidence; AS 47.30.735(b), .745, .750.
- Expert Witnesses – Evidence Rules 702 and 703.

BURDEN OF PROOF

- **Clear and Convincing** AS 47.30.735(c) and 740(c). (Highly probable but not beyond a reasonable doubt or a certainty or conclusive).
- Clear and convincing evidence of:
    - o **Mental illness** as defined in AS 47.30.915(12) **as a result** of mental illness the patient is **likely to cause serious harm** to **self** or **others** ***and/or*** is **gravely disabled.** (See Appendix 1).
    - o if allegation of gravely disabled then proof that the respondent's mental condition could be improved by the course of treatment sought. AS 47.30.730(a)(3, *Wetherhorn,* 156 P.3d at 378.
    - o no viable less restrictive alternative available. AS 47.30.735 (d), AS 47.30.915 (9), *Wetherhorn, Id.* at 378.

- Findings of fact relating to the respondent's behavior made at 30-day and 90-day commitment hearings under AS 47.30.735 and AS 47.30.750 (a the previous 180-day hearing) shall be admitted as evidence and may not be rebutted except that newly discovered evidence may be used for the purpose of rebutting the findings. AS 47.30.770(d). Note: Findings made at previous hearing do not mean respondent is still gravely disabled or a danger to self or others.

FINDINGS

Form MC-320
AS 47.30.770

- Findings of fact relating to the respondent's behavior made at 30-day 90-day commitment hearings under AS 47.30.735 and AS 47.30.750 shall be admitted as evidence and may not be rebutted except that newly discovered evidence may be used for the purpose of rebutting the findings. AS 47.30.770(d). NOTE: Still requires determination that respondent currently fits requirements for involuntary commitment.
- If the court finds that that the grounds for the 90 day commitment set out in AS 47.30.755 are currently present, the court may order the respondent committed for an additional treatment period not to exceed 180 days from the date on which the first 90-day treatment period would have expired.
- A petition for180-day commitment was filed on __________, 20__.
- A hearing was held on ________, 20__, to inquire into the mental condition of the respondent. Respondent ___was ___was not personally present at the hearing and was represented by ______________, attorney. Representing the State was ______________.
- Having considered the allegations of the petition, the evidence presented and the arguments of counsel, the court finds:
- Clear and convincing evidence:
    - o Respondent is mentally ill and, as a result, is:
        - ▪ likely to cause harm to___ self or ___ others, __ gravely disabled
        - ▪ For a **gravely disabled respondent**, that respondent continues to be gravely disabled.
        - ▪ reason to believe that the patient's mental condition could be improved by the course of treatment sought. AS 47.30.730(a)(3). *Wetherhorn,* 156 P.3d at378.
        - ▪ For a gravely disabled respondent, the "distress" that justifies commitment refers to the level of incapacity that prevents the person from being able to live safely outside of a controlled environment. *Wetherhorn*, 156 P.3d at 378 (see Appendix 1).
    - o No less restrictive treatment alternative has been found which would adequately protect the respondent or others.

  - o The respondent has received appropriate and adequate care and treatment during the respondent's 90/180-day commitment. AS 47.30.740(2)
- Respondent has been advised of and refused voluntary treatment.
- Respondent is a resident of the State of ___________.
- Respondent was given verbal notice that if commitment or other involuntary treatment beyond the 90 days is sought, respondent will have the right to full hearing or jury trial.

Additional findings at 180-day commitment hearing include, clear and convincing evidence that:

- the respondent **was committed initially** as a result of conduct in which the respondent attempted or **inflicted serious bodily harm** upon the respondent or another, based on the testimony of ______ that respondent ________________ ____ or
- that the respondent demonstrates a **current intent** to carry out plans of **serious harm** to the respondent or another. Based on the testimony of ______ that respondent ____

  ____
- the respondent is gravely disabled based on the evidence/testimony of ________ and the respondent's mental condition could be improved by the course of treatment sought. [AS 47.30.730(a)(3); AS 47.30.740(a)(1); *Wetherhorn*, 156 P.3d at 378.] or
- the respondent demonstrates a **current intent** to carry out plans of **serious harm** to the respondent or another, based on the testimony of ______ that respondent ____

The facts with support the above conclusion are:

See: Appendix 1 Mentally Ill and as result danger self/others or gravely disabled Appendix 4. No less restrictive alternative available.

ORDER

- It is ordered that respondent ______is committed to ______for a period of time not to exceed 180 days.
- Successive 180-day commitments are permissible on the same ground and under the same procedures as the original 180-day commitment. Any order of commitment may not exceed 180 days. AS 47.30.770(c).

POST FINDING NOTICE REQUIREMENT

- Respondent has the right to a decision by the court within 20 days after the petition was filed. AS 47.30.745(g).
- Respondent has the right to an appeal from an order of involuntary commitment. (The court shall inform the respondent of this right.) AS 47.30.765.
- The court is required to specifically notify the respondent that if the treatment facility seeks a commitment past 180 days the respondent has the **right to a full hearing or jury trial.**

Court May Advise:

- That the facility has the authority to discharge prior to end of the commitment period.
- If commitment is extended respondent has a right to an independent second opinion and the court will appoint someone if the respondent is indigent. AS 47.30.745(e).

APPEAL

- Respondent has right to appeal an involuntary commitment order. AS 47.30.765.
- Respondent may file objections to Master's Recommendations (usually within 3 days).
- Nothing in AS 47.30.660 - 47.30.915 may be construed as limiting a person's right to a writ of habeas corpus. AS 47.30.810.

HEARING ON COURT ORDERED ADMINISTRATION OF MEDICATION

Relevant Statues/Rules/Cases

AS 47.30.817 Advance Health Care Directives.
AS 47.30.825 Patient Medical Rights.
AS 47.30.830 Prohibition of Experimental Treatments.
AS 47.30.833 Nutritional Evaluation; Right to Proper Diet.
AS 47.30 835 Civil Rights Not Impaired.
AS 47.30.836 Psychotropic Medication in Non-emergency.
AS 47.30.837 Informed Consent.
AS 47.30.838 Psychotropic Medication in Emergencies.
AS 47.30.839 Court-Ordered Administration of Medication.
AS 47.30.840 Right to Privacy and Personal Possessions.
AS 47.30.845 Confidential Records.
AS 47.30.847 Patients' Grievance Procedures.
AS 47.30.850 Expunging or Sealing Records.
AS 47.30.855 Posting of Rights.
AS 47.30.860 Notices in Languages Other Than English.
AS 47.30.865 Discrimination Prohibited.
Wetherhorn v. *API,* 156 P.3d 371 (Alaska 2007)
Myers v. *API,* 138 P.3d 238 (Alaska 2006)
Jarvis v. *Levine,* 418 N.W.2d 139 (Minn. 1988)
Steele v. *Hamilton County Mental Health Board,* 736 N.E.2d 10 (Wis. 2007)
Wayne B. v. API, Supreme Court, S-12677, August 29, 2008
AK Rule of Probate 2 Appointment and Authority of Masters

PETITION AS 47.30.839

If (1) there have been, or if it appears that there will be, repeated crisis situations as described in AS 47.30.838(a)(l) [ones that required use of medication to preserve the life of, or prevent significant harm to, the respondent or another person] and the evaluation or designated treatment facility wants to use psychotropic medication in future crisis situations: or (2) the facility wants to use psychotropic medication in a non-crisis situation and has reason to believe the patient is incapable of giving informed consent, the facility may petition the court to obtain court approval of administration of medication. AS 47.30.839(a)(l) & (2).

Petition:

- Requests a hearing on the respondent's capacity to give or withhold informed consent for the proposed use of psychotropic medication. AS 47.30.839(b)

Petition must allege that:

- There have been, or appears there will be, repeated crisis situations, requiring the immediate use of medication to preserve the life of, or prevent significant physical harm to, the patient or another person. The facility wishes to use psychotropic medication in future crisis situations. AS 47.30.839(a)(1); AS 47.30.838(a)(I).

  or
- There is reason to believe the patient is incapable of giving or withholding informed consent. The facility wishes to use psychotropic medication in a non-crisis situation. AS 47.30.839(a)(2)

  or
- Court approval has been granted during previous commitment period, and the facility wishes to continue medication during the subsequent commitment period. A day petition for the next commitment period is being filed. The patient continues to be incapable of giving or withholding informed consent. AS 47.30.839(h).

PREHEARING COURT ORDERS

Appoint visitor: Upon the filing of a petition, the court directs OPA to appoint a visitor to assist the court in investigating the issue of whether the patient has the capacity to give or withhold informed consent to the administration of psychotropic medication by gathering pertinent information. The visitor's report must include documentation of the patient's responses to a capacity assessment instrument and any expressed wishes of the patient regarding psychotropic medication made at any time in any way, including oral statements to relatives and friends. AS 47.30.839(d).

Right to counsel: The respondent has the right to be represented by an attorney. If the respondent is indigent, the court will appoint the Public Defender Agency. If the respondent's attorney requests, the court may direct OPA to appoint a GAL for the respondent. AS 47.30.839(c).

Notice

See Appendix 2 NOTICE

RIGHTS

APPENDIX 3 RIGHTS
AS 47.30.817 - AS 47.30.865 PATIENT RIGHTS
AS 47.30.870 - AS 47.30.915 MISCELLANEOUS PROVISIONS

TIME FRAMES

- The hearing to determine the patient's capacity to give or withhold informed consent as described in AS 47.30.837 and the patient's capacity to give or withhold informed consent at the time of previously expressed wishes regarding medication if previously expressed wishes are documented must be scheduled to occur within **72 hours** of filing of petition for non-consensual medication (not respondent's commitment). **AS 47.30.839(e).**
- The hearing on **medication petition must be continued** so that the statutory protections including a comprehensive visitor's report are not completed. *Wetherhorn,* 156 P.3d at 381.
- If respondent is refusing antipsychotic medication recommended by the hospital a Petition for Court Approval To Administer Non-Emergency Psychotropic Medication is usually filed at same time as a new petition for further commitment.

EVIDENCE

- The court shall consider all evidence presented at the hearing, including evidence presented by the guardian ad litem, the petitioner, the visitor, and the patient. The patient's attorney may cross-examine any witness, including the guardian ad litem and the visitor. AS 47.30. 839(e).
- The reports prepared for a previous hearing on a petition for non-emergency nonconsensual administration of medication are admissible in the new hearing provided that they are updated by the visitor and any guardian ad litem. AS 47.30.838(h).
- Expert Witness - Evidence Rules 702(a) and 703.

Burden of Proof

- If the court finds by **clear and convincing evidence** that (1) the patient is presently **not competent to give or withhold informed consent** and (2) the patient **did not previously express any competent wish** not to be medicated in the future, then the court may authorize non-consensual treatment with psychotropic medications so long as the treatment is in the patient's best interest. AS 47.30.839(g), *Myers,* 138 P.3d a1.253.
- **The court must find by clear and convincing evidence** that the proposed course of treatment is in respondent's **best interest**.
  - o The court must consider the factors in AS 47.30.837(d)(2):
    - ▪ an explanation of the patient's diagnosis and prognosis with and without the medication;
    - ▪ information about the medication, including purpose, administration, possible side effects and benefits, ways to prevent side effects and other risks, including tardive dyskinesia;

    - the patient's history, including medication and side effect history
    - any interaction of the medication with other drugs, including OTC and street drugs and alcohol;
    - alternative treatments with risks, side effects, and benefits, including the risks of non-treatment.
  - There must be **clear and convincing evidence** that no less intrusive treatment alternative is available and that the recommended course of treatment meets the standard of medical care in the state. *Myers,* 138 P.3d at 250-253.

FINDINGS

- A petition for court approval of administration of psychotropic medication was filed on _____, 20__.
- Respondent was committed on ________, 20__ for a period of time not to exceed ______days.
- A hearing was held on _________, 20__, to inquire into respondent's capacity to give and withhold informed consent to the use of psychotropic medication.
- Having considered the allegations of the petition, the evidence presented and the arguments of counsel, the court finds:

______ The respondent has the capacity to give informed consent concerning administration of psychotropic medication for purposes of AS 47.30.386 as respondent is not found by clear and convincing evidence to be incompetent to make mental health and/or medical decisions. Petition is denied.

or

______ By **clear and convincing evidence** that the respondent is not competent to provide informed consent concerning administration of psychotropic medication and has not expressed a desire not to consent to such medication when competent.

and

______ The proposed medication plan

- ______ Is in the best interest of the respondent.
- ______ Meets the standard of medical care in the state.
- ______ There is no less intrusive means of protecting the respondent at this time.

The treating facility's proposed use of psychotropic medication is approved for the respondent's present commitment.

The facts which support the above conclusion are:

See Appendix - 7 Ability to Give and Withhold Informed Consent
Appendix - 8 Best Interest

ORDER

- The court having determined that the patient is competent to provide informed consent, and the patient having not done so, it is ordered that the treating facility shall honor respondent's decision about administration of psychotropic medication.

or

- The court having found that the patient is not competent to provide informed consent and has not expressed a competent desire not to be treated as requested, and that it is in the patient's best interest to receive the treatment, it is ordered that the treating facility's proposed use of psychotropic medication to treat the respondent is approved for the period of the respondent's current commitment.

FUTURE HEARINGS ON MEDICATION

If an evaluation facility or designated treatment facility wishes to continue the use of psychotropic medication without the patient's consent during a period of commitment that occurs after the period in which the court's approval was obtained, the facility must file a request to continue the medication when it files the petition to continue the patient's commitment. The court that determines whether commitment shall continue shall also determine whether the patient continues to lack the capacity to give or withhold informed consent by following the procedures described in AS 47.30.839(b)-(e). The reports prepared for a previous hearing are admissible in the hearing to continue the non-consensual treatment provided that they are updated by the visitor and any guardian ad litem. AS 47.30.839(h).

APPEAL RIGHTS

- Respondent may file objections to Master's Recommendations (usually within 3 days). Probate Rule 2(f)(1).
- Nothing in AS 47.30.660 - 47.30.915 may be construed as limiting a person's right to a writ of habeas corpus. AS 47.30.810.

APPENDIX 1
MENTALLY, GRAVELY DISABLED, DANGER TO SELF OR OTHERS

Mentally ill and as a result of mental illness a danger to self or others or gravely disabled

I. Mentally ill[1] and as a result a danger to Self:

1. Clear and convincing evidence of **mental illness** including**:**

- Dr. _________________ testimony regarding

  ____ Medical/neurological exam and results: ____

  ____ Psychiatric examination re mental condition results: ____

- **Signs** and symptoms of the diagnosed illness including : ____ ____

2. and as a result of mental illness[2] is likely to cause danger to self:

3. Clear and convincing evidence including testimony that respondent is likely to cause serious harm[3] **to self.[4]** AS 47.30.915(10) Including testimony of ______that respondent ____________________ ____

4. Clear and convincing evidence there is **no less restrictive viable alternative[5]** available based on:

- the testimony that there is no viable less restrictive alternative, including the testimony of ______ that ____ is appropriate and that there is no appropriate less restrictive alternative because___________________________________ and

---

[1] Mental illness alone is insufficient to form a constitutionally adequate basis for involuntary commitment. Before a person can be involuntarily committed, the court must either find person presents a danger to self or others or is gravely disabled to the extent that the person is "helpless to avoid the hazards of freedom either through his own efforts or with the aid of willing family members or friends. Wetherhorn v, API, 156 P.3d 371, at 379 (Alaska 2007).

[2] Mental illness alone is insufficient to form a constitutionally adequate basis for involuntary commitment. Before a person can be involuntarily committed, the court must either find person presents a danger to self or others or is gravely disabled to the extent that the person is "helpless to avoid the hazards of freedom either throught his own efforts or with the aid of willing family members or friends. Wetherhorn v. API, 156P.3d 371, at 379 (Alaska 2007).

[3] "likely to cause serious harm" means a person who (A) poses a substantial risk of bodily harm to that person's self, as manifested by recent behavior causing, attempting, or threatening that harm;….or (C) manifests a current intent to carry out plans of serious harm to that person's self or another.

[4] Risk of harm refers to active risk rather than passive risk for of harm. In Wetherhorn the Supreme Court said that risk of harm is concerned with active forms of harm where patient has demonstrated an affirmative ability or inclination to inflict harm. It does not mean a passive condition of risk.

[5] See Appendix 4 No Less Restrictive Alternative.

- other options have been considered and rejected on the grounds that the conditions of treatment are no more, harsh, hazardous, ______________
- and, there are no restrictions on physical movement nor supervised residential or inpatient care except as reasonably necessary for treatment or protection of patient or others from injury.

II. Mentally Ill and as a result a Danger to Others**:**

1. Clear and convincing evidence of **mental illness** including**:**

- Dr. ______________ testimony regarding
  ____ Medical / neurological exam and results:
  ____
  ____ Psychiatric examination re mental condition results:
  ____
- **Signs** and symptoms of the diagnosed illness including :
  ____
  ____

2. as a result of the mental illness is **likely to cause harm to others**[6] based on the testimony of _______________that respondent:

o **Is likely in the near future** to cause **physical injury, physical abuse,** or **substantial property damage** to **another person,** ____
____
or

o manifests a **current intent** to **carry out plans** of **serious harm to another**
____

3. Clear and convincing evidence that that the evaluation staff has considered but not found that there are any less restrictive alternatives available based on:

o the testimony of _____ that there is no viable less restrictive alternative, including the testimony of ________ that ____ is appropriate and that there is no appropriate less restrictive alternative because ____ and

o other options have been considered and rejected on the grounds that the conditions of treatment are no more, harsh, hazardous, or intrusive than necessary to achieve the treatment objectives because____ and

o there are no restrictions on physical movement nor supervised

residential or inpatient care except as reasonably necessary for treatment or protection of patient or others from injury.[3]

III. Finding of Mentally Ill and Danger **Self and Others**
See above I. and II

IV. Mentally ill and as a result is **gravely disabled**[7]

1. Clear and convincing evidence of **mental illness** including**:**

- Dr. ________________ testimony regarding
  ____ Medical / neurological exam and results:
  ____
  ____ Psychiatric examination re mental condition results:
  ____
- **Signs** and symptoms of the diagnosed illness including :
  ____
  ____

2. and as a result of the mental illness is **gravely disabled**[4]

3. Clear and convincing evidence that the evaluation staff has considered but has not found that there are any less restrictive alternatives available *Wetherhorn. 156 P.3d* at 378.

See Appendix 4 No Less Restrictive Alternative.

4. Clear and convincing evidence with respect to **grave disability** that there is reason to believe that respondent's mental condition could be improved by the course of treatment sought. *Wetherhorn*, 156 P.3d at 378.

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[6] Risk of harm refers to active rather than passive forms of harm. In Wetherhorn the Supreme Court said that risk of harm is concerned with active forms of harm where the patient has demonstrated an affirmative ability or inclination to inflict harm. It does not mean a passive condition of risk. Wetherhorn vs. API, 156 P.2d 371 (AK 2007). "likely to cause serious harm" means a person who … B) poses a substantial risk of harm to others as manifested by recent behavior causing, atte7mpting, or threatening harm, and is likely in the near future to cause physical injury, physical abuse, or substantial property damage to another person; or (C) manifests a current intent to carry out plans of serious harm to that person's self or another. AS.47.30.915 (10).

[7] "gravely disabled" means a condition in which a person as a result of mental illness (A) is in danger of physical harm arising from such complete neglect of basic needs for food, clothing, shelter, or personal safety as to render serious accident, illness, or death highly probable if care by another is not taken; or (B) will, if not treated, suffer or continue to suffer severe and abnormal mental, emotional, or physical distress, and this distress is associated with significant impairment of judgment, reason, or behavior causing a substantial deterioration of the person's previous ability to function independently. AS 47.30.915(7)
NOTE: the distress justifying involuntary commitment must be construed as a level of incapacity which prevents the patient from being able to live safely in freedom outside a controlled environment. Wetherhorn.
NOTE: A petition that alleges one is gravely disabled must indicate there is reason to believe respondent's mental condition could be improved by the course of treatment sought in order to be constitutional and that finding must be by clear and convincing evidence. Wetherhorn; AS 47.30.730(3).

Checklist for finding of gravely disabled finding under AS 47.30.915(7)(A):

NOTE: **Section (A)** has req. that a person merely present "***some danger***" to self.

1. ______ Clear and convincing evidence that respondent is mentally ill and as a result is gravely disabled including testimony that respondent:

___ in "**some**" danger of **physical harm** from complete neglect of basic needs for

___ **FOOD** ___ **CLOTHING** ___ **SHELTER** ___ **PERSONAL SAFETY** as to render **HIGHLY PROBABLE**, if care by another is not taken;

___ serious accident, ___ illness, or ___ death will occur.

Supporting evidence includes testimony that ________________________

____

____

2. that the evaluation staff has considered but not found that there are any **less restrictive alternatives** available.

Checklist for finding of gravely disabled finding under AS 47.30.915(7)(B) :

1. Clear and convincing evidence that respondent is mentally ill and as a result of the mental illness is **GRAVELY DISABLED** and will, if not treated, suffer or continue to suffer **severe** and **abnormal**:

____ mental distress,
____ emotional distress, or
____ physical distress,

and this **distress** is associated with **significant impairment of:**

____ **judgment,**
____ **reason, or**
____ **behavior causing a substantial deterioration of the person's previous ability to function independently.**[8]

____ **MENTAL DISTRESS**

Supporting evidence of **SEVERE** and **ABNORMAL MENTAL DISTRESS** includes testimony of __________ that the respondent is unable to function independently and safely outside the hospital environment because **mental distress results in/causes** ________________________________

and the hospital setting is needed to avoid the danger of___

____

and/or the threat of ________________________________

____

____ **EMOTIONAL DISTRESS**

Supporting evidence of **SEVERE** and **ABNORMAL EMOTIONAL DISTRESS** includes testimony of _________that the respondent is unable to function independently and safely outside the hospital environment because the **emotional distress causes**___________

and the hospital setting is needed to avoid the danger of_______ and/or the threat of ____________________________________

____ **PHYSICAL DISTRESS,**

Supporting evidence of **SEVERE** and **ABNORMAL PHYSICAL DISTRESS** includes testimony of __________that the respondent is unable to function independently and safely outside the hospital because the **physical distress causes** ____

____

and the hospital setting is needed to avoid the danger of_________ and/or the threat of ______________________________________

and

2. Respondent's **severe** and **abnormal** **mental**, **emotional** and/or **physical distress** is associated with impairment of judgment, reason and/or behavior causing a **substantial deterioration of a previous ability to function independently** and **inability to live safely in freedom outside the hospital environment.**

NOTE: The nexus/association must be between the **distress** and the **impairment** of **judgment**, **reason and/or behavior** - **not** a nexus between mental illness and any relationship to impaired judgment/reason/ behavior.

____ **JUDGMENT**

The __mental __ emotional and/or __ physical distress significantly impairs respondent's **JUDGMENT** and prevents the respondent from **living safely in freedom outside** the hospital environment by causing a substantial deterioration of respondent's previous ability to function independently including testimony of ________that the

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[8] NOTE: Section (A) has a requirement that a person merely present "some danger" to self. However, Section (B) requires that respondent must suffer distress that rises to the level of "genuine and serious suffering" and that there be a "significant" impairment" causing a "substantial" deterioration. The "distress" that justified commitment refers to a level of incapacity that prevents the person in question from being able to live safely outside of a controlled environment. Wetherhorn, 156 P.3d at 378.

*Testimony needs to address ability to function independently and safely outside the hospital environment. A person may not be involuntarily committed if they are dangerous to no one and can live safely in freedom. Addington v. Texas 441 U.S. 418, AS 47.30.915(7)(B) requires that there be a "significant" impairment causing a "substantial" deterioration.

respondents suffers __ physical __ mental __ emotional distress including:
Impaired judgment as evidenced by:________________________
____

Distress due to significantly impaired judgment has caused substantial deterioration of a previous ability to function independently as evidenced by: ______________________________________
____

A substantial deterioration and inability to function independently/ safely outside of the hospital environment as evidenced by:
____
____

and the **hospital setting is needed to avoid the danger/threat of:**

____

____ **REASONING**
The __mental __ emotional and/or __ physical distress significantly impairs respondent's reasoning and prevents the respondent from **living safely in freedom outside** the hospital environment by causing a substantial deterioration of respondent's previous ability to function independently including **testimony** that the respondent suffers __physical __mental __emotional distress including:
Impaired reasoning as evidenced by:______________________
____

Distress due to significantly impaired reasoning that has caused a substantial deterioration of a previous ability to function independently as evidenced by:

____
____

A substantial deterioration and inability to function independently/ safely outside of the hospital environment as evidenced by: ______
____

and the **hospital setting is needed to avoid the danger/threat of:**

____

____ **BEHAVIOR**
The __mental __ emotional and/or __ physical distress significantly impairs respondent's **BEHAVIOR** and prevents the respondent from **living safely in freedom outside** the hospital environment by

causing a substantial deterioration of respondent's previous ability to function independently including **testimony** that the respondent suffers __ physical __ mental __ emotional distress including

Impaired behavior as evidenced by:________________________
____

Distress due to significantly impaired behavior that has caused a substantial deterioration of a previous ability to function independently as evidenced by: ____________________________

A substantial deterioration and inability to function independently/ safely outside of the hospital environment as evidenced by:______
____

and the **hospital setting is needed to avoid the danger/threat of:**

____

3. Clear and convincing evidence that that the evaluation staff has considered but not found that there are any less restrictive alternatives available based on:

- o the testimony of _____ that there is no viable less restrictive alternative, including the testimony of ______ that ____ is appropriate and that there is no appropriate less restrictive alternative because ____ and
- o other options have been considered and rejected on the grounds that the conditions of treatment are no more, harsh, hazardous, or intrusive than necessary to achieve the treatment objectives because ____ and
- o there are no restrictions on physical movement nor supervised residential or inpatient care except as reasonably necessary for treatment or protection of patient or others from injury.
  See Appendix 4 No Less Restrictive Alternative.

4. Finding of **gravely disabled** requires the court also find**:**

- Clear and convincing evidence, with respect to respondent's grave disability, that there is reason to believe that respondent's mental condition could be improved by the course of treatment sought. *Wetherhorn*, 156 P.3d at 378.
- respondent is helpless, as a result of being gravely disabled, to avoid the hazards of freedom either through own efforts or with the aid of willing family members or friends and is unable to exist safely outside the institutional framework. *Wetherhorn*, 156 P.3d at 379.

APPENDIX 2
NOTICE

EMERGENCY HEARING

AS 47.30.715
AS 47.39.725
AS 47.30.775

- Notice of Rights upon Detention for Evaluation (MC-405) will be completed and read to respondent by peace officer or member of facility staff upon admittance. AS 47.30.725.
- Notices required to be served on adult respondent shall be served on minor respondent and the minor's parents or guardians. AS 47.30.775.
- When a facility receives a proper order for evaluation, it shall accept the order and the respondent for an evaluation period not to exceed 72 hours. The facility shall promptly notify the court of the date and time of the respondent's arrival. The court shall set a date, time and place for a 30-day commitment hearing, to be held if needed within 72 hours after the respondent's arrival, and the court shall notify the facility, the respondent, the respondent's attorney, and the prosecuting attorney of the hearing arrangements. AS 47.30.715.

NONEMERGENCY HEARING

(same as Emergency Hearing)

30-DAY COMMITMENT HEARING

AS 47.30.725
AS 47.30.730
AS 47.30.735

Notice given to:

- respondent, respondent's guardian, any adult designated by respondent, (AS 47.30.715)
- respondent's attorney AS 47.30.725(a)
- parent/legal guardian, if respondent a minor AS 47.30.775
- parents or guardians of a **minor** respondent shall be notified. AS 47.30.775
- the parents or guardians of a respondent who is a **minor,** AS 47.30.775 [Parents or guardians must also be told that they may appear as parties in any commitment proceeding concerning the minor and as parties are entitled to retain or have an attorney appointed by court. Treatment facility

must also notify parents or guardians of minor if detained/admitted or committed to a treatment facility. AS 47.30.693]

Due process requires notice in a manner that respondent has a reasonable opportunity to prepare and reasonably calculated to inform the respondent of the nature and purpose of the commitment hearing. Notice should inform respondent of the purpose of hearing, statutory scheme, evidentiary standard and facts to be adduced at hearing. *Wetherhorn,* 156 P.3d at 380.

Notice must be in language understood by respondent. AS 47.30.725(a).

The court shall specifically state to the respondent, and give the respondent written notice, that if commitment or other involuntary treatment beyond the 30 days is to be sought, the respondent has the right to a full hearing or jury trial. AS 47.30.735(e).

90-DAY COMMITMENT HEARING

- Same as Notice at the 30-Day Commitment

180-DAY COMMITMENT HEARING

- Same as Notice at the 30 and 90-Day Commitment
- The procedures for service of the petition, notification of rights, and judicial hearing shall be as set out in AS 47.30.740 - 47.30.750. AS 47.30.770 (b).

HEARING ON PETITION FOR AUTHORIZATION OF MEDICATION

AS 47.30.725(e); See 30/90/180-Day Notice Requirements

APPENDIX 3
RIGHTS

The United States Supreme Court has characterized involuntary commitment as a "massive curtailment of Liberty" that cannot be accomplished without due process of law. *Addington v. Texas*, 441 U.S. 418, 425 (1979).

EMERGENCY HEARING

MC-405 Notice of Rights Upon Detention for Evaluation
See also:
AS 47.30.817-AS 47.30.865 PATIENT RIGHTS
AS 47.30.870-AS 47.30.915 MISCELLANEOUS PROVISIONS

<u>Minor's Rights</u>

- Minor is an individual under 18 years of age. AS 47.30.705.
- Emergency protective custody and detention for evaluation under AS 47.30.705 may not include placement of a **minor** in a jail or secure facility. AS 47.30.705(a).
- Notice served on minor/and parents or guardians. AS 47.30.775.
- Appointment of a guardian ad litem made to monitor **minor's** best interest as soon as possible after admission. AS.47.30.690(b).
- If guardian ad litem finds the placement of **minor** not appropriate, GAL may request attorney appointment under AS 25.24.310.
- Attorney (appointed at request of GAL) may request a hearing on behalf of **minor** during the 30 day admittance. AS 47.30.690(b).
- Minor may be released at any time if the designated mental health professional determines minor would no longer benefit from continued treatment and minor is not dangerous. AS 47. 30.690(c).
- If parent or guardian requests release of **minor** but the physician's opinion is that minor is likely to cause serious harm to self or others and there is a reason to believe release could place child in imminent danger, physician shall refuse release and file involuntary commitment proceedings and hold minor until court order is issued. AS 47.30.690(3).
- Minor's parents or guardian must be notified by the facility of the contemplated release. AS 47. 30.690(c)
- When a **minor** is detained or admitted to a treatment facility, the facility shall inform the parents or guardians of the location of minor ASAP after arrival. AS 47.30.693.
- A **minor** as well as the parents or guardians have right to counsel (party status), including representation at public expense. AS 47.30.775.

- Right to be present at hearing, may be **waived** only with **respondent's informed consent**. If incapable of informed consent, respondent **may be excluded only** if court, **after hearing**, finds incapacity exists and there is a substantial likelihood that respondent's presence at hearing would be severely injurious to his or her mental or physical health. AS 47.30.735 (b)(1).
- A **minor** respondent has same rights to waiver and informed consent as an adult respondent under AS 47.30.660 - 47.30.915; however, the minor must be represented by counsel in waiver and consent proceedings. AS 47.30.775.
- **A minor who turns 18 while admitted voluntarily or detained is entitled to Notice of Rights (adult version).** AS 47.30.675.

<u>**Adult Rights**</u>

- An adult taken into custody for an emergency evaluation may not be placed in jail or other correctional facility except for protective custody purposes while awaiting transport to treatment facility. AS.47.30.705(a).
- In emergency applications, the peace officer or mental health professional shall complete an application for examination of the person in custody and the person must be interviewed by a mental health professional at the facility. AS 47.30.705(a).
- A respondent who is delivered under AS 47.30.700 - 47.30.705 to an evaluation facility for emergency examination and treatment must be examined and evaluated as to mental and physical condition by a mental health professional and by a physician within 24 hours after arrival at the facility. AS 47.30.710(a).
- When a facility receives a proper order for evaluation, it must accept the order and the respondent for an evaluation period not to exceed 72 hours. The facility must promptly notify the court of the date and time of the respondent's arrival. The court must set a date, time and place for a 30-day commitment hearing to be held, if needed, within 72 hours after the respondent's arrival, and the court must notify the facility, the respondent, the respondent's attorney, and the prosecuting attorney of the hearing arrangements. AS 47.30.715.
- When the facility receives proper order for evaluation, the evaluation period is not to exceed 72 hours. Having been noticed of arrival, court shall set 30 day commitment hearing to be held, if needed, within 72 hours of respondent's arrival. AS 47.30.715.
- The respondent has the right to be discharged if at any time if the mental health professionals conducting the evaluation conclude that the respondent does not meet the standards for commitment specified in AS 47.30.700. AS 47.30.720.

- If the respondent is so released, the petitioner and the court must be notified. AS 47.30.720.
- When a respondent is detained for evaluation under AS 47.30.660 - 47.30.915, the respondent shall be immediately notified orally and in writing of rights specified in AS 74.30.725(a).
- Notification must be in a language understood by the respondent. AS 47.30.725(a)
- The respondent's guardian, if any, and if the respondent requests, an adult designated by the respondent, shall also be notified of the respondent's rights under section AS 47.30.725(a).
- Respondent is entitled to a court hearing to be held not later than the end of the 72-hour evaluation period to determine whether there is cause for detention after the 72 hours have expired for up to an additional 30 days on the grounds that the respondent is mentally ill, and as a result presents a likelihood of serious harm to the respondent or others, or is gravely disabled. AS 47.30.725(b).
- Respondent has a right to communicate immediately, at the department's expense, with the respondent's guardian, if any, or an adult designated by the respondent, and the attorney appointed in the ex parte order, or an attorney of the respondent's choice. AS 47.30.725(c).
- Respondent has the right to be represented by an attorney, to present evidence, and to cross-examine witnesses who testify against the respondent at the hearing. AS 47.30.700(a) and AS 47.30.725(d).
- Respondent has the right to be free of the effects of medication and other forms of treatment to the maximum extent possible before the 30-day commitment hearing; however, the facility or evaluation personnel may treat the respondent with medication under prescription by a licensed physician or by a less restrictive alternative of the respondent's preference, if, in the opinion of a licensed physician in the case of medication, or of a mental health professional in the case of alternative treatment, the treatment is necessary to
  (1) prevent bodily harm to the respondent or others;
  (2) prevent such deterioration of the respondent's mental condition that subsequent treatment might not enable the respondent to recover, or
  (3) allow the respondent to prepare for and participate in the proceedings.
- Respondent, if represented by counsel, may waive, orally or in writing, the 72-hour time limit on the 30-day commitment hearing and have the hearing set for a date no more than seven calendar days after arrival at the facility. The respondent's counsel shall immediately notify the court of the waiver. AS 47.30 725(f).

NONEMERGENCY HEARING

Rights same as EMERGENCY HEARING

30-DAY COMMITMENT HEARING

AS 47.30.725
AS 47.30.735
AS 47.30.660 - AS 47.30.915
AS 47.30.817 - AS 47.30.865 PATIENT RIGHTS
AS 47.30.870 - AS 47.30.915 MISCELLANEOUS PROVISIONS

See also:

- Change of Judge as a Matter of Right Civil Rule 42(c)
- Respondent entitled to all the rights in AS 47.30.725 (summarized in the Emergency Commitment Hearing checklist)
- The respondent has the right to a hearing on the petition for a 30-day commitment according to procedures set out in AS 47.30.715.

Rights of respondent at the 30, 90 and 180 Day Commitment Hearings:

- To hearing in physical setting least likely to have harmful effect on mental or physical health of respondent, within practical limits. AS 47.30.735(b).
- To be present at hearing, **waived** only with **respondent's informed consent**. If incapable of informed consent, respondent **may be excluded only** if court, **after hearing**, finds incapacity exists and there is a substantial likelihood that respondent's presence at hearing would be severely injurious to his/her mental or physical health. AS 47.30.735 (b)(1).
- To view and copy all petitioners and reports in the court file. AS 47.30.735(b)(2).
- To have the hearing open or closed to public as respondent elects. AS 47.30.735(b)(3).
- To have rules of evidence and civil pro applied to provide for informal but efficient presentation of evidence. AS 47.30.735(b)(4).
- To have an interpreter. AS 47.30.735(b)(5).
- To present evidence. AS 47.30.735(b)(6)
- To cross examine witnesses. AS 47.30.735(b)(7).
- To remain silent. AS 47.30.735(b)(8).
- To call experts and other witnesses to testify on respondent's behalf. AS 47.30.735(b)(9).
- To be committed for no more than 30 days, if the court finds by clear and convincing evidence that respondent is mentally ill and as a result is likely to cause harm to respondent or others or is gravely disabled. AS

47.30.735(c).

- To be committed to the viable less restrictive alternative available. AS 47.30.735(d).
- To verbal and written notice of right to full hearing or jury trial if commitment or other involuntary treatment beyond 30 days is sought. AS 47.30.735 (e)
- Until the court issues a final decision, to be treated at the treatment facility unless the petition for 30-day commitment is withdrawn.
- To be released, if a decision has not been made on the petition within 20 days of filing of the petition, not including extensions of time due to jury trial or other requests by the respondent. AS 47.30.745(g)
- To treatment at facility closest to home unless another treatment facility is more suited to respondent's condition or another treatment facility is closer to friends or relatives who could benefit respondent through visits/communication or respondent wants to be further removed from home, and mental health professionals who sought respondent's commitment concur in the desirability of removed placement. AS 47.30.760.
- To early discharge if the professional person in charge concludes that the respondent is no longer gravely disabled or likely to cause serious harm as a result of mental illness. A certificate to this effect shall be sent to the court which shall enter an order officially terminating the involuntary commitment. AS 47.30.780.
- To authorized absences from the treatment facility during times specified by the professional person in charge, or that person's professional designee, when an authorization to be absent is in the best interests of the respondent and the respondent is not likely to cause harm to self or others. AS 47.30.785.
- To appeal from order of involuntary commitment and to be so informed by the court. AS 47.30.765.
- To seek a writ of habeas corpus. AS 47.30.810.

Minor's Additional Rights - a minor is an individual under 18 years of age. AS 47.30.705

- To not be placed in a jail or a secure facility for emergency protective custody or detention for evaluation under AS 47.30.705.
- To appointment of a guardian ad litem to monitor **minor's** best interest as soon as possible after admission. AS.47.30.690(b).
- To have the GAL seek appointment of an attorney, if guardian ad litem finds the placement of **minor** not appropriate. AS 25.24.310.
- To have the attorney may request a hearing on behalf of **minor** during the 30-day admittance. AS 47.30.690(b).
- To be released at any time if designated mental health professional determines the minor would no longer benefit from continued treatment

and is not dangerous. AS 47. 30.690(c).

- To release upon request of parents or guardians, unless physician's opinion is that minor is likely to cause serious harm to self/others and the physician has reason to believe release could place child in imminent danger. In that case the physician can refuse release and file involuntary commitment proceedings and hold minor until court order issued. AS 47.30.690(3)
- To have parents or guardians be notified by the facility of any contemplated release. AS 47. 30.690(c)
- To have the parents or guardians notified of the location of the minor ASAP after arrival when minor is detained or admitted to a treatment facility. AS 47.30.693.
- To counsel (and party status).
- To be present at hearing, **waived** only with **respondent's informed consent**. If incapable of informed consent, respondent **may be excluded only** if court, **after hearing**, finds incapacity exists and there is a substantial likelihood that respondent's presence at hearing would be severely injurious to his/her mental or physical health. AS 47.30.735 (b)(1).
- To waiver and informed consent the same as an adult respondent under AS 47.30.660 - 47.30.915; but the minor must be represented by counsel in waiver and consent proceedings.

90-DAY COMMITMENT HEARING

AS.47.30.725
AS 47.30.735
AS 47.30.660 – AS 47.30.915
AS 47.30.817 - AS 47.30.865 PATIENT RIGHTS
AS 47.30.870 - AS 47.30.915 MISCELLANEOUS PROVISIONS

In addition to all 30-Day Commitment Hearing Rights listed above, a respondent who is the subject of a petition for 90-day commitment has, in addition to rights specified elsewhere in Title 47 section 30, or otherwise applicable, the rights enumerated in AS 47.30.745, including:

- Service of written notice of rights and service on attorney and guardian, if any. An adult designated by the respondent may be served at the time the petition for 90-day commitment is served. AS 47.30.745(a).
- To an oral attempt to explain the rights to ensure that the respondent understands the rights. AS 47.30.745(a).
- To a judicial hearing within 5 judicial days of the filing of petition. AS 47.30.745 (b).
- To a petition and hearing for 180-day commitment, if at any time during the respondent's voluntary admission under this subsection, the respondent submits to the facility a written request to leave and the professional

person does not agree to discharge. The 180-day commitment hearing must be scheduled for a date not later than 90 days after the respondent's voluntary admission. AS 47.30.745(b).

- To a 6 person jury trial, if request made at least 2 days before hearing. AS 47.30.745(c).
- If jury trial not requested, to have the hearing without continuance of more than 10 calendar days. AS 47.30.745(d).
- To retain an independent licensed physician or other mental health professional to examine the respondent and to testify on the respondent's behalf (court appointed if indigent). AS 47.30.745(e)
- To have all proceedings comport with constitutional guarantees of due process and, except as otherwise specifically provided in AS 47.30.700 - 47.30.915, the rules of evidence and procedure in civil proceedings. AS 47.30.745(f).
- To treatment at the treatment facility until the court's decision is made unless the petition for 90-day commitment is withdrawn**.** AS 47.30.745(g)
- **To release if the decision not been made within 20 days of filing of the petition**, not including extensions of time due to jury trial or other requests by respondent. AS 47.30.745(g)
- To have the 90-day hearing conducted in same manner and with same rights set out in AS 47.30.735(b). AS 47.30.750.

180-DAY COMMITMENT HEARING

AS 47.30.770
AS 47.30.817 - AS 47.30.865 PATIENT RIGHTS
AS 47.30.870 - AS 47.30.915 MISCELLANEOUS PROVISIONS

- In addition to all the 30/90-Day Commitment Hearing Rights listed above, the respondent has these rights:
- To release at 90 days unless petition for 180-day commitment filed. AS 47.30.770(a)
- To proper service of the petition, notification of rights, and judicial hearing as set out in AS 47.30.740 - 47.30.750. AS 47.30.770 (b).
- Finding by clear and convincing evidence by the court or jury that the grounds for 90-day commitment as set out in AS 47.30.755 present. Court may order respondent committed for additional treatment not to exceed 180 days from date on which first 90-day treatment period would have expired. AS 47.30.770(b)

COURT ORDERED ADMINISTRATION OF ANTIPSYCHOTIC MEDICATION

AS 47.30.817 - AS 47.30.865 PATIENT RIGHTS
AS 47.30.870 - AS 47.30.915 MISCELLANEOUS PROVISIONS

- See AS 47.30.838 for **use of psychotropic** medication **in emergencies** and exceptions.
- See AS 47.30.839 for **procedures for treatment facility to obtain court approval** for administration of psychotropic medication.

Other rights:

- Hearing to determine the patient's capacity to give or withhold informed consent must occur within **72 hours** of filing of petition (not admission). AS 47.30.839(e).
- Representation by an attorney (court appointed if indigent). AS 47.30.839(c)
- A guardian ad litem may be appointed at the request of patient's attorney. AS 47.30.839(c).
- An evaluation facility or designated treatment facility may administer medication or other treatment to an involuntarily committed patient only in a manner that is consistent with the provisions of AS 47.30.825 - 47.30.865. AS 47.30.772.
- The patient's attorney may cross-examine any witness, including the guardian ad litem and the visitor. AS 47.30.839(e).
- Visitor must be appointed to assist the court in investigating (1) whether patient has capacity to give or withhold informed consent to the administration of psychotropic meds and (2) whether patient made an earlier statement re: treatment with psychotropic medication when competent. AS 47.30.839(d).
- Information from visitor **MUST** include (1) responses to a **capacity assessment instrument** administered at the request of the visitor and (2) any expressed wishes of the respondent regarding medication. AS 47.30.839(d).
- A hearing within 72 hours after the filing of a petition to determine patient's capacity to give or withhold informed consent (AS 47.30.837) and patient's ability to give or withhold informed consent as time of previously expressed wishes. AS 47.30.839(e).
    - NOTE: The hearing on medication petition may be continued if the visitor's report has not been filed. ***Wetherhorn***, 156 P.3d at 381.
- If court determines patient is competent to provide informed consent, the court must order the facility to honor patient's decision. AS 47.30.839(f)
- Facility must document patient's consent in file in writing if at any time during the period of the patient's commitment the patient regains competency and gives informed consent to the continuation of medication. AS 47.30.839(i).

- An evaluation facility or designated treatment facility may administer medication or other treatment to an involuntarily committed patient only in a manner that is consistent with the provisions of AS 47.30.825 - 47.30.865. AS 47.30.772.
- A facility shall follow the procedures required under AS47.30.836 - 47.30.839 **before administering psychotropic medication**.
- An evaluation facility or designated treatment facility may not administer psychotropic medication to a patient in a situation that does not involve an emergency under AS47.30.838(a)(1), unless the patient
  - o **has the capacity to give informed consent to** the medication, as described in AS47.30.837, and gives that consent [the facility must document the consent in the patient's medical chart;
  - o **authorized the use** of psychotropic medication in an **advance health care directive** properly executed under AS 13.52 or authorized an agent or surrogate under AS 13.52 to consent to the use of psychotropic medication for the patient and the agent or surrogate does consent; or
  - o is **determined by a court to lack the capacity** to give informed consent to the medication and the **court approves use** of the medication under AS47.30.839. AS 47.30.836.
- A patient has the capacity to give informed consent for purposes of AS 47.30.836 if the patient is **competent** to make mental health or medical treatment decisions and the consent is **voluntary** and **informed**. The designated treatment facility shall give the patient information that is necessary for informed consent in a manner that ensures maximum possible comprehension by the patient. AS 47.30.837 (b).
- AS 47.30.837(d) further defines a **competent**, **informed** and **voluntary** consent:
  - **"informed**" means that the evaluation facility or designated treatment facility has given the patient all information that is material to the patient's decision to give or withhold consent, including **A)** an explanation of the patient's diagnosis and prognosis, or their predominant symptoms, with and without the medication; **(B)** information about the proposed medication, its purpose, the method of its administration, the recommended ranges of dosages, possible side effects and benefits, ways to treat side effects, and risks of other conditions, such as tardive dyskinesia; **(C)** a review of the patient's history, including medication history and previous side effects from medication; **(D)** an explanation of interactions with other drugs, including over-the-counter drugs, street drugs, and alcohol; **(E)** information about alternative treatments and their risks, side effects, and benefits, including the risks of nontreatment; and **(F)** a statement describing the patient's right to give or withhold consent

to the administration of psychotropic medications in non-emergency situations, the procedure for withdrawing consent, and notification that a court may override the patient's refusal; AS 47.30.837

NOTE: The court in *Myers,* 138 P.3d 238 found consideration of these factors outlined in AS.47.30.837(d)(2) to be "**at a minimum**" crucial in establishing the **patient's best interests** as well as in illuminating the existence of **alternative treatments.** Courts should **balance the need for treatment against** the **intrusiveness of the prescribed treatment**. The following factors should be considered in balancing the need for treatment against the intrusiveness of the prescribed treatment:

(1) the extent and duration of changes in behavior patterns and mental activity effected by the treatment:

(2) the risk of adverse side effects:

(3) the experimental nature of the treatment:

(4) its acceptance by the medical community of the state: and

(5) the extent of intrusion into the patient's body and the pain connected with the treatment. *Myers,* 138 P.3d at 252.

- Court may not approve request to administer medication absent clear and convincing evidence that patient is not competent to provide informed consent and was not competent to provide informed consent at the time of any previously expressed documented wishes. AS 47.30.839(g).
- The court's approval under this subsection applies to the patient's initial period of commitment if the decision is made during that time period. If the decision is made during a period for which the initial commitment has been extended, the court's approval under this subsection applies to the period for which commitment is extended. AS 47.30.839(g).
- If an evaluation facility or designated treatment facility wants to continue the use of psychotropic medication without the patient's consent during a period of commitment that occurs after the period in which the court's approval was obtained, the facility must file a request to continue the medication when it files the petition to continue the patient's commitment. The court that determines further commitment must also determine whether the patient continues to lack the capacity to give or withhold informed consent. AS 47.30.839(h).
- If a patient for whom a court has approved medication under this section regains competency at any time during the period of the patient's commitment and gives informed consent to the continuation of medication, the evaluation facility or designated treatment facility shall document the patient's consent in the patient's file in writing. AS 47.30.839(i).

APPENDIX 4
NO LESS RESTRICTIVE ALTERNATIVE

AS 47.30.730(a) (4)
AS 47.30.735 (d)
AS 47.30.730(a)(2)
AS 47.30.740(a)
AS 47.30.755 (b)
AS 47.30.915 (9)
Wetherhorn v. API, 156 P.3d 371, 378 (Alaska 2007)

This finding is required at the 30, 90 and 180 day commitment hearings.

- AS 47.30.915 **(9)** states that "least restrictive alternative" means mental health treatment facilities and conditions of treatment that are **(A)** no more harsh, hazardous, or intrusive than necessary to achieve the treatment objectives of the patient; and **(B)** involve no restrictions on physical movement nor supervised residence or inpatient care except as reasonably necessary for the administration of treatment or the protection of the patient or others from physical injury.
- If there is a viable less restrictive available, but the respondent does not agree to go voluntarily, the court can order commitment to that facility for 30/90/180 days. The hospital then makes arrangements. AS 47.35.735(d).

THE FINDING (of no less restrictive alternative) IS BASED ON:

- the testimony of ____that there is no viable less restrictive alternative, including the testimony of ______ that ____ is appropriate and that there is no appropriate less restrictive alternative because _____________ and
- other options have been considered and rejected on the grounds that the conditions of treatment are no more, harsh, hazardous, or intrusive than necessary to achieve the treatment objectives because ______ _____________________________ and there are no restrictions on physical movement nor supervised residential or inpatient care except as reasonably necessary for treatment or protection of patient or others from injury.

APPENDIX 5
PLACEMENT AT CLOSEST FACILITY

AS 47.30.760

The statutory preference is for treatment at the facility closest to the respondent's home that has space and will accept the respondent for treatment.

Treatment shall always be available at a state-operated hospital. However, if space is available, and another treatment facility accepts the respondent, it committed the respondent must be placed by the department at the designated treatment facility closest to the respondent's home, **unless the court finds that**

- **another** treatment facility in the state has a **program more suited to the respondent's condition**, and this interest outweighs the desirability of the respondent being closer to home; **or**
- **another treatment facility** in the state is closer to the respondent's friends or relatives who **could benefit** the respondent through their **visits** and **communications; or**
- the **respondent wants** to be further removed from home, and the mental health professionals who sought the respondent's commitment concur in the desirability of removed placement.

APPENDIX 6
MENTAL COMMITMENT FORMS

Petition/Applications (MC-100 - MC-120)

MC-100 (1/07)	Petition for Initiation of Involuntary Commitment
MC-105 (1/07)	Peace Officer/Mental Health Professional Application for Exam
MC-110 (1/07)	Petition for 30-Day Commitment
MC-120 (1/07)	Petition for 180-Day Commitment

Court Orders

MC-300 (3/01)	Order for Screening Investigation
MC-305 (3/01)	Ex Parte Order (Temporary Custody for Examination/Treatment
MC-310 (3/01)	Order for 30-Day Commitment
MC-320 (3/01)	Order for 90-Day Commitment
MC-325 (3/01)	Order of Dismissal of Petition for Commitment
MC-330 (3/01)	Order Appointing Counsel for Minor

Notices of Hearings

MC-200 (3/01)	Notice of 30-Day Commitment Hearing
MC-205 (3/01)	Notice of 90-Day Commitment Hearing
MC-210 (3/01)	Notice of 180-Day Commitment Hearing

Forms Used by Evaluation or Treatment Facility (MC-400 - MC-515)

MC-400 (3/01)	Notice of Respondent's Arrival at Evaluation Facility
MC-405 (3/01)	Notice of Respondent's Upon Detention for Evaluation
MC-410 (3/01)	Notice of Release
MC-415 (3/01)	Notice of Voluntary Admission
MC-420 (12/87)	Conditions of Early Release to Outpatient Treatment
MC-425 (12/87)	Notice to Outpatient to Return to Treatment Facility Where Committed
MC-430 (3/01)	Notice of Absence from Treatment Facility
MC-435 (3/01)	Notice of Extension of Commitment Period

OTHER FORMS

MC-500 (3/01)	Affidavit of Service of Documents
MC-505 (12/87)	Motion for Dismissal of Petition
MC-506 (3/01)	Affidavit in Support of Motion to Dismiss Petition
MC-510 (12/87)	Summary of Guardian Ad Litem Contact with Minor
MC-515 (12/87)	Stipulation to Continue Commitment Hearing

MEDICATION

Findings and Order Concerning Administration of Medication

APPENDIX 7
ABILITY TO GIVE AND WITHHOLD INFORMED CONSENT

In *Myers v. API*, 138 P.2d 238 (Alaska 2006), the Alaska Supreme Court noted that an order authorizing a person's involuntary commitment does not authorize the state to treat the committed person with psychotropic drugs. Nor does it amount to a finding that the patient is incapable of giving or withholding informed consent to submit to treatment. **Involuntarily committed patients are competent until adjudicated incompetent.**

Alaska law requires that before a treatment facility may administer psychotropic medication it must provide the patient with the information necessary for consent to be informed and the patient must voluntarily consent to the medication. If the facility has **reason to believe** that the patient is **not competent** to make medical or mental health treatment decisions and the facility wants to administer psychotropic medication to the patient in a non-emergency situation, the facility must follow the procedures for court-ordered administration of medication found in AS 47.30.839.

The state is required to prove by **clear and convincing evidence that**

1. The patient is currently unable to give or withhold informed consent regarding an appropriate course of treatment. [AS 47.30.839(g), *Myers*, 138 P.3d at 242-43.]

   - Patient **lacks capacity to assimilate relevant** facts **and** to **understand his or her situation** with regard to such facts
     and
   - does not appreciate that the patient has a mental disorder or impairment; **[Note:** A patient's inability to appreciate the presence of a significantly disabling disorder or impairment mental disorder, when faced with substantial evidence of its existence is a **relative consideration but not dispositive.**]
     and
   - is **unable to participate in treatment decisions** by means of a **rational thought process**
     and
   - is **unable to assimilate any reasonable objection** to the proposed medication. AS 47.30.837(d).
     AND

2. The patient never previously made a statement while competent that expressed a **desire to refuse future treatment** with psychotropic medication. AS 47.30.839(d)(2) and .839(g).

Testimony regarding competency and ability to to give/withhold Informed Consent

<u>Inquiry of Doctor</u>

(See also APPENDIX 7 BEST INTEREST CHECKLIST)

At a minimum, has respondent been advised verbally and in writing of the information required by AS 47.30.837(d)?

Has doctor meet with and had discussions with respondent? If so, how many times?

Has doctor reviewed the patient's history, including medication history and previous side effects from medication?

Has respondent been given an explanation of interactions with other drugs, including over-the-counter drugs, street drugs, and alcohol, and information about alternative treatments and their risks, side effects, and benefits, including the risks of nontreatment?

ADVANCE DIRECTIVES

Has respondent had any **expressed wishes** regarding the regarding medication, including:

- wishes that may have been expressed in a power of attorney, a living will, an advance health care directive under AS 13.52,
- or oral statements of the patient, including conversations with relatives and friends that are significant persons in the patient's life as those conversations are remembered by the relatives and friends;

Did you administer a **capacity assessment instrument** at the request of the visitor?

Please state your opinion and the factual basis of opinion, regarding respondents;

- o **ability to assimilate facts**
- o **thought process**
- o ability to cognitively **process information**
- o **judgment**
- o **insight** into mental illness
- o **capacity to participate in treatment plan and decisions with rational thought**
- o **ability to articulate reasonable objections** to medication
- o ability to give/withhold Informed Consent (informed, competent and voluntary).

INQUIRY OF VISITOR (AS 47.30.839(d))

VISITOR'S REPORT. **CAUTION: DO NOT PROCEED TO HEARING WITHOUT A VISITOR'S REPORT**, to do so is plain error. *See Wetherhorn*, 156.3d at 381-82. The purpose of the visitor's report is to assist the court in investigating the issue of whether the patient has the capacity to give or withhold informed consent to the administration of psychotropic medication. Visitor interviews respondent and gathers pertinent information to present it to the court in written or oral form at the hearing. The information must include documentation of the results of:

- **interview** with respondent
- the patient's **responses to a capacity assessment instrument** administered at the request of the visitor;
- any **expressed wishes of patient** regarding medication at any time, expressed in any context, including
  - power of attorney
  - living will
  - advance health care directive AS 13.52
  - oral statements (should be accompanied by description of circumstances under which patient made statements when possible)
  - conversations with relatives/friends
- **review of chart**
- information from speaking with **family**
- information from speaking with **provider**
- Respondent's **prior statements** re: administration of medication
- Discussion regarding respondent's **understanding of why respondent is at the hospital**
- **Discussion regarding side effects** and **concerns of medication**
- Visitor's conclusions, and **supporting evidence** re respondent's competency
- **responses to a capacity assessment instrument** administered at the request of the visitor
  - Respondents **ability to assimilate facts,**
  - **thought process,**
  - ability to cognitively **process information** is ______________________
  - **Judgment** is ____
  - **insight** into mental illness ______________________________________
  - **Capacity to participate** in **treatment plan and decisions** with **rational thought** ____
  - **Ability to articulate reasonable objections** to medication

- **Opinion** regarding ability to **give/withhold Informed Consent** that is **competent, informed and voluntary.** See AS 47.30.837

FINDINGS ON ISSUE OF ABILITY TO GIVE/WITHHOLD INFORMED CONSENT

Visitor's testimony:

- The court visitor reported that she did/did not speak with respondent /Dr _____ and ____
- Based on the information available, the visitor :
  - found no evidence/evidence of prior medical directive by the respondent
  - concluded that the respondent can/can not participate rationally in a discussion concerning antipsychotic medication.
- Visitor testified that respondent's
  - **ability to assimilate facts is** ______________________________
  - **thought process is** ____________________________________
  - ability to cognitively **process information** is ____________________
  - **judgment** is ____
  - **insight** into mental illness is _______________________________
  - **capacity to participate** in **treatment plan and decisions** with **rational thought is** ____
  - **ability to articulate reasonable objections** to medication is ________
- **Visitor's Opinion** regarding ability to **give/withhold Informed Consent** that is/ is not **competent, informed and voluntary.** AS 47.30.837 _____________

Doctor's testimony

- no evidence/evidence of prior medical directive by the respondent
- respondent provided/not provided the information required by AS 47.30.837(d)
- doctor did/did not discuss information with respondent (briefly/at length)
- concluded that the respondent can/can not participate rationally in a discussion concerning antipsychotic medication
- Dr. ____testified that _______administered a **capacity assessment instrument** and concluded respondent's
  - **ability to assimilate facts is** ______________________________
  - **thought process is** ____________________________________
  - ability to cognitively **process information** is ____________________
  - **judgment** is ____
  - **insight** into mental illness is _______________________________
  - **capacity to participate** in **treatment plan and decisions** with **rational thought is** ____
  - **ability to articulate reasonable objections** to medication is ________
- **Opinion** regarding ability to **give/withhold Informed Consent** that is/is not **competent, informed and voluntary.** AS 47.30.837.

NOTE: Informed consent requires that an individual is competent and informed and that the consent is voluntary. Definitions from AS 47.30.837:

"**COMPETENT**" means that the patient has:

(A) has the capacity to assimilate relevant facts and to appreciate and understand the patient's situation with regard to those facts, including the information under the definition of "informed,"

(B) appreciates that the patient has a mental disorder or impairment, if the evidence so indicates. Denial of a significantly disabling disorder or impairment, when faced with substantial evidence of its existence, constitutes evidence that the patient lacks the capability to make mental health treatment decisions [but it is not conclusive proof],

(C) has the capacity to participate in treatment decisions by means of a rational thought process; **and**

(D) is able to articulate reasonable objections to using the offered medication.

"**INFORMED**" means that the evaluation facility or designated treatment facility has given the patient all information that is material to the patient's decision to give or withhold consent, including

(A) an explanation of the patient's diagnosis and prognosis, or their predominant symptoms, with and without the medication;

(B) information about the proposed medication, its purpose, the method of its administration, the recommended ranges of dosages, possible side effects and benefits, ways to treat side effects, and risks of other conditions, such as tardive dyskinesia;

(C) a review of the patient's history, including medication history and previous side effects from medication;

(D) an explanation of interactions with other drugs, including over-the-counter drugs, street drugs, and alcohol;

(E) information about alternative treatments and their risks, side effects, and benefits, including the risks of nontreatment; and

(F) a statement describing the patient's right to give or withhold consent to the administration of psychotropic medications in nonemergency situations, the procedure for withdrawing consent, and notification that a court may override the patient's refusal;

"**VOLUNTARY**" means having genuine freedom of choice; a choice may be encouraged and remain voluntary, but consent obtained by using force, threats, or direct or indirect coercion is not voluntary.

APPENDIX 8
BEST INTEREST INQUIRY

Because administration of psychotropic medications could negatively effect a patient's mind and body, the Alaska Supreme Court held in the *Myers v. API*, 138 P.3d 238, 246 (2006) that Alaska's pertinent statutory provisions for involuntary psychotropic medication treatment implicate fundamental liberty and privacy interests. Accordingly, the Court ruled that before the state may administer psychotropic medication to a non-consenting mentally ill patient in a non-emergency case, "…an **independent judicial best interest determination** is constitutionally necessary to ensure that the proposed treatment is actually the least intrusive means of protecting the patient." *Myers,* 138 P.3d at 250. Alaska's constitutional guarantees of liberty and privacy require this independent judicial determination of an incompetent patient's best interest before the court may authorize psychotropic medication treatment. *Myers*, 138 P.3d at 246, 254. In evaluating whether a proposed course of psychotropic medication is in the best interest of a patient, the court must consider (at a minimum) the information that AS 47.30.837(d) requires the treatment facility to furnish patients. *Myers*, 138 P.3d at 252.

Court must find by clear and convincing evidence that the proposed course of treatment is in the respondent's best interest. This is an independent judicial best interest determination that is constitutionally necessary to ensure that the proposed treatment is actually the **least intrusive means of protecting the patient. The issue is not one of medical competence or expertise to be decided by the doctor.** This is because the choice to choose or reject medical treatment finds its source in the fundamental constitutional guarantees of liberty and privacy. Although a patient's decision must be fully informed by medical advice, appropriate deference, in the final analysis, must take the form of a legal judgment that hinges not on medical expertise but on constitutional principles aimed at protecting individual choice. The *Myers* court also cited a second factor favoring judicial review-the inherent risk of procedural unfairness that inevitably arises when a public treatment facility possesses unreviewable power to determine its own patients' best interests. *Myers,* 138 P.3d at 253.

The *Myers* court found it crucial in establishing the **patient's best interests** as well as in illuminating the existence of alternative treatments that consideration be given to the information required by statute for the facility to give the respondent to reach informed consent found in AS 47.30.837(d)(2). Factors to consider in **BALANCING** patient's **NEED FOR TREATMENT** against **INTRUSIVENESS** of prescribed treatment include:

- the **extent** and **duration** of **changes in behavior patterns** and **mental activity** from the medication;
- the **risks** of adverse **side effects**;
- the **experimental nature** of the treatment;
- its **acceptance by the medical community** of the **state**; and
- the **extent of intrusion** into patient's **body** and the **pain** connected with treatment. *Myers,* 138 P.3d at 252.

Before a state may administer psychotropic drugs to a nonconsenting mentally ill patient in a non-emergency setting, an independent judicial best interests determination is constitutionally necessary to ensure that the proposed treatment is actually the lest intrusive means of protecting the patient. *Myers,* 138 P.3d at 250.

CHECKLIST for JUDICIAL DETERMINATION of BEST INTEREST

- Has doctor spoken with patient? How often and for how long?
- Has patient been given written and verbal information regarding medication?
- Did patient object to medication?
- Did patient state reasons for objections?
- Has doctor/API, at a minimum, furnished the patient (**and now the court**) with the requirements of AS 47.30.837(d), including:
- Explanation of patient's **diagnosis** and **prognosis**;
  Diagnosis ___________________________________
  Prognosis ___________________________________
- Explanation of predominant symptoms;
- Effect of medication on diagnosis /prognosis/symptoms;
- Effect of NO medication on diagnosis/prognosis/ symptoms;
- Symptoms and behavior the medication is intended to improve:
  - Symptoms;
  - Expected improvement:
    - Behavior;
    - Expected improvement;
- Information about proposed medication;
- Purpose of proposed medication;
- Method of administration of medication;
- Extent of intrusion into patient's body and the pain connected with the treatment;
- Recommended range of dosage;
- Side effects, or risks (including tardive dyskinesia);
- Ways to treat side effects or risks;
- Benefits of medication;
- Does medication cause changes in behavior?
- Does medication cause changes in patterns and mental activity?
- What is extent and duration of changes?
- Patient's medication history and prior side effects;
- Interaction of other drugs including over-the-counter drugs, street drugs, and alcohol;
- Will the patient recover without treatment?
- Alternative treatment
  - options risks and side effects __________________________
  - benefits of alternative treatment ________________________

- No treatment
  - Risks of no treatment ________________________________
  - Benefits of no treatment ______________________________
- Experimental nature of the treatment __________________________
- Does medication dosage and method of administration meet the standard of care in Alaska?
- Is there any less intrusive treatment alternative available (such as no medication, a lower dosage, therapy, an alternative structured living situation)?

#25

25. Points to Consider in an Adult Guardianship

#26

26. Points to Consider in an Adult Conservatorship

Table 2. Alphabetical DSM-IV Codes

Name	Number
Academic Problem	V62.3
Acculturation Problem	V62.4
Acute Stress Disorder	308.3
Adjustment Disorder Unspecified	309.9
Adjustment Disorder With Anxiety	309.24
Adjustment Disorder With Depressed Mood	309.0
Adjustment Disorder With Disturbance of Conduct	309.3
Adjustment Disorder With Mixed Anxiety and Depressed Mood	309.28
Adjustment Disorder With Mixed Disturbance of Emotions and Conduct	309.4
Adult Antisocial Behavior	V71.01
Adverse Effects of Medication NOS	995.2
Age-Related Cognitive Decline	780.9
Agoraphobia Without History of Panic Disorder	300.22
Alcohol Abuse	305.00
Alcohol Dependence	303.90
Alcohol Intoxication	303.00
Alcohol Intoxication Delirium	291.0
Alcohol Withdrawal	291.8
Alcohol Withdrawal Delirium	291.0
Alcohol-Induced Anxiety Disorder	291.8
Alcohol-Induced Mood Disorder	291.8
Alcohol-Induced Persisting Amnestic Disorder	291.1
Alcohol-Induced Persisting Dementia	291.2
Alcohol-Induced Psychotic Disorder With Delusions	291.5
Alcohol-Induced Psychotic Disorder With Hallucinations	291.3
Alcohol-Induced Sexual Dysfunction	291.8
Alcohol-Induced Sleep Disorder	291.8
Alcohol-Related Disorder NOS	291.9
Amnestic Disorder Due to General Medical Condition	294.0
Amphetamine Abuse	305.70
Amphetamine Dependence	304.40
Anorexia Nervosa	307.1
Antisocial Personality Disorder	301.7
Anxiety Disorder Due to General Medical Condition	293.89
Anxiety Disorder NOS	300.00
Asperger's Disorder	299.80

Attention-Deficit/Hyperactivity Disorder Combined Type	314.01
Attention-Deficit/Hyperactivity Disorder NOS	314.9
Attention-Deficit/Hyperactivity Disorder Predominantly hyperactive-Impulsive Type	314.01
Attention-Deficit/Hyperactivity Disorder Predominantly Inattentive Type	314.00
Autistic Disorder	299.00
Avoidant Personality Disorder	301.82
Bereavement	V62.82
Bipolar Disorder NOS	296.80
Bipolar I Disorder Most Recent Episode Depressed	296.5x
Bipolar I Disorder Most Recent Episode Hypomanic	296.40
Bipolar I Disorder Most Recent Episode Manic	296.4x
Bipolar I Disorder Most Recent Episode Mixed	296.6x
Bipolar I Disorder Single Manic Episode	296.0x
Bipolar I Disorder, Most recent episode Unspecified	296.7
Bipolar II Disorder	296.89
Body Dysmorphic Disorder	300.7
Borderline Intellectual Functioning	V62.89
Borderline Personality Disorder	301.83
Breathing-Related Sleep Disorder	780.59
Brief Psychotic Disorder	298.8
Bulimia Nervosa	307.51
Cannabis Abuse	305.20
Cannabis Dependence	304.30
Catatonic Disorder Due to General Medical Condition	293.89
Child or Adolescent Antisocial Behavior	V71.02
Childhood Disintegrative Disorder	299.10
Chronic Motor or Vocal Tic Disorder	307.22
Circadian Rhythm Sleep Disorder	307.45
Cocaine Abuse	305.60
Cocaine Dependence	304.20
Cognitive Disorder NOS	294.9
Communication Disorder NOS	307.9
Conduct Disorder	312.81
Conversion Disorder	300.11
Cyclothymic Disorder	301.13
Delirium Due to General Medical Condition	293.0
Delirium NOS	780.09
Delusional Disorder	297.1

Dementia Due to [Other General Medical Condition]	294.1
Dementia due to Creutzfeld-Jacob disease	290.10
Dementia Due to Head Trauma	294.1
Dementia Due to HIV Disease	294.9
Dementia Due to Huntington's Disease	294.1
Dementia Due to Parkinson's Disease	294.1
Dementia due to Pick's Disease	290.10
Dementia NOS or Amnestic Disorder NOS	294.8
Dementia of the Alzheimer's Type, With Early Onset, Uncomplicated	290.10
Dementia of the Alzheimer's Type, With Early Onset, With Delirium	290.11
Dementia of the Alzheimer's Type, With Early Onset, With Delusions	290.12
Dementia of the Alzheimer's Type, With Early Onset, With Depressed Mood	290.13
Dementia of the Alzheimer's Type, With Late Onset, Uncomplicated	290.0
Dementia of the Alzheimer's Type, With Late Onset, With Delirium	290.3
Dementia of the Alzheimer's Type, With Late Onset, With Delusions	290.20
Dementia of the Alzheimer's Type, With Late Onset, With Depressed Mood	290.21
Dependent Personality Disorder	301.6
Depersonalization Disorder	300.6
Depressive Disorder NOS	311
Developmental Coordination Disorder	315.4
Diagnosis or Condition Deferred on Axis I or Diagnosis Deferred on Axis II	799.9
Disorder of Infancy, Childhood, or Adolescence NOS	313.9
Disorder of Written Expression	315.2
Disruptive Behavior Disorder NOS	312.9
Dissociative Amnesia	300.12
Dissociative Disorder NOS	300.15
Dissociative Fugue	300.13
Dissociative Identity Disorder	300.14
Dyspareunia (Not Due to a General Medical Condition)	302.76
Dyssomnia NOS	307.47
Dysthymic Disorder	300.4
Eating Disorder NOS	307.50
Encopresis Without Constipation and Overflow Incontinence	307.7
Encopresis, With Constipation and Overflow Incontinence	787.6
Enuresis (Not Due to a General Medical Condition)	307.6
Exhibitionism	302.4
Expressive Language Disorder	315.31
Factitious Disorder NOS	300.19

Factitious Disorder With Combined Psychological and Physical Signs and Symptoms	300.19
Factitious Disorder With Predominantly Physical Signs and Symptoms	300.19
Factitious Disorder With Predominantly Psychological Signs and Symptoms	300.16
Feeding Disorder of Infancy or Early Childhood	307.59
Female Dyspareunia Due to [General Medical Condition]	625.0
Female Hypoactive Sexual Desire Disorder Due to [General Medical Condition]	625.8
Female Orgasmic Disorder	302.73
Female Sexual Arousal Disorder	302.72
Fetishism	302.81
Frotteurism	302.89
Gender Identity Disorder in Adolescents or Adults	302.85
Gender Identity Disorder in Children or Gender Identity Disorder NOS	302.6
Gender Identity Disorder NOS	302.6
Generalized Anxiety Disorder	300.02
Hallucinogen Abuse	305.30
Hallucinogen Dependence	304.50
Hallucinogen Persisting Perception Disorder (Flashbacks)	292.89
Histrionic Personality Disorder	301.50
Hypersomnia Related to [General Medical Condition]	307.44
Hypoactive Sexual Desire Disorder	302.71
Hypochondriasis	300.7
Identity Problem	313.82
Impulse-Control Disorder NOS	312.30
Inhalant Abuse	305.90
Inhalant Dependence	304.60
Insomnia Related to [General Medical Condition]	307.42
Intermittent Explosive Disorder	312.34
Kleptomania	312.32
Learning Disorder NOS	315.9
Major Depressive Disorder Recurrent	296.3x
Major Depressive Disorder Single Episode	296.2x
Male Dyspareunia Due to [General Medical Condition]	608.89
Male Erectile Disorder	302.72
Male Erectile Disorder Due to [General Medical Condition]	607.84
Male Hypoactive Sexual Desire Disorder Due to [General Medical Condition]	608.89
Male Orgasmic Disorder	302.74
Malingering	V65.2
Mathematics Disorder	315.1

Medication-Induced Movement Disorder NOS	333.90
Medication-Induced Postural Tremor	333.1
Mental Disorder due to General Medical Condition	293.9
Mental Retardation, Severity Unspecified	319
Mild mental retardation	317
Mixed Receptive-Expressive Language Disorder	315.31
Moderate Mental Retardation	318.0
Mood Disorder Due to General Medical Condition	293.83
Mood Disorder NOS	296.90
Narcissistic Personality Disorder	301.81
Narcolepsy	347
Neglect of Child (if focus of attention is on victim)	995.5
Neuroleptic Malignant Syndrome	333.92
Neuroleptic-Induced Acute Akathisia	333.99
Neuroleptic-Induced Acute Dystonia	333.7
Neuroleptic-Induced Parkinsonism	332.1
Neuroleptic-Induced Tardive Dyskinesia	333.82
Nicotine Dependence	305.10
Nightmare Disorder	307.47
No Diagnosis or Condition on Axis I or Axis II	V71.09
Noncompliance With Treatment	V15.81
Obsessive-Compulsive Disorder	300.3
Obsessive-Compulsive Personality Disorder	301.4
Occupational Problem	V62.2
Opioid Abuse	305.50
Opioid Dependence	304.00
Oppositional Defiant Disorder	313.81
Oppositional Defiant Disorder	313.81
Other (or Unknown) Substance Abuse	305.90
Other (or Unknown) Substance Dependence	304.90
Other Female Sexual Dysfunction Due to [General Medical Condition]	625.8
Other Male Sexual Dysfunction Due to [General Medical Condition]	608.89
Pain Disorder Associated With Both Psychological Factors and a General Medical Condition	307.89
Pain Disorder Associated With Psychological Factors	307.80
Panic Disorder With Agoraphobia	300.21
Panic Disorder Without Agoraphobia	300.01
Paranoid Personality Disorder	301.0

Paraphilia NOS	302.9
Parasomnia NOS	307.47
Parent-Child Relational Problem	V61.20
Partner Relational Problem	V61.1
Pathological Gambling	312.31
Pedophilia	302.2
Personality Disorder Due to General Medical Condition	310.1
Personality Disorder NOS	301.9
Pervasive Developmental Disorder NOS	299.80
Phase of Life Problem	V62.89
Phencyclidine Abuse	305.90
Phencyclidine Dependence	304.90
Phonological Disorder	315.39
Physical abuse of adult (if focus of attention is on victim)	995.81
Physical abuse of child (if focus of attention is on victim)	995.5
Physical or Sexual Abuse of Adult	V61.1
Pica	307.52
Polysubstance Dependence	304.80
Posttraumatic Stress Disorder	309.81
Premature Ejaculation	302.75
Primary Hypersomnia	307.44
Primary Insomnia	307.42
Profound Mental Retardation	318.2
Psychological Factors Affecting Medical Condition	316
Psychotic Disorder Due to [General Medical Condition], With Delusions	293.81
Psychotic Disorder Due to [General Medical Condition], With Hallucinations	293.82
Psychotic Disorder NOS	298.9
Pyromania	312.33
Reactive Attachment Disorder of Infancy or Early Childhood	313.89
Reading Disorder	315.00
Relational Problem NOS	V62.81
Relational Problem Related to [a Mental Disorder or General Medical Condition]	V61.9
Religious or Spiritual Problem	V62.89
Rett's Disorder	299.80
Rumination Disorder	307.53
Schizoaffective Disorder	295.70
Schizoid Personality Disorder	301.20
Schizophrenia Undifferentiated Type	295.90

Schizophrenia, Catatonic Type	295.20
Schizophrenia, Disorganized Type	295.10
Schizophrenia, Paranoid Type	295.30
Schizophrenia, Residual Type	295.60
Schizophreniform Disorder	295.40
Schizotypal Personality Disorder	301.22
Sedative, Hypnotic, or Anxiolytic Abuse	305.40
Sedative, Hypnotic, or Anxiolytic Dependence	304.10
Selective Mutism	313.23
Separation Anxiety Disorder	309.21
Severe Mental Retardation	318.1
Sexual abuse of adult (if focus of attention is on victim)	995.81
Sexual abuse of child (if focus of attention is on victim)	995.5
Sexual Aversion Disorder	302.79
Sexual Disorder NOS	302.9
Sexual Dysfunction NOS	302.70
Sexual Masochism	302.83
Sexual or Physical Abuse or Neglect of Child	V61.21
Sexual Sadism	302.84
Shared Psychotic Disorder	297.3
Sibling Relational Problem	V61.8
Sleep Disorder Due to [General Medical Condition], Hypersomnia Type	780.54
Sleep Disorder Due to [General Medical Condition], Insomnia Type	780.52
Sleep Disorder Due to [General Medical Condition], Mixed Type	780.59
Sleep Disorder Due to [General Medical Condition], Parasomnia	780.59
Sleep Terror Disorder	307.46
Sleepwalking Disorder	307.46
Social Phobia	300.23
Somatization Disorder	300.81
Somatoform Disorder NOS	300.81
Specific Phobia	300.29
Stereotypic Movement Disorder	307.3
Stuttering	307.0
Substance [Amphetamine, Caffeine, Cannabis, Cocaine, Hallucinogen, Inhalant, Phencyclidine, Sedative*, Other (or Unknown)]-Induced Anxiety Disorder	292.89
Substance [Amphetamine, Caffeine, Cannabis, Cocaine, Hallucinogen, Inhalant, Nicotine, Opioid, Phencyclidine, Sedative*, Other (or Unknown)]-Related Disorder NOS	292.9

Substance [Amphetamine, Caffeine, Cocaine, Opioid, Sedative*, Other (or Unknown)]-Induced Sleep Disorder	292.89
Substance [Amphetamine, Cannabis, Cocaine, Hallucinogen, Inhalant, Opioid, Phencyclidine, Sedative*, Other (or Unknown)]-Induced Psychotic Disorder, With Delusions	292.11
Substance [Amphetamine, Cannabis, Cocaine, Hallucinogen, Inhalant, Opioid, Phencyclidine, Sedative*, Other (or Unknown)]-Induced Psychotic Disorder, With Hallucinations	292.12
Substance [Amphetamine, Cannabis, Cocaine, Hallucinogen, Inhalant, Opioid, Phencyclidine, Sedative*, Other (or Unknown)] Intoxication Delirium	292.81
Substance [Amphetamine, Cannabis, Cocaine, Hallucinogen, Inhalant, Opioid, Phencyclidine, Sedative*, Other (or Unknown)] Intoxication	292.89
Substance [Amphetamine, Cocaine, Hallucinogen, Inhalant, Opioid, Phencyclidine, Sedative*, Other (or Unknown)]-Induced Mood Disorder	292.84
Substance [Amphetamine, Cocaine, Nicotine, Opioid, Sedative*, Other (or Unknown)] Withdrawal	292.0
Substance [Amphetamine, Cocaine, Opioid, Sedative*, Other (or Unknown)]-Induced Sexual Dysfunction	292.89
Substance [Inhalant, Sedative*, Other (or Unknown)]-Induced Persisting Dementia	292.82
Substance [Sedative*, Other (or Unknown)] Withdrawal Delirium	292.81
Substance [Sedative*, Other (or Unknown)]-Induced Persisting Amnestic Disorder	292.83
Tic Disorder NOS	307.20
Tourette's Disorder	307.23
Transient Tic Disorder	307.21
Transvestic Fetishism	302.3
Trichotillomania	312.39
Undifferentiated Somatoform Disorder	300.81
Unspecified Mental Disorder (nonpsychotic)	300.9
Vaginismus (Not Due to a General Medical Condition)	306.51
Vascular Dementia, Uncomplicated	290.40
Vascular Dementia, With Delirium	290.41
Vascular Dementia, With Delusions	290.42
Vascular Dementia, With Depressed Mood	290.43
Voyeurism	302.82

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Psychotherapeutic Medications 2006

What Every Counselor Should Know

- Generic and Brand Medication Names
- Purpose
- Usual dose and frequency
- Potential Side Effects
- Emergency Conditions
- Cautions
- Addiction Treatment Medications

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Charles G. Curie, MA, ACSW, served as the SAMHSA Administrator. H. Westley Clark, MD, JD, MPH, served as CSAT Director and Karl D. White, EdD, served as the CSAT Project Officer.

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6th Edition 2006

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Talking with Clients about Their Medications ..... Attachment

ABOUT THIS BROCHURE

Originally developed as a companion piece to the Mid-America ATTC systems change curriculum, A Collaborative Response: Addressing the Needs of Consumers with Co-Occurring Substance Use and Mental Health Disorders, this edition includes adaptations made for inclusion in CSAT's TIP 42: Substance Abuse Treatment for Persons with Co-Occurring Disorders. The language has been modified to increase readability for a larger audience, and in keeping with the goal of updating the brochure annually, several new medications are included.

COUNSELORS' USE OF THIS BROCHURE

A list of generic and brand names is included for the following medications:

Antipsychotics/Neuroleptics
Antiparkinsonian Medications
Antimanic Medications
Antidepressant Medications
Antianxiety Medications
Stimulant Medications
Narcotic and Opioid Analgesics
Hypnotics (Sleep Aids)
Addiction Treatment Medications
Alcohol
Opioids
Others

Each section includes the following topics for the different medication types:

Purpose: Describes typical uses of medications, including specific symptoms treated and positive treatment response expected.

Usual dose, frequency, and side effects: Discusses when and how medications are administered, typical side effects, and methods for monitoring side effects.

Potential side effects: Lists common side effects.

Potential for abuse or dependence: Elaborates upon those medications with potential for abuse and/or physical dependence. Discusses withdrawal reactions and management of withdrawal.

Emergency Conditions: Includes risks associated with overdose, withdrawal or other drug reactions.

Cautions: Describes risks associated with use of additional medications (i.e., over the counter), increasing or discontinuing use of medications, adverse consequences with concurrent use of alcohol and/or street drugs.

Special Considerations for Pregnant Women: Describes risks for pregnant women prescribed psychotherapeutic medications. References to research are included. The special role of the substance abuse counselor in encouraging discussion between clients and the prescribing physician is emphasized.

IMPORTANT NOTES ACROSS MEDICATION TYPES

Name brand medications have a limited patent. When the patent expires, the medication may be made as a generic. The generic name of a medication is the *actual name of the medication and never changes*. A generic medication may be made by many different manufacturers. Additionally, manufacturers can make several forms of a single medication with only slight variations. For instance, they may vary the color, size, or shape of the medication. If a person says his or her medication "looks different" AND he or she is experiencing new side effects, *contact the prescriber immediately*.

For ease of reading, some technical terms are defined in accompanying footnotes. All medications are listed in the index along with page numbers for quick reference. When specific brands are discussed in the accompanying text, the name of the medication is **bolded** to assist the reader in finding the reference.

This brochure is available for free download via the Mid-America ATTC Web site at www.mattc.org.

LIMITATIONS OF THE BROCHURE

This brochure is designed as a quick "desk reference" for substance abuse and mental health treatment providers. It is not intended to be used as a complete reference for psychotherapeutic medications. The section, "Tips for Communicating with Physicians," is meant to be just that: tips for communicating. The brochure assumes providers are knowledgeable about the Health Insurance Portability and Accountability Act (HIPPA) regulations, including issues related to privacy and confidentiality and will use these communication tips in accordance with those regulations. For more information about HIPPA, refer to the SAMHSA Web site "HIPPA: What It Means for Mental Health and Substance Abuse Services" at http://www.hipaa.samhsa.gov/hipaa.html.

The section, "Talking with Clients about their Medication," is a prompt designed to help the provider initiate conversation about medication management and adherence with clients who have co-occurring mental health and substance use disorders. It is not intended as a complete guide to client education. For a more thorough discussion of these issues, see the current edition of the American Society of Addiction Medicine's (ASAM) *Principles of Addiction Medicine*, Third Edition (ASAM 2003).

For physicians desiring a more in-depth discussion regarding the challenges of treating specific population groups with substance use disorders (e.g., homeless, older adults, people with HIV/AIDS or hepatitis, pregnant or nursing women, etc.), which include medication compliance, adverse drug interactions, and relapse with the use of potentially addictive medications, refer to the current edition of the American Society of Addiction Medicine's (ASAM's) *Principles of Addiction Medicine*, Third Edition (ASAM 2003).

ANTIPSYCHOTICS / NEUROLEPTICS

GENERIC	BRAND
Traditional antipsychotics	
chlopromazine	Thorazine, Largactil
fluphenazine	Prolixin, Permitil, Anatensol
haloperidol	Haldol
loxapine	Loxitane, Daxolin
mesoridazine	Serentil
molindone	Moban, Lidon
perphenazine	Trilafon, Etrafon
pimozide	Orap
thioridazine	Mellaril
thiothixene	Navane
trifluoperazine	Stelazine
Novel or atypical antipsychotics	
aripiprazole	Abilify
clozapine	Clozaril
olanzapine	Zyprexa, Zyprexa Zydis
quetiapine fumarate	Seroquel
resperidone	Risperdal
risperidone long-acting injection	Risperdal Consta
ziprasidone	Geodon

PURPOSE

Antipsychotics (neuroleptics) are most frequently used for persons who experience psychotic symptoms as a result of having some form of schizophrenia, severe depression or bipolar disorder. They may be used to treat brief psychotic episodes caused by drugs of abuse. Psychotic symptoms may include being out of touch with reality, "hearing voices," and having false perceptions (e.g., thinking you are a famous person, thinking someone is out to hurt you). Antipsychotic medications can be effective in either minimizing or stopping these symptoms altogether. In some cases, these medications can shorten the course of the illness or prevent it from happening again.

Positive treatment response to antipsychotic medications allows many with severe and disabling mental disorders to live and function in the community, often relatively normally. This positive response may include thoughts that are more rational, decreased psychosis,[1] paranoia and delusions, behavior that is more appropriate, and the ability to have relationships and work.

[1] *psychosis:* A mental disorder characterized by distinct distortions of a person'smental capacity, ability to recognize reality, and relationships to others to such a degree that it interferes with that person's ability to function in everyday life.

All of the older and newer antipsychotic medications are approved by the Food and Drug Administration (FDA) and are thus evidence-based treatments (EBT) for schizophrenia. The newest antipsychotic medications—Risperdal, Zyprexa, Seroquel, Geodon, and Abilify—are showing positive effects across a range of disorders. These medications stabilize mood and are also used to treat bipolar disorder. They are being added to antidepressants to treat severe depressions. Some have been shown to be effective at relieving anxiety in low doses, but the FDA does not approve this use. A growing number of the atypical antipsychotic medications have received FDA approval for treatment of manic episodes, and some for extended treatment of bipolar disorder.

USUAL DOSE, FREQUENCY & SIDE EFFECTS

All medications have specific doses and frequencies. The physician will specify the exact amount of medication and when it should be taken. This information is on the prescription bottle.

Many medications are taken once a day, some at bedtime to take advantage of the drowsiness side effect of some antipsychotic medications. Several medications are taken in pill form or liquid form. Others are given by injection once or twice per month to ensure that the medication is taken reliably. It is important to take medications on schedule. It is also important that people talk to their doctor so they know about potential side effects and steps they need to take to monitor their health.

Novel or atypical antipsychotics are different from traditional antipsychotics. These medications are more powerful with treatment-resistant schizophrenia but may also be used with severe depression or other psychiatric illness. Because the atypical antipsychotics work in a slightly different way than traditional antipsychotics, they are less likely to produce serious side effects, such as tardive dyskinesia[2] or neuroleptic malignant syndrome[3]. The most common mild side effects are either sedation[4] or agitation, especially when starting the medications. The most worrisome side effects are weight gain and elevated blood sugar and lipids[5]. There is also some evidence that the use of atypical antipsychotics may lead to the development of diabetes mellitus[6].

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[2] tardive dyskinesia: A central nervous system disorder characterized by twitching of the face and tongue, and involuntary motor movements of the trunk and limbs; occurring especially as a side effect of prolonged use of antipsychotic medications.

[3] neuroleptic malignant syndrome: A very rare but life-threatening neurological disorder most often caused by a reaction to antipsychotic/neuroleptic medications. Typically developing within the first 2 weeks of treatment; but can develop at any time. The syndrome can also occur in people taking anti-Parkinsonian medications if discontinued abruptly.

[4] sedation: Inducing a relaxed easy state especially by the use of sedatives (drugs).

[5] lipids: Any of various substances including fats, waxes, and phosphatides that with proteins and carbohydrates make up the principal structural components of living cells.

[6] diabetes mellitus: An endocrine disorder in which insulin is inadequately secreted or used by the body.

(Sernyak et al. 2002). Because diabetes is associated with obesity, it is unclear whether the diabetes is actually caused by certain atypical antipsychotic medications or obesity. These issues can be medically worrisome and can lead to medication noncompliance. Since effectiveness and side effects vary across medications and people, matching the right medication to the right person is the key.

Clozaril can very rarely cause serious abnormalities or irregularities in the blood cells (blood dyscrasias[7]). Approximately 1 to 2 percent of people who take **Clozaril** develop a condition in which their white blood cell count drops drastically (agranulocytosis[8]). As a result, they are at high risk for infections due to a compromised immune system, and this could be fatal. However, most cases of agranulocytosis can be treated successfully by stopping **Clozaril** treatment. To maintain safety, white blood cell counts must be checked each week for 6 months and every 2 weeks thereafter. The results must be sent to the person's pharmacy before he or she can pick up the next supply of medication.

Abilify is a new antipsychotic that acts as either an enhancer or an inhibitor of dopamine[9] activity. Useful in the treatment of schizophrenia and other psychotic disorders, side effects include headache, anxiety and insomnia.[10]

Risperdal Consta, also a newly approved antipsychotic, is an injection of microencapsulated[11] medication that releases into the body at a constant level. An injection is usually given every 2 weeks. Side effects are similar to those for **Risperdal**.

Traditional antipsychotics are cheap, and the newer ones are expensive. In general, the newer antipsychotics, when taken in proper dosage, have fewer clinical side effects and a broader treatment response than traditional antipsychotics.

POTENTIAL SIDE EFFECTS

Tardive Dyskinesia

- Involuntary movements of the tongue or mouth
- Jerky, purposeless movements of legs, arms or entire body
- More often seen in women
- Risk increases with age and length of time on medication
- Usually seen with long-term treatment using traditional antipsychotic medications; rarely seen with atypical antipsychotic medications

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[7] *blood dyscrasias:* A disease of the blood usually involving cellular abnormalities (i.e., poorly functioning or fewer than normal platelets, or loss of certain blood proteins called "clotting factors"; poorly functioning or decreased numbers of red and/or white blood cells.

[8] *agranulocytosis:* A condition in which there are too few of a specific type of white blood cell called neutrophils in the blood. Affected people are susceptible to infections.

[9] *dopamine:* A type of neurotransmitter in the brain.

[10] *insomnia*: Difficulty falling or staying asleep, or poor sleep quality.

[11] *microencapsulated:* To enclose in a tiny capsule material (as a medicine) that is released when the capsule is broken, melted, or dissolved.

Symptoms of diabetes mellitus (associated with obesity)
- Excessive thirst and hunger
- Fatigue
- Frequent urination
- Headaches
- Slow healing cuts and/or blemishes
- Weight loss

Neuroleptic Malignant Syndrome (very rare)
- Blood pressure up and down
- Dazed and confused
- Difficulty breathing
- Muscle stiffness
- Rapid heart rate
- Sweating and shakiness
- Temperature above normal

Other
- Blurred vision
- Changes in sexual functioning
- Constipation
- Diminished enthusiasm
- Dizziness
- Drowsiness
- Dry mouth
- Lowered blood pressure
- Muscle rigidity
- Nasal congestion
- Restlessness
- Sensitivity to bright light
- Slowed heart rate
- Slurred speech
- Upset stomach
- Weight gain

Note: Any side effects that bother a person need to be reported and discussed with the prescribing physician. Anticholinergic/antiparkinsonian medications like **Cogentin** or **Artane** may be prescribed to control movement difficulties associated with the use of antipsychotic medications.

EMERGENCY CONDITIONS

Contact a physician and/or seek emergency medical assistance if the person experiences involuntary muscle movements, painful muscle spasms, difficulty urinating, eye pain, skin rash or the symptoms listed under tardive dyskinesia, and neuroleptic malignant syndrome. An overdose is always considered an emergency and treatment should be sought immediately.

CAUTIONS

- Doctors and pharmacists should be told about all medications being taken and dosage, including over-the-counter preparations, vitamins, minerals, and herbal supplements (i.e., St. John's wort, echinacea, ginkgo, ginseng).

- People taking antipsychotic medications should not increase their dose unless this has been *checked with their physician and a change is ordered*.

SPECIAL CONSIDERATIONS FOR PREGNANT WOMEN

For women of childbearing age who may be or think they may be pregnant, the physician should discuss the safety of this medication before starting, continuing, or discontinuing medication treatment. Substance abuse counselors may have a role in encouraging this discussion by suggesting their clients talk with the prescribing physician.

Generally, the use of antipsychotic medications should be avoided in the first trimester unless the mother poses a danger to herself, to others, or to the unborn child, or if the mother shows signs of profound psychosis (Cohen 1989). Tapering and discontinuation of antipsychotic medication 10 days to 2 weeks before delivery is generally advised, though the way this is done varies by medication (Mortola 1989).

ANTIPARKINSONIAN MEDICATIONS

GENERIC	BRAND
amantadine hydrochloride	Symmetrel, Symadine
benztropine mesylate	Cogentin
diphenhydramine hydrochloride	Benadryl
trihexyphenidyl hydrochloride	Artane

PURPOSE

Antiparkinsonian (anticholinergic) medications are used to control the side effects associated with antipsychotic medications. They are called antiparkinsonian because the neurological side effects of antipsychotic medications are similar to the symptoms of Parkinson's disease (i.e., tremors, stiff or rigid muscles, poor balance, and a distinctive unsteady walk).

USUAL DOSE & FREQUENCY

All medications have specific doses and frequencies. The physician will specify the exact amount of medication and when it should be taken. This information is on the prescription bottle. These medications have very specific doses and taking too much can be harmful. A doctor must be consulted in order to safely change the dose in response to side effects of the antipsychotic medications.

POTENTIAL SIDE EFFECTS

- Constipation
- Dizziness
- Dry mouth
- Heart failure
- Irritability
- Light-headedness
- Stomach upset
- Tiredness

EMERGENCY CONDITIONS

Report immediately any overdose or changes in heart rate and/or rhythm to the doctor.

POTENTIAL FOR ABUSE OR DEPENDENCE

Despite their utility, these medications can be abused by some persons with severe mental illness who require neuroleptics. Survey research has found that many abusers of antiparkinsonians used these medications "to get high, to increase pleasure, to decrease depression, to increase energy and to relax" (Buhrich et al. 2000, p. 929). The survey also found that the misuse of other drugs accompanied the misuse of antiparkinsonian medications.

Consequently, in the context of co-occurring mental health and substance use disorders, providers and consumers need to be aware of and openly communicate about the abuse potential of these medications.

CAUTIONS

- Doctors and pharmacists should be told about all medications being taken and dosage, including over-the-counter preparations, vitamins, minerals, and herbal supplements (i.e.,St. John's wort, echinacea, ginkgo, ginseng).

- People taking antiparkinsonian medications should not increase their dose unless this has been *checked with their physician and a change is ordered*.

SPECIAL CONSIDERATIONS FOR PREGNANT WOMEN

The risk of birth defects associated with **Cogentin**, **Artane**, and **Benadryl** is not clear, although there is some evidence to suggest that amantadine (**Symmetrel, Symadine**) may produce adeformed baby (Mortola 1989). For all women of childbearing age who may be or think they may be pregnant, the physician should discuss the safety of this medication before starting, continuing, or discontinuing medication treatment. Substance abuse counselors may have a role in encouraging this discussion by suggesting their clients talk with the prescribing physician.

ANTIMANIC MEDICATIONS

GENERIC	BRAND
Lithium products	
lithium carbonate	Eskalith, Eskalith CR, Lithane, Lithobid, Lithonate, Lithotabs
lithium citrate	Cibalith
Anticonvulsant products	
carbamazepine	Tegretol
divalproex sodium	Depakote, Depakote, Sprinkle, Depakote ER
lamotrigine	Lamictal
Atypical antipsychotics	
(see Antipsychotics/Neuroleptics, p. 6 for side effects)	
aripiprazole	Abilify
olanzapine	Zyprexa, Zyprexa Zydis
olanzapine plus fluoxetine	Symbyax
quetiapine fumarate	Seroquel
risperidone	Risperdal
ziprasidone	Geodon
Other anticonvulsant products	
(not FDA approved for the treatment of mania)	
gabapentin	Neurontin
levetiracetam	Keppra
oxcarbazepine	Trileptal
tiagabine hydrochloride	Gabitril
topiramate	Topamax, Topamax Sprinkle
valproate sodium	Depakene, Depacon
valproic acid	Depakene

PURPOSE

Antimanic medications are used to control the mood swings of bipolar (manic-depressive) illness. Bipolar illness is characterized by cycling mood changes from severe highs (mania) to severe lows (depression). The "highs" and "lows" vary in intensity, frequency, and severity. Bipolar I conditions include full manic episodes. Bipolar II conditions, by definition do not include full mania, but are characterized more as depression plus a low level of mania (hypomania). Bipolar cycles that occur more often than 3 times a year are considered "rapid cycling," a condition often found in people with higher rates of substance abuse.

Positive treatment responses to antimanic medications include less hyperactivity, pressured speech and/or illogical thought. They improve the clients' ability to sleep, concentrate and allow the person to function more normally.

If bipolar disorder is left untreated, the associated mania may worsen into a psychotic state and depression may result in thoughts of suicide. By leveling mood swings with antimanic medications, some of the suicidal and other self-harming behaviors can be decreased. Additionally, appropriate treatment with antimanic medications can reduce a person's violent outbursts toward others or property.

All of the lithium products, **Tegretol**, **Depakote**, and those products listed under atypical antipsychotics qualify as evidence-based treatments (EBT) for Bipolar I disorder. **Lamictal** qualifies as an EBT for Bipolar II disorder.

USUAL DOSE, FREQUENCY & SIDE EFFECTS

All medications have specific doses and frequencies. The physician will specify the exact amount of medication and when it should be taken. This information is provided on the prescription bottle. Most medications in this class are given 2 to 4 times per day. Some extended release formulations[12] may be given every 12 hours. Dosage is determined by the active amount of medication found in the person's blood after taking the medication, and by his or her response to the medication. Expect a check of monthly blood levels until the person is at his or her optimal dose.

Lithium products: Most common side effects are tremor, acne, and weight gain. People taking these products may require more fluids than they did before taking the medication. However, too much fluid in a person's diet can "wash" the lithium out of his or her system, and too little fluid can allow the lithium to concentrate in the system. Additionally, anything that can decrease sodium in the body (i.e., decreased table salt intake, a low-salt diet, excessive sweating during strenuous exercise, diarrhea, vomiting) could result in lithium toxicity.[13] People taking any antimanic medications should have blood levels tested regularly to check the concentration level of the medication in their bodies. Specifically, people taking lithium products, **Tegretol**, **Depakote**, and **Depakene** need their blood levels monitored.

Anticonvulsant products:[14] Most common side effects are sedation and weight gain. **Keppra** is noted for causing mood changes, primarily depression and anger in some people. This may limit its use as a mood stabilizer.

[12] *extended release formulations:* Medications that have been made so that they act over a long period of time and do not have to be taken as often; may be referred to as CR (controlled release), ER or XR (extended release), or SR (sustained release).

[13] *lithium toxicity:* The quality, state, or relative degree of being poisonous, in this instance because of the presence or concentration of too much of the drug lithium in the blood.

[14] *anticonvulsants:* Usually refers to an agent that prevents or stops *convulsions*; an abnormal violent, involuntary contraction or series of contractions of the muscles.

For the most common side effects of atypical antipsychotics, refer to *Antipsychotics/ Neuroleptics,* p. 6. It is likely that all of the newer atypical antipsychotics mentioned in the previous section will soon be FDA approved for treatment of mania.

POTENTIAL SIDE EFFECTS

- Blurred vision
- Coma*
- Diarrhea*
- Drowsiness
- Fatigue
- Hand tremor*
- Increased thirst and urination*
- Inflammation of the pancreas
- Irregular heart beats
- Kidney damage*
- Liver inflammation, hepatitis
- Nausea or vomiting
- Problems with the blood, both red and white cells
- Rash and skin changes
- Seizures
- Under or overactive thyroid*
- Weakness
- Weight gain

* These side effects are associated with lithium, anticonvulsants, and atypical antipsychotics only. Effects vary greatly between persons.

EMERGENCY CONDITIONS

Lithium overdose is a life-threatening emergency. Signs of lithium toxicity may include nausea, vomiting, diarrhea, drowsiness, mental dullness, slurred speech, confusion, dizziness, muscle twitching, irregular heartbeat and blurred vision. An overdose of any of the other antimanic medications is always considered an emergency and treatment should be sought immediately.

CAUTIONS

- Doctors and pharmacists should be told about all medications being taken and dosage, including over-the-counter preparations, vitamins, minerals, and herbal supplements (i.e., St. John's wort, echinacea, ginkgo, ginseng).

- People taking antimanic medications should not increase their dose unless this has been *checked with their physician and a change is ordered*.

- Persons taking antimanic medications are particularly vulnerable to adverse medical consequences if they concurrently use alcohol and/or street drugs.

- Lithium can cause birth defects in the first 3 months of pregnancy.
- Thyroid function must be monitored if a person takes lithium.
- Heavy sweating or use of products that cause excessive urination (i.e., coffee, tea, some high caffeine sodas, use of diuretics) can lower the level of lithium in the blood.
- Blood tests for medication levels need to be checked every 1 to 2 months.
- Use of these medications will lower the effectiveness of birth control medications.

SPECIAL CONSIDERATIONS FOR PREGNANT WOMEN

Some antimanic medications, such as Depakene (valproic acid), are associated with several birth defects if taken during pregnancy. If this type of medication must be used during pregnancy, the woman must be told that there is substantial risk of malformations (Robert et al. 2001). Lithium is also a medication that may be harmful to an unborn child. Those exposed to lithium before week 12 of gestation are at increased risk of heart abnormalities. For women taking lithium, blood levels of the medication should be monitored every 2 weeks. Ultrasound examinations should be performed on the fetus to rule out the development of an enlarged thyroid (goiter) in the unborn child (Mortola 1989).

Generally, the use of antipsychotic medications should be avoided in the first trimester unless the mother poses a danger to herself, to others, or to the unborn child, or if the mother shows signs of profound psychosis (Cohen 1989). Tapering and discontinuation of antipsychotic medication 10 days to 2 weeks before delivery is generally advised, though the way this is done varies by medication (Mortola 1989).

For women of childbearing age who may be or think they may be pregnant, the physician should discuss the safety of these medications before starting, continuing, or discontinuing medication treatment. Substance abuse counselors may have a role in encouraging this discussion by suggesting their clients talk with the prescribing physician.

ANTIDEPRESSANT MEDICATIONS

GENERIC	BRAND
SSRIs — Selective Serotonin Reuptake Inhibitors	
citalopram	Celexa
escitalopram oxalate	Lexapro
fluoxetine	Prozac, Prozac Weekly, Sarafem
fluvoxamine	Luvox
paroxetine	Paxil, Paxil CR
sertraline	Zoloft
Other new antidepressants	
bupropion	Wellbutrin, Wellbutrin SR
duloxetine	Cymbalta
mirtazapine	Remeron, Remeron SolTab
nefazodone	Serzone
trazodone	Desyrel
venlafaxine	Effexor, Effexor ER
Tricyclics & quatracyclics	
amitriptyline	Elavil
amoxapine	Asendin
clomipramine	Anafranil
desipramine	Nopramin, Pertofrane
doxepin	Sinequan
imipramine	Tofranil
maprotiline	Ludiomil
nortriptyline	Pamelor
protriptyline	Vivactil
Monoamine Oxidase (MAO) Inhibitors	
isocarboxazid	Marplan
phenelzine	Nardil
tranylcypromine	Parnate

PURPOSE

Antidepressant medications are used for moderate to serious depressions, but they can also be very helpful for milder depressions such as dysthymia. Most antidepressants must be taken for a period of 3 to 4 weeks to begin to reduce or take away the symptoms of depression but a full therapeutic effect may not be present for several months. Antidepressants are also the first line medications for certain anxiety disorders such as panic disorder, social phobia, and obsessive-compulsive disorders.

Positive early treatment responses to antidepressant medications include improved energy, concentration, and sleep. Later positive treatment responses include improved mood, attitude, and statements of "feeling better."

Treatment for a single episode of major depression should be continued for 2 years before discontinuing. Since major depression is a chronic recurrent illness for many people, long-term use of antidepressants is often indicated (much as one would take medication for high blood pressure or diabetes for a long period of time). Discontinuing antidepressant therapy before the depression is completely resolved may result in the person decompensating[15] and possibly becoming medication resistant. Untreated depression may result in suicide, especially with co-occurring substance use disorders. Therefore, treatment for depression must be taken as seriously as treatment for any other major life-threatening illness.

TYPES OF ANTIDEPRESSANTS

SSRIs are the most frequently prescribed class of antidepressants because of their broad effectiveness, low side effects, and safety. They are thought to affect the serotonin[16] system to reduce symptoms of depression. Prozac Weekly is an extended release formula of Prozac (fluoxetine) that can be dosed once per week. Sarafem is fluoxetine under another label used for treatment of Premenstrual Dysphoric Disorder. SSRIs include both less expensive generic medications (fluoxetine, citalopram, and paroxetine) and more expensive brand name only versions.

Other new antidepressants, such as Effexor work on both the serotonin and norepinephrine[17] levels. Wellbutrin is an antidepressant unrelated to other antidepressants. It has more effect on norepinephrine and dopamine levels than on serotonin levels in the brain. In addition, Wellbutrin can be "activating" (as opposed to sedating). It is not associated with weight gain or sexual dysfunction like many other antidepressant medications. Wellbutrin should, however, be avoided by people who are at risk for or who currently have a seizure disorder.

The MAO inhibitors and the tricyclic and quatracyclic antidepressants (named for their chemical structures) are older and less commonly used due to safety and side effects. MAOs are used for "atypical depressions," which produce symptoms like oversleeping, anxiety or panic attacks, and phobias. Also, they may be used when a person does not respond to other antidepressants. The older tricyclics may be preferred in spite of their common side effects because they are inexpensive.

[15] decompensate: Loss of the body's ability to correct a defect by over development of or increased functioning of another organ or unimpaired parts of the same organ; loss of psychological ability to counterbalance feelings of inferiority, frustration, or failure in one area by achievement in another.

[16] serotonin: A type of neurotransmitter in the brain.

[17] norepinephrine: A hormone secreted by the adrenal gland, which (together with epinephrine) brings about changes in the body known as the "fight or flight" reaction.

USUAL DOSE, FREQUENCY & SIDE EFFECTS

All medications have specific doses and frequencies. The physician will specify the exact amount of medication and when it should be taken. This information is provided on the prescription bottle. Several factors are considered before an antidepressant is prescribed: the type of medication, the person's individual body chemistry, weight, and age. Generally, people are started on a low dose, and the dosage is slowly raised until the optimal effects are reached without troublesome side effects.

Both mild sedation and mild agitation sometimes occur with SSRI use. The most troubling SSRI side effect is decreased sexual performance, which may be difficult for many persons to discuss. Common side effects specific to both **Wellbutrin** and **Effexor** include sleeplessness and agitation. For the older tricyclics, side effects include dry mouth and sedation.

POTENTIAL SIDE EFFECTS

SSRIs

- Anxiety, agitation or nervousness
- Change in appetite (lack of or increase)
- Change in sexual desire
- Confusion
- Decrease in sexual ability
- Diarrhea or loose stools
- Dizziness
- Dry mouth
- Headache
- Heart rhythm changes
- Increased sweating
- Insomnia or sleepiness
- Lack or increase of appetite
- Shakiness
- Stomach upset
- Taste disturbances (**Wellbutrin**)
- Weight loss or gain

Tricyclics & quatracyclics

- Allergic reactions
- Blood cell problems (both white and red cells)
- Blurred vision
- Change in sexual desire
- Changes in heartbeat and rhythm
- Constipation
- Decrease in sexual ability
- Difficulty with urination
- Dizziness when changing position
- Dry mouth

- Fatigue
- Heart block[18]
- Increased sweating
- Kidney failure (**Asendin**)
- Muscle twitches
- Neuroleptic Malignant Syndrome (**Asendin**)
- Seizures
- Stroke
- Weakness
- Weight gain

MAO Inhibitors

- Blood cell problems (both white and red cells)
- Dizziness when changing position
- Fluid retention (swollen ankles, feet, legs or hands)
- Headache
- High blood pressure crisis[19]
- Insomnia
- Lack of appetite
- Rapid heart beat

EMERGENCY CONDITIONS

An overdose of any of the MAO inhibitors, tricyclics, quatracyclics, or other antidepressants is serious and potentially life threatening and *must be reported to a physician immediately*. Symptoms of tricyclic and quatracyclic overdose may include rapid heartbeat, dilated pupils, flushed face, agitation, loss of consciousness, seizures, irregular heart rhythm, heart and breathing stopping, and death.

The potential for a fatal outcome from an overdose with the SSRIs is much less. However, the possibility that a person has attempted suicide should be dealt with as an emergency situation that needs immediate intervention.

CAUTIONS

- Doctors and pharmacists should be told about all medications being taken and dosage, including over-the-counter preparations, vitamins, minerals, and herbal supplements (i.e., St. John's wort, echinacea, ginkgo, ginseng).
- People taking antidepressant medications should not increase their dose unless this has been *checked with their physician and a change is ordered.*

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[18] *heart block:* A condition where the heart beats irregularly or much more slowly than normal. Sometimes the heart may even stop for up to 20 seconds; caused by a delay or disruption of the electrical signals that usually control the heartbeat.

[19] *high blood pressure crisis:* A severe increase in blood pressure that can lead to stroke. Two types—emergency and urgent—require immediate medical attention.

- Withdrawal from SSRIs and other new antidepressants can cause flu-like symptoms. Discontinuing antidepressant therapy should be done gradually under a physician's care.
- People taking MAO inhibitors must avoid all foods with high levels of tryptophan or tyramine (e.g., aged cheese, wine, beer, chicken liver, chocolate, bananas, soy sauce, meat tenderizers,salami, bologna, and pickled fish). High levels of caffeine must also be avoided. If eaten, these foods may react with the MAO inhibitors to raise blood pressure to dangerous levels.
- Many medications interact with the MAO inhibitors. It is largely for this reason that they are rarely used. Other medications should not be taken unless the treating physician approves them. Even a simple over-the-counter cold medication can cause life-threatening side effects.
- People using MAO inhibitors should check all new medications with a physician or pharmacist before taking them.
- People taking antidepressant medications are particularly vulnerable to adverse medical consequences if they concurrently use alcohol and/or street drugs.
- If there is little to no change in symptoms after 3 to 4 weeks, talk to the doctor about raising the dose or changing the antidepressant.
- Treatment with antidepressants usually lasts a minimum of 9 to 12 months. Many patients are on long-term antidepressant therapy to avoid the frequency and severity of depressive episodes.

SPECIAL CONSIDERATIONS FOR PREGNANT WOMEN

Using SSRIs is safer for the mother and fetus than using tricyclic antidepressants. **Prozac** (fluoxetine) is the most studied SSRI in pregnancy and no increased incidence in birth defects has been noted, nor were developmental abnormalities of the nervous system observed in preschool-age children (Garbis and McElhatton 2001). However, possible withdrawal signs have been observed in the newborn. Given that the greatest amount of data are available for **Prozac**, this is the recommended SSRI for use during pregnancy (Garbis and McElhatton 2001). MAO Inhibitor use is not advised in pregnancy, and its use should be discontinued immediately if a woman discovers she is pregnant (Mortola 1989).

The physician should discuss the safety of antidepressant medications before starting, continuing, or discontinuing medication treatment with all women of childbearing age who may be or think they may be pregnant. Substance abuse counselors may have a role in encouraging this discussion between their clients and the prescribing physician.

ANTIANXIETY MEDICATIONS

GENERIC	BRAND
See also SSRI Antidepressants (p. 17)	
Benzodiazepines	
alprazolam	Xanax
chlordiazepoxide	Librium, Libritabs, Librax
clonazepam	Klonopin
clorazepate	Tranxene
diazepam	Valium
lorazepam	Ativan
oxazepam	Serax
Beta-blockers	
propranolol	Inderal
Other	
buspirone	BuSpar
hydroxazine embonate	Atarax
hydroxazine pamoate	Vistaril
olanzapine	Zyprexa, Zyprexa Zydis
quetiapine fumarate	Seroquel
risperidone	Risperdal
tiagabine hydrochloride	Gabitril

PURPOSE

Antianxiety medications are used to help calm and relax the anxious person as well as remove troubling symptoms associated with generalized anxiety disorder, posttraumatic stress disorder (PTSD), panic, phobias, and obsessive-compulsive disorders (OCD). The most common antianxiety medications are the antidepressants and the benzodiazepines. Positive treatment response to antianxiety medications varies a great deal by medication class.

SSRI antidepressants have become first line medications for the treatment of panic, social phobia, obsessive-compulsive disorders (in higher doses) and, more recently, generalized anxiety disorder. Positive treatment response to antidepressant medications includes a gradual reduction in anxiety, panic, and PTSD or OCD symptoms over weeks to months.

Benzodiazepines have a depressant effect on the central nervous system. Positive treatment response to benzodiazepines occurs rapidly, within days. However, especially among persons with co-occurring substance use disorders, the response may be short-lived and tolerance develops leading to the need for increased doses.

Additionally, benzodiazepines are cross tolerant[20] with alcohol and have a market as street drugs. For these reasons, most addiction medicine physicians only use them for a short time as alcohol withdrawal medicines, or as sedatives in acute[21] psychotic or manic episodes. If used in outpatient settings, careful monitoring for tolerance and abuse is needed.

Beta-blockers work on the central nervous system to reduce the flight or fight response. **Inderal**, occasionally prescribed for performance anxiety, is not addictive.

BuSpar works through the serotonin system to induce calm. It takes 3 to 4 weeks for **BuSpar** to reach adequate levels in the brain to successfully combat anxiety. **Atarax** and **Vistaril** are antihistamines that use the drowsiness side effect of the antihistamine group to calm and relax. **Atarax** and **Vistaril** work within an hour of being taken. **BuSpar**, **Atarax** and **Vistaril** are not addictive.

Low doses of **Risperdal**, **Seroquel**, **Zyprexa**, or other atypical antipsychotics may be used as non-addictive antianxiety medications. They are usually used when several other medications have failed (though use of atypical antipsychotics is expensive and not FDA approved for treatment of anxiety disorders). Their special formulation works to reduce anxiety and help the person think more clearly, though the mechanism for this is unclear.

Gabitril may be used to treat anxiety because it enhances the effects of the body's own naturally produced calmative agent, gamma aminobutyric acid (GABA). **Gabitril** is not FDA approved for treatment of anxiety disorders.

USUAL DOSE, FREQUENCY & SIDE EFFECTS

All medications have specific doses and frequencies. The physician will specify the exact amount of medication and when it should be taken. This information is provided on the prescription bottle. Usually, people are started on a low dose of medication, which is raised gradually until symptoms are removed or diminished. Major factors considered in establishing the correct dose are individual body chemistry, weight, and ability to tolerate the medication.

People taking benzodiazepines for longer than 4 to 8 weeks may develop physical tolerance to the medication. Benzodiazepines have a moderate potential for abuse. Even when taken as directed, withdrawal symptoms may occur if regular use of benzodiazepines

[20] *cross tolerant:* Refers to a drug that produces a similar effect as the misused substance but does not produce the "high." Withdrawal symptoms can be minimized through use of *cross-tolerant* substances (i.e., alcohol withdrawal symptoms can be minimized through use of *cross-tolerant* sedatives, like benzodiazepines).

[21] *acute*: Marked by sharpness of severity (an *acute* pain). Having a sudden onset and short duration (*acute* disease). Urgent or critical condition.

is abruptly stopped. Withdrawal from high dose abuse of benzodiazepines may be a life-threatening situation. For these reasons benzodiazepines are usually prescribed for brief periods of time—days or weeks—and sometimes intermittently for stressful situations or anxiety attacks. Ongoing continuous use of benzodiazepines is not recommended for most people, especially those with a past or current history of substance abuse or dependence.

Beta-blockers act on the sympathetic nervous system and are not considered addictive. They also are used to treat high blood pressure, thus side effects might be low blood pressure or dizziness. Beta-blockers may enhance the effects of other sychotropic medications and are inexpensive. **Inderal** is taken as needed for performance anxiety. It is taken regularly (as prescribed) for treatment of high blood pressure or other heart conditions.

BuSpar is often used to control mild anxiety and is considered safe for long-term therapy but is expensive.

Atarax and **Vistaril** are safe, nonaddictive medications used to reduce anxiety. They are inexpensive and may be used for longer-term therapy. Their most common side effects are dry mouth and sedation. In older men, urinary retention may develop and this is a serious condition.

POTENTIAL SIDE EFFECTS

- Blood cell irregularities
- Constipation
- Depression
- Drowsiness or lightheadedness
- Dry mouth
- Fatigue
- Heart collapse (weakened heart muscles)
- Loss of coordination
- Memory impairment (**Inderal**)
- Mental slowing or confusion
- Slowed heart beat (**Valium**)
- Stomach upset
- Suppressed breathing (restrained or inhibited)
- Weight gain

POTENTIAL FOR ABUSE OR DEPENDENCE

Between 11 and 15 percent of people in the U.S. take a form of antianxiety medication—including benzodiazepines—at least once each year. If antidepressants are included, this figure is doubled. Benzodiazepines may cause at least mild physical dependence in almost everyone who uses the medication for longer than 6 months (i.e., if the medicine is abruptly stopped, the person will experience anxiety, increased blood pressure, fast heart beat, and insomnia). However, becoming physically dependent on benzodiazepines does not necessarily mean a person will become psychologically dependent or addicted to the medication. Most people can be gradually withdrawn from the medication—when indicated—and will not develop psychological dependence.

In general, abuse and dependence occur at lower rates with long-acting antianxiety medications (e.g., **Klonopin**, **Serax**, and **Tranxene**). Abuse and dependence are more likely to occur with faster-acting, high-potency antianxiety medications (e.g., **Ativan**, **Valium**, and **Xanax**).

Risk Factors Related to Developing Dependency on Antianxiety Medication:

Less than 1% of persons *who do not have a current substance abuse problem or a history of substance abuse* becomes dependent on antianxiety medications. These people are at ***little or no risk.*** They are more likely to skip doses, take lower doses than prescribed, or decrease their dose over time.

People with a prior history of substance abuse or dependence who are in recovery are at increased risk of becoming dependent on antianxiety medications. These people are at ***moderate risk.***

Those with a history of abusing antianxiety medications or those who are opiate users are at ***higher risk*** of becoming dependent on antianxiety medications. Some studies indicate there is a moderately higher risk for alcohol dependent persons to become dependent on antianxiety medications.

EMERGENCY CONDITIONS

High doses of **Valium** can cause slowed heartbeat, suppression of breathing, and stop the heart from beating. Overdose on the older tricyclic antidepressant medications, which are often used for combined anxiety depression disorders, can be life threatening and immediate referral to emergency care is indicated.

Withdrawal from regular use of any of the benzodiazepines and similar medications must be done slowly over a month's time. Abrupt withdrawal from these medications can cause hallucinations, delusions and delirium, disorientation, difficulty breathing, hyperactivity, and grand mal seizures. A protocol for decreasing or tapering off doses of benzodiazepines is needed.

CAUTIONS

- Doctors and pharmacists should be told about all medications being taken and dosage, including over-the-counter preparations, vitamins, minerals, and herbal supplements (i.e., St. John's wort, echinacea, ginkgo, ginseng).

- People taking antianxiety medications should not increase their dose unless this has been *checked with their physician and a change is ordered*.

- People should not stop using these medications without talking to a doctor.

- People taking antianxiety medication are particularly vulnerable to adverse medical consequences if they concurrently use alcohol and/or street drugs.

- Using alcohol in combination with benzodiazepines may result in breathing failure and sudden death.

SPECIAL CONSIDERATIONS FOR PREGNANT WOMEN

The current state of knowledge suggests that benzodiazepine therapy in general does not pose as much risk of producing a deformed baby as compared to anticonvulsants (e.g., valproic acid) as long as they are given over a short time period. It appears that short-acting benzodiazepines, like those used to treat alcohol withdrawal (detoxification22), can be used in low doses even in the first trimester (Robert et al. 2001). Long-acting benzodiazepines should be avoided—their use during the third trimester or near delivery can result in a withdrawal syndrome in the baby (Garbis and McElhatton 2001). For use of the SSRIs in pregnancy, see page 21.

During pregnancy, the capacity of many drugs to bind to proteins[23] is decreased, including diazepam (a benzodiazepine) and **Methadone** (Adams and Wacher 1968; Dean et al. 1980; Ganrot 1972) with the greatest decrease noted during the third trimester (Perucca and Crema 1982). From a clinical standpoint, pregnant women could be at risk for developing greater toxicity[24] and side effects to these medications. Yet at the same time, increased metabolism of the medication may result, reducing the therapeutic effect (such as with methadone since many women seem to require an increase in their dose of methadone during the first trimester) (Pond et al. 1985).

[22] *detoxification:* A medical and biopsychosocial procedure that assists a person who is dependent on one or more substance to withdraw from dependence on all substances of abuse.

[23] *protein binding:* The affinity of a drug to attach (*bind*) to blood plasma proteins. The extent to which a drug is *bound* to plasma proteins can affect the distribution of the drug in the body. In most cases, *binding* to plasma proteins is reversible.

[24] *toxicity:* Poisonous nature; poisonous quality.

et al. 1985). In addition, there is a documented withdrawal syndrome in newborns exposed to benzodiazepines in utero (Sutton and Hinderliter 1990). Onset of this syndrome may be delayed more so than that associated with other drugs. For more information, see the forthcoming TIP *Substance Abuse Treatment: Addressing the Specific Needs of Women* (CSAT in development *b*).

For all women of childbearing age who may be or think they may be pregnant, the physician should discuss the safety of this medication before starting, continuing, or discontinuing medication treatment. Substance abuse counselors may have a role in encouraging this discussion by suggesting their clients talk with the prescribing physician.

STIMULANT MEDICATIONS

GENERIC	BRAND
d-amphetamine	Dexedrine
l & d-amphetamine	Adderall, Adderall CII, Adderall XR
methamphetamine	Desoxyn
methylphenidate	Ritalin, Ritalin SR, Concerta, Metadate ER,
Metadate CD,	
	Methylin ER, Focalin
pemoline	Cylert
modafinil	Provigil

Non-stimulants for ADHD

atomoxetine hydrochloride	Strattera
bupropion	Wellbutrin
guanfacine	Tenex

PURPOSE

Stimulant medications are used to treat attention deficit/hyperactivity disorder (AD/HD), which is typically diagnosed in childhood but also occurs in adults. Symptoms consistent with AD/HD include short attention span, excessive activity (hyperactivity), impulsivity, and emotional development below the level expected for the person's age. The underlying manifestation of AD/HD is that it severely impacts and interferes with a person's daily functioning. Other conditions that may be treated with stimulants are narcolepsy,25 obesity, and sometimes depression.

Positive treatment responses to stimulant medications include increased attention, focus and/or ability to stay on task, less hyperactivity, and moderation of impulsive behavior. People with AD/HD generally report that they feel "normal" when taking stimulants.

Non-stimulant medications for AD/HD differ somewhat. **Strattera** blocks the reuptake of norepinephrine, which helps reduce the symptoms of AD/HD. **Tenex** and **Wellbutrin** are non-stimulants that have been used successfully to treat symptoms of AD/HD. The advantage of these medications is that they are non-addictive, and do not cause a "high" even in larger doses. **Strattera** is FDA approved. While studies have shown **Wellbutrin** to be effective, it is not FDA approved.

[25] *narcolepsy:* A condition characterized by brief attacks of deep sleep.

USUAL DOSE, FREQUENCY & SIDE EFFECTS

All medications have specific doses and frequencies. The physician will specify the exact amount of medication and when it should be taken. This information is provided on the prescription bottle. With stimulants, there may be periods when the medication is not to be taken. The most common side effects of the stimulants are nervousness, sleeplessness, and loss of appetite. Some of these medications are expensive, but others are generic and quite inexpensive.

POTENTIAL SIDE EFFECTS

Stimulants

- Blood disorders (**Ritalin** and **Cylert**)
- Change in heart rhythm
- Delayed growth
- Dilated pupils
- Elevated blood pressure
- Euphoria
- Excitability
- Increased pulse rate
- Insomnia
- Irritability
- Liver damage (**Cylert**)
- Loss of appetite
- Rash
- Seizures (**Ritalin** and **Cylert**)
- Tourette's syndrome (**Cylert**)
- Tremor

Non-stimulants for AD/HD

Strattera *side effects include:*
- High blood pressure
- Nervousness, and side effects similar to some antidepressants

Wellbutrin *side effects include:*
- Increased chance of seizure activity

Tenex side effects include:
- Constipation
- Dizziness
- Dry mouth
- Low blood pressure
- Sleepiness

POTENTIAL FOR ABUSE OR DEPENDENCE

Stimulant medications may be misused. Recreational or non- medically indicated uses have been reported for performance enhancement and/or weight loss. People with AD/HD or narcolepsy, however, rarely abuse or become dependent on stimulant medications. Most addiction medicine doctors use antidepressants or **Strattera** (both non-stimulants) to treat AD/HD in adults with co-occurring substance use disorders. Using stimulant medications to treat AD/HD in children has been shown to reduce the potential development of substance use disorders.

EMERGENCY CONDITIONS

Psychiatric symptoms including paranoid delusions, thought disorders, and hallucinations have been reported when stimulants are used for long periods or taken at high dosages. Overdose with stimulants is a medical emergency. Seek help immediately.

CAUTIONS

- Doctors and pharmacists should be told about all medications being taken and dosage, including over-the-counter preparations, vitamins, minerals, and herbal supplements (i.e., St. John's wort, echinacea, ginkgo, ginseng).
- People taking stimulant medications should not increase their dose unless this has been *checked with their physician and a change is ordered*.
- People taking stimulant medications are particularly vulnerable to adverse medical consequences if they concurrently use alcohol and/or street drugs.
- With stimulants, there is the potential for development of tolerance and dependence on the medications with accompanying withdrawal. The potential for abuse and misuse is high, as is true with all Schedule II drugs.[26]

SPECIAL CONSIDERATIONS FOR PREGNANT WOMEN

For women of childbearing age who may be or think they may be pregnant, the physician should discuss the safety of this medication before starting, continuing, or discontinuing medication treatment. Substance abuse counselors may have a role in encouraging this discussion by suggesting their clients talk with the prescribing physician.

[26] *Schedule II drugs:* Drugs classified in *Schedule II* of the Controlled Substances Act; have a high potential for abuse with severe liability to cause psychic or physical dependence, but have some approved medical use.

NARCOTIC AND OPIOID ANALGESICS

Natural opioids

Opium, morphine and codeine products

Pure, semi or totally synthetic derivatives

Heroin, Percodan, Demerol, Darvon, oxycodone, and others

GENERIC	BRAND
buprenorphine	Buprinex
buprenorphine	Subutex, Suboxone*
butorphanol tartarate	Stadol spray
codeine phosphate	Codeine tablets
codeine sulfate	Codeine tablets
dihydromorphone hydrochloride	Dilaudid-5, Dilaudid HP
fentanyl transdermal	Duragesic patches
fentanyl transmucosal	Fentanyl, Oraley
hypromorphone hydrochloride	Dilaudid
meperidine hydrochloride	Demerol
methadone hydrochloride	Methadone
morphine hydrochloride	Morphine
morphine sulfate	Oramorph, Roxanol, Statex
oxycodone hydrochloride	Roxicodone, OxyContin
oxymorphone hydrochloride	Numorphan
pentazocine hydrochloride	Talwin
propoxyphene hydrochloride	Darvon
propoxyphene napsylate	Darvon-N
tramadol hydrochloride	Ultram

*Combined with naloxone[27] and taken under the tongue (sublingually).

The following products use a combination of an opioid or narcotic along with aspirin, **Tylenol**, or other pain reliever to treat mild to moderate pain.

Anesxia 5/50
Capital with Codeine
Darvocet N 100
Darvocet N 50
E-Lor or Wygesic
Empirin or Phenaphen with Codeine #3
Empirin or Phenaphen with Codeine #4
Endocet
Fioricet with Codeine

[27] *naloxone:* A narcotic antagonist used to reverse the effects of opioids.

Fiorinal with Codeine
Lorcet Plus Lortab Percocet Percodan Roxicet
Roxicet oral solution (contains alcohol) Roxiprin
Talacen
Talwin Compound
Tylenol with Codeine
Tylenol with Codeine syrup (contains alcohol) Tylox
Vicodin
Vicodin ES

PURPOSE

Some of these medications are used to control acute pain that is moderate to severe. They are normally used only for this type of pain—and for a short time—because they could become addictive. An exception is using opioids to alleviate the chronic pain associated with cancer, where research has shown that abuse or addiction to these medications rarely occurs. Severe and chronic pain has long been under treated in the United States. This is partly due to concerns about addiction and partly due to laws that made certain opioids, like heroin, illegal. However, people with addictions still feel pain and, in certain situations, they need pain management just like anyone else. Physicians are beginning to prescribe opioids more freely to manage pain—including methadone and buprenorphine.

Methadone is a synthetic opioid used in heroin detoxification treatment programs to maintain sobriety from heroin addiction. Many people who have been addicted to heroin have returned to a productive life because of methadone treatment. **Methadone** is also frequently used to provide relief for specific types of pain, especially in pain clinics. The management of chronic pain in a person who has been opiate abusing and dependent is one of the most challenging tasks in addiction medicine.

Heroin is a drug of abuse.

USUAL DOSE & FREQUENCY

All narcotic and opioid analgesics have specific doses and frequencies. The physician will specify the exact amount of medication and when it should be taken. This information is provided on the prescription bottle. Many narcotic or opioid medications are taken 2 or

more times a day. Some medications are taken in pill or liquid form. A few are taken in a nasal spray or as transdermal patches. Injectable narcotics are not listed here because they are not often used outside a hospital setting.

POTENTIAL SIDE EFFECTS

- Constipation
- Decreased ability to see clearly
- Decreased ability to think clearly
- Flushing and sweating
- Pupil constriction
- Respiratory depression (slowed breathing rate)
- Stomach upset
- Tolerance

POTENTIAL FOR ABUSE OR DEPENDENCE

With narcotic and opioid medications, there is a potential for the development of tolerance and dependence as well as the possibility of abuse and severe withdrawal reactions. There are many nonaddictive pain medications available for pain management that can be used after acute pain is reduced.

EMERGENCY CONDITIONS

- Convulsions and/or cardiac arrest with high dosages.
- Overdose may increase pulse rate, result in convulsions followed by coma or death.
- Overdose may depress the breathing centers in the brain leading to inability to breathe.
- An overdose is always considered an emergency and treatment should be sought immediately.

CAUTIONS

- Doctors and pharmacists should be told about all medications being taken and dosage, including over-the-counter preparations, vitamins, minerals, and herbal supplements (i.e., St. John's wort, echinacea, ginkgo, ginseng).

- People taking narcotic and opioid analgesics should not increase their dose unless this has been *checked with their physician and a change is ordered*.

- Persons taking an opioid medication are particularly vulnerable to adverse medical consequences if they concurrently use alcohol and/or street drugs, because alcohol and street drugs can increase the sedation effects of the opioids.

- Potential for development of tolerance and dependence exists.

SPECIAL CONSIDERATIONS FOR PREGNANT WOMEN

For all women of childbearing age who may be or think they may be pregnant, the physician should discuss the safety of this medication before starting, continuing, or discontinuing medication treatment. Both pregnant women and their unborn infants can become tolerant and physically dependent on opioids. This dependence as well as possible withdrawal syndromes needs to be assessed. Substance abuse counselors may have a role in encouraging this discussion by suggesting their clients talk with the prescribing physician. See p. 45 for information about methadone use during pregnancy.

HYPNOTICS (SLEEP AIDS)

GENERIC	BRAND
Barbiturates	
secobarbital	Seconal
Benzodiazepines	
clonazepam	Klonopin
diazepam	Valium
estazolam	ProSom
flurazepam	Dalmane
lorazepam	Ativan
oxazepam	Serax
quazepam	Doral
temazepam	Restoril
triazolam	Halcion
Non-benzodiazepines	
anticonvulsants	Neurontin*, Depakote*, Topamax*
sedating antidepressants	Desyrel, Remeron, Serzone, Sinequan
sedating antipsychotics	Seroquel*, Zyprexa*, Zyprexa Zydis*
zaleplon	Sonata
zolpidem	Ambien

*Use of these medications for sleep aid is "off-label."

PURPOSE

Hypnotics are used to help people with sleep disturbances get restful sleep. Lack of sleep is one of the greatest problems faced by those with chemical dependency and psychiatric illnesses. It can cause the symptoms of these disorders to worsen. For example, mood changes, psychosis and irritability increase with insomnia. Lack of sleep diminishes a person's ability to think clearly or process information. Sleep-wake cycles and the body's ability to heal itself also suffer when a person is sleep deprived. Older hypnotics, like barbiturates, cause the body to slow down and "pass out" or sleep. However, they also have a tendency to disturb sleep cycles. For this reason, and because of their potential for abuse and dependence, barbiturates are now rarely used.

Benzodiazepines enhance the body's natural calming agents, which induces sleep. Non-benzodiazepines such as **Ambien** and **Sonata** affect one of the body's receptors for the natural calming agent, GABA. These medications are short acting and do not disturb sleep-staging cycles. Rebound insomnia is a side effect of both, however, if the medications are used for more than 2 weeks and then abruptly stopped.

Sedating antidepressants work by using their sleep producing side effects to induce sleep. They are nonaddictive but have the capacity to produce all the side effects of their class of antidepressant. Sedating antipsychotics use their calming and sedation side effects to induce sleep. They are non-addictive but have the capacity to produce all the side effects of atypical antipsychotics. Anticonvulsants may be used for sedation when treating acute or prolonged withdrawal symptoms from alcohol.

Paradoxically, those with addiction disorders can become rapidly tolerant and dependent on the most commonly used hypnotics, which are the benzodiazepines and even one of the non-benzodiazepines—**Ambien.** Tolerance can lead to decreasing effectiveness, escalating doses, and an even worse sleep disorder when the agent is withdrawn. For this reason, most addiction medicine doctors use sedating antidepressants, anticonvulsants, or sedating antihistamines if the sleep problem continues past acute withdrawal symptoms.

USUAL DOSE & FREQUENCY

All medications have specific doses and frequencies. The physician will specify the exact amount of medication and when it should be taken. This information is provided on the prescription bottle. All of these medications are generally used for limited periods (3 to 4 days for barbiturates or up to a month for others). All of these medications quickly develop tolerance and eventually the usual dose will no longer help the person sleep.

POTENTIAL SIDE EFFECTS

- Breathing difficulty (**Seconal**)
- Dizziness
- Drowsiness
- Hangover feeling or daytime sleepiness
- Headache
- Lethargy
- Weakness

POTENTIAL FOR ABUSE OR DEPENDENCE

With hypnotics, there is the potential for development of tolerance and dependence on the medications with accompanying withdrawal. The potential for abuse and misuse is high. See *Potential for Abuse or Dependence* for benzodiazepines, p. 25. There are many drawbacks to long-term use of hypnotics such as damaged sleep staging and addiction. Even **Ambien** and **Sonata**, if taken for longer than 7 to 14 days, can have a discontinuation rebound insomnia effect. Nonaddictive medications are available to treat insomnia.

EMERGENCY CONDITIONS

Overdose with any of these medications can be life threatening. Seek help immediately.

Combinations of alcohol and barbiturates or alcohol and benzodiazepines can be deadly.

CAUTIONS

- Doctors and pharmacists should be told about all medications being taken and dosage, including over-the-counter preparations, vitamins, minerals, and herbal supplements (i.e., St. John's wort, echinacea, ginkgo, ginseng).
- People taking hypnotic medications should not increase their dose unless this has been *checked with their physician and a change is ordered*.
- People taking hypnotic medications are particularly vulnerable to adverse medical consequences if they concurrently use alcohol and/or street drugs.
- There is potential for development of tolerance and dependence with accompanying withdrawal. Potential for abuse and misuse is high.

SPECIAL CONSIDERATIONS FOR PREGNANT WOMEN

Barbiturate use during pregnancy has been studied to some extent, but the risk of taking this medication should be discussed with the client (Robert et al. 2001). There also are reports of a withdrawal syndrome in newborns following prenatal exposure to some barbiturates (Kuhnz et al. 1988). For all women of childbearing age who may be or think they may be pregnant, the physician should discuss the safety of this medication before starting, continuing, or discontinuing medication treatment. Substance abuse counselors may have a role in encouraging this discussion by suggesting their clients talk with the prescribing physician.

ADDICTION TREATMENT MEDICATIONS

ALCOHOL

GENERIC	BRAND
Alcohol withdrawal agents	
benzodiazepines (e.g., lorazepam)	Ativan
anticonvulsants (e.g., carbamazepine, divalproex sodium, gabapentin)	Tegretol, Depakote, Neurontin
barbiturates	
Alcohol relapse prevention agents	
disulfiram	Antabuse
naltrexone hydrochloride	ReVia, Depade
acamprosate	Campral
nalmefene hydrochloride	Revex
topiramate	Topamax

PURPOSE

Medications involved in alcohol treatment include those used for acute alcohol withdrawal as well as a growing number used for alcohol relapse prevention. Alcohol relapse prevention medications are just starting to be accepted in the field. It is anticipated that within the next few years, medications like **ReVia, Depade** and **Campral** will be more widely used given the developing body of research indicating that these medications work.

Alcohol withdrawal: Though usually only treated for 1 to 5 days, signs and symptoms of alcohol withdrawal go on for weeks or months. Signs and symptoms especially include sleep disorder, anxiety, agitation, and craving alcohol, knowing that a few drinks may temporarily make the alcoholic with "protracted withdrawal" feel more normal.

Benzodiazepines are by far the most commonly used medications for acute withdrawal in the U.S. However, if used longer than a few days, they induce tolerance and dependence. Anticonvulsants such as carbamazepine, divalproex sodium, and gabapentin are more commonly used in Europe. The advantage in using these medications is that they can be prescribed for weeks and months versus only days. A well-designed U.S. study (Malcolm et al. 2002) demonstrated that carbamazepine is much superior to lorazepam, a commonly used benzodiazepine, in treating alcohol withdrawal. **Inderal**, a beta-blocker, is sometimes used in alcohol withdrawal treatment along with either benzodiazepines or anticonvulsants to decrease anxiety, heart rate, sweating, and blood pressure. Antipsychotics may be used if the person develops severe alcohol withdrawal with hallucinations.

Alcohol relapse prevention: The oldest medication used in alcohol relapse prevention is **Antabuse**. It has been used for over 50 years. **Antabuse** blocks the breakdown of alcohol, resulting in toxic acetaldehyde[28] levels in the body. This in turn leads to severe nausea and vomiting. Research indicates **Antabuse** works better than placebo only in persons motivated enough to take it regularly, or in those that receive it in a "monitored" fashion 3 to 5 times per week. It works by causing the person to rethink a move to impulsive drinking, since they know if they have **Antabuse** on board, they will get sick.

Naltrexone (**ReVia, Depade**) was first developed as an opioid receptor blocker and used in monitored treatment programs for opioid dependence. Many opioid addicts, however, stopped taking it and returned to opioid use or they preferred methadone maintenance therapy. In spite of this, clinical observation of persons taking naltrexone showed that those who also used alcohol seemed to drink less and reported that alcohol use affected them less. Subsequent controlled, clinical trials comparing use of naltrexone to placebo condition have shown its effectiveness over placebo to decrease alcohol craving and relapse potential. Research with community populations (where persons are not monitored as closely for medication adherence) has not supported its effectiveness over a placebo condition to promote abstinence.

A new long-acting injectable form of naltrexone is now available. Use of this monthly treatment with even those persons who are less motivated about their recovery has led to a reduction in days drinking; and when drinking does occur, they consume less alcohol. Thus, naltrexone may be best seen as a "harm reduction" medicine versus a "complete abstinence" treatment enhancer.

Naltrexone is nonpsychoactive[29] and as an opioid receptor blocker, it can interfere with the use of opioids for treatment of acute pain. For more information on Naltrexone, see *TIP* 28: *Naltrexone and Alcoholism Treatment* (CSAT 1998).

Acamprosate **(Campral**) was FDA approved in early 2005. It has been available in Europe and other countries for over 10 years. Acamprosate appears to work through the GABA system andholds promise for alcohol craving and preventing relapse through a method different than naltrexone. It is reported to be nonpsycho-active, does not interact with most other medications, and does not cause any kind of tolerance or withdrawal symptoms even if the person uses alcohol when taking the medication.

[28] *acetaldehyde:* A chemical compound produced when the body metabolizes alcohol; the liver enzyme, alcohol dehydrogenase, converts ethanol into *acetaldehyde*, which is then further converted into the harmless acetic acid by *acetaldehyde* dehydrogenase.

[29] *psychoactive*: Substances or drugs that affect the mind, especially mood, thought, or perception.

Unlike the injectable naltrexone, acamprosate does not appear to be effective in persons who are less than moderately motivated to abstain from alcohol use. Because of the way the medication is absorbed in the body, it must be taken several times a day. Outcome studies indicate that acamprosate is best at increasing complete abstinence from alcohol, or increasing the time before the first drink (relapse). The profile of the person for whom acamprosate would be selected is one seeking complete abstinence and who is moderately to highly motivated to abstain from alcohol use.

Nalmefene (**Revex**) is beginning to be used in its oral form to reduce alcohol craving; it is also beginning to be used in gambling and nicotine addictions.

OPIOIDS

GENERIC	BRAND
Opioid withdrawal agents	
buprenorphine	Subutex
buprenorphine and naloxone	Suboxone
clonidine	Catapres
methadone hydrochloride	Methadone
nalmefene hydrochloride	ReVia, Depade
naltrexone hydrochloride	Revex
Opioid maintenance agents	
buprenorphine	Subutex
buprenorphine and naloxone	Suboxone
LAAM (levo-alpha-acetyl-methadol)	
methadone hydrochloride	Methadone

PURPOSE

Medications for opioid withdrawal and maintenance are a key component in the stabilization of persons addicted to opiates. These medications have shown marked ability to decrease illness, crime, and deaths in this population. **Methadone** maintenance treatment is extensibely researched. See TIP 19: Detoxification from Alcohol and *Other Drugs* (CSAT 1995) and *TIP 20: Matching Treatment to Patient Needs in Opioid Substitution Therapy* (CSAT 1995).

Opioid withdrawal: Mild opioid withdrawal can be accomplished with clonidine, a medication for treatment of high blood pressure. Usually clonidine is used in combination with sedatives such as benzodiazepines, antihistamines or even phenobarbital. Major opioid withdrawal is usually treated with either an equivalent dose of methadone gradually decreased over time, or more recently, a single dose of 24 mg of buprenorphine. In pilot studies, buprenorphine appears superior to clonidine.

Opioid maintenance agents: **Methadone** has been used in the U.S. for maintenance treatment of opioid addiction since the 1960s. It is a synthetic, long-acting medication used in heroin detoxification programs to maintain abstinence from heroin use. When used in proper doses, methadone stops the cravings but does not create euphoria, sedation, or an analgesic[30] effect. Many people who have been addicted to heroin have returned to a productive life because of methadone treatment programs. **Methadone** also is occasionally used to provide relief for specific types of pain. (See also *Narcotic and Opioid Analgesics*, p. 31.)

Buprenorphine, or **Subutex**, is a prescription medication approved in 2002 for treating opioid addiction. It can be used for both opioid withdrawal and as a substitute for opioids in long-term treatment. Buprenorphine is the first medication available to doctors for use in their office-based practice. At low doses, it acts like methadone and satisfies the dependent person's need for an opioid to avoid painful withdrawal. It does not provide the user with the euphoria or rush typically associated with use of other opioids or narcotics. At moderate to high doses, it can precipitate withdrawal. It is, therefore, safer in overdose than methadone. **Suboxone** is buprenorphine combined with naloxone, a narcotic antagonist[31] used to reverse the effects of opioids. **Suboxone** is also approved for treating opioid addiction and offers the same benefits as those previously stated for buprenorphine.

LAAM, a synthetic opioid agonist[32] medication, is also used in the treatment of opiate addiction.

Naltrexone and nalmefene completely block the pleasurable reinforcement that comes from opioids. They are beginning to be more widely used for alcohol relapse prevention (see pp. 38-39). Nalmefene is more commonly used in its injectable form to reverse the effects of opioids when used for anesthesia. It is beginning to be used in its oral form to reduce alcohol craving; it is also beginning to be used in gambling and nicotine addictions.

OTHERS

Stimulant intoxication: Agitation and even paranoia and psychosis are treated with antipsychotics, often combined with benzodiazepines. Both alcohol and stimulant intoxication together commonly appear to cause these symptoms.

Stimulant withdrawal: There are no standard effective agents to treat stimulant withdrawal, though dopamine-enhancing agents such as amantadine, **Wellbutrin**, and desipramine have been tried with mixed results. This area has not been well researched.

[30] *analgesic:* Producing relief or insensibility to pain without loss of consciousness.
[31] *antagonist:* A substance that blocks the normal physiological function of a receptor site in the brain.
[32] *agonist:* A substance that binds to a receptor site in the brain and triggers a response by the cell; produces an action that often mimics the action of another substance.

Stimulant relapse prevention: Again, dopamine-enhancing agents such as **Wellbutrin** and desipramine have mixed results. The National Institute on Drug Abuse (NIDA) is researching agents that might alter how stimulants act on a person, including the development of "inoculation" agents that might inactivate stimulants.

Club Drugs: Little research has occurred in this area. There are reports that SSRI's may be protective of the damage caused to nerve cells by some of these drugs. Antipsychotics and sedatives are used to treat induced psychoses associated with club drug abuse.

Marijuana: Recently, a withdrawal syndrome to marijuana dependence has been described and validated. Medications for treating this syndrome have not been adequately tested. THC,[33] the chief intoxicant in marijuana, is a strong anticholinergic agent and is sedating. Therefore some clinicians have used moderate doses of the older tricyclic antidepressants (e.g., **Elavil** or **Tofranil)** to treat withdrawal from marijuana as they also have anticholinergic and sedating qualities but do not cause a high, nor are they abused.

USUAL DOSE & FREQUENCY

All medications have specific doses and frequencies. The physician will specify the exact amount of medication and when it should be taken. This information is provided on the prescription bottle. **Antabuse** should never be given to people without their full knowledge or when they are intoxicated. It should not be given until the person has abstained from alcohol for at least 12 hours. A daily, uninterrupted dose of **Antabuse** is continued until the person is in full and mature recovery and has reorganized his or her life to maintain recovery. Maintenance therapy may be required for months or even years.

Naltrexone (**ReVia, Depade**) in its oral form is usually taken once a day but can be taken at a higher dose every second or third day. It is usually started at full dose. The injectable form of naltrexone is taken once a month. Because of the way acamprosate (**Campral**) is absorbed, it must be taken as 2 pills 3 times a day with each dose separated by at least 4 hours.

Suboxone is given as a sublingual tablet (it is absorbed under the tongue). It is not absorbed if swallowed or chewed. If injected intravenously, Suboxone will cause opioid withdrawal. **Suboxone** and **Subutex** can be given by prescription and do not require daily attendance at a clinic. This is an advantage for persons who do not live near a methadone clinic.

People should continue to take naltrexone, acamprosate or **Suboxone** until they have reached full and mature recovery and have reorganized their life to maintain recovery.

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[33] *THC: T*etra*h*ydro*c*annabinol: an active chemical from hemp plant resin that is the chief intoxicant in marijuana.

POTENTIAL SIDE EFFECTS

Potential side effects for **Antabuse***:*

- Dark urine
- Drowsiness
- Eye pain
- Fatigue
- Impotence
- Indigestion
- Inflammation of optic nerve
- Jaundice
- Light colored stool
- Liver inflammation
- Loss of vision
- Psychotic reactions
- Skin rashes, itching
- Tingling sensation in arms and legs

Potential side effects for **Campral** *(acamprosate):*

- Agitation
- Coma
- Confusion
- Decreased urine output
- Depression
- Dizziness
- Headache
- Irritability and hostility
- Lethargy
- Muscle twitching
- Nausea
- Rapid weight gain
- Seizures
- Swelling of face ankles or hands
- Unusual tiredness or weakness

Potential side effects for opioid treatment medications (See also Narcotic and Opioid Analgesics, p. 31)

- Abdominal cramps
- Body aches lasting 5–7 days
- Diarrhea
- Dizziness
- Fatigue
- Headache
- Insomnia
- Nausea
- Nervousness

- Opioid withdrawal (in some cases)
- Runny eyes and nose
- Severe anxiety
- Vomiting

EMERGENCY CONDITIONS

- Convulsions and/or cardiac arrest with high dosages.
- Overdose may increase pulse rate, result in convulsions followed by coma or death.
- Overdose may depress the breathing centers in the brain leading to inability to breathe.
- An overdose is always considered an emergency and treatment should be sought immediately.

CAUTIONS

- Doctors and pharmacists should be told about all medications being taken and dosage, including over-the-counter preparations, vitamins, minerals, and herbal supplements (i.e., St. John's wort, echinacea, ginkgo, ginseng).
- People taking **Antabuse** should be warned to avoid even small amounts of alcohol in other food products or "disguised forms" as this will cause a reaction (i.e., vanilla, sauces, vinegars, cold and cough medicines, aftershave lotions, liniments).
- People taking **Antabuse** should be warned that consuming even small amounts of alcohol will produce flushing, throbbing in head and neck, headache, difficulty breathing, nausea, vomiting, sweating, thirst, chest pain, rapid heart rate, blurred vision, dizziness, and confusion.
- People taking opioid medications should not increase or decrease their dose unless this has been *checked with their physician and a change is ordered*.
- People taking opioid medications are particularly vulnerable to adverse medical consequences if they concurrently use alcohol and/or street drugs.
- People taking naltrexone or nalmefene should be warned that if they are dependent on opioids, taking these medications will cause opioid withdrawal for up to 3 days and block the effect of any opioids taken for up to 3 days.

SPECIAL CONSIDERATIONS FOR PREGNANT WOMEN

A National Institutes of Health consensus panel recommended methadone maintenance as the standard of care for pregnant women with opioid dependence. Pregnant women should be maintained on an adequate (i.e., therapeutic) methadone dose. An effective dose prevents the onset of withdrawal for 24 hours, reduces or eliminates drug craving, and blocks the euphoric effects of other narcotics. An effective dose usually is in the range of 50–150mg (Drozdick et al. 2002). Dosage must be individually determined, and some pregnant women may be able to be successfully maintained on less than 50mg while others may require much higher doses than 150mg. The dose often needs to be increased as a woman progresses through pregnancy, due to increases in blood volume and metabolic changes specific to pregnancy (Drozdick et al. 2002; Finnegan and Wapner 1988).

Generally, dosing of methadone is for a 24-hour period. However, because of metabolic changes during pregnancy it might not be possible to adequately manage a pregnant woman during a 24-hour period on a single dose. Split dosing (giving half the dose in the morning and half in the evening), particularly during the third trimester of pregnancy, may stabilize the woman's blood methadone levels and effectively treat withdrawal symptoms and craving.

Women who are on methadone may breastfeed their infant(s). Very little methadone comes through breast milk. The American Academy of Pediatrics (AAP) Committee on Drugs lists methadone as a "maternal medication usually compatible with breastfeeding" (AAP 2001, pp. 780–781).

The Federal government mandates that prenatal care be available for pregnant women on methadone. It is the responsibility of treatment providers to arrange this care. More than ever, there is need for collaboration involving obstetric, pediatric, and substance abuse treatment providers. Comprehensive care for the pregnant woman who is opioid dependent must include a combination of methadone maintenance, prenatal care, and substance abuse treatment. While it is not recommended that pregnant women who are maintained on methadone undergo detoxification, if these women require detoxification, the safest time is during the second trimester. In contrast, it is possible to detoxify women dependent on heroin who are abusing illicit opioids by using a methadone taper. For further information, consult the forthcoming TIP *Substance Abuse Treatment: Addressing the Specific Needs of Women* (CSAT in development *b*).

Buprenorphine has been examined in pregnancy and appears not to cause birth defects but it may be associated with a withdrawal syndrome in the newborn (Jones and Johnson 2001). Buprenorphine has not yet been approved for use with this population. More

data are needed about the safety and effectiveness of buprenorphine with pregnant women.

LAAM, a medication that is also used in the treatment of opioid addiction, is not approved for use with pregnant women.

Naloxone should not be given to a pregnant woman even as a last resort for severe opioid overdose. Withdrawal can result in spontaneous abortion, premature labor, or stillbirth (Weaver 2003).

Inderal, **Trandate**, and **Lopressor** are the beta-blockers of choice for treating high blood pressure during pregnancy (McElhatton 2001). However, the impact of using them for alcohol detoxification during pregnancy is unclear.

For all women of childbearing age who may be or think they may be pregnant, the physician should discuss the safety of these medications before starting, continuing, or discontinuing medication treatment. Substance abuse counselors may have a role in encouraging this discussion by suggesting their clients talk with the prescribing physician.

TIPS FOR COMMUNICATING WITH PHYSICIANS

ABOUT CLIENTS AND MEDICATION

Send a written report.

The goal is to get your concerns included in the client's medical record. When information is in a medical record, it is more likely to be acted on. Records of phone calls and letters may or may not be placed in the chart.

Make it look like a report—and be brief.

Include date of report, client name and Social Security Number. Most medical consultation reports are one page. Longer reports are less likely to be read. Include and prominently label sections:

- Presenting Problem
- Assessment
- Treatment and Progress
- Recommendations and Questions

Keep the tone neutral.

Provide details about the client's use or abuse of prescription medications. Avoid making direct recommendations about prescribed medications. Allow the physician to draw his or her own conclusions. This will enhance your alliance with the physician and makes it more likely that he or she will act on your input.

Download Sample Written Report Form—www.mattc.org

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For clients who admit to choosing NOT to take their medication:

- Acknowledge they have a right to choose NOT to use any medication.

- Stress that they owe it to themselves to make sure their decision is well thought out. It is an important decision about their personal health and they need to discuss it with their prescribing physician.

- Ask their reason for choosing not to take the medication.

- Don't accept *"I just don't like pills."* Tell them you are sure they wouldn't make such an important decision without having a reason.

- Offer as examples reasons others might choose not to take medication. For instance, they:

1. Don't believe they ever needed it; *never were mentally ill*
2. Don't believe they need it anymore; *cured*
3. Don't like the side effects
4. Fear the medication will harm them
5. Struggle with objections or ridicule of friends and family members
6. Feel taking medication means they're not personally in control

Transition to topics other than psychiatric medications.

Ask what supports or techniques they use to assist with emotions and behaviors when they choose not to take the medication.

General Approach: The approach when talking with clients about psychiatric medication is exactly the same as when talking about their substance abuse decisions.

- Explore the triggers or cues that led to the undesired behavior (either taking drugs of abuse or not taking prescribed psychiatric medications).

- Review why the undesired behavior seemed like a good idea at the time.

- Review the actual outcome resulting from their choice.

- Ask if their choice got them what they were seeking.

- Strategize with clients about what they could do differently in the future.

TALKING WITH CLIENTS ABOUT THEIR MEDICATION

Untreated psychiatric problems are a common cause for treatment failure in substance abuse treatment programs. Supporting clients with mental illness in continuing to take their psychiatric medications can significantly improve substance abuse treatment outcomes.

Getting Started. Take 5-10 minutes every few sessions to go over these topics with your clients:

- Remind them that taking care of their mental health will help prevent relapse.
- Ask how their psychiatric medication is helpful.
- Acknowledge that taking a pill every day is a hassle.
- Acknowledge that everybody on medication misses taking it sometimes.
- Do not ask *if* they have missed any doses, rather ask, "*How many doses have you missed?"*
- Ask if they felt or acted different on days when they missed their medication.
- Was missing the medication related to any substance use relapse?
- Without judgment, ask *"Why did you miss the medication? Did you forget, or did you choose not to take it at that time?"*

For clients who forgot, ask them to consider the following strategies:

- *Keep medication where it cannot be missed:* with the TV remote control, near the refrigerator, or taped to the handle of a toothbrush. Everyone has 2 or 3 things they do everyday without fail. Put the medication in a place where it cannot be avoided when doing that activity, but always away from children.
- *Suggest they use an alarm clock* set for the time of day they should take their medication. Reset the alarm as needed.
- *Suggest they use a Mediset®:* a small plastic box with places to keep medications for each day of the week, available at any pharmacy. The Mediset® acts as a reminder and helps track whether or not medications were taken.

Handbook for Working with Defendants and Offenders with Mental Disorders

Third Edition

Federal Judicial Center
October 2003

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Handbook for Working with Defendants and Offenders with Mental Disorders

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This Federal Judicial Center publication was undertaken in furtherance of the Center's statutory mission to develop and conduct education programs for judicial branch employees. The views expressed are those of the authors and not necessarily those of the Federal Judicial Center.

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Preface

The Center first published the *Handbook for Working with Defendants and Offenders with Mental Disorders* in 1994. It has revised this handbook twice since its initial publication in order to provide officers with up-to-date information on therapeutic and supervision practices, new medications, and the growing number of national mental health associations. The Center would like to thank those mental health professionals who contributed to each of the three editions. Cynthia Barry, PhD, and Glen Skoler, PhD, served as reviewers for the 1994 edition. Susan E. Holliday, MSW, LCSW-C, joined Dr. Skoler in updating the second edition in 1999. Migdalia Baerga, MSW, LCSW, and Melissa Cahill, PhD, served as the reviewers for this, the third edition. The Center also thanks the National Institute of Corrections for its financial support for the participation of Dr. Cahill, Chief Psychologist, Dallas County Community Supervision and Corrections Department in Dallas, Texas, in this project.

This *Handbook for Working with Defendants and Offenders with Mental Disorders* is a reference guide for all probation and pretrial services officers regardless of their experience supervising individuals with mental disorders. Officers with little or no experience in this area will also want to view the three-part Federal Judicial Television Network (FJTN) training program *Supervising Defendants and Offenders with Mental Disorders*. Part 1 examines the types and causes of mental disorders most often encountered by federal probation and pretrial services officers and includes a description of frequently prescribed treatments. Part 2 addresses the officer's role in identifying individuals with mental disorders and recommending conditions for their supervision. In Part 3, the series concludes with a discussion of the officer's role in referring individuals for treatment, coordinating the treatment process, and responding to supervision challenges presented by individuals with mental disorders. Each broadcast is two hours long. Videotapes of the broadcast and participant guides are available from the Center's Information Services Office.

Introduction

While intended as a reference guide for federal probation and pretrial services officers, this handbook does not provide all the information you need to work effectively with individuals with mental disorders. To enhance your ability to work with individuals with mental disorders, you should

- refer to the *Guide to Judiciary Policies and Procedures*, volume 10, chapter 11, "Mental Health Supervision," and applicable district policies for guidance on confidentiality, third-party risk, and other supervision issues related to supervising mentally disordered persons;

- refer to the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR)*[1], the authoritative source for information on clinical diagnoses, including specific diagnostic criteria for each disorder and discussions of possible alternative diagnoses for each set of symptoms;

- refer to the *2003 Physicians' Desk Reference* and the new *PDR® Drug Guide for Mental Health Professionals* which includes information on 70 common brand name psychotropic drugs, approved uses of common prescription drugs, psychological side effects of those drugs, and prescription drugs with potential for abuse.

- consult with your mental health specialist or community mental health professionals regarding case-specific characteristics and treatment strategies;

- staff cases with colleagues and management to determine the most effective supervision plan based on the resources available in your district;

[1]. The most recent version of this manual is the fourth edition, text revision, known as the *DSM-IV-TR*. There are relatively few changes from IV to IV-TR and they don't affect the criteria for most disorders; therefore, most professionals are still using the *DSM-IV*. We will refer to the *DSM-IV* in this manual. The *DSM-IV* defines mental disorders in terms of descriptive symptoms and behaviors. It does not generally address the causes of a psychiatric disorder.

- work with your training coordinator to develop in-service training conducted by community mental health professionals or the district's mental health specialist; and

- broaden your knowledge of mental disorders by reading journals and books, viewing videos, and attending seminars.

Chapter 1: Case Management and the Individual with a Mental Disorder

This chapter contains clinical information on selected mental disorders. It also contains general strategies for supervising all persons with mental disorders on federal pretrial and probation supervision, as well as information for supervising those with a particular mental disorder. Medical terms are defined in Appendix A.

The diagnostic criteria and associated features for the mental disorders are reprinted with permission from the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV),* the authoritative source for clinical information. Copies can be ordered at cost from the American Psychiatric Press at (800) 368-5777.

All statistical and treatment information is adapted with permission from the *Synopsis of Psychiatry*, by Harold I. Kaplan and Benjamin J. Sadock (Baltimore, Md.: Williams & Wilkins, 1991).

Supervision strategies and case-management techniques are adapted from volume 10, chapter 11 of the *Guide to Judiciary Policies and Procedures* and from information provided by experienced senior officers and mental health specialists in federal probation and pretrial services.

The Office of General Counsel of the Administrative Office of the U.S. Courts reviewed information about legal issues in this chapter.

Introduction to Mental Disorders

The *Guide to Judiciary Policies and Procedures,* volume 10, chapter 11, states that "[a] n individual is considered suffering from some form of mental disease or defect when his or her exhibited behaviors or feelings deviate so substantially from the norm as to indicate disorganized thinking, perception, mood, orientation, and memory.

Mental disease or defect can range from mildly maladaptive to profoundly psychotic and can result in

- unrealistic behavior;
- marked inability to control impulses;
- grossly impaired judgment;
- aberrant behavior;
- an inability to care for oneself or meet the demands of daily life;
- a loss of contact with reality; or
- violence to self or others."

The *Guide* also states that individuals with mental disorders constitute a relatively small percentage of the overall population under federal supervision, but their importance is disproportionate because they

- require more monitoring and supervision than other cases;
- tend to be viewed as more dangerous than other individuals;
- pose difficult management problems and must be carefully monitored, as these persons often require individualized or specialized treatment; and
- require more flexibility and patience on the part of the officer than other cases.

DSM-IV

Widely used by mental health professionals as an aid in diagnosis, the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)* defines mental disorders in terms of descriptive symptoms and behaviors. The manual does not generally address the causes of a psychiatric disorder based on any one psychological theory.

The *DSM-IV* is a standard reference in the criminal justice system, and the descriptions of mental disorders in this manual are based on it, with the following caveats to officers:

- Not all *DSM-IV* disorders are included in this handbook. The handbook omits *DSM-IV* sections on medical conditions; dementias; delirium; and cognitive, drug/alcohol, and neurological disorders, which can mimic psychological disorders such as psychosis, depression, and anxiety.

- *DSM-IV* criteria are provided to help officers identify possible mental disorders and symptoms. Diagnoses should only be made by qualified mental health professionals. This caveat is especially important in light of the fact that many symptoms (e.g., depression, anxiety, confusion, and inattention) can be seen in many different disorders. Depressive symptoms, for example, can be present in schizophrenia and delusional disorders.
- Although all five *DSM-IV* diagnostic axes are listed below, it is not unusual to see reports that only specify a mental disorder on Axis I or a personality disorder on Axis II.

The *DSM-IV* employs a classification system that consists of five axes:

- Axis I: clinical disorders, including major psychiatric disorders that may be a focus of clinical attention;
- Axis II: personality disorders and mental retardation;
- Axis III: general medical conditions that are relevant to etiology or case management;
- Axis IV: psychosocial and environmental problems; and
- Axis V: global assessment and highest level of adaptive functioning.

Psychiatrists and psychologists may use all five axes to diagnose an individual. This multiaxial system, a comprehensive or holistic approach to evaluation that considers the psychosocial and environmental problems that affect individuals, leads to an accurate diagnosis and prognosis and to effective treatment planning. Appendix B to this handbook provides an overview of the *DSM-IV* classification system, including a description of the Global Assessment of Functioning (GAF) and Social and Occupational Functioning Assessment Scale (SOFAS).

The axes that are most relevant to officers are I and II, which classify mental and personality disorders. A description of Axis IV is included, since psychosocial and environmental problems may affect the diagnosis, treatment, and prognosis of Axis I and Axis II disorders.

Axis I Disorders

Axis I disorders are the major psychiatric disorders that most people associate with mental illness. The Axis I disorders included in this handbook are

- mood disorders, including major depression and bipolar disorder;
- schizophrenia and other psychotic disorders;
- anxiety disorders, including panic disorder, phobias, and post-traumatic stress disorder, and obsessive-compulsive disorder;
- delusional disorders;
- paraphilias; and
- dissociative disorders.

Many Axis I disorders are treated with medication and therapy. Psychotropic medications include antidepressant, antimanic, anticonvulsant, antianxiety, and antipsychotic medications. Although medication and therapy are often indicated, disorders vary in their prognosis for complete recovery.

Axis II Disorders

The key to understanding Axis II personality disorders is the word *personality*. *Personality* is defined as all the emotional and behavioral traits that characterize a person in day-to-day living under ordinary conditions. These traits, which differ from individual to individual, define who we are, how we see the world, and how the world sees us.

In mentally healthy individuals, the emotional and behavioral traits that compose their personalities are relatively stable, consistent, and predictable. These traits, although dominant, are also flexible and adaptive. This flexibility allows the individual to survive stress and to function within an ever-changing environment.

In contrast, individuals with a personality disorder have traits that are inflexible and maladaptive. These traits begin in early adulthood and are present in a variety of contexts. Rather than adapting to their environment, individuals with personality disorders expect the environment to adapt to them. Unlike persons diagnosed with Axis I disorders, persons diagnosed with Axis II disorders generally do not feel anxiety or distress about their maladaptive behavior. When they feel pain and discomfort, they rarely assume

there is anything wrong with them. Rather, they think the difficulties lie outside themselves.

DSM-IV classifies personality disorders into three clusters:

- Cluster A includes the paranoid, schizoid, and schizotypal personality disorders.
- Cluster B includes the antisocial, borderline, histrionic, and narcissistic personality disorders.
- Cluster C includes the avoidant, dependent, and obsessive-compulsive personality disorders.

It should be noted that this clustering system, although useful in some research and educational situations, has serious limitations and has not been consistently validated. According to *DSM-IV,* many patients exhibit traits that meet the diagnostic criteria for more than one personality disorder.

Individuals with personality disorders often deny their problems, refuse psychiatric help, or resist treatment. The pervasive and inappropriate character traits associated with personality disorders generally are not treated with medication. Therapy is the treatment of choice for personality disorders; however, certain personality disorders do not have a good prognosis for treatment, since patients are resistant to changing their personalities. Occasionally, medication may be prescribed to treat other or associated psychiatric symptoms, such as depression or anxiety. Psychiatric and treatment information for personality disorders is given later in this chapter.

Mental Retardation

Axis II is also where mental retardation is coded. Mental retardation is a disorder in which a person has below average intelligence (an IQ of 70 or below), with an onset before age 18, and impairments in everyday functioning. Mental retardation can be characterized as mild, moderate, severe, or profound. The following traits are often seen in individuals with mental retardation:

- limited vocabulary;
- difficulty understanding and answering questions;
- mimic responses;
- easily led by others (especially those in authority);

- naïvely eager to please;
- displays of childlike behavior;
- lack of awareness of social norms and appropriate behavior; and
- difficulty staying focused and easily distracted.

In community corrections, we most often see individuals with mild mental retardation. Individuals with mild mental retardation can develop social and communication skills, can usually obtain academic skills up to a sixth-grade level, and may be self-supporting. Individuals with mild retardation will usually need help when under stress.

Axis IV: Psychosocial and Environmental Problems

A psychosocial or environmental problem may be a negative life event, an environmental difficulty or deficiency, family stress or other interpersonal stress, lack of adequate social support or personal resources, or other problems relating to the context in which a person's difficulties have developed. So-called positive stressors, such as job promotion, are listed on a clinician's report only if they constitute or lead to a problem, as when a person has difficulty adapting to the new situation. In addition to playing a role in the initiation or exacerbation of a mental disorder, psychosocial problems may also develop as a consequence of a person's psychopathology or may constitute problems that should be considered in the overall management plan.

For convenience, the problems are grouped together in the following categories:

- **problems with the primary support group**—e.g., death of a family member; health problems in the family; disruption of the family by separation, divorce, or estrangement; removal from the home; remarriage of a parent; sexual or physical abuse; parental overprotection; neglect of a child; inadequate discipline; discord with siblings; birth of a sibling;

- **problems related to the social environment**—e.g., death or loss of a friend, inadequate social support, living alone, difficulty with acculturation, discrimination, adjustment to life-cycle transition (such as retirement);

- **educational problems**—e.g., illiteracy, academic problems, discord with teachers or classmates, inadequate school environment;

- **occupational problems**—e.g., homelessness, inadequate housing, unsafe neighborhood, discord with neighbors or a landlord;

- **economic problems**—e.g., extreme poverty, inadequate finances, insufficient welfare support;

- **problems related to access to health care services**—e.g., inadequate health care services, lack of transportation to health care facilities, inadequate health insurance;

- **problems related to interaction with the legal system or to crime**—e.g., arrest, incarceration, litigation, victimization (robbery, assault, etc.); and

- **other psychosocial and environmental problems**—e.g., exposure to disaster or war; discord with non-family caregivers, such as counselors, social workers, or physicians; lack of social services.

Multiple Diagnoses

An individual can be diagnosed with

- more than one Axis I disorder (e.g., both schizophrenia and major depression) or Axis II disorder; or
- both an Axis I disorder and an Axis II disorder (e.g., major depression and borderline personality disorder).

When multiple disorders exist, all applicable diagnoses should be listed in the mental health professional's report. Although many mental health professionals list what they consider to be the primary diagnosis first, that is not always the case. Therefore, don't assume that the first diagnosis listed is the primary diagnosis.

Recently, mental health professionals have been using the term *co-occurring disorders* to refer to individuals with both a substance abuse or dependence disorder and another Axis I disorder, and the term *dual diagnosis* to refer to an individual diagnosed with both mental retardation and an Axis I disorder.

Medical Notations

There are three notations you may see on medical reports dealing with multiple diagnoses:

1. R/O means "rule out." For example, you may read "Axis I major depressive episode R/O bipolar disorder." This means that the individual was exhibiting symptoms associated with both major depression and bipolar disorder. Upon evaluation, the mental health treatment provider determined the individual's behavior probably met *DSM-IV* criteria for a depressive disorder and that bipolar disorder still needed to be ruled out.
2. Personality Disorder NOS (not otherwise specified). You may see this on an evaluation when an individual is exhibiting symptoms of one or several personality disorders, but does not meet the diagnostic criteria for a specific personality disorder. The NOS category can also be used for Axis I disorders.
3. Provisional. A mental health professional may put this after a diagnosis, indicating that he or she believes the person meets criteria for the diagnosis, but is not certain.

Brain Damage

Brain damage can occur from very traumatic events (e.g., getting shot) or less traumatic, repeated events (e.g., multiple physical fights) and can occur with or without a loss of consciousness. Brain damage results in a host of different symptoms that may look like an Axis I or Axis II disorder. Men are twice as likely as women to sustain brain damage, and men age 14–24 are at highest risk.

The most typical causes of brain damage are car accidents (where injury can occur even without a loss of consciousness), anoxia (loss of oxygen to the brain), aneurysm (weakened blood vessels bursting and causing bleeding in the brain), brain tumor, stroke or cardiovascular accident, epilepsy, infectious diseases, and substance abuse.

Symptoms which suggest brain damage include persistent headaches, unusual fatigue, poor concentration, memory deficits, mood swings or frequent irritability, poor judgment, difficulty making decisions, poor organization or planning skills, impulsivity, difficulty performing multiple tasks, and problems with strength, balance, or coordination.

Introduction to Supervision Issues

Supervising a person with a mental disorder can pose many challenges for the probation and pretrial services officer. To ensure successful supervision, the officer must have a thorough understanding of the case prior to supervision. The officer should take an active role in developing prerelease plans and coordinating mental health care or treatment services. Officers who work with individuals with mental disorders must be patient and flexible, must have knowledge of mental disorders, and must develop the skills necessary to work effectively with these individuals.

Because of the unique problems and needs associated with each individual with a mental disorder, supervision strategies vary from case to case. This section reviews issues common to the majority of cases. The remaining sections in Chapter 1 identify treatment and supervision issues specific to selected mental disorders.

Treatment Issues

According to the *Guide to Judiciary Policies and Procedures*, an officer should consider recommending professional evaluation when the individual

- exhibits behavior that is bizarre or dangerous to himself or herself or to others;
- has a history of psychiatric problems as documented in hospital records and prior criminal record, or a history of suicidal gestures;
- verbalizes suicidal ideation or has feelings of depression or other symptoms of mental disorder (e.g., hallucinations, delusions, or manic episodes); or
- warrants evaluation because of the nature of the offenses (e.g., making threats to public officials).

The officer should be alert to possible significant changes in the person's behavior or appearance and to all significant stressors that could result in mental deterioration, including family difficulties, employment changes, or recent losses that are due to events like divorce or death.

Mental health treatment should begin with an assessment, highlighting the risk for violence or suicide, which is common in some disorders and may be evident during pretrial release and probation supervision. Treatment may consist of therapy, medication, or both, provided by professional mental health treatment practitioners.

Therapy. A psychiatrist, psychologist, or social worker can provide therapy. Whenever possible, the officer should refer an individual with a mental disorder to a therapist experienced in treating similarly diagnosed patients or to a clinic that provides treatment for specific disorders. Only psychiatrists, other medical doctors, and qualified practitioners, such as qualified nurse practitioners with prescriptive authority, who meet their state regulatory boards' standards can prescribe medications. Psychotropic medications should be prescribed in conjunction with a treatment regimen. The individual should be considered to be in treatment as long as he or she is taking medication or participating in therapy.

There are numerous public and private mental health services. Most counties have community mental health centers to serve a range of patients at all socioeconomic levels. Agencies vary in

- types of disorders treated;
- available forms of treatment;
- intake procedures;
- willingness to accept a person who is mandated to attend treatment but is unmotivated or has a history of violence;
- staff credentials;
- fees and funding sources; and
- location and hours of operation.

The accurate matching of treatment agency or provider to individual increases the chance for a successful adjustment. Officers should be knowledgeable about local treatment resources and should carefully evaluate programs before referring individuals for treatment. In addition, officers should consider agency policies and procedures that may affect their ability to monitor compliance with treatment. Officers should also determine the agency's ability to provide comprehensive programs and services (including inpatient, outpatient, individual, family and group services, and medication) as well as its staff's sensitivity to cultural differences.

The particular treatment approach is the sole decision of the mental health provider. At the outset of treatment, the officer's role should be clarified with the clinician and explained to the individual. The officer may act as treatment liaison, judicial system representative, or monitor and enforcer of conditions. As a liaison between the client and the treatment provider (particularly in cases of conditional release), the officer

stresses to the client the need to communicate fully with the treatment provider, brings pertinent information about the family situation and environment to the attention of the treatment provider, and alerts the treatment provider to adverse side effects of medication. As the representative of the court or the U.S. Parole Commission, the officer is responsible for monitoring and enforcing compliance with any treatment conditions and medication regimen. The officer needs to maintain ongoing contact with the treatment provider and to ask the provider to immediately report to him or her any instance of the individual's failing to comply with treatment.

Medication. Officers should familiarize themselves with the intended effects and side effects of medications taken by individuals with mental disorders. Side effects can range from mild (dry mouth, drowsiness) to severe (low blood pressure, involuntary muscle spasms). Some medications cause anxiety or disorientation.

Antipsychotic medication, which must be taken continually over a period of time to effectively control delusions and hallucinations, can cause side effects, such as slurred speech, drowsiness, or constipation, that lessen over time as the body adapts to the medication. Other side effects? such as changes in white blood cell count, low blood pressure, facial muscle spasms, and involuntary muscle movement? are more severe and pose greater risk. Some of these side effects may become permanent if not detected early. There are fewer and less severe side effects with the newer antipsychotic medications, such as Zyprexa and Risperdal. See Appendix C for a list of commonly prescribed antipsychotic medications.

Individuals experiencing side effects may refuse to take their medication. They may also become noncompliant because they are experiencing symptoms of their disorder that make them think they don't need the medication or that may prevent them from remembering to take their medication.

Officers should remind these individuals that the medication may not be effective unless taken as prescribed and encourage them to discuss the side effects with their treatment providers.

Ask the prescribing physician about the interaction of the medication and alcohol. Some medications, such as those that combat anxiety, increase the effects of alcohol. Share with the physician information regarding the individual's alcohol use or abuse and warn the individual about the danger of mixing alcohol and medication.

If you suspect that an individual is not taking prescribed medication, consider asking the physician to take blood tests to help monitor medication compliance. You may request tests but may not demand them without a special condition of supervision. Advise the individual that he or she is not required to provide blood samples but that a refusal to do so could be reported to the court and the conditions of supervision could be modified to specifically require testing.

Release of confidential information. Obtain consent from the individual so that you may receive information directly from mental health evaluators or treatment providers regarding the individual's compliance with all requirements. Have the individual sign the United States Probation System Authorization to Release Confidential Information – Mental Health Treatment Programs (Probation Form 11I) or, in the case of pretrial services, United States Pretrial Services System Authorization to Release Confidential Information – Mental Health Treatment Programs (Pretrial Services Form 6D).

In co-occurring cases, have the individual complete Probation Form 11B, an authorization to release confidential drug abuse treatment information, in addition to Probation Form 11I.

Files of parolees with mental disorders that are controlled by the Unites States Parole Commission can be requested from the regional office under the Freedom of Information Act and the Privacy Act. Disclosure of such information to social services agencies and treatment providers should be discussed in advance with the case analyst in the regional office.

Like other probation and pretrial services records, files on individuals with mental disorders are confidential and are under the court's jurisdiction. The court is exempt from both the Freedom of Information Act and the Privacy Act, pursuant to 5 U.S.C. § 552. Disclosure of the contents of the files is the prerogative of the court and occurs only when required by statute, rule, guideline, established court policy, or specific direction of the court. Therefore, information disclosed to social services agencies and treatment providers must have the prior approval of the court. The law does not require the consent of individuals. However, since some officers are licensed mental health practitioners and all licensed practitioners are required by professional standards and ethics to have clients sign release forms, those officers who are licensed may wish to secure a client's permission before disclosing information. (See *Guide to Judiciary Policies and Procedures*, vol. 10, chap. 2/A: Confidentiality, Non-disclosure and Exclusions Issues; chap. 4/D: Releasing File Information.)

Funding sources. Officers are responsible for investigating payment options and for determining whether the person can contribute to the cost of treatment. In some cases, the person may be entitled to services from community mental health centers and veterans' hospitals. If not, the government or the individual may be required to subsidize treatment (18 U.S.C. § 3672). The director of the Administrative Office of the United States Courts (AO) has the authority to contract for mental health services. The AO's probation budget has funds allocated for mental health treatment, but recommends copayment for contract mental health services. (See *Guide to* Judiciary Policies and Procedures, vol. 10, chap. 12/A: Purpose and Approach.)

Individual-based payment can come from health insurance, Social Security Income (SSI), employment assistance programs, or cash. Many persons with chronic mental disorders have been maintained on SSI, a type of disability income. The application process is long and complicated. Persons with mental disorders may need assistance when applying for SSI benefits. Officers can provide this assistance or refer the individual to local community resources, such as case-management services offered by United Way agencies.

An individual with a mental disorder whose SSI disability income payments have been suspended because of incarceration may have these benefits reinstated by showing his or her release forms to the local Social Security office. Individuals whose SSI disability income payments have been terminated, for whatever reason, must reapply for the payments to be reinstated.

Treatment Compliance

Mental health treatment is often court ordered or required by the officer as part of supervision. Yet, many individuals resist treatment, fail to attend treatment sessions regularly or at all, or drop out of treatment prematurely. Some may see a psychiatrist for medication and report that they are in treatment but may not be participating in therapy. Others may report that they have been in treatment for several months, when in fact they have attended only a few sessions.

In addition to personal contacts with the treatment provider to solicit essential information, obtain written documentation about treatment through the use of a monthly treatment report (Probation Form 46), which should include information such as

- dates of appointments (kept and missed);
- type, dosage, and administration of medications;

- compliance with the medication regimen; and
- treatment progress (or lack of progress).

Ensure that the mental health professional knows if you are to be contacted about missed appointments or lack of treatment and evaluation compliance. Cases receiving contracted treatment services can have these requirements spelled out in the Treatment Program Plan (Probation Form 45).

Treatment Termination

Treatment termination should be a joint decision by the officer, the treatment provider, and the individual. Each should feel confident that the individual is symptom-free and has benefited as much as possible from the therapeutic process.

Occasionally, a mental health treatment provider will recommend terminating treatment because the provider feels that the individual is not participating or cooperating in therapy or that the individual has progressed as far as possible. When a treatment provider recommends terminating treatment, the officer should determine the reason and request a written report. Submit the report to the court if district policy requires you to do so. If you are concerned or disagree with the provider about terminating treatment, discuss the case with the district's mental health specialist or your chief or supervisor, or seek the opinion of another treatment provider.

Treatment should not be terminated if you believe any of the following to be true:

- The individual is currently dangerous to himself or herself or to others, potentially suicidal, noncompliant with the medication regime, or unable to care for himself or herself.

- The individual's condition may in the future deteriorate or the individual may become dangerous without treatment. Even if the individual is making little or no progress, continued treatment enables the provider to monitor his or her mental state.

- The individual continues to exhibit symptoms of a disorder. If necessary, refer the individual to another mental health professional.

Because persons with mental disorders are prone to relapse, many mental health specialists recommend that the treatment condition not be removed when treatment is terminated. The standard mental health treatment condition is sufficiently broad to permit treatment termination without the officer having to ask the court to remove the

treatment condition or having to adk the court to reinstate the condition if the person has a relapse. When termination occurs, the court should be informed that the person is no longer in treatment and that the officer will monitor his or her behavior for signs of relapse.

Note: Follow all applicable policies regarding the imposition, modification, and removal of special conditions of release or supervision.

Responding to Crisis Situations

A crisis situation is any situation that presents an imminent risk to an individual or to others, and demands immediate intervention by the officer. Some examples of crisis situations are threats of suicide, physical assaults, and major psychotic episodes.

First and foremost, officers are generally not trained nor authorized to physically intervene in crisis situations. In order to respond effectively in a crisis, the officer should have a prearranged plan of action that includes having on hand emergency telephone numbers for security, the primary therapist, the crisis or mental health center, local law enforcement, and family members.

General crisis situations. According to the *Guide to Judiciary Policies and Procedures*, vol. 10, chap. 11/D, the officer's role in any crisis is to

- assess the nature and degree of danger presented by the situation (e.g., whether the situation is life threatening, weapons are involved, or others besides the individual are at risk);
- determine the extent of direct intervention necessary;
- immediately notify the treatment provider, when applicable;
- immediately notify any third party at risk;
- be sensitive to personal safety and security;
- notify necessary emergency advocates (e.g., hot lines); and
- follow through until the crisis is resolved.

Disclosure in crisis situations. Disclosure of confidential information in crisis situations is generally governed by the same rules that govern other disclosures, but the application of those rules may be somewhat different. By definition, crisis situations present risks to the individual or third parties, and the officer has an obligation to do what

is necessary to reduce that risk. Insofar as the necessary actions involve disclosure of otherwise confidential information, the officer is authorized to disclose, without prior approval by the court (unless the court in the officer's district has determined otherwise), as much information as the officer believes is necessary to reduce the risk. Disclosure may be made to parties at risk and to entities, such as law enforcement agencies, that may be able to intervene to prevent the harm. It would be good practice to advise the court of such disclosures as soon as you are able to do so. (See the discussion of third-party risk on page 18.)

Suicidal crisis situations. The *Guide* states, "The probation/pretrial services officer, in assessing suicide risk in the individual, should be aware that suicidal statements must always be taken seriously . . . and must respond promptly to any indication that the individual may be suicidal" (vol. 10, chap. 11/A). Evaluate the risk posed by any suicidal threats and gestures.

When an individual makes a suicidal threat, immediately ask questions about the suicide plan—ask when, where, and how the individual will execute the plan. Previous suicide attempts and definitiveness of a suicide plan indicate a high risk of suicide. Keep the person talking. If you have reason to believe an individual is imminently suicidal, attempt to secure his or her safety. Call the mental health treatment provider and discuss admitting the person to a hospital. Use collateral contacts, such as family, friends, or trained professionals on a suicide hotline such as 800-SUICIDE (800-784-2433), to persuade the person to go to the treatment provider or hospital.

Transporting the individual to a treatment facility yourself is too risky because the individual can open the car doors. Also, the person may require restraint. (Similarly, suggesting that a friend or family member transport the individual presents a risk.) Therefore, consider requesting police assistance to transport a suicidal individual to a hospital emergency room or an emergency psychiatric facility. In many states it is the responsibility of law enforcement officers to do so.

When talking with suicidal individuals, there are several things you can do:

- Tell the person that you are concerned about his or her safety.
- Don't hesitate to use the word "suicide." This will not put the idea into the person's head.
- Don't sound shocked or defensive about what the person says, or shame or engage the person in philosophical or theological debate about the morality of suicide.

- Be wary if the person says the crisis is over; this may indicate that he or she has made the decision to follow through with the suicide.
- Insist that the person have an immediate intake interview at the local community mental health center, which may have a walk-in clinic or an emergency services unit.
- Give the person the telephone number of a local suicide hotline.
- If the person has a treatment provider, make the provider aware of the concern.
- If the person does not have a treatment provider, initiate a referral for a mental health evaluation.

Should a suicide occur record the event and all efforts made to assist an individual prior to the suicide in your chronological records.

Suicides, while rare, have occurred even though the officer did everything that was expected of him or her. A suicide can cause a variety of troubling feelings for the officer. Should someone on your caseload commit suicide you may want to seek out a supervisor or other officers to talk with about the suicide.

Psychotic episodes. Psychosis is characteristic of a number of mental disorders, including schizophrenia and severe mood disorders. During a psychotic episode, the person incorrectly evaluates the accuracy of his or her perceptions, thoughts, and moods, and makes incorrect inferences about external reality. The ability to think, respond emotionally, remember, communicate, interpret reality, and behave appropriately is impaired. The person with a mental disorder may deteriorate into a psychotic state for a variety of reasons, for instance, by failing to take medication or experiencing extreme stress or anxiety.

Research indicates that when persons with mental disorders are experiencing active psychotic symptoms, such as delusions and hallucinations, their risk of violence increases. Obtain immediate evaluation or treatment for an individual experiencing a psychotic episode. Arrange for transportation to a local hospital emergency room, community mental health center, or emergency psychiatric facility, and contact the treatment provider.

Third-party risk. According to the *Guide to Judiciary Policies and Procedures*, vol. 10, chap. 11/D, the officer who works with persons with mental disorders has a responsibility not only to protect them from themselves but also to protect the community at large. At no time should an officer lose sight of this responsibility to protect the community. When the officer senses the

prospect of harm, he or she has a duty to warn the parties at risk. Failure to perform this duty may result in civil liability. However, the officer has no authority to disclose confidential information unless such disclosure is necessary to prevent harm to the individual or to others. Even then, the officer has to adhere strictly to established judiciary policies and procedures.

Chapter 4 of the *Probation Manual* and *Code of Federal Regulations,* Title 28, section 2.37(a)–(b) provide guidelines for third-party risk and information on disclosure policy. Before taking action after determining possible third-party risk, the officer should bring the matter to the attention of, and seek consultation with, his or her supervisor or the chief probation officer. The reasons for notification should be documented in the case files.

Violence and Individuals with Mental Disorders

Many people believe that people with mental disorders are more prone to violence and dangerous behavior than the average person; however, research does not substantiate this belief. Studies suggest that violent acts committed by individuals with major mental disorders account for at most 3% of the violence in American society.

Some mental disorders have features that are clearly associated with violent behavior toward the self or others (e.g., suicidal behavior, self-mutilation, psychotic episodes, and persecutory delusions). But violent behavior by persons with mental disorders results from the interaction of diverse personal, situational, and clinical factors; simply being diagnosed with a mental disorder does not indicate an individual's predisposition to violence.

The MacArthur Research Network on Mental Health and the Law at the University of Virginia designed the MacArthur Violence Risk Assessment Study as a supplement to its ongoing work in this area. Among the conclusions from this study are the following:

> The prevalence of violence among people who have been discharged from a hospital and who do not have symptoms of substance abuse is about the same as the prevalence of violence among other people living in their communities who do not have symptoms of substance abuse.

> The prevalence of violence is higher among people—discharged psychiatric patients or non-patients—who have symptoms of substance abuse. People who have been discharged from a psychiatric hospital are more likely than other people living in their communities to have symptoms of substance abuse.
>
> The prevalence of violence among people who have been discharged from a psychiatric hospital and who have symptoms of substance abuse is significantly higher than the prevalence of violence among other people living in their communities who have symptoms of substance abuse, for the first several months after discharge.
>
> Violence committed by people discharged from a hospital is very similar to violence committed by other people living in their communities in terms of type (i.e., hitting), target (i.e., family members), and location (i.e., at home).[2]

Nevertheless, this unpredictability warrants precautionary measures on the officer's part. The only death of a federal probation officer while on duty occurred at the hands of an individual with a mental disorder. To distinguish dangerous individuals from the less dangerous, the officer should carefully consider if any of the following characteristics are present:

- past or present substance abuse, including alcohol abuse;
- history of violence or threats of violence;
- past involuntary psychiatric commitments;
- persecutory delusions;
- acute psychotic episode(s);
- history of borderline, antisocial, or paranoid personality disorder;
- history of medication noncompliance;
- history of suicidal ideation or gestures;
- history of self-mutilation;

[2]. MacArthur Research Network on Mandated Community Treatment, "The MacArthur Community Violence Study," http://www.macarthur.virginia.edu/violence.html. (accessed August 26, 2003). For more information on the MacArthur Violence Risk Assessment Study, see H. Steadman et al., "Violence by People Discharged from Acute Psychiatric Inpatient Facilities and by Others in the Same Neighborhoods." *Archives of General Psychiatry*, 55 (1998): 393–401.

- possession and knowledge of, or interest in, firearms, explosives, or other weaponry;
- uncontrolled displays of hostility toward authority figures; and
- hypersensitivity to the contacts and professional involvement of family members, friends, or significant others with the officer.

Conditional Release Cases[3]

Conditional release, unlike probation, parole, and supervised release, is a civil, not criminal, form of supervision. Section 701 of the Federal Courts Administration Act of 1992 authorized probation and pretrial services officers to supervise persons conditionally released under the provisions of 18 U.S.C. §§ 4243 (Hospitalization of a Person Not Found Guilty by Reason of Insanity) and 4246 (Hospitalization of a Person Found Guilty and Due for Release but Suffering from a Mental Disease or Defect).

Discretionary conditions of conditionally released persons must be measured against the following considerations established by 18 U.S.C. §§ 4243 and 4246:

Individuals are released under a prescribed regimen of medical, psychiatric, or psychological care or treatment.

Release of individuals will not create a substantial risk of bodily injury to another person or serious damage to property of another.

Standard conditions designed routinely for probation, parole, and supervised release cases do not apply, and should not be enforced in conditional release cases unless they are specifically imposed by the court as part of the regimen of treatment and care authorized by 18 U.S.C. §§ 4243 and 4246. Enforcement of a regimen of care or treatment that is not medically or psychologically justified has been held to constitute a denial of due process.[4]

A psychiatrist, psychologist, or medical expert at the Federal Bureau of Prisons (BOP) recommends the conditional releasee's regimen of care and treatment while at a BOP

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3. From Appendix 3: The Supervision of Federal Offenders, Monograph 109. Office of Probation and Pretrial Services. Administrative Office of the U.S. Courts. 2003.
4. United States v. Woods, 995 F.2d 894 (9th Cir. 1993).

facility. A treatment team reviews the status of a committed person on a regular basis. When the team believes that a committed person should be considered for a conditional release, a risk assessment is performed. A panel of psychiatrists or psychologists conducts the assessment in some institutions, and in other institutions a forensic psychologist conducts it. Ultimately, the risk assessment renders an opinion as to what should be addressed in the conditions of release.

In most cases, the social work staff at BOP medical centers is primarily involved in the discharge planning for persons granted conditional release. The primary BOP facilities that house persons eligible for conditional release are Federal Medical Center, Butner, North Carolina; Federal Medical Center, Carswell Air Force Base, Fort Worth, Texas; Federal Medical Center, Rochester, Minnesota; and Medical Center for Federal Prisoners, Springfield, Missouri. The social work staff, relying on the recommendations in the risk assessment, makes referrals to various community agencies, such as state hospitals, community mental health agencies, and residential care providers. The social work staff routinely consults and collaborates with probation officers in the discharge planning process.

Once an appropriate discharge plan is formed, the court is petitioned for a conditional release. The recommendations for specified conditions of release are set forth by the BOP staff, primarily social workers, with input from the probation office, and ordered by the court. For 18 U.S.C. § 4243 cases, the court of jurisdiction is the court where the case originated. For 18 U.S.C. § 4246 cases, the court of jurisdiction is the court nearest to the institutional facility where the person is housed.

The following are examples of the conditions of release that have been imposed on conditionally released individuals in various districts nationwide.

Mr./Ms. X shall be and remain under the supervision of the United States Probation Office until further orders of this court and he/she shall comply with all of the specified conditions herein set forth:

1. Mr./Ms. X shall reside with ____________________at __________________telephone number: ___________________________________. His/her supervising United States probation officer must approve any change in Mr./Ms. X's residence.

2. Mr./Ms. X shall maintain active participation in a regimen of outpatient mental health care administered by _________________________________located at __________. Any noncompliance with his/her treatment regimen

shall be reported to the supervising United States probation officer immediately.

3. Mr./Ms. X shall continue to take such medication, including injectable units, as shall be prescribed by the medical/mental health treatment provider. Any noncompliance with his/her treatment regimen shall be immediately reported to the supervising United States probation officer.

4. Mr./Ms. X shall not associate with individuals consuming alcoholic beverages, shall not frequent business establishments whose primary product to the consumer is alcoholic beverages or places where controlled substances are illegally sold, used, distributed, or administered.

5. Mr./Ms. X shall refrain from the use of alcohol and illegal possession/use of drugs, and shall submit to urinalyses or other forms of testing to ensure compliance. It is further ordered that Mr./Ms. X shall submit to alcohol/drug aftercare treatment, on an outpatient or inpatient basis, if directed by the United States Probation Office. Mr./Ms. X shall abide by the rules of any program and shall remain in treatment until satisfactorily discharged with the approval of the United States Probation Office.

6. By accepting release pursuant to this order, Mr./Ms. X waives his/her right to confidentiality regarding his/her mental health treatment in order to allow unrestricted sharing of information with his/her supervising United States probation officer, who will assist in evaluating his/her ongoing appropriateness for community placement.

7. Mr./Ms. X shall not have in his/her possession at any time real or imitation firearms, destructive devices, or other deadly weapons. He/she shall submit to a warrantless search on request of his/her probation officer or any law enforcement officer of his/her property for the purpose of determining compliance with this order.

8. Mr./Ms. X shall not commit a federal, state, or local crime, and must immediately notify his/her United States probation officer if he/she is arrested or questioned by any law enforcement officer. He/she shall not associate with any person convicted of a felony unless granted permission to do so from his/her United States probation officer.

9. Mr./Ms. X is prohibited from operating, possessing, or purchasing a motor vehicle without written permission from his/her United States probation officer. He/she may not travel outside the "local area" as that area specifically is defined by the United States probation officer, except with the prior approval of that officer.

10. Mr./Ms. X must meet his/her financial obligations and maintain employment or participate in a vocational training program unless excused by his/her probation officer.

11. At the recommendation of a mental health treatment provider, Mr./Ms. X shall voluntarily admit himself/herself for inpatient mental health treatment. Should Mr./ Ms. X refuse to do so and he/she presents a risk to the community, involuntary state civil commitment procedures should be pursued.

12. Mr./Ms. X shall agree to undergo serum blood level screening as directed by the treating physician, to ensure that a therapeutic level of medication is maintained.

13. Mr./Ms. X shall reside for a period of _____________months in a community corrections center, halfway house, or similar residential facility and shall observe all the rules of that facility.

14. Mr./Ms. X shall report to the probation officer as directed by the court or the probation officer, shall submit a truthful and complete written report within the first five days of each month, and shall follow the instructions of the probation officer.

Supervision Strategies

In general, all mental health cases require the following supervision strategies:

- Schedule the initial contact with a person with a mental disorder in the office because the individual may view home visits as threatening.
- Review all psychiatric documentation and other relevant medical documentation pertaining to the person.
- Assess the degree of general danger and third-party risk that the individual poses to himself or herself or to others. Note any history of dangerous behavior. Review the supervision plan with your supervisor and alert the supervisor to any special issues associated with the case.
- Identify areas in which the person may need assistance (e.g., obtaining medical assistance, disability income, housing, or vocational training).
- Have the individual sign release of confidential information forms.
- Take several photographs of the individual for the record file.

- Work with the mental health treatment provider to monitor the individual's compliance with the medication regime and to assess his/her therapeutic progress.
- Familiarize yourself with the individual's psychotropic medication so that you can talk with him or her about the medication regime and encourage him or her to take the medication as prescribed.
- Be alert to drug and alcohol abuse relapses associated with co-occurring cases.
- Coordinate treatment services. Share information with the providers as needed and in accordance with confidentiality regulations and statutes.
- Schedule contacts with the individual based on the severity of the mental disorder, the state of his or her physical health, and occupational and social circumstances.
- Clearly establish and explain the limits of acceptable and unacceptable behavior. Explain the consequences of noncompliance with the conditions of supervision.
- Identify the individual's support system (family, friends, employers, and others) and make frequent contact with these individuals.

Note: Officers should not disclose any more pretrial, presentence, or supervision information than necessary to obtain requested information from collateral contacts. Although officers may say that a person is under presentence investigation or supervision, details of the offense and of supervision should not be disclosed unless absolutely necessary to elicit information. Refer to the *Guide to Judiciary Policies and Procedures* for additional guidance on confidentiality and investigation techniques.

Under no circumstances should drug aftercare information be disclosed to collateral contacts. Release of such information could subject the officer to criminal penalties.

- Prepare crisis intervention plans for handling suicide threats or attempts, psychotic episodes, assault threats, and other crises that may arise as a result of the individual's mental disorder. Officers may want to consult with local crisis screening centers or crisis intervention teams in preparing these plans.

Build rapport with the individual and work to maximize the individual's motivation to comply with special conditions and treatment requirements. Work to alleviate fears and misconceptions about mental health treatment. Talk openly about the need for treatment. Address the issue of medication and its side effects. Stress the importance

of the individual's not stopping treatment without first consulting the treating physician or nurse practitioner with prescriptive authority.

The person's mental disorder and personal circumstances determine additional supervision strategies. In general, more time and attention must be spent on individuals with severe disorders or with suicidal tendencies. For example, an individual suffering from paranoid schizophrenia who fails to take medication regularly and who has no steady residence or source of income requires intensive supervision, including frequent collateral contact with the health treatment provider. In contrast, an individual with major depression who is stabilized on medication and participating in therapy and who has a supportive family and a stable job requires less frequent contact. Refer to the remaining sections of chapter 1 of this handbook for information on supervision issues unique to specific mental disorders.

Note: All supervision strategies an officer uses must be in accordance with district policy.

Treatment Conditions

Wording. Carefully word mental health treatment conditions. Many mental health specialists find it advantageous to phrase treatment conditions in a manner that provides flexibility during supervision. However, lack of specificity may make a condition difficult to enforce. The individual may claim that the condition does not give the officer authority to order a particular activity. In general, the greater the deprivation of liberty the officer's directive entails, the greater the likelihood the individual will challenge the authority of the officer to order the activity. As a general rule, officers should request specificity in mental health conditions as soon as the need for a highly restrictive form of treatment is anticipated.

For example, if you are using the general treatment condition "the individual shall participate in psychiatric services or mental health counseling as approved by the U.S. Probation Office" and an individual exhibits suicidal or psychotic behavior that requires hospitalization, order such treatment only on an emergency basis. Since hospitalization or any inpatient care results in a significant deprivation of liberty, ask the court as soon as possible for a modiffication of the condition to specify inpatient care.

Recommended mental health-related special conditions. Below are listed some mental health special conditions for illustrative purposes.

- Mr./Ms. X shall participate in a mental health program for evaluation and/or treatment under the guidance and supervision of the United States Probation Office. The defendant shall remain in treatment until satisfactorily discharged with the approval of the United States Probation Office.

- Mr./Ms. X shall comply with his/her prescribed medication regimen and shall contribute to the cost of any prescribed psychotropic medications via copayment or full payment based upon the defendant's ability to pay or the availability of third-party payment.

- Mr./Ms. X shall participate in a mental health treatment program to include treatment for gambling, as approved by the United States Probation Office. The defendant shall contribute to the cost of services rendered or any prescribed psychotropic medications via copayment or full payment based upon the defendant's ability to pay and/or the availability of third-party payment. The defendant is prohibited from engaging in any gambling activity, legal or illegal, or from travel to any casino-based geographical location.

- Mr./Ms. X shall submit to evaluation or treatment in an approved domestic violence prevention treatment program under the guidance and supervision of the United States Probation Office. The defendant shall remain in treatment until satisfactorily discharged by the program and with the approval of the U.S. Probation Office. The defendant shall contribute to the cost of treatment services rendered or any prescribed psychotropic medications via copayment or full payment based upon the defendant's ability to pay and/or the availability of third-party payment. The defendant shall have no direct or indirect contact via telephone, face-to-face encounters or, written correspondence, or through third-party means, with____________________ (name of victim).

[5]. Joseph L. Hendrickson, in a *News and Views* article dated July 17, 2002, notes that any treatment condition that contains the wording "as approved by the U.S. Probation Office or Pretrial Services Office" stands a better chance of being upheld if challenged than does a condition with the wording "as approved by the U.S. Probation or Pretrial Services Officer." Occasionally conditions with the latter wording have been stricken when challenged on the basis that there was an improper delegation of judicial functions to an officer.

Officer Safety

Officers should be particularly concerned about individuals with mental disorders who are perceived to be dangerous. Personal safety must be the first priority for officers. The following are some general safety considerations.

- Be aware of the status of the person's mental health at all times. Pay special attention to medication compliance. Communicate regularly with the treatment provider and collateral contacts.
- Refrain from confronting or provoking the individual unnecessarily.
- Maintain a safe physical distance from the individual.
- Do not tower over the person or stare at him or her. Both you and the individual should sit, if possible, during interviews and home contacts.
- Identify and stay close to an accessible exit while meeting with an individual with a mental disorder.
- Depending on the current state of the individual's mental health and risk of dangerousness, consider taking another officer with you on home contacts. Notify the individual ahead of time of any home contact at which another person will be present.
- Alert another officer or support staff of the times and places of your contacts with individuals with mental disorders, particularly those with histories of violence or medication noncompliance. Establish a method of soliciting assistance when in the field.
- Never let an individual know your address or details about your family or personal life. In the office, keep photographs of your family out of sight; remove plaques or mementos that give personal information.

Major Depression

A major depression is a sustained period (at least two weeks) during which an individual experiences a depressed mood or a loss of interest or pleasure in most or all activities. During this period, the individual may also exhibit other symptoms of depression. Twice as many women as men suffer from major depression.

DSM-IV Diagnostic Criteria for a Major Depressive Episode

For a diagnosis of major depression, at least five of the following symptoms must have been present every day, or almost all day, over a two-week period. These symptoms will represent a change from previous functioning. A depressed mood, loss of interest or pleasure, or both will be among the symptoms.

- Depressed mood
- Disinterest or lack of enjoyment in usual activities
- Significant weight loss or weight gain when not dieting
- Insomnia or increased need for sleep (hypersomnia)
- Psychomotor agitation or psychomotor retardation
- Fatigue or loss of energy
- Feelings of worthlessness or excessive or inappropriate guilt
- Diminished concentration or ability to think clearly
- Recurrent thoughts of death, or suicidal thoughts, attempts, or plans

Associated Features of Major Depression

- Tearfulness
- Anxiety
- Irritability
- Brooding or obsessive rumination
- Excessive concern with physical health
- Phobia or panic attacks

Treatment Regime for Major Depression

The treatment regime for major depression includes the following:

- psychotherapy, often in conjunction with medication;
- antidepressant medications;
- antianxiety medications if the depression is accompanied by anxiety;

- antipsychotic medications for brief periods of time for severe depression with psychotic features, for example, depression accompanied by delusions and hallucinations; and
- hospitalization for severe cases.

Antidepressant medications do not take effect immediately and are generally prescribed for a period of six months or longer.

Supervision Issues for Major Depression

Some studies suggest that many depressed patients think about suicide and that as many as 10% to 15% successfully commit suicide. For example, suicide is a possibility with the white-collar individual who becomes severely depressed upon entering the criminal justice system for the first time and losing family, job, income, or friends because of the arrest or conviction.

The risk of suicide sometimes increases as the depressed person initially improves and regains the energy needed to plan and carry out the suicide. Monitor these cases for suicidal thoughts and gestures.

Individuals can take medication as long as six weeks before experiencing significant relief from depression symptoms. Sometimes those with major depression will not take their antidepressant medication because of its side effects (e.g., fatigue, dry mouth, constipation, blurred vision, muscle weakness, or lightheadedness) or because they feel better. Remind them that for antidepressant medications to be effective they must be taken every day, not only when the person feels depressed.

Major depression is a cyclic disorder consisting of periods of illness separated by periods of stable mental health. The psychiatrist or mental health treatment provider may recommend that the individual terminate treatment when the depressive episode ends. However, remain alert for renewed signs of depression. Encourage the individual to return to therapy for a progress check if mild depression returns, rather than wait until he or she is seriously depressed.

Bipolar Disorders (Manic and Manic-Depressive Illness)

Individuals with bipolar disorders suffer one or more manic episodes, usually accompanied by one or more major depressive episodes. With manic-depressive illness, mood swings are sometimes separated by periods of normal mood. Equally prevalent in men and women, bipolar disorder affects an estimated 0.4% to 1.2% of the adult population.

***DSM-IV* Diagnostic Criteria and Associated Features for a Depressive Episode**

Refer to the diagnostic criteria and associated features for major depression.

***DSM-IV* Diagnostic Criteria for a Manic Episode**

- A distinct period of abnormally and persistently elevated, expansive, or irritable mood lasting for at least one week has occurred.
- During a period of mood disturbance, at least three of the following symptoms have persisted and have been present to a significant degree:
  - — grandiosity, inflated self-esteem;
  - — decreased need for sleep;
  - — increased talkativeness;
  - — flight of ideas or racing thoughts;
  - — distractibility, i.e., attention is too easily drawn to unimportant or irrelevant externa stimuli;
  - — increase in goal-oriented activity (either socially, at work, at school, or sexually), or psychomotor agitation; or
  - — excessive involvement in pleasurable activities, with a lack of concern for the high potential for painful consequences, such as buying sprees, foolish business ventures, reckless driving, or casual sex.
- Mood disturbance is severe enough to cause marked impairment in occupational or social functioning or to necessitate hospitalization to prevent harm to others.

Associated Features of a Manic Episode

- Inability to recognize presence of an illness; resistance to treatment
- Rapid shift to depression or anger
- Hallucinations or delusions
- Euphoric, elevated, expansive, or irritable mood

Treatment Regime for Bipolar Disorders

The treatment regime for bipolar disorders includes the following:

- Psychotherapy is often used in conjunction with medication.
- Lithium is the standard drug treatment for acute manic episodes. Depakote (valproic acid) is also frequently used.
- Antidepressant medications are sometimes prescribed for bipolar disorders, but the patient must be carefully observed for the emergence of manic symptoms.
- Antipsychotic, and sometimes antianxiety, medications are occasionally used at the initiation of treatment to control agitation.
- Hospitalization may be necessary during acute phases of the illness.

Lithium can be toxic. When a patient first starts taking lithium, doctors will take blood samples frequently until they know that the proper dosage is established in the patient's bloodstream. To ensure compliance with treatment, and the efficacy and safety of the drug, blood samples may be taken every three months to measure the level of the lithium in the bloodstream.

Supervision Issues for Bipolar Disorders

During a manic episode, poor judgment, hyperactivity, and other symptoms of the disorder may lead an individual into activities such as reckless driving, foolish business ventures, spending sprees, or involvement in crime.

When an individual is experiencing a major depressed state, monitor him or her for suicidal thoughts or gestures. Sometimes involuntary hospitalization is required to prevent harm to the self or others.

Although elevated mood is the primary symptom of a manic episode, in instances where the individual is hindered or frustrated in some manner, the mood disturbance

may be characterized by complaints, irritability, hostile comments, or angry tirades. The individual may become threatening or violent.

Noncompliance with the medication regime is a common supervision problem because of the side effects of antimanic and antidepressant medications and because many individuals like the euphoric feelings associated with manic episodes. Remind them that antimanic and antidepressant medications must be taken over a period of several weeks to be effective and that the medications must be taken every day.

Many individuals with bipolar disorder will need to take medication and participate in treatment during the entire supervision period.

Schizophrenia

Schizophrenia is a group of disorders manifested by disturbances in communication, language, thought, perception, affect, and behavior that last longer than six months.

***DSM-IV* Diagnostic Criteria for Schizophrenia**

- Characteristic psychotic symptoms (1, 2, or 3, below) are present in the active phase for at least one week (unless the symptoms are successfully treated).
  - — 1. Two of the following:
    - (a) delusions
    - (b) hallucinations
    - (c) incoherent or disorganized speech
    - (d) catatonic behavior
    - (e) flatly or grossly inappropriate affect
    - (f) disorganized speech
  - — 2. Bizarre delusions
  - — 3. Prominent hallucinations of a voice or voices

- During the course of the disturbance, the person's ability to work, interact with others, and take care of himself or herself is markedly below the highest level achieved before onset of the disturbance.
- Schizoaffective disorder and mood disorder with psychotic features have been ruled out.

- Signs of disturbance persist for at least six months. The six-month period must include an active phase (of at least one week—less if symptoms have been successfully treated) during which there were psychotic symptoms, with or without a prodromal or residual phase, as defined below.

  Prodromal phase: a clear deterioration in functioning before the active phase of the disturbance that is not due to a mood disorder or to a psychoactive substance abuse disorder, and that involves at least two of the symptoms listed below.

  Residual phase: following the active phase of the disturbance, persistence of at least two of the symptoms listed below; symptoms are not due to a mood disorder or to a psychoactive substance abuse disorder. Prodromal or residual symptoms:
  - — marked social isolation or withdrawal;
  - — marked impairment in role functioning as wage earner, student, or homemaker;
  - — peculiar behavior, such as collecting garbage or hoarding food;
  - — marked impairment in personal hygiene and grooming;
  - — blunted or inappropriate affect;
  - — digressive, vague, over elaborate, or circumstantial speech; poverty of speech; or poverty of content of speech;
  - — odd beliefs or magical thinking that influences behavior and is inconsistent with cultural norms, such as a belief in clairvoyance or telepathy;
  - — unusual perceptual experiences, such as recurrent illusions; or
  - — marked lack of initiative, interests, or energy.

Associated Features of Schizophrenia

- Perplexed or disheveled appearance
- Abnormal psychomotor activity, such as rocking or pacing
- Poverty of speech: brief and unelaborated responses to inquiries
- Depression, anger, or anxiety
- Depersonalization and derealization
- Ritualistic or stereotypical behavior
- Bizarre concerns with physical health (e.g., a conviction that limbs are artificial or that saliva is poisoned with no evidence that this is true)
- Excessive concern with physical health

Types of Schizophrenia

The diagnosis of a particular type should be based on the predominant clinical picture that occasioned the most recent evaluation or admission to clinical care.

- Catatonic type, in which the clinical picture is dominated by at least two of the following:
  - — catatonic stupor (marked decrease in ability to react to the environment);
  - — catatonic negativism (motiveless resistance to all instructions or attempts to be moved);
  - — catatonic rigidity (maintenance of a rigid posture);
  - — catatonic excitement (purposeless excited motor activity); and
  - — catatonic posturing (voluntary assumption of inappropriate or bizarre posture).
- Disorganized type, in which the following criteria are met:
  - — incoherence, marked loosening of associations, or grossly disorganized behavior;
  - — flat or grossly inappropriate affect; and
  - — criteria for catatonic type unmet.
- Paranoid type, in which there are:
  - — preoccupation with one or more systematized delusions or with frequent auditory hallucinations related to a single theme; and
  - — none of the following: incoherence, marked loosening of associations, flat or grossly inappropriate affect, catatonic behavior, or grossly disorganized behavior.
- Undifferentiated type, in which there are
  - — prominent delusions, hallucinations, incoherence, or grossly disorganized behavior; and
  - — the criteria for paranoid, catatonic or disorganized type are unmet.
- Residual type in which there is
  - — absence of delusions, hallucinations, incoherence, or grossly disorganized behavior;
  - — continuing evidence of illness or disturbance, as indicated by two or more of the residual symptoms of schizophrenia (e.g., flattened affect and poverty of speech).

Treatment Regime for Schizophrenia

The treatment regime for schizophrenia includes the following:

- antipsychotic medications;
- supportive therapy;
- hospitalization during acute periods of illness;
- outpatient follow-up to administer and monitor medication;
- day treatment or group home programs; and
- recreational, group, or vocational support therapy (potentially necessary to help the individual function).

Many persons with schizophrenia can only maintain emotional and mental stability by taking medication. Although any medical physician can prescribe anti-psychotic medication, a psychiatrist should be the primary treatment provider because medication is such an important part of the treatment regime.

Antipsychotic medications treat the symptoms of the illness; medications are not a cure for schizophrenia. See Appendix C for more information on antipsychotic medications. Long-term use of some antipsychotic medications may result in serious side effects including Parkinsonian effects (rigidity, shuffling gait, stooped posture, and drooling) or tardive dyskinesia (abnormal, involuntary, irregular movements of the muscles in the head and body, including darting, twisting, and protruding movements of the tongue; chewing and lateral jaw movement; and grimacing around the eyes and mouth).

Supervision Issues for Schizophrenia

People with schizophrenia are often impaired in several areas of routine daily functioning, such as work, social relations, and ability to care for self. Placement in a group house or structured day treatment program may be necessary to ensure that the person is properly fed and clothed and to protect the individual from the consequences of poor judgment, impaired thinking, or actions based on hallucinations or delusions. Some individuals require these support services for the duration of the supervision period.

DSM-IV indicates that patients with schizophrenia have a higher rate of suicide than the general population. Studies indicate that nearly half of all patients with

schizophrenia attempt suicide and that approximately 10% succeed. Monitor cases with schizophrenia for suicidal thoughts or gestures.

Noncompliance with the medication regime as a result of the medication's side effects is a common supervision problem. Those with schizophrenia may become noncompliant with other conditions of supervision or dangerous to themselves or others when they stop taking their medication. Monitor their behavior for indications of not following the prescribed medication regime.

Many cases with schizophrenia require mental treatment throughout supervision. With continual antipsychotic medication and treatment, individuals with schizophrenia can live relatively normal lives.

Research indicates that violence is no more common in patients with schizophrenia than in the general population. However, be alert to the potential for violent behavior when the individual has a history of aggression or assault, fails to comply with the medication regime, or experiences a psychotic episode.

Paranoid schizophrenia

DSM-IV lists violence as an associated feature of paranoid schizophrenia, presenting a possible third-party or officer safety risk, particularly if an individual forms persecutory delusions concerning the officer. Only office contacts should be scheduled with those who exhibit paranoid symptoms and who do not take their medication regularly. Alert the receptionist and building security that the individual will be reporting to the office.

Panic Disorder

Panic disorder is characterized by recurrent panic attacks, that is, discrete periods of fear or discomfort, often accompanied by a sense of impending doom.

***DSM-IV* Diagnostic Criteria for Panic Disorder**

- At some time during the disturbance, one or more panic attacks have occurred that were unexpected and were not triggered by situations in which the person was the focus of others' attention.

- Either four attacks occurred within a four-week period, or one or more attacks were followed by at least a month of persistent fear of having another attack.
- At least four of the following symptoms developed during at least one of the attacks:
  — shortness of breath or smothering sensations
  — dizziness, unsteady feelings, or faintness
  — palpitations or accelerated heart rate
  — trembling or shaking
  — sweating
  — feeling of choking
  — nausea or abdominal distress
  — depersonalization or derealization
  — numbness or tingling sensations
  — hot flashes or chills
  — chest pain or discomfort
  — fear of dying
  — fear of going crazy or doing something uncontrolled.
- During at least some of the attacks, at least four of the above symptoms developed suddenly and increased in intensity within ten minutes of the beginning of the first symptom.

Associated Features of Panic Disorder

- Nervousness or apprehension between attacks
- Coexisting depressive disorder
- Alcohol abuse or antianxiety medication abuse

Treatment Regime for Panic Disorder

The treatment regime for panic disorder includes the following:

- behavior therapy
- insight-oriented psychotherapy
- antianxiety medications.

Supervision Issues for Panic Disorder

A panic attack generally begins with a ten-minute period of rapidly increasing symptoms and lasts twenty to thirty minutes. During an attack, the individual may appear confused, have trouble concentrating, experience physical symptoms, such as sweating or shaking, and not be able to name the source of the fear. If you observe an individual having a panic attack, quietly and calmly reassure him or her that the attack will pass, that he or she will be fine, and that you will not leave. After the attack, encourage the person to contact his or her treatment provider.

Phobias

A phobia is a persistent or irrational fear of, and a powerful desire to avoid, an object, situation, or place.

DSM-IV Diagnostic Criteria for Specific Phobia

- Persistent fear of an object or situation, other than fear of having a panic attack (as in panic disorder) or of humiliation or embarrassment in certain social situations (as in social phobia).
- Exposure to the specific phobic stimulus (or stimuli) almost invariably provokes an immediate anxiety response that may take the form of a panic attack.
- The object, situation, or place is avoided, or endured with intense anxiety.
- Fear or the avoidance behavior interferes with the individual's normal routine or with social activities or relationships with others, or there is marked distress about having the fear.
- Realization that the fear is unreasonable or excessive.
- The phobic stimulus is unrelated to the content of the obsessions of obsessive-compulsive disorder or the trauma of post-traumatic stress disorder.

Associated Features of Phobias

- Lifestyle or occupational restrictions
- Panic disorder or other phobia
- Depression

Subtypes of Phobias

- Social phobia is characterized by the following:
  - persistent fear of one or more situations in which the person is exposed to possible scrutiny by others and fears that he or she may do something or act in a way that will be humiliating or embarrassing;
  - phobic situation is avoided, or is endured with intense anxiety;
  - avoidance behavior interferes with occupational functioning or with usual social activities or relationships with others, or there is marked distress about having the fear; and
  - person recognizes that his or her fear is excessive or unreasonable.
- Panic disorder with agoraphobia is characterized by the following:
  - meets the criteria for panic disorder; and
  - fear of places or situations from which escape might be difficult (or embarrassing) or in which help might not be available in the event of a panic attack. As a result of this fear, the person either restricts travel or needs a companion when away from home, or else endures agoraphobic situations despite intense anxiety. Common agoraphobic situations include being outside the home alone, being in a crowd or standing in a line, being on a bridge, and traveling in a bus, train, or car.
- Agoraphobia without history of panic disorder is characterized by the following:
  - fear of being in places or situations from which escape might be difficult (or embarrassing) or in which help might not be available in the event of suddenly developing a symptom that could be incapacitating or extremely embarrassing; and
  - has never met the criteria for panic disorder.
- Simple phobias, such as
  - acrophobia (fear of heights)
  - claustrophobia (fear of closed spaces)
  - blood-injury phobia (fear of witnessing blood or tissue injury)
  - fear of animals
  - fear of air travel.

Treatment Regime for Phobias

The treatment regime for phobias includes the following:

- behavior therapy
- insight-oriented psychotherapy
- antianxiety or antidepressant medications during acute phases of illness.

Supervision Issues for Phobias

Most persons with phobias live relatively normal lives because they simply avoid the phobic object or situation. However, some phobias may require special accommodations. For example, an individual with a phobia involving elevators or heights may not be able to report to the probation office if it is in a high-rise building. The contact could be scheduled in the building lobby or the individual's home. Do not allow an individual's phobia, susceptibility to panic attacks, or other anxieties to keep the individual from complying with the conditions of supervision.

Post-Traumatic Stress Disorder

Individuals develop post-traumatic stress disorder following exposure to extreme traumatic stressors—by directly experiencing an event that involves actual or threatened death or serious injury or some other threat to one's physical integrity; by witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or by earning about an unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate (e.g., military combat, rape, assault, or natural disaster).

DSM-IV Diagnostic Criteria for Post-Traumatic Stress Disorder

- The person has been exposed to a traumatic event in which he or she
  - experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury or a threat to the physical integrity of self or others and
  - responded with intense fear, helplessness, or horror.

- The traumatic event is persistently re-experienced in one (or more) of the following ways:
  - recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions;
  - recurrent distressing dreams of the event;
  - acting or feeling as if the traumatic event were recurring (including a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated);
  - intense psychological distress when exposed to internal or external cues that symbolize or resemble an aspect of the traumatic event;
  - physiological reactions on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.
- Persistent avoidance of stimuli associated with the traumatic event and numbing of general responsiveness (not present before the trauma), as indicated by three or more of the following:
  - efforts to avoid thoughts, feelings, or conversations associated with the trauma;
  - efforts to avoid activities, places, or people that arouse recollections of the trauma;
  - inability to recall an important aspect of the trauma;
  - markedly diminished interest or participation in significant activities;
  - feelings of detachment or estrangement from others;
  - restricted range of affect (e.g., inability to have loving feelings);
  - sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span).
- Persistent symptoms of increased arousal (not present before the trauma), as indicated by two or more of the following:
  - difficulty falling asleep or staying asleep;
  - irritability or outbursts of anger;
  - difficulty concentrating;
  - hypervigilance;
  - exaggerated startle response.

- Duration of the disturbance (symptoms above) is more than one month.
- The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Associated Features of Post-Traumatic Stress Disorder

- Guilt feelings about surviving trauma or being a "participant" in past childhood physical or sexual abuse.
- Phobic avoidance of situations or activities that resemble or symbolize the original trauma which may lead to interpersonal, marital, or job problems.
- Impaired ability to modulate moods or anxiety.
- Flashbacks
- Lapses of memory
- Panic attacks
- Self-destructive, self-mutilating, or impulsive behavior
- Feelings of ineffectiveness, shame, despair, hopelessness, damage, or social withdrawal
- Increased possible concurrence of panic disorder, other anxiety disorders, obsessive-compulsive disorder, depression, somatization, and substance abuse related disorders.

Treatment Regime for Post-Traumatic Stress Disorder

The treatment regime for post-traumatic stress disorder includes the following:

- psychotherapy
- group therapy for specific trauma (e.g., incest, child abuse, accident, combat, rape)
- psychotropic drugs for controlling associated panic attacks, anxiety, depression, and, in severe cases, delusional thoughts.

Supervision Issues for Post-Traumatic Stress Disorder

Beware of emotional instability or mood swings. Guilt, depression, and reenactment of trauma may result in self-destructive and self-mutilating behavior, including suicidal gestures.

Cases with Post-Traumatic Stress Disorder may attempt to "self-medicate" with alcohol and drugs. Monitor such abuse.

Cases with Post-Traumatic Stress Disorder may suffer from panic attacks, flashbacks, and agoraphobia and therefore may not be malingering in expressing difficulty dealing with reasonable supervision requirements. Work with a mental health professional to establish reasonable limits and demands.

Obsessive-Compulsive Disorder

Obsessive-compulsive disorder is characterized by recurrent obsessions or compulsions that are distressful, time-consuming, and interfere significantly with the individual's occupational and social functioning.

***DSM-IV* Diagnostic Criteria for Obsessive-Compulsive Disorder**

- Either obsessions or compulsions: Obsessions
  - — recurrent and persistent ideas, thoughts, impulses, or images causing marked anxiety or distress that are experienced, at least initially, as intrusive and "senseless" (e.g., a parent's having repeated impulses to kill a loved child, or a religious person's having recurrent blasphemous thoughts);
  - — the person attempts to ignore or suppress such thoughts or impulses or to neutralize them with some other thought or action;
  - — the person recognizes that the obsessions are created within his or her own mind and are not imposed from without
  - — if another Axis I disorder is present, the content of the obsession is unrelated to it (e.g., the ideas, thoughts, impulses, or images are not about food in the presence of an eating disorder, about drugs in the presence of a psychoactive substance abuse disorder, or guilty in the presence of a major depression); and
  - — the thoughts, images, or impulses are not simply excessive worries about real-life problems.

Compulsions
  - — repetitive behaviors (hand washing, checking) or mental acts (repeating words silently, counting) that are performed in response to an obsession, according to certain rules, or in a stereotyped fashion;

— the behavior or mental act is designed to neutralize or prevent discomfort or some dreaded event or situation; however, either the activity is not connected in a realistic way with what it is designed to neutralize or prevent, or it is clearly excessive; and
— the person realizes that the compulsions are excessive and unreasonable.

Associated Features of Obsessive-Compulsive Disorder

- Hypochondria
- Tension if the compulsive activity is not performed
- Avoidance of situations that involve the content of the obsession

Treatment Regime for Obsessive-Compulsive Disorder

The treatment regime for obsessive-compulsive disorder includes the following:

- behavior therapy
- psychotherapy
- antianxiety or antidepressant medications during acute phases of illness.

(Note: The mechanisms of certain antidepressant medications are sometimes effective for obsessive-compulsive disorder.)

Supervision Issues for Obsessive-Compulsive Disorder

DSM-IV indicates that excessive alcohol or sedative drug use may be a complication of this disorder. Monitor the individual's alcohol and drug use.

Other Disorders of Impulse Control

Many mental and personality disorders can or do involve problems with or loss of impulse control. For example, substance abuse disorders, eating disorders, obsessive compulsive disorders, paraphilias, and some symptoms of mood, personality, and schizophrenic disorders may involve difficulty controlling impulses. The essential feature of an impulse-control disorder is the failure to resist an impulse, drive, or temptation to perform an act that is harmful to the person or to other persons. For most of the disorders in this category, the individual feels an increasing sense of tension or arousal before the act and pleasure, gratification, or relief while

committing it. The act may or may not be followed by regret, self-reproach, or guilt. The following disorders are included:

- intermittent explosive disorder
- kleptomania
- pyromania
- pathological gambling

DSM-IV criteria for intermittent explosive disorder, kleptomania, pyromania, and pathological gambling are listed below to familiarize officers with the pathological basis of such behavior.

***DSM-IV* Diagnostic Criteria for Intermittent Explosive Disorder**

- Several discrete episodes of failure to resist aggressive impulses that result in serious assault or destruction of property.
- The degree of aggressiveness expressed during the episodes is grossly out of proportion to any precipitating psychosocial stressors.
- The aggressive episodes are not better accounted for by another mental disorder (e.g., antisocial personality disorder, borderline personality disorder, a psychotic disorder, a manic episode, conduct disorder, or attention-deficit hyperactivity disorder) and are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., head trauma, Alzheimer's disease).

***DSM-IV* Diagnostic Criteria for Kleptomania**

- Recurrent failure to resist impulses to steal objects that are not needed for personal use or for their monetary value.
- Increasing sense of tension immediately before the theft.
- Pleasure, gratification, or relief at the time of the theft.
- The stealing is not committed to express anger or vengeance and is not in response to a delusion or a hallucination.
- The stealing is not better accounted for by conduct disorder, a manic episode, or antisocial personality disorder.

DSM-IV Diagnostic Criteria for Pyromania

- Deliberate and purposeful fire setting of fires more than once.
- Tension or excitement before the act.
- Fascination with, interest in, curiosity about, or attraction to fire, its paraphernalia, uses, and consequences, etc.
- Pleasure, gratification, or relief when setting fires, or when witnessing or participating in their aftermath.
- The fires are set not for monetary gain, to express sociopolitical ideology, to conceal criminal activity, to express anger or vengeance, to improve the person's living circumstances, in response to a delusion or hallucination, or as a result of impaired judgment (e.g., in dementia, mental retardation, substance intoxication).
- The behavior is not better accounted for by conduct disorder, a manic episode, or antisocial personality disorder.

DSM-IV Diagnostic Criteria for Pathological Gambling

- Persistent and recurrent maladaptive gambling behavior as indicated by five (or more) of the following:
  - — is preoccupied with gambling (e.g., reliving past gambling experiences, handicapping or planning the next venture, or thinking of ways to get money with which to gamble);
  - — needs to gamble with increasing amounts of money in order to achieve the desired excitement;
  - — has repeated unsuccessful efforts to control, cut back, or stop gambling;
  - — is restless or irritable when attempting to cut down or stop gambling;
  - — gambles as a way of escaping from problems or of relieving a dysphoric mood (e.g., feelings of helplessness, guilt, anxiety, depression);
  - — after losing money gambling, often returns another day to get even ("chasing" one's losses);
  - — lies to family members, therapist, or others to conceal the extent of gambling;
  - — has committed illegal acts such as forgery, fraud, theft, or embezzlement to finance gambling;

— has jeopardized or lost a significant relationship, job, or educational or career opportunity because of gambling;
— relies on others to provide money to relieve a desperate financial situation caused by gambling.

- The gambling behavior is not better accounted for by a manic episode.

Paraphilias

The essential feature of disorders in this subclass is sexual arousal in response to objects or situations that are not part of normal sexual arousal activities. It may interfere with the individual's capacity for normal, reciprocal, affectionate sexual activity. An individual may suffer from several types of paraphilia.

DSM-IV **Diagnostic Criteria for Paraphilias**

- Recurrent, intense sexual urges and sexually arousing fantasies involving:
  — nonhuman objects;
  — children or non-consenting adults; or
  — the suffering or humiliation of oneself or one's partner.
- The person has acted on these urges, or is markedly distressed by them.

Associated Features for Paraphilias

- Use of specific stimuli or imagery in sexual fantasies
- Personality disturbances that may be severe enough to warrant an Axis II diagnosis
- Decreased ability or inability to participate in normal, affectionate sexual relationships
- Denial that the paraphilic behavior is a source of stress for the individual, and the assertion that problems emerge from society's reaction to the behavior

Types of Paraphilias

- Exhibitionism: intense sexual urges and sexual fantasies associated with exposing one's genitals to a stranger; without further sexual activity with the stranger.
- Fetishism: intense sexual urges and sexual fantasies involving the use of nonliving objects.

- Frotteurism: intense sexual urges and sexual fantasies involving touching or rubbing against a non-consenting person.
- Pedophilia: intense sexual urges and sexual fantasies involving sexual activity with a child.
- Sexual masochism: intense sexual urges and sexual fantasies involving the act of being humiliated, bound, beaten, or otherwise made to suffer.
- Sexual sadism: intense sexual urges and sexual fantasies involving acts in which the individual causes psychological or physical suffering, humiliation, or harm to another person.
- Transvestic fetishism: intense sexual urges and sexual fantasies involving cross-dressing.
- Voyeurism: intense sexual urges and sexual fantasies involving observing unsuspecting people (usually strangers) who are naked, disrobing, or engaging in sexual activity.
- Paraphilia not otherwise specified: paraphilias that do not meet the criteria for any of the other types of paraphilia. Examples include (erotic stimulus in parenthesis):
  — telephone scatologia (lewdness);
  — necrophilia (corpses);
  — partialism (particular part of the body);
  — zoophilia (animals);
  — coprophilia (feces);
  — klismaphilia (enemas); and
  — urophilia (urine).

Treatment Issues for Paraphilias

The treatment regime for paraphilias includes the following:

- specialized psychotherapy;
- sex hormone treatment in extreme cases; and
- antidepressant medications to treat compulsive sexual behaviors.

Depo-provera, a hormone that decreases sexual drive, as well as the severity and frequency of aberrant sexual fantasies, is sometimes used to treat paraphiliacs. The medication is administered by injection on a weekly basis. Its use is highly controversial and has been

the subject of a great deal of litigation. It may be administered only if the individual has consented to its use.

Supervision Issues for Paraphilias

Many individuals with paraphilias do not respond well to traditional psychotherapy. Whenever possible, refer the individual to a therapist or clinic specializing in the treatment of paraphilia.

Sex offender treatment teaches coping skills to help the individual resist acting on his or her abnormal sexual interests; it does not cure the paraphilia. Relapse prevention is a critical part of the treatment regime and generally consists of requiring the individual to attend aftercare groups and focusing therapy on one's sexually abusive and deviant behavior.

The clinical polygraph has been used in recent years to identify individuals involved in past and current sexual offenses and has become an integral part of many sex offender treatment programs. The clinical polygraph is merely a diagnostic tool to elicit admissions from, and to detect deception by, the sex offender to aid supervision and treatment. It is not admissible in court and should not be used in a court proceeding.

Individuals should be in treatment throughout the supervision period. If the treatment provider and the officer jointly determine that treatment may be terminated, the sex offender should be closely monitored for the remainder of the supervision period.

Managing risk is the primary focus of supervision and necessitates an extraordinary amount of contact with both the offender and the treatment provider. Consider the following supervision strategies:

- Restrict the offender's employment and recreational activities. Offenders with paraphilia should not be able to come in contact with potential victims. For example, pedophiles and child molesters should not be allowed to work in a daycare centers, drive school buses, or frequent public swimming pools, school playgrounds, or video arcades. In general, no arrested or convicted sex offender should be allowed to work in an adult bookstore.
- Restrict the offender's travel. Offenders with paraphilias often travel to find new victims.

- Monitor the offender's contact with victims. Victims should be told that any contact with the offender should be brought to the immediate attention of the officer.
- Work with local law enforcement and with law enforcement agencies that investigate sex offense-related crimes, including U.S. Customs, U.S. Postal Inspectors, and the FBI. Most metropolitan police departments have units that specialize in the investigation of sex offenders.
- Verify compliance with local and state sex offender registration laws, when applicable. Failure to register as required may constitute a violation of state law, which in turn constitutes a violation of the conditions of release.
- Whenever possible, refer the sex offender to a therapist or clinic specializing in the treatment of paraphilias.

Suicide is a possibility for some sex offenders who experience severe depression upon entering the criminal justice system. For example, a middle-class offender who loses family, friends, job, and personal reputation because of an arrest or conviction for child molestation may become suicidal.

Paranoid Personality Disorder

Paranoid personality disorder involves a pervasive and unwarranted tendency, beginning by early adulthood, to interpret the actions of others as deliberately threatening and demeaning. This disorder is more commonly diagnosed in men than in women.

***DSM-IV* Diagnostic Criteria for Paranoid Personality Disorder**

To be diagnosed as having paranoid personality disorder, an individual must exhibit at least four of the following:

- expects, without sufficient basis, to be exploited, deceived, or harmed by others;
- questions, without justification, the loyalty or trustworthiness of friends or associates;
- reads hidden demeaning or threatening meanings into benign remarks or events (e.g., suspects that a neighbor put out trash early to annoy him or her);
- bears grudges or is unforgiving of insults or slights;

- is reluctant to confide in others because of the unwarranted fear that the information will be used against him or her;
- is easily slighted and quick to react with anger or to counterattack; or
- questions, without justification, fidelity of a spouse or sexual partner.

Associated Features of Paranoid Personality Disorder

- Hostility, defensiveness, or stubbornness
- Argumentativeness, recurrent complaining, hostile aloofness
- Inflexibility, criticalness of others, inability to collaborate
- Avoidance of intimacy or group activities
- Excessive need for self-sufficiency
- Restricted affect that prevents individual from being warm, affectionate, or emotional
- Attraction to simplistic formulations of the world; tendency to develop negative stereotypes of cultural groups distinct from his or her own
- During periods of extreme stress, transient psychotic symptoms, but usually of insufficient duration to warrant an additional diagnosis

Treatment Regime for Paranoid Personality Disorder

The treatment regime for paranoid personality disorder is psychotherapy, preferably individual therapy.

Supervision Issues for Paranoid Personality Disorder

Cases with paranoid personality disorder are sometimes argumentative, hostile, irritable, or angry. Often, they experience lifelong problems with working and living with others. They may need help framing their perceptions more realistically and projecting their own hostile or unacceptable feelings onto others.

Schizoid Personality Disorder

A lifelong pattern of social withdrawal and a restricted range of emotional experience and expression characterize schizoid personality disorder.

DSM-IV Diagnostic Criteria for Schizoid Personality Disorder

To be diagnosed as having schizoid personality disorder, an individual must exhibit at least four of the following:

- neither desires nor enjoys close relationships, including being part of a family;
- almost always chooses solitary activities;
- takes pleasure in few, if any activities;
- indicates little, if any, desire to have sexual experiences with another person;
- is indifferent to praise or criticism;
- has no close friends or confidants outside immediate family; or
- displays constricted affect; is aloof and cold and rarely reciprocates gestures or facial expressions, such as smiles or nods.

Associated Features of Schizoid Personality Disorder

- Inability to express aggressiveness or hostility
- Inability to define goals; indecisiveness, self-absorption, and absent-mindedness

Treatment Regime for Schizoid Personality Disorder

The treatment regime for schizoid personality disorder is psychotherapy, and sometimes medication is used as well.

Supervision Issues

The individual's withdrawing style should be countered by enhancing personal, social, and professional spheres.

Schizotypal Personality Disorder

Schizotypal personality disorder involves a pervasive pattern of acute discomfort with and reduced capacity for interpersonal relationships, as well as peculiarities of ideation, appearance, and behavior.

DSM-IV Diagnostic Criteria for Schizotypal Personality Disorder

To be diagnosed as having schizotypal personality disorder, an individual must exhibit at least five of the following:

- ideas of reference (excluding delusions of reference);
- excessive social anxiety (e.g., extreme discomfort in social situations involving unfamiliar people);
- odd beliefs or magical thinking which influences behavior and is inconsistent with cultural norms (e.g., clairvoyance, telepathy);
- unusual perceptual experiences, such as illusions or sensing the presence of a force or person not actually present;
- odd or eccentric appearance or behaviors, such as talking to himself or herself;
- lack of close friends or confidants outside immediate family;
- odd speech, such as impoverished, vague, or digressive speech;
- silly, aloof, or inappropriate facial expressions or gestures; or
- suspiciousness or paranoid ideas.

Associated Features of Schizotypal Personality Disorder

- Anxiety or depression
- Eccentric convictions
- During periods of extreme stress, may experience transient psychotic symptoms, but these symptoms are usually of insufficient duration to warrant an additional diagnosis

Treatment Regime for Schizotypal Personality Disorder

The treatment regime for schizotypal personality disorder is psychotherapy, and sometimes medication is used as well.

Supervision Issues for Schizotypal Personality Disorder

Those with schizotypal personality disorder are likely to be involved in bizarre groups, cults, or strange religious practices. Their companions may be eccentric and unpredictable. As a precaution, the first contact with the individual should be in the office. To the extent possible, before making subsequent home contacts determine who is living in the home or who frequently visits the home.

Ten percent of all patients with schizotypal personality disorder commit suicide. Monitor cases with this disorder for signs of suicidal thoughts and gestures.

Antisocial Personality Disorder

Antisocial personality disorder is characterized by an inability to conform to social norms and a continuous display of irresponsible and antisocial behavior. A diagnosis of antisocial personality disorder can only be made after age 18 and must include evidence of antisocial conduct that began prior to age 15. This disorder is more common in men than in women. As much as 75% of the prisoner population may have antisocial personality disorder.

DSM-IV Diagnostic Criteria for Antisocial Personality Disorder

- Current age at least 18.
- Evidence of conduct disorder with onset before age 15, as indicated by a history of three or more of the following:
  - — often bullied, threatened, or intimidated others;
  - — was often truant;
  - — before age 13, stayed out all night despite parental restrictions;
  - — ran away from home overnight at least twice while living in parental or parental surrogate's home;
  - — often initiated physical fights;
  - — used a weapon in more than one fight;
  - — forced someone into sexual activity with him or her;
  - — was physically cruel to animals;
  - — was physically cruel to other people;

— deliberately destroyed others' property (other than by setting fires);
— deliberately set a fire;
— often lied (other than to avoid physical or sexual abuse);
— has broken into another's house, building, or car;
— has stolen without confronting the victim on more than one occasion; or
— has stolen and confronted the victim (e.g., mugging or armed robbery).

- A pattern of irresponsible and antisocial behavior since age of 15, as indicated by at least four of the following:
  — unable to sustain consistent work behavior, as indicated by any of the following:
- significant unemployment for six months or more within five years when expected to work and work was available;
- repeated absences from work unexplained by illness of self or family; or
- abandonment of several jobs without realistic plans for others
  — fails to conform to social norms with respect to lawful behavior, as indicated by repeatedly performing antisocial acts that are grounds for arrest;
  — is irritable and aggressive, as indicated by physical fights or assaults;
  — repeatedly fails to honor financial obligations, such as defaulting on debts;
  — fails to plan ahead or is impulsive, as indicated by either a lack of a permanent address, traveling from place to place with no purpose in mind, or both;
  — has no regard for truth, as indicated by repeatedly lying or using aliases;
  — is reckless regarding his or her own or others' safety;
  — lacks remorse.

Associated Features of Antisocial Personality Disorder

- Use of alcohol and drugs and engaging in casual sexual intercourse in early adolescence and adulthood
- Signs of personal distress, such as tension, depression, or boredom
- Inability to form or sustain healthy, loving relationships with family, friends, or sexual partners

Treatment Regime for Antisocial Personality Disorder

The treatment regime for antisocial personality disorder is psychotherapy.

Supervision Issues for Antisocial Personality Disorder

Some mental health providers find antisocial personality disorder difficult to treat and may refuse to take a referral. Prognosis for successful treatment is extremely poor.

Rely on supervision strategies more than treatment to manage risk. Some persons with this disorder are very charming and manipulative. Set, clarify, and enforce limits on behavior. Monitor these cases for drug and alcohol use and antisocial acts such as physical fights and assaults, association with criminals, reckless or drunk driving.

Antisocial personality disorder, in the presence of a history of aggressive behavior, increases the likelihood of continued aggressive behavior.

Borderline Personality Disorder

Borderline personality disorder is characterized by a pervasive pattern of unstable mood, self-image, and interpersonal relationships and marked impulsivity, beginning by early adulthood. This disorder is more prevalent in women than in men.

DSM-IV Diagnostic Criteria for Borderline Personality Disorder

To be diagnosed as having borderline personality disorder, an individual must exhibit at least five of the following:

- a pattern of unstable and intense interpersonal relationships characterized by alternation between extremes of idealization and devaluation;
- impulsiveness in at least two areas that are potentially self-damaging, such as excessive spending, casual sex, shoplifting, reckless driving, and binge eating;
- marked shifts in mood, leading to depression, anxiety, or irritability;
- inappropriate displays of intense anger or a lack of control concerning anger;
- recurrent suicidal threats, gestures, or behavior, or self-mutilating behavior;

- marked and persistent identity disturbance, as evidenced by at least two of the following: uncertainty about life issues, sexual orientation, life goals, career choices, choice of friends, and values;
- chronic feelings of boredom and emptiness;
- frantic efforts to avoid real or imagined abandonment;
- brief stress-related paranoid thinking or severe dissociative symptoms.

Associated Features of Borderline Personality Disorder

- Features of other personality disorders may be present and severe enough to warrant more than one diagnosis
- Pessimistic outlook and social contrariness
- Depression
- Alternation between self-assertion and dependency
- During periods of extreme stress, may experience transient psychotic symptoms, but they are usually of insufficient duration to warrant an additional diagnosis

Treatment Regime for Borderline Personality Disorder

The treatment regime for borderline personality disorder includes the following:

- psychotherapy;
- behavior therapy to help the individual control impulses and anger;
- insight oriented therapy;
- social skills training to help the individual improve interpersonal skills;
- antidepressant medications to treat depression and mood swings; and
- antipsychotic medication to control anger, hostility, and brief psychotic episodes.

Supervision Issues for Borderline Personality Disorder

Prognosis for treatment is extremely poor. These cases may play the treatment provider and the officer against each other. If possible, make referrals to a provider experienced in treating persons with borderline personality disorder. At the beginning of treatment, schedule a

meeting with all parties to discuss treatment goals. Remain vigilant for manipulative gestures throughout supervision.

Recurrent suicidal threats and behavior, or self-mutilation (e.g., slashing wrists or arms) are common in severe cases. Although the suicide or self-mutilating gestures may be manipulative, attention-seeking behaviors, treat these incidents as life threatening.

Hospitalization may be required when a person is excessively self-destructive or self-mutilating. Placement in a halfway house or group home may provide a helpful support system.

Because of their unpredictable and impulsive behavior, persons with borderline personality disorder are often in a state of extreme crisis involving problems with finances, health, relationships, or other areas of their lives. Focus supervision on defining acceptable and unacceptable behavior and parameters of compliance and providing structure that will enable the individual to comply.

Monitor drug or alcohol use.

These cases demonstrate poor judgment in relationships and frequently change partners. As a precaution, attempt to find out whom the individual is living with prior to making a home contact.

Females with borderline personality disorder are often seductive and may have trouble maintaining appropriate boundaries. Thus, it is often best to have another officer accompany you on home contacts.

A diagnosis of borderline personality disorder does not itself suggest violent, aggressive behavior toward others. It does suggest violent, destructive acts towards oneself and impulsiveness and anger that may at times result in violent acts toward others.

Histrionic Personality Disorder

Excessive emotionality and attention seeking characterize histrionic personality disorder. This disorder, which begins in early adulthood, is more commonly diagnosed in women than in men.

DSM-IV Diagnostic Criteria for Histrionic Personality Disorder

To be diagnosed as having histrionic personality disorder, an individual must exhibit at least four of the following:

- is often inappropriately sexually seductive in appearance or behavior;
- consistently uses physical appearance to draw attention to self;
- emotional expressions are inappropriately exaggerated, such as embracing casual acquaintances with excessive ardor or sobbing uncontrollably on minor sentimental occasions;
- is uncomfortable in situations in which he or she is not the center of attention;
- displays rapidly shifting and shallow expression of emotions;
- is easily influenced by other or circumstances;
- has a style of speech that is excessively impressionistic and lacking in detail (e.g., says "My vacation was fantastic!" without being able to provide details);
- considers relationships to be more intimate than they actually are.

Associated Features of Histrionic Personality Disorder

- Is lively and dramatic
- Craves novelty, stimulation, and excitement and is easily bored with routine
- Has superficial personal relationships
- Lacks interest in intellectual pursuits
- Is impressionable and easily influenced; is drawn to strong authority figures and thinks that they can provide a magical solution to his or her problems
- Frequently complains about poor health
- During periods of extreme stress, may experience transient psychotic symptoms, but they are usually of insufficient duration to warrant an additional diagnosis

Treatment Regime for Histrionic Personality Disorder

The treatment regime for histrionic personality disorder is psychotherapy.

Supervision Issues for Histrionic Personality Disorder

Cases with histrionic personality disorder have superficial relationships, although they have strong dependency needs. Seductive behavior is common in both male and females. Discourage it by defining the parameters of the officer-client relationship throughout the supervision period. To the extent possible, make home contacts in teams.

Persons with histrionic personality disorder sometimes appear to be in crisis because they are excessive in their expression of emotion. They are sensation seekers who may get into trouble with the law, abuse drugs, or act promiscuously.

Narcissistic Personality Disorder

Narcissistic personality disorder is characterized by a heightened sense of self-importance in fantasy or behavior, hypersensitivity to evaluation by others, and a lack of empathy.

DSM-IV Diagnostic Criteria for Narcissistic Personality Disorder

To be diagnosed as having narcissistic personality disorder, an individual must exhibit at least five of the following:

- shows arrogant, haughty behaviors or attitudes;
- takes advantages of others;
- has a grandiose sense of self-importance;
- believes that his or her problems are unique and can only be understood by other high-status, special people or institutions;
- is preoccupied with fantasies of unlimited success, power, brilliance, beauty, or ideal love;
- has an unreasonable expectation of favorable treatment;
- requires excessive admiration;
- lacks empathy;

- is preoccupied with feelings of envy.

Associated Features of Narcissistic Personality Disorder

- Features of other personality disorders may be present and severe enough to warrant more than one diagnosis
- Depression
- Preoccupation with grooming, personal health, and youth
- Rationalizing or lying about personal deficits
- Reacts to criticism with feelings of rage, shame, or humiliation.

Treatment Regime for Narcissistic Personality Disorder

The treatment regime for narcissistic personality disorder is psychotherapy.

Supervision Issues for Narcissistic Personality Disorder

The individual with narcissistic personality disorder is often arrogant, aloof, superior, and condescending. He or she is likely to play power games with the officer, and winning any of these games will only reinforce the narcissistic behavior. In addition, these cases have fragile self-esteem and are prone to suicide.

Individuals with narcissistic personality disorder respond negatively to aging and are susceptible to mid-life crises because they place excessive value on youth, beauty, and strength. Major depression can occur during this time.

Because these cases frequently experience interpersonal problems and exploit others to achieve their ends, rely on supervision strategies more than treatment to manage risk. Set, clarify, and enforce limits on behavior. Intensive supervision is recommended for the duration of supervision.

Avoidant Personality Disorder

Avoidant personality disorder is characterized by a pervasive pattern of social discomfort, hypersensitivity to negative evaluation, and feelings of inadequacy beginning by early adulthood.

DSM-IV Diagnostic Criteria for Avoidant Personality Disorder

To be diagnosed as having avoidant personality disorder, an individual must exhibit at least four of the following:

- is preoccupied with being criticized or rejected in social situations;
- shows restraint within intimate relationships because of the fear of being shamed or ridiculed;
- is unwilling to get involved with people unless certain of being liked;
- avoids social or occupational situations that involve significant interpersonal contact, because of fears of criticism, disapproval, or rejection;
- is inhibited in new social situations because of feelings of inadequacy;
- views self as socially inept, personally unappealing, or inferior;
- is unusually reluctant to take personal risks or to engage in any new activities because they may prove embarrassing.

Associated Features of Avoidant Personality Disorder

- Depression, anxiety, or anger at oneself for failing to develop social relationships
- Specific phobias, such as social phobia

Treatment Regime for Avoidant Personality Disorder

The treatment regime for avoidant personality disorder includes the following:

- psychotherapy
- assertiveness training—sometimes useful in building social and interpersonal skills and improving self-esteem.

Supervision Issues for Avoidant Personality Disorder

Whereas the person with schizoid personality disorder avoids social contact because he or she prefers to be alone, the person with avoidant personality disorder avoids social contact for fear of rejection. Many persons with avoidant personality disorder are able to function as long as they are in a safe, protected family environment. Should this support system fail, however, they may experience anger, depression, or anxiety.

Individuals with avoidant personality disorder generally respond poorly to the slightest perceived rejection or criticism and on rare occasions may avoid an officer because they are angry or hurt by something the officer said or did.

Dependent Personality Disorder

Dependent personality disorder is characterized by a pervasive and excessive need to be taken care of that leads to dependent and submissive behavior. This disorder, which begins by early adulthood, is more commonly diagnosed in women than in men.

***DSM-IV* Diagnostic Criteria for Dependent Personality Disorder**

To be diagnosed as having dependent personality disorder, an individual must exhibit at least five of the following:

- is unable to make everyday decisions without an excessive amount of advice and reassurance from others;
- needs others to assume responsibility for most major areas of his or her life;
- agrees with people when he or she believes they are wrong because of a fear of being rejected;
- has difficulty initiating projects or doing things alone because of a lack of self-confidence in his or her own judgment or abilities rather than a lack of motivation;
- volunteers to do things that are unpleasant or demeaning in order to get others to like him or her;
- feels uncomfortable and helpless when alone, or goes to great lengths to avoid being alone;
- urgently seeks another relationship as a source of care and support when a close relationship ends;
- is frequently preoccupied with fears of being abandoned.

Associated Features of Dependent Personality Disorder

- Sometimes, features of other personality disorders severe enough to warrant more than one diagnosis

- Depression and anxiety
- Lack of self-confidence
- Easily hurt by criticism or disapproval.
- Belittling personal assets and abilities
- Seeking or encouraging relationships in which they are overprotected or dominated by others

Treatment Regime for Dependent Personality Disorder

The treatment regime for dependent personality disorder includes the following:

- psychotherapy, including behavior therapy, family therapy, and group therapy; and
- assertiveness training—sometimes useful for improving self-esteem.

Supervision Issues for Dependent Personality Disorder

Cases with this disorder will most likely have a long-standing relationship with one person upon whom they are grossly dependent. If anything should happen to that person or to the relationship, the individual might develop depression. Be aware of the status of this individual's relationship with his or her significant other and remain alert to the signs of possible depression or suicide when the relationship is unstable.

A person with dependent personality disorder may be involved in an abusive relationship. For example, he or she may have a physically abusive, unfaithful, or alcoholic spouse. The abuse may increase as the person becomes more self-sufficient through therapy and begins to display what the abusive partner perceives as independent or defiant behavior.

Obsessive-Compulsive Personality Disorder

Obsessive-compulsive personality disorder is characterized by a preoccupation with orderliness, perfectionism and mental and interpersonal control at the expense of flexibility, openness, and efficiency. It begins by early adulthood. *(Do not confuse this personality disorder with the Axis I obsessive-compulsive disorder.)* This disorder is more commonly diagnosed in men than in women.

DSM-IV Diagnostic Criteria for Obsessive-Compulsive Personality Disorder

To be diagnosed with obsessive-compulsive personality disorder, an individual must exhibit at least five of the following:

- perfectionism that interferes with task completion;
- preoccupation with details and organization, rules, order, or schedules to the extent that the major point of the activity is lost;
- unreasonable insistence that others submit to his or her ways of doing things, or unreasonable reluctance to allow others to do things because of the conviction that things will be done incorrectly;
- excessive devotion to work and productivity to the exclusion of leisure time and friendships;
- overly conscientious, inflexible, and scrupulous concerning matters of morality, ethics, or values (not accounted for by cultural or religious identifications);
- miserly spending style toward both self and others; money hoarded for future catastrophes;
- stinginess with time and material possessions when no personal gain is likely to result from sharing; or
- inability to discard worn-out or worthless objects.

Associated Features of Obsessive-Compulsive Personality Disorder

- Difficulty expressing warm and tender feelings or affection
- Indecisiveness that leads to personal distress
- Depression
- A need to control others or situations; individual ruminates or becomes angry if control cannot be attained
- Extreme sensitivity to social criticism

Treatment Regime for Obsessive-Compulsive Personality Disorder

The treatment regime for obsessive-compulsive personality disorder is psychotherapy.

Supervision Issues for Obsessive-Compulsive Personality Disorder

Anything that threatens to upset the individual's daily routine or rituals may cause him or her a great deal of anxiety. For example, unannounced home contacts are not recommended.

Chapter 2: Co-occurring Disorders

Recently, mental health professionals have been using the term *co-occurring disorders* to refer to both a substance abuse or dependence disorder and another Axis I disorder; and the term *dual diagnosis* to refer to both mental retardation and an Axis I disorder. Co-occurring disorders should not be confused with multiple diagnoses, which refers to more than one Axis I disorder or Axis II disorder or both an Axis I disorder and an Axis II disorder.

Mental health professionals estimate that as many as half the individuals with a mental disorder abuse alcohol or drugs. Co-occurring disorders have become the norm, rather than the exception, especially with individuals in the criminal justice system. Some common co-occurring disorders are major depression and alcohol abuse, and antisocial personality disorder and drug abuse.

Researchers and medical professionals debate whether mental disorders lead to substance abuse or vice versa. An individual with a mental disorder may self-medicate to ease symptoms of a mental disorder, thereby creating a substance abuse problem. Research indicates that excessive use of alcohol and drugs can result in mental disorders, such as anxiety and depression.

Individuals with co-occurring disorders may have a high rate of

- hospitalization;
- violent and criminal behavior;
- suicidal behavior;
- noncompliance with medication regimes; and
- housing instability and homelessness.

Treatment Issues

Many mental health and drug abuse therapists disagree on how to treat the individual with co-occurring disorders. For example, some mental health therapists believe that sobriety must be achieved before treatment for a psychological or psychiatric disorder can begin.

Conversely, some drug treatment providers will insist that the person be psychiatrically stabilized before being admitted to their programs. Some drug abuse facilities endorse a drug-free philosophy and refuse to treat individuals who are taking psychiatric medication. Many treatment programs are not designed to address the unique treatment needs of the individual with co-occurring disorders.

Direct the person with co-occurring disorders to a treatment facility that specializes in dual diagnosis in order to determine which condition occurred first. When this is not feasible, ensure that both mental health and substance abuse evaluators are aware of each other's involvement in the case so that between them they can determine which disorder occurred first and immediately start treatment for that disorder. Then locate a treatment provider for the disorder that occurred second. Coordinate the various treatment programs, making sure that all the problems are addressed. Ensure that medication information is shared with all the treatment providers involved in the case.

Generally, an individual with co-occurring disorders will require treatment throughout the supervision period.

Supervision Issues

Because individuals with co-occurring disorders suffer from two problems, they have a higher incidence of hospitalization, violent and criminal behavior, noncompliance with the medication regime, and housing instability and homelessness than other individuals with mental disorders. Depending on the mental disorder, some cases may be at increased risk for suicide. Monitor these cases for suicidal thoughts and gestures. Accidental death by overdose is a risk with this population.

For individuals with a history of co-occurring disorders, a very strict urine collection regimen should be maintained to determine if they are using drugs. These individuals should be educated regarding the hazards of mixing illicit drugs and prescribed medication. Alcohol or drug abusers should be required to attend some form of Alcoholics Anonymous or Narcotics Anonymous meetings regularly. Alcohol and drugs are both physically and psychologically addictive. You should expect relapses and possible lying about drug and alcohol use.

Whenever possible, do not schedule a home contact without first meeting the individual with co-occurring disorders in the office, treatment facility, or other safe location. Subsequent home contacts should be made with caution, preferably with another officer.

A history of violence, substance abuse, or psychotic episodes increases the potential for violence and third-party risk. For persons with co-occurring disorders, a recent psychiatric hospitalization significantly increases the risk of violence, especially within the first few months after discharge. Generally, the violence committed by individuals discharged from a hospital is very similar to violence committed by other people living in their communities in terms of type (i.e., hitting), target (i.e., family members), and location (i.e., at home).

Chapter 3: Child Molesters[6]

This chapter describes child molesters and provides information to help officers identify this type of offender and better manage the associated third-party risk.

Pedophile or Child Molester?

What is the difference between a child molester and a pedophile? For many, the terms have become interchangeable. There are, however, clear differences between the two types of individuals who sexually abuse children, and law enforcement officers handling such cases need to be aware of the distinctions.

A pedophile experiences recurrent, intense sexual urges and sexually arousing fantasies involving sexual activity with a child. Although a pedophile may have a sexual preference for children, if the pedophile does not act on this preference by actually molesting a child, that person is not a child molester. For example, some individuals engage in pedophilia by fantasizing and masturbating, or by simply watching or talking to children and later masturbating. Some have sex with dolls or mannequins that resemble children. Still others engage in sexual activities with adults who look like children (small stature, flat-chested, no body hair) or dress or act like them. Others act out child fantasy games with adult prostitutes.

Conversely, not all child molesters are pedophiles. A person who prefers sexual relations with an adult may, for any number of reasons, have sex with a child. Such reasons might include availability, curiosity, stress, sexual experimentation, or a desire to hurt a loved one of the child. Since this individual's sexual preference is not for children, he or she is not a pedophile.

[6]. The material in this chapter is adapted from pages 5–9, 15–21, and 37–40 of *Child Molesters: A Behavioral Analysis* ©1992, authored by Kenneth V. Lanning in cooperation with the Federal Bureau of Investigation, U.S. Department of Justice, and published by the National Center for Missing and Exploited Children. It is reprinted with permission of the National Center for Missing and Exploited Children, Arlington, Virginia. All rights reserved.

Dr. Park Elliot Dietz divides child molesters into two broad categories: situational and preferential child molesters. Expanding on Dietz's ideas, Kenneth Lanning of the Behavioral Science Unit of the FBI developed a typology of child molesters for use by criminal justice professionals. Lanning avoids using diagnostic criteria in favor of descriptive terms. The purpose of this typology is not to gain insight into *why* child molesters have sex with children in order to help or treat them, but to recognize and evaluate *how* child molesters have sex with children in order to identify, arrest, and convict them. What evidence to look for, whether there are additional victims, how to interview a suspect, and so on, depend on the type of child molester involved.

Situational Child Molesters

The situational child molester does not have a true sexual preference for children, but engages in sex with children for a number of reasons. For such a child molester, sex with children may range from a once-in-a-lifetime act to a long-term pattern of abusive behavior. The more long-term the pattern of abuse, the harder it is to distinguish from preferential molesting. The situational child molester usually has fewer child victims. Other vulnerable individuals, such as the sick, elderly, or disabled, may also be at risk of sexual victimization by a situational child molester. Some law enforcement officials indicate that cases involving this type of child molester are increasing. Also, most of the profiles of sexually motivated child murderers developed by the FBI's Behavioral Science Unit involve situational child molesters. Members of lower socioeconomic groups tend to be over represented among situational child molesters.

There are four types of situational child molesters: regressed, morally indiscriminate, sexually indiscriminate, and inadequate.

Regressed Child Molester

The regressed child molester usually has low self-esteem and poor coping skills; the individual turns to the child as a sexual substitute for the preferred peer sexual partner. Precipitating stress may also play a role in the molester's behavior. The regressed child molester chooses victims based on availability, which is why many of these individuals molest their own children. The molester's method of operation is to coerce the child into having sex. This type of situational child molester may or may not collect child or adult pornography. If the molester does have child pornography, it will usually be the best kind from an investigative point of view: home videos or photographs of the offender's victims.

Morally Indiscriminate Child Molester

The morally indiscriminate child molester abuses everyone in his or her life—spouse, children, and co-workers. The molester is a user and abuser of people. The sexual abuse of children is simply part of the molester's general pattern of abusive behavior. This individual lies, steals, or cheats whenever possible and molests children for a simple reason—"why not?" The molester selects victims based on opportunity and vulnerability—if the molester has the urge and a child is available, the molester will sexually abuse the child. The morally indiscriminate child molester typically uses force, lures, and manipulation to obtain victims. The molester may violently or nonviolently abduct victims. Although most victims are strangers, this type of molester may victimize his or her own children. The morally indiscriminate child molester frequently collects detective magazines or adult pornography of a sadomasochistic nature and may collect child pornography, especially that which depicts prepubescent children. Because this type of molester is an impulsive person who lacks a conscience, he or she is an especially high risk to prepubescent children.

Sexually Indiscriminate Child Molester

The sexually indiscriminate child molester's pattern of behavior is the most difficult to define. Whereas the morally indiscriminate molester is often a sexual experimenter, the sexually indiscriminate molester is discriminating in behavior except when it comes to sex. The sexually indiscriminate child molester will try anything sexual. Much of the molester's behavior is similar to and often confused with that of the preferential child molester. While the sexually indiscriminate molester may have a clearly defined paraphilic or sexual preference—bondage or sadomasochism—he or she has no real sexual preference for children. The molester's basic motivation is sexual experimentation, and he or she appears to have sex with children out of boredom. The molester's main criterion for children is that they are new and different, and he or she involves children in previously existing sexual activity. The indiscriminate child molester may abuse strangers or his or her own children. Although much of the molester's sexual activity with adults may be legal, such an individual may also provide his or her children to other adults as part of group sex, spouse-swapping activities, or bizarre rituals. Of all the situational child molesters, this type of molester is by far the most likely to have multiple victims, to be from a higher socioeconomic background, and to collect pornography and erotica. Child pornography, however, will only be a small portion of the molester's large and varied collection.

Inadequate Child Molester

The inadequate child molester's pattern of behavior is also difficult to define. Such molesters include those suffering from psychoses, eccentric personality disorders, mental retardation, or senility. In layperson's terms, this type of molester is the social misfit, the withdrawn, and the unusual. The molester might be the shy teenager with no friends or the eccentric loner who still lives with his or her parents. Although most such individuals are harmless, some can be child molesters, and in a few cases, child killers. The inadequate child molester typically becomes sexually involved with children out of insecurity or curiosity. Victims are chosen because they are non- threatening objects that allow the molester to explore sexual fantasies. The victim may be a relative, a friend, or a complete stranger. In some cases the child victim might be a specific "stranger" selected as a substitute for a specific adult (possibly a relative of the child) whom the molester is afraid to approach directly. Often the molester's sexual activity with children is the result of built-up impulses. Some of these individuals find it hard to express anger and hostility, which builds until it explodes—possibly against a child victim. Because of mental or emotional problems, some molesters take out their frustrations in cruel sexual torture. The molester's victims could be the elderly as well as children, or anyone who appears helpless at first sight. The inadequate child molester may collect pornography, but it will most likely be of adults.

Almost any child molester is capable of violence or even murder to avoid identification. With a few notable exceptions—Theodore Frank in California and Gary Arthur Bishop in Utah—most of the sexually motivated child murders profiled and assessed by the FBI's Behavioral Science Unit have involved situational child molesters, especially the morally indiscriminate and inadequate patterns of behavior. Low social competence seems to be the most significant factor in why a child molester might abduct a victim.

Preferential Child Molesters

Preferential child molesters have a definite sexual preference for children, and their sexual fantasies and erotic imagery focus on children. They have sex with children not because of some situational stress or insecurity but because they are sexually attracted to and prefer children. They can possess a wide variety of character traits but engage in highly predictable sexual behavior patterns. These patterns are called sexual rituals and are frequently engaged in even when they are counterproductive to getting away with the criminal activity.

Although they may be smaller in number than situationa child molesters, preferential child molesters have the potential to molest a larger number of victims. For many of them, their problem is not only one of sex drive (attraction to children), but also quantity (need for frequent and repeated sex with children). They usually have age and gender preferences for their victims. Members of higher socioeconomic groups tend to be over represented among preferential child molesters.

There are three types of preferential child molesters: seductive, introverted, and sadistic.

Seductive Child Molester

The seductive child molester "seduces" children, courting them with attention, affection, and gifts. Over time this behavior gradually reduces the child's sexual inhibitions. Frequently, the victims reach a point where they are willing to trade sex for the attention, affection, and other benefits they receive from the molester. Many seductive child molesters are simultaneously involved with multiple victims, operating what some law enforcement officers call child sex rings (e.g., groups of children in the same school class, neighborhood, day care center, or scout troop). The characteristic that makes the seductive child molester so successful is his or her ability to identify with children. This type of molester knows how to talk to and listen to children. The molester's status and authority as an adult are also an important part of the seduction process. In addition, this type of molester often selects children who are victims of emotional or physical neglect.

The seductive child molester generally prefers victims of a particular sex and age, such as blond, 12-year-old boys, and will seek a new victim when the current victim ages or is no longer considered desirable. Generally the individual's biggest problem is not obtaining child victims but getting rid of a victim when the child becomes too old or unattractive. These offenders may use threats and physical violence to avoid identification and disclosure or to prevent a victim from leaving before the molester is ready to "dump" the victim.

Introverted Child Molester

The introverted child molester has a preference for children but lacks the interpersonal skills necessary to seduce them. Therefore, the molester typically engages in a minal amount of

verbal communication with the victim and usually victimizes strangers or very young children. In many ways, the introverted child molester fits the old stereotype of the child molester (for example, a man who hangs around playgrounds, exposing himself to children, watching them, or engaging them in brief sexual encounters). The molester may also make obscene phone calls to children. Unable to gain access to children any other way, this molester may use child prostitutes or may even marry and have children, later molesting them as infants. The introverted child molester is similar to the inadequate situational child molester except that he or she has a definite preference for children, and the selection of only children as victims is more predictable.

Sadistic Child Molester

The sadistic child molester not only has a sexual preference for children, but also must inflict physiological or psychological pain on the child in order to achieve sexual arousal. (The molester is aroused by the victim's response to the infliction of pain and suffering.) The sadistic child molester often uses lures or force to gain access to the child and is more likely than the other preferential child molesters to abduct and murder victims. Although there are few sadistic child molesters, they are very dangerous.

Identifying Preferential Child Molesters

Preferential child molesters exhibit several predictable and repetitive behavior patterns that serve as indicators or red flags. If the officer notes that an individual exhibits several of these behaviors, he or she will be able to assess the need for recommending that the individual receive a sex offender evaluation and, possibly, a condition for sex offender treatment. Following are the behavior patterns exhibited by preferential child molesters.

- Long-term and persistent pattern of behavior
  - *Sexual abuse in the offender's background.* Research indicates that many child molesters were sexually abused as children, although not all sexually abused children grow up to molest children. It is well worth the officer's time and effort to determine if an individual has ever been a victim of sexual abuse and, if so, the nature of the abuse.

— *Limited social contact during adolescence.* Sexual preference for children usually appears during adolescence, and early pedophiliac behavior may be indicated by a lack of interest in adolescent peers. Like several of these indicators, however, this characteristic alone means little.

— *Frequent and unexpected moves or premature separation from the military.* When discovered, pedophiles are sometimes asked to leave town in lieu of being prosecuted. It is helpful to look for a pattern of frequent moving or job changes. Frequently there is no formal documentation of what actually happened, so other indicators such as driver's license records can sometimes detect moving patterns. Premature separation from the military with no specific reason given or available may also be a red flag worth noting.

— *Prior arrests.* Any arrest for child abuse or contributing to the delinquency of a minor is a red flag requiring investigation. However, there might also be other prior arrests not involving sexual abuse that may also be less obvious indicators of pedophilia, such as falsifying a teaching certificate or impersonating a police officer. All arrest records and court documents should be analyzed to determine their significance.

— *Multiple victims.* The greater the number of victims, the more likely the individual is a pedophile. In addition, if the individual is a known or suspected pedophile, investigate for multiple victims, because there is a high probability that the individual molested more than one child.

— *Means of obtaining victims.* If the individual used clever and skillful planning to obtain victims or made high-risk attempts to obtain victims, such as snatching a child from a parked car, the chances are high that the individual is a pedophile.

- Children as preferred sexual objects

— *Is unmarried, lives alone or with parents, or dates infrequently*. By itself, this characteristic means nothing. It only has significance when combined with several other characteristics. Since pedophiles usually have some difficulty performing sexually with adults, they typically do not date, marry, or have a sexual relationship with another adult. They often live alone or with their parents. However, some pedophiles marry to gain access to potential victims.

— *Has a dysfunctional relationship with spouse.* If a pedophile is married, it is unlikely that he or she has a normal marital relationship with a spouse. Male pedophiles often marry women who are either very strong and domineering or very weak and passive. Because the pedophile is not sexually attracted to his or her spouse, sexual problems in the

marriage are not uncommon. Although they may not readily reveal this information, wives, husbands, ex-spouses, and significant others should be considered important collateral contacts.

— *Associates and circle of friends are young.* Pedophiles frequently socialize with children and get involved in youth activities. Suspicion should be raised when an individual clearly prefers to be around or socialize with young people, tending to hang around the school playground, the neighborhood video arcade, or the shopping center. The individual's friends may be male or female or members of both sexes, and they may be very young or teenagers, all depending on the age and gender preference of the individual.

— *Shows excessive interest in children.* This is not proof that someone is a pedophile, but it is reason to be suspicious. It becomes more significant when this excessive interest is combined with other characteristics.

— *Has limited peer relationships.* Pedophiles cannot share their sexual interests with other adults, so they tend to avoid socializing with peers. The majority of pedophiles only seek the company of other pedophiles in order to validate their lifestyle. If a suspected pedophile has a close adult friend, the possibility that the friend is also a pedophile must be considered.

— *Has an age and gender preference.* Most pedophiles prefer children of a certain sex and age range. The older the age preference, the more exclusive the gender preference. For example, a pedophile attracted to toddlers is likely to molest boys and girls; a pedophile attracted to teenagers is more likely to prefer either boys or girls exclusively. The preferred age bracket for the child may also vary; one pedophile might prefer boys 8 to 12, whereas another might prefer boys 6 to 12. How old a victim looks and acts is more important than actual chronological age. A 13-year-old who looks and acts like a 10-year-old could be the victim of a molester preferring 8- to 10-year-old victims. For the introverted child molester, how old the child looks is more important than how old the child acts. Puberty seems to be an important dividing line for many pedophiles. This is only an age and gender preference, not an exclusive limitation. Any individual expressing a strong desire to adopt or care for a child of a specific age and sex should be viewed with suspicion.

— *Idealizes children.* Pedophiles tend to refer to children in idealistic ways. Frequently they describe children and childhood as clean, pure, or innocent. Sometimes they refer to children as objects, projects, or possessions. For example, a pedophile might say, "I've been working on this project for six months."

- Well-developed techniques to obtain victims
  - — *Is skilled at identifying vulnerable children.* Some pedophiles can watch a group of children for a brief period of time and then select a potential victim. More often than not, the victim turns out to be from a broken home or the victim of physical or emotional neglect.
  - — *Identifies with children.* Pedophiles usually can identify with children better than they can with adults. This trait makes pedophiles masters of seduction. They know how to talk to children and how to listen to them.
  - — *Has access to children.* This is one of the most important indicators of a pedophile. Pedophiles will seek employment and volunteer work that gives them access to children. Examples are teacher, clergymen, police officer, coach, scout leader, Big Brother, or foster parent. The pedophile will also find ways to get the child into a situation where other adults are absent. For example, on a scout trip the pedophile will volunteer to stay with the scouts while the other scout leaders go into town to purchase supplies.
  - — *Seduces children.* This is the most common characteristic of pedophiles. They literally seduce children by spending time with them, listening to and paying attention to them, and buying them gifts. As occurs in the courtship process, the victim often develops positive feelings for the molester. This is one reason some children are reluctant to report a molestation.
  - — *Manipulates children.* The pedophile uses seduction techniques, competition, peer pressure, child and group psychology, motivation techniques, threats, and blackmail to obtain victims. Part of the manipulation process is the lowering of the child's inhibitions. A skilled pedophile who can get children into a situation in which they must change clothing or stay overnight will almost always succeed in seducing them. However, not all pedophiles possess these skills. The introverted child molester lacks these abilities.
  - — *Has toys and playthings.* The pedophile is likely to have toys and playthings at home that appeal to children, such as model boats or planes, dolls, video games, or magic tricks. A pedophile interested in older children may lure victims with pornography, alcohol, or drugs or pretend to have a hobby or interest in things that interest an adolescent, such as stereo equipment or computer games. A house full of children's playthings may indicate pedophilia, particularly if the individual is not a parent; however, this indicator by itself means little. It only has significance when combined with other indicators.

— *Shows sexual materials to children.* Any adult who shows sexually explicit material to children should be viewed with suspicion. This behavior is usually part of the seduction process intended to lower the child's inhibitions. A pedophile may also encourage children to call a dial-a-porn service or send them sexually explicit material via a computer as part of the seduction process.

- Sexual fantasies focusing on children

— *Has youth-oriented decorations in house or room.* The homes of some pedophiles have been described as shrines to children or as miniature amusement parks. For example, a pedophile attracted to teenage boys might decorate his home the way a teenage boy would with stereos, rock posters, computers, weight equipment, and so on.

— *Photographs children.* Many pedophiles enjoy taking photographs of their victims, preferably during sexual behavior. Some, however, photograph children fully dressed. For example, a pedophile may go to baseball games or the playground to photograph children. After developing the pictures, the pedophile fantasizes about having sex with the children in the photographs. Such an individual might also frequent youth athletic contests, child beauty pageants, or child exercise classes and photograph them.

— *Collects child pornography or child erotica.* Most pedophiles collect child pornography. The individual uses the material for sexual arousal and for seducing new victims. An interest in child pornography should always be a red flag indicating possible pedophilia.

Not to be confused with child pornography, child erotica is any material relating to children that serves a sexual purpose for a given individual. Erotica includes non-pornographic photographs of children, children's clothing, and accessories. Just as pictures of children in underwear or swim wear may be very arousing to the pedophile, combs, barrettes, purses, and other accessories might also be used for sexual arousal. In addition, pedophiles sometimes keep a memento or trophy of their victims, such as a pair of underpants or a lock of hair.

Reactions After Identification

When a child molestation case is uncovered and the individual is identified, there are several predictable reactions by the individual. This is especially true of the preferential child molester. Knowledge of these reactions will help officers investigate the case.

- **Deny the incident.** When a child molester is arrested, his or her first reaction is usually complete denial. The individual will act shocked, surprised, or even indignant about the allegation. The individual may claim to not remember the incident or deny the incident involved sexual gratification. The individual may imply that his or her actions were misunderstood and that a mistake has been made. For example, the individual may state, "I didn't know hugging and kissing my son goodnight was a crime!" Friends and relatives, who may hinder the police investigation or be uncooperative collateral contacts, may aid this denial.
- **Minimize the incident.** If evidence rules out total denial, the individual may minimize the incident, especially in terms of quantity and quality. The individual might claim that it happened once or that he or she only touched or caressed the victim. The individual might admit certain acts, but deny that he or she was engaged in the acts for sexual gratification. For example, the individual may say, "Yeah, I admit I may have fondled my daughter once or twice, but I never had intercourse with her." The daughter explains that in actuality, her father raped her repeatedly over a six-month period. The individual may also admit to lesser offenses or misdemeanors. Victims may sometimes minimize the incident or deny certain aspects of the sexual behavior. For example, many adolescent boys will often deny being victimized.
- **Justify the incident.** Many child molesters, especially preferential child molesters, spend their lives attempting to convince themselves that they are not immoral, sexually deviant, or criminals. They prefer to believe that they are loving individuals whose behavior is misunderstood or politically incorrect at this time in history. Recognizing this rationalization system is key to interviewing these individuals. For example, a pedophile may justify the incident by stating that stress or drinking led to the sexual behavior or by declaring that he or she cares more for the child than the child's parents do. If the individual is the father of the victim, a standard justification is that he is best suited to teach his child about sex. The most common rationalization centers on blaming the victim—the child seduced the individual or initiated the sexual activity, or the child is promiscuous or even a prostitute.
- **Fabricate a reason.** Some of the more clever child molesters come up with ingenious stories to explain their behavior. For example, a doctor may claim to be doing research on pedophilia; a teacher may explain that he or she was providing sex education; a father may claim he slept with his child only because the child had a nightmare and couldn't fall asleep; or a neighbor may claim that neighborhood children made the sexually explicit video, which he kept only to show the children's parents. Some individuals have recently claimed they

are artists victimized by censorship and their pornography collections are works of art protected by the First Amendment. These stories work particularly well when the child molester is a professional, such as a teacher, doctor, or therapist. Law enforcement officials and prosecutors must be prepared to confront such stories and disprove them. Finding child pornography or erotica in the individual's possession is one effective way to do this.

- **Feign mental illness.** The child molester may feign mental illness. It is interesting to note, however, that child molesters will admit mental illness only after they are identified or arrested, or after all other tactics fail. If all pedophiles are not necessarily child molesters, then pedophilia alone cannot be the cause of their child molesting. However, if the behavior of a child molester is considered to be the result of mental illness, then the individual requires treatment. The seriousness of the offenses and the effectiveness of the treatment must be carefully evaluated by the court. Treatment and punishment are not mutually exclusive.
- **Elicit sympathy.** Pedophiles may resort to the "nice guy defense". In this defense, the individual expresses deep regret and attempts to show how he or she is a pillar of the community, a devoted family person, a church leader, a military hero, a nonviolent individual with no prior arrests, or a victim whose many personal problems led to some sort of breakdown. Many traits described by the individual as evidence of good character in fact contribute to the individual's ability to access and seduce children.
- **Attack.** The identified pedophile may become threatening and assaultive during the investigation or prosecution. This reaction consists of attacking or going on the offensive. For example, the individual may harass, threaten, or bribe witnesses and victims, attack the reputation and personal life of the officer or prosecuting attorney, raise issues such as gay rights if the victim is the same sex as the individual, or enlist the support of groups or organizations. In extreme cases violence is a possibility. Pedophiles have been known to murder their victims or witnesses to avoid identification and prosecution.
- **Plead guilty, but not guilty.** Some individuals will try to make a deal to avoid a public trial. Although this results in the highly desirable objective of avoiding child victim testimony, the unfortunate aspect of this situation is that the individual is often allowed to plead, in essence, "guilty, but not guilty". This sometimes involves a plea of *nolo contendere* to avoid civil liability. On other occasions the individual pleads not guilty by reason of insanity or agrees to plead guilty to less severe charges, such as contributing to the delinquency of a minor, lewd and lascivious conduct, or indecent liberties. These are all tactics to escape

prosecution, keep the public from fully understanding the arrest or charge, and prevent the pedophile from acknowledging his or her behavior.

- **Commit suicide.** This extreme reaction is possible for some pedophiles, especially middle-class individuals with no prior convictions. Arrest or conviction may cost them their job, family, or reputation, leading to severe depression and possibly suicide.

Appendix A: Frequently Encountered Terminology[7]

affect—a pattern of observable behaviors that express a subjectively experienced feeling state, or emotion, such as euphoria, anger, or sadness. Types of affect may be described as broad (normal), restricted (a limited number of feeling states), blunted (reduced intensity of emotion), flat (lacks emotion), or inappropriate (emotion and content of conversation do not match).

affective disorder—a disorder in which mood change or disturbance is the primary symptom.

agoraphobia—a fear of being in places or situations from which escape might be difficult or embarrassing or in which help might not be available if needed. According to *DSM-IV*, it is frequently associated with panic disorder.

alcohol abuse—use of alcohol to the point that the individual's physical, mental, emotional, or social well-being is impaired.

antidepressant medication—medication prescribed to treat the symptoms of depression. Some antidepressant drugs are used to treat obsessive-compulsive disorders and other disorders as well.

antimanic medication—medication prescribed to treat the symptoms associated with a manic episode or bipolar disorder. Also referred to as "mood levelers" or "mood- stabilizing drugs."

antipsychotic medication—medication prescribed to treat the symptoms of schizophrenia and other disorders involving psychotic symptoms. Such drugs are often more effective at controlling certain symptoms than at "curing" the disorder.

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7. Developed for the Federal Judicial Center by Dr. Melissa Cahill, Chief Psychologist, Dallas County Community Supervision and Corrections Department, Dallas, Tex. Sources include the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., rev. 2000); Evelyn M. Stone, *American Psychiatric Glossary*. 6th ed. Washington, D.C.: APA, 1988, 1-75; memorandum from L. Ralph Mecham to all chief judges, chief probation officers, and chief pretrial services officers: "Reimbursement/Copayment for Treatment Services—Information," March 22, 1993; "The Americans with Disabilities Act: Impact on Training," *Info-Line* 9203 (March 1992), 10-11.

antisocial personality disorder—a disorder characterized by an inability to conform to social norms and a continuous display of irresponsible and antisocial behavior that violates the rights of others. A diagnosis of this disorder can only be made after age 18 and must include evidence of antisocial conduct with an onset prior to age 15.

anxiety—apprehension, tension, or uneasiness that stems from the anticipation of danger without an identifiable source.

anxiety disorder—a disorder in which anxiety is the most prominent symptom. Anxiety disorders include panic disorder, phobias, obsessive-compulsive disorder, and post-traumatic stress disorder.

avoidant personality disorder—a pervasive pattern of social discomfort, fear of negative evaluation, and timidity beginning by early adulthood and present in a variety of contexts.

Axes I, II, III, IV, and V—*DSM-IV* divides disorders into five diagnostic classes or axes: Axis I: clinical disorders including major psychiatric disorders; Axis II: personality disorders and mental retardation; Axis III: general medical conditions; Axis IV: psychosocial and environmental problems; and Axis V: global assessment and highest level of adaptive functioning.

behavior therapy—a mode of treatment that focuses on modifying an individual's observable behavior by manipulating the environment, dysfunctional behavior, or both.

bipolar disorder—a disorder in which there are episodes of mania, alone or with depression; sometimes referred to as manic-depressive illness.

borderline personality disorder—a disorder characterized by a pattern of extremely unstable mood, self-image, and relationships that begins by early adulthood and is present in a variety of contexts.

child molester—an individual who sexually abuses children. A child molester may or may not be a pedophile.

claustrophobia—a type of phobia in which the individual has a fear of closed spaces.

compulsion—repetitive, purposeful, and intentional behaviors that are performed in response to an obsession, according to certain rules, or in a stereotyped fashion. Failure to perform such behaviors may lead to overt anxiety.

co-occurring disorder—term used to describe an individual with an Axis I disorder and a substance abuse or alcohol problem.

cyclothymia—a chronic mood disturbance of at least two years' duration, involving numerous episodes of mania or depression that are not severe enough to be diagnosed as major depression or bipolar disorder. Some researchers feel cyclothymia is a mild form of bipolar disorder.

decompensation—the deterioration of defense mechanisms, leading to an intensification of the disorder.

defense mechanisms—unconscious processes that serve to provide relief from emotional conflict and anxiety. Some common defense mechanisms are dissociation, idealization, and denial.

delirium—an acute organic mental disorder characterized by confusion and altered, possibly fluctuating, consciousness owing to an alteration of cerebral metabolism. It may include delusions, illusions, and hallucinations.

delusions—false beliefs based on incorrect inferences about external reality. These beliefs are firmly held in spite of what almost everyone else believes and in spite of proof or evidence to the contrary.

dementia—an organic mental disorder in which an individual's previously acquired intellectual abilities deteriorate to the point that social or occupational functioning is impaired.

denial—a defense mechanism, operating unconsciously, that enables an individual to disavow thoughts, feelings, wishes, needs, or external reality factors that are consciously intolerable.

dependent personality disorder—a pervasive pattern of dependence and submission beginning by early adulthood and present in a variety of contexts.

depersonalization—an altered perception or experience of the self in which an individual's own reality is temporarily lost. This is manifested in a sense of self-estrangement or unreality, which may include the feeling that one's extremities have changed in size or a sense of perceiving oneself from a distance (usually from above).

depression—when used to describe mood, depression refers to feelings of sadness, despair, and discouragement. As such, depression may be a normal feeling state. Depression is also a symptom of a variety of mental or physical disorders. Depression that results in a depressive episode can be classified as a mental disorder. The *DSM-IV* defines a depressive episode as a sustained period (at least two weeks) during which an individual experiences depression and all associated features of depression or a loss of interest or pleasure in most or all activities.

derealization—a feeling of detachment from one's environment.

devaluation—a defense mechanism in which an individual attributes overly negative qualities to oneself or others.

diagnosis—a mental health treatment provider's professional determination that an individual has a mental disorder based on a professional analysis of the individual's behavior and the diagnostic classifications in *DSM-IV*.

Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR)—the fourth revised edition of the American Psychiatric Association publication used by mental health professionals to diagnose mental disorders. *DSM-IV-TR* does not generally address the causes or different theories for a psychiatric disorder, but defines mental disorders in terms of descriptive symptoms and behaviors.

dissociation—the splitting off of clusters of mental contents from conscious awareness, a mechanism central to hysterical conversion and dissociative disorders; the separation of an idea from its emotional significance and affect as seen in the inappropriate affect of patients with schizophrenia.

drug interaction—the effects of two or more drugs or medications taken simultaneously, which differ from the usual effects of either drug or medication taken alone.

dual diagnosis—a diagnosis given to individuals with both mental retardation and an Axis I disorder.

dysthymia—a chronic disturbance of mood lasting at least two years and involving depressed mood and other associated symptoms of depression. The symptoms of depression are not severe enough to warrant a diagnosis of major depression.

enabler—someone who helps a mentally disordered or substance-abusing individual avoid crises and the consequences of his or her behavior.

etiology—the cause or origin of a disease or disorder as determined by medical or psychiatric diagnosis.

family therapy—psychotherapy of more than one member of a family in the same session. The assumption is that a mental disorder in one member of the family may be sustained and exacerbated by interaction patterns within the family.

flight of ideas—a nearly continuous flow of accelerated speech with abrupt changes from topic to topic, usually based on understandable associations, distracting stimuli, or plays on words. When the condition is severe, speech may be disorganized and incoherent.

grandiosity—an inflated appraisal of one's worth, power, knowledge, importance, or identity.

group therapy—a form of psychotherapy in which the interaction of a group of patients helps to modify the behavior of individual patients in the group.

hallucination—a sensory perception in the absence of external stimuli; may occur in any of the senses.

hallucination, auditory—a hallucination of sound, most commonly of voices but sometimes of clicks, rushing noises, or music.

hallucination, visual—a hallucination of formed images, such as people, or of unformed images, such as flashes of light.

histrionic personality disorder—a pervasive pattern of colorful, dramatic, extroverted behavior accompanied by excessive emotionality and attention-seeking that begins by early adulthood and is present in a variety of contexts.

hypersomnia—a behavior involving excessive amounts of sleep, sometimes associated with confusion upon waking. Hypersomnia may involve sleeping for a longer amount of time than usual, experiencing daytime sleepiness, or taking excessive naps.

hypervigilance—behavior involving excessive alertness and watchfulness.

idealization—a defense mechanism in which an individual attributes overly positive qualities to oneself or to others.

ideas of reference—ideas, held less firmly than delusions, that events, objects, or other people in the individual's immediate environment have a particular and unusual meaning for him or her.

ideation—the forming of a mental image or an idea or concept.

incoherence—speech that, for the most part, is not understandable because of a lack of logical or meaningful connection between words, phrases, or sentences; excessive use of incomplete sentences; excessive irrelevancies or abrupt changes in subject matter; idiosyncratic word usage; or distorted grammar.

insomnia—inability to fall asleep or stay asleep, or early morning waking.

local study—a court-ordered evaluation undertaken to assess an individual's mental health in order to determine sentencing. Local studies are conducted by a community mental health treatment provider or by the Bureau of Prisons if the court feels there is a compelling reason the evaluation cannot be done by a community provider.

loosening of associations—thinking characterized by speech in which ideas shift from one subject to another without the speaker showing any awareness that the topics are unconnected or only obliquely related to one another.

magical thinking—a conviction that thinking creates action or circumstances. It occurs in dreams, in children, in primitive peoples, and in patients under a variety of conditions. It is characterized by lack of a realistic understanding of the relationship between cause and effect.

major depression—a disorder in which there is a history of episodes of depressed mood or a loss of pleasure in most or all activities.

mania—a disorder characterized by excessive elation, hyperactivity, agitation, and accelerated thinking and speaking. Mania is associated with Axis I mood disorders and certain organic mental disorders.

manic-depressive illness—a disorder characterized by periods of both mania and depression. Also called bipolar disorder.

mental disorder—an illness with psychological or behavioral manifestations and/or impairment in functioning that is due to a social, psychological, genetic, physical-chemical, or biological disturbance. The illness is characterized by symptoms, impairment in functioning, or both.

mental health treatment provider—any treatment source that provides treatment services to individuals with mental disorders. The provider may be under contract to the Administrative Office of the U.S. Courts.

mental retardation—significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and first manifested during childhood.

multiple diagnoses—a term used to describe an individual diagnosed with more than one Axis I disorder or Axis II disorder or both an Axis I disorder and an Axis II disorder (e.g., major depression and borderline personality disorder).

multiple personalities—an extreme form of dissociation in which an individual's personality is split into two or (usually) more distinct personalities, often alternating with one another. This condition is rare.

narcissistic personality disorder—a heightened sense of grandiosity, hypersensitivity to evaluation by others, and lack of empathy for others beginning by early adulthood and present in a variety of contexts.

obsessions—persistent ideas, thoughts, impulses, and images that invade the consciousness and are intrusive, senseless, or repugnant, such as thoughts of violence, fears of contamination, or feelings of doubt.

obsessive-compulsive disorder—recurrent obsessions or compulsions that are distressful and time-consuming and significantly interfere with the individual's occupational and social functioning.

obsessive-compulsive personality disorder—a disorder characterized by restricted emotions, orderliness, indecisiveness, perfectionism, and inflexibility that begins by early adulthood and is present in a variety of contexts.

organic mental disorder—a transient or permanent dysfunction of the brain caused by a disturbance of physiological functioning of brain tissue. Causes are associated with aging, toxic substances, and a variety of physical disorders.

panic—sudden, overwhelming anxiety of such intensity that it produces terror and physiological changes.

panic attack—discrete periods of intense fear or discomfort, often associated with feelings of impending doom.

panic disorder—an anxiety disorder, with or without agoraphobia, that includes recurrent panic attacks accompanied by various physical symptoms.

paranoid—a term commonly used to describe an overly suspicious person. In technical use, the term refers to a type of schizophrenia or a class of delusional disorders.

paranoid personality disorder—a pervasive and unwarranted tendency to interpret the actions of others as deliberately threatening and demeaning. This disorder begins by early adulthood and is present in a variety of contexts.

paraphilia—a condition in which persistent and sexually arousing fantasies of an unusual nature are associated with preference for or use of a nonhuman object, sexual activity with human beings involving real or simulated suffering or humiliation, or sexual activity with children or non-consenting partners.

pedophile—an individual whose sexual fantasies, urges, and behavior involve sexual activity with prepubescent children.

pedophilia—intense sexual urges and sexual fantasies involving sexual activity with a child.

personality—deeply ingrained patterns of behavior, thinking, and feeling that an individual develops, both consciously and unconsciously, as a style of life or a way of adapting to the environment.

personality disorder—pervasive, inflexible, and maladaptive patterns of behavior and character that are severe enough to cause either significant impairment in adaptive functioning or subjective distress. Personality disorders are generally recognizable by adolescence or earlier and continue throughout adulthood.

phobia—a persistent, irrational fear of, and compelling desire to avoid, a specific object, activity, or situation.

pornography—sexually explicit reading or video material or photographs.

post-traumatic stress disorder (PTSD)—a disorder that develops after the person has experienced, witnessed, or was confronted with an event that involved actual or threatened death or serious injury or that threatened the physical integrity of the individual or others (e.g., military combat, rape, child abuse).

poverty of speech—a restriction in the amount of speech such that spontaneous speech and replies to questions are brief and unelaborated.

prodromal—having to do with early signs or symptoms of a disorder.

prognosis—a professional opinion concerning the probable treatment success and recovery of an individual with a diagnosed mental disorder.

psychiatrist—a licensed physician who specializes in diagnosing, treating, and preventing mental disorders. A psychiatrist must have a medical degree and four years or more of approved postgraduate training.

psychomotor agitation—generalized physical and emotional overactivity in response to internal stimuli or external stimuli or both.

psychomotor retardation—generalized slowing of physical and emotional reactions.

psychosis—a major mental disorder of organic or emotional origin in which a person's ability to think, respond emotionally, remember, communicate, interpret reality, and behave appropriately is impaired so as to interfere grossly with the capacity to meet the ordinary demands of life. The term is applicable to conditions with a wide range of severity and duration, such as schizophrenia, bipolar disorder, depression, and organic mental disorder.

psychosocial—involving aspects of both psychological and social behavior.

psychotherapist—a person trained to treat mental disorders.

psychotherapy—the treatment of mental disorders through the uncovering of unconscious conflict and its resolution. Psychotherapy may be conducted with individuals, couples, family members, or groups.

psychotic episode—an episode that occurs when a mentally disordered individual incorrectly evaluates the accuracy of his or her perceptions, thoughts, and moods and makes incorrect inferences about external reality. During a psychotic episode an individual's ability to think, respond emotionally, remember, communicate, interpret reality, and behave appropriately is impaired.

rationalization—a defense mechanism in which the person devises reassuring or self-serving, but incorrect, explanations for his or her own behavior and the behavior of others.

reality testing—the objective evaluation and judgment of the world outside oneself.

residuals—the phases of illness during which the person is not exhibiting the symptoms.

ruminate—to excessively reflect or meditate on an issue, thought, or concept.

schizoid personality disorder—a lifelong pattern of social withdrawal beginning by early adulthood and present in a variety of contexts.

schizophrenia—a group of disorders manifested by disturbances in communication, language, thought, perception, affect, and behavior which last longer than six months.

schizotypal personality disorder—a pervasive pattern of peculiarities of ideation, appearance, and behavior beginning by early adulthood and present in a variety of contexts.

somatization—a defense mechanism in which the individual becomes preoccupied with physical symptoms disproportionate to any actual physical illness or injury.

stereotypy—persistent, mechanical repetition of speech or movements observed in individuals with schizophrenia.

syndrome—a group of symptoms that occur together and constitute a recognizable condition.

treatment plan—a strategy for treating the symptoms of a mental disorder or curing the disorder. Treatment plans are developed by mental health professionals and usually consist of therapy and, if required, medication.

Appendix B: *DMS-IV* Classification Axes

This appendix provides an overview of the *DSM-IV* classification system, including a description of the Global Assessment of Functioning (GAF) and Social and Occupational Functioning Assessment Scale (SOFAS).

DSM-IV Classification Axes

Axis I Clinical syndromes and V codes: V codes are other conditions that are a focus of clinical attention for which there is insufficient information to know whether or not a presenting problem is attributable to a mental disorder
Axis II Personality disorders and mental retardation
Axis III General medical conditions that are relevant to etiology or case management
Axis IV Psychosocial and environmental problems
Axis V Global Assessment of Functioning (GAF) scale

Example of a *DSM-IV* Multiaxial Evaluation

Axis I Major depression disorder, single episode, severe without psychotic features; alcohol abuse
Axis II Dependent personality disorder; frequent use of denial
Axis III None
Axis IV Threat of job loss
Axis V GAF = 35 (current)

Codes for Axis V: GAF Scale

Axis V is for reporting the clinician's judgment of the individual's overall level of functioning. This information is useful in planning treatment and measuring its impact, and in predicting outcome. The GAF scale may be particularly useful in tracking the clinical progress of individuals in global terms, using a single measure. The scale is used with respect only to psychological, social, and occupational functioning. It does not include impairment in functioning due to physical or environmental limitations.

Code (*Note*: The GAF scale is a continuum of mental health and mental disorders. Intermediate codes can be used when appropriate, e.g., 45, 68, 72.)

91–100 There is superior functioning in a wide range of activities; life's problems never seem to get out of hand; individual is sought out by others because of his or her many positive qualities. No symptoms.

81–90 Symptoms are absent or minimal (e.g., mild anxiety before an exam); there is good functioning in all areas; individual is interested and involved in a wide range of activities, socially effective, and generally satisfied with life, and has no more than everyday problems or concerns (e.g., an occasional argument with family members).

71–80 If symptoms are present, they are transient and expectable reactions to psychosocial stressors (e.g., difficulty concentrating after family argument); individual has no more than slight impairment in social, occupational, or school functioning (e.g., temporarily falling behind in schoolwork).

61–70 Some mild symptoms are present (e.g. depressed mood and mild insomnia), or there is some difficulty in social, occupational, or school functioning (e.g. occasional truancy, or theft within the household), but generally individual is functioning pretty well and has some meaningful interpersonal relationships.

51–60 Moderate symptoms are present (e.g., flat affect and circumstantial speech, occasional panic attacks), or there is moderate difficulty in social, occupational, or school functioning (e.g., individual has few friends, conflicts with peers or co-workers).

41-50 Serious symptoms are present (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting), or there is serious impairment in social, occupational, or school functioning (e.g., individual has no friends, is unable to keep a job).

31–40 Some impairment in reality testing or communication is present (e.g., speech at times is illogical, obscure, or irrelevant), or there is major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood (e.g., depressed man avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant at home, and is failing at school).

21–30 Behavior is considerably influenced by delusions or hallucinations, or there is serious impairment in communication or judgment (e.g., individual sometimes is incoherent, acts grossly inappropriately, has suicidal preoccupations) or individual is unable to function in almost all areas (e.g., stays in bed all day; no job, home, or friends).

11–20 There is some danger that individual may hurt himself or herself or others (e.g., individual attempts suicide without clear expectation of death; is frequently violent; exhibits manic excitement); or individual occasionally fails to maintain minimal personal hygiene (e.g., smears feces), or there is gross impairment in communication (e.g., largely incoherent or mute).

1–10 There is a persistent danger that individual will severely hurt himself or herself or others (e.g., there have been instances of recurrent violence), or individual exhibits a persistent inability to maintain minimal personal hygiene or serious suicidal act with a clear expectation of death.

0 Inadequate information.

Social and Occupational Functioning Assessment Scale (SOFAS)

SOFAS is a new scale that differs from the GAF scale in that it focuses exclusively on the individual's level of social and occupational functioning and is not directly influenced by the overall severity of the individual's psychological symptoms. Also in contrast to the GAF scale, any impairment in social and occupational functioning that is due to general medical conditions is considered in making the SOFAS rating. SOFAS is usually used to rate functioning for the current period (i.e., the level of functioning at the time of the evaluation), and may also be used to rate functioning for the past year (i.e., the highest level of functioning for at least a few months during the past year).

To be counted, impairment must be a direct consequence of mental and physical health problems; the effects of lack of opportunity and other environmental limitations are not to be considered.

Code (*Note:* Intermediate codes may be used when appropriate, e.g., 45, 68, 72.)

91–100 Superior functioning in a wide range of activities

81–90 Good functioning in all areas; occupational and social effectiveness

71–80 No more than a slight impairment in social, occupational, or school functioning (e.g., infrequent interpersonal conflict, temporary falling behind in schoolwork)

61–70 Some difficulty in social, occupational, or school functioning, but generally good functioning well, some meaningful interpersonal relationships

51–60 Moderate difficulty in social, occupational, or school functioning (e.g., individual has few friends, conflicts with peers or co-workers)

41-50 Serious impairment in social, occupational, or school functioning (e.g., individual has no friends, is unable to keep a job)

31–40 Major impairment in several areas, such as work or school, family relations (e.g.,depressed man avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant at home and failing at school)

21–30 Inability to function in almost all areas (e.g., individual stays in bed all day, has no job, home, or friends).

11–20 Occasional failure to maintain minimal personal hygiene; inability to function independently

1–10 Persistent inability to maintain minimal personal hygiene; inability to function without harming self or others or without considerable external support (e.g., nursing care and supervision)

0 Inadequate information

Appendix C: Antipsychotic Medications

The chart below lists commonly prescribed antipsychotic medications.[8]

Generic Name	Brand Name	Dosage Range[1]	Sedation	EPS[2]	ACH Effects[3]	Equivalence[4]
Low Potency						
chlorpromazine	Thorazine	50-1500 mg	high	++		100 mg
thioridazine	Mellaril	150-800 mg	high	+	+++++	100 mg
clozapine	Clozaril	300-900 mg	high	0	+++++	50 mg
mesoridazine	Serentil	50-500 mg	high	+	+++++	50 mg
quetiapine	Seroquel	150-400 mg	mid	+/0		50 mg
High Potency						
molindone	Moban	20-225 mg	low	+++		10 mg
perphenazine	Trilafon	8-60 mg	mid	++++		10 mg
loxapine	Loxitane	50-250 mg	low	+++		10 mg
trifluoperazine	Stelazine	10-40 mg	low	++++		5 mg
fluphenazine	Prolixin5	3-45	low	+++++		2 mg
thiothixene	Navane	10-60 mg	low	++++		5 mg
haloperidol	Haldol[5]	2-40 mg	low	+++++		2 mg
pimozide	Orap	1-10 mg	low	+++++		1-2 mg
risperidone	Risperdal	4-16 mg	low	+		1-2 mg
olanzapine	Zyprexa	5-20 mg	mid	+/0		1-2 mg
ziprasidone	Geodon	60-160 mg	low	+/0		10 mg

1. Usual daily oral dosage.
2. Acute: Parkinson's, dystonias, akathisia. Does not reflect risk for tardive dyskinesia. All neuroleptics may cause tardive dyskinesia, except clozapine.
3. Anticholionergic side effects.
4. Dose required to achieve efficacy of 100 mg chlorpromazine.
5. Available in time-release IM format.

[8]. Identified as free download at Web Site www.PsyD-fx.com. (October 2003).

Appendix D: National Associations, Agencies, and Clearinghouses

The organizations listed below provide information, research, or educational materials on mental disorders. Addresses and telephone numbers are current as of August 2003.

American Psychiatric Association APA)
1000 Wilson Boulevard, Suite 1825
Arlington, VA 22209-3901
(703) 907-7300

Anxiety Disorders Association of America
8730 Georgia Avenue, Suite 600
Silver Spring, MD 20910 (240) 485-1001

Bureau of Justice Assistance Clearinghouse
Box 6000
Rockville, MD 40849-6000
(800) 688-4252

National Alliance for the Mentally Ill (NAMI)
2107 Wilson Boulevard, Suite 300
Arlington, VA 22201-3042
(703) 524-7600 (Main office number)
(800) 950-6264 (Helpline)

National Association of State Mental Health Program Directors
66 Canal Center Plaza, Suite 302
Alexandria, VA 22314-1591
(703) 739-9333

National Council for Community Behavioral Health Care
12300 Twinbrook Parkway
Suite 320
Rockville, MD 20852
(301) 984-6200
(Publishes the *National Registry of Community Mental Health Services*, a directory of community mental health centers in each state.)

Depression and Related Affective
Disorders Association (DRADA) Johns
Hopkins Hospital
600 North Wolfe Street
Baltimore, MD 21287-7381
(410) 583-2919

National Institute of Corrections (NIC)
Information Center
1860 Industrial Circle, Suite A
Longmont, CO 80501
(303) 682-0213

National Institute of Justice Clearinghouse
P.O. Box 6000
Rockville, MD 20849-6000
(800) 851-3420

National Institute of Mental Health
Information
Resources and Inquiries Branch
Office of Scientific Information
5600 Fishers Lane
Room 7C-02
Rockville, MD 20857 (301) 443-4513

National Depressive and Manic
Depressive Association
730 North Franklin Street, Suite 501
Chicago, IL 60610
(312) 642-0049

National Mental Health Association
(NMHA)
2001 North Beauregard Street, 12th Floor
Alexandria, VA 22311
(703) 684-7722 (Main office number)
(800) 969-6642 (Information Center)

National Rural Health Association
1 West Armour Boulevard,
Suite 203
Kansas City, MO 64111 (816)
756-3140

Appendix E: Related Web Sites

J-Net Resource

http://jnet/courtoperations/fcsd/html/mentalhealth/policy.htm - Office of Probation and Pretrial Services of the Administrative Office of the U.S. Courts Offers a mental health and substance abuse page designed to support officers and staff in their work with individuals with mental disorders by providing resources such as

- a collection of better practices and innovative programs to consider relating to mental health and substance abuse;
- a collection of frequently asked questions pertaining to mental health, substance abuse, and contract administration;
- policies and procedures documents;
- a monthly "ask the expert" column;
- a page of links to other mental health resources Web sites; and
- a national directory of probation and pretrial services officers, including contract administrators and intensive supervision specialists working with mental health and sex offender cases.

Nonprofit Organizations

www.nami.org - National Alliance for the Mentally Ill
Information on local support groups, educational programs, advocacy, and research.

www.narsad.org - National Alliance for Research on Schizophrenia and Depression Information about research on mental illness.

www.ndmda.org - National Depressive and Manic Depressive Association now called DBSA, Depression and Bipolar Support Alliance) Information on mood disorders, support groups, and other resources.

www.nmha.org - National Mental Health Association
Information about mental illness, advocacy, etc.

www.bazelon.org - Bazelon Center for Mental Health Law
Information about current legislative issues, including legal cases, criminalization of the mentally ill, and managed care.

Federal Government Sites

www.nimh.nih.gov - National Institiute of Mental Health

www.mentalhealth.org - Substance Abuse and Mental Health Services Administration's National Mental Health Information Center.

Professional Organizations

www.apa.org - American Psychological Association
www.psych.org - American Psychiatric Association
www.naswdc.org - National Association of Social Workers

Other

www.schizophrenia.com
Information on schizophrenia, chat rooms, etc.

www.well-connected.com
Health site that gives information on all health issues, including mental illness, and free reports and quarterly highlights. E-mail: bppad@yahoo.

Appendix F: Commonly Used Abbreviations

Professional Degrees and Licenses

BSW. - Bachelor of Social Work

MA - Master of Arts

MS- Master of Science

MSW - Master of Social Work PsyD - Doctor of Psychology PhD - Doctor of Philosophy MD - Doctor of Medicine

NP - Nurse Practitioner

CSW - Clinical or Certified Social Worker

LCDC - Licensed Chemical Dependency Counselor

LMSW - Licensed Master Social Worker

LMSW-ACP - Licensed Master Social Worker - Advanced Clinical Practitioner

LPC - Licensed Professional Counselor

Diagnoses and Conditions

BP - blood pressure

CVA - cerebral vascular accident

CHI - closed head injury

DM - diabetes mellitus

ED - emotionally disturbed

h/a - headache

H/A - heart attack

GSW - gunshot wound

LD - learning disabled

MVA - motor vehicle accident

sz - seizures

Treatment

AMA - against medical advice d/c - discharge or discontinue Dx - diagnosis

H/o - history of

Hx - history

Rx/Tx - treatment

Sx - symptoms

WNL - within normal limits

Provisional – not certain if person meets criteria for diagnosis

Personality disorder NOS – not otherwise specified, symptoms that do not meet the criteria for a specific personality disorder

Shorthand

@ - at or about
c - with
s - without
w/i - within
w/o - without
? - change
a - before
p - after
s/p - status post, which means after something (e.g., s/p GSW mean status post gunshot wound)

- increase
- decrease
NS - no show
w/d - withdrawal
RTC - return to clinic
RTW - returen to work
D.O - disorder
R.O - rule out
TP - treatment plan
MDT - multidisciplinary team

COMMONLY USED ACRONYMS

AA	Alcoholics Anonymous
ACMH	Anchorage Community Mental Health
CBT	Cognitive Behavioral Therapy
COD	Co-Occuring Disorders
DBT	Dialectical Behavioral Therapy
DD	Developmental Disabilities
DSM	Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Assoc)
ED	Emotionally Disturbed
FAS	Fetal Alcohol Syndrome
GAF	Global Assessment of Functioning
HHS	U.S. Department of Health and Human Services (Federal)
ICM	Intensive Case Management
IOC	Involuntary Outpatient Commitment
JLI	Judges' Criminal Justice/Mental Health Leadership Initiative
MET	Motivational Enhancement Therapy
MR	Mental Retardation
MSE	Mental Status Examination
NA	Narcotics Anonymous
PTSD	Post Traumatic Stress Disorder
SAMSHA	Substance Abuse and Mental Health Services Administration (Federal)

SPMI	Serious and Persistent Mental Illness
SSDI	Social Security Disability Insurance
SSI	Supplemental Security Income
SSRI	Selective Serotonin Reuptake Inhibitors
TAPA	CMHS GAINS Technical Assistance and Policy Analysis Center for Jail Diversion
TC	Theraputic Community
TREM	Trauma Recovery and Empowerment Model
WRAP	Wellness Recovery Action Plan

QUICK REFERENCE TO PSYCHOTROPIC MEDICATION®

DEVELOPED BY JOHN PRESTON, PSY.D., ABPP

To the best of our knowledge recommended doses and side effects listed below are accurate. However, this is meant as a general reference only, and should not serve as a guideline for prescribing of medications. Please check the manufacturer's product information sheet or the P.D.R. for any changes in dosage schedule or contraindications. (Brand names are registered trademarks.)

ANTIDEPRESSANTS

NAMES		Usual			Selective Action On Neurotransmitters[2]		
Generic	Brand	Daily Dosage Range	Sedation	ACH[1]	NE	5-HT	DA
imipramine	Tofranil	150-300 mg	mid	mid	+ +	+++	0
desipramine	Norpramin	150-300 mg	low	low	+++++	0	0
amitriptyline	Elavil	150-300 mg	high	high	++	++++	0
nortriptyline	Aventyl, Pamelor	75-125 mg	mid	mid	+++	++	0
protriptyline	Vivactil	15-40 mg	mid	mid	++++	+	0
trimipramine	Surmontil[3]	100-300 mg	high	mid	++	++	0
doxepin	Sinequan, Adapin[3]	150-300 mg	high	mid	++	+++	0
clomipramine	Anafranil	150-250 mg	high	high	0	+++++	0
maprotiline	Ludiomil	150-225 mg	high	mid	+++++	0	0
amoxapine	Asendin	150-400 mg	mid	low	+++	++	0
trazodone	Desyrel	150-400 mg	mid	none	0	++++	0
fluoxetine	Prozac[4], Sarafem	20-80 mg	low	none	0	+++++	0
bupropion-X.L.	Wellbutrin-X.L.[4]	150-400 mg	low	none	++	0	++
sertraline	Zoloft	50-200 mg	low	none	0	+++++	0
paroxetine	Paxil	20-50 mg	low	low	+	+++++	0
venlafaxine-X.R.	Effexor-X.R.[4]	75-350 mg	low	none	++	+++	+
fluvoxamine	Luvox	50-300 mg	low	low	0	+++++	0
mirtazapine	Remeron	15-45 mg	mid	mid	+++	+++	0
citalopram	Celexa	10-60 mg	low	none	0	+++++	0
escitalopram	Lexapro	5-20 mg	low	none	0	+++++	0
duloxetine	Cymbalta	20-80 mg	low	none	++++	++++	0
atomoxetine	Strattera	60-120 mg	low	low	+++++	0	0
MAO INHIBITORS							
phenelzine	Nardil	30-90 mg	low	none	+++	+++	+++
tranylcypromine	Parnate	20-60 mg	low	none	+++	+++	+++
selegiline	Emsam (patch)	6-12 mg	low	none	+++	+++	+++

[1]ACH: Anticholinergic Side Effects
[2]NE: Norepinephrine, 5-HT: Serotonin, DA: Dopamine (0 = no effect, + = minimal effect, +++ = moderate effect, +++++ = high effect)
[3]Uncertain, but likely effects
[4]Available in standard formulation and time release (XR, XL or CR). Prozac available in 90mg time released/weekly formulation

BIPOLAR DISORDER MEDICATIONS

NAMES		Daily	Serum[1]
Generic	Brand	Dosage Range	Level
lithium carbonate	Eskalith, Lithonate	600-2400	0.6-1.5
olanzapine/ fluoxetine	Symbyax	6/25-12/50mg[4]	2
carbamazepine	Tegretol,Equetro	600-1600	4-10+
oxcarbazepine	Trileptal	1200-2400	(2)

NAMES		Daily	Serum[1]
Generic	Brand Dosage	Range	Level
divalproex	Depakote	750-1500	50-100
gabapentin	Neurontin	300-2400	(2)
lamotrigine	Lamictal	50-500	(2)
topiramate	Topamax	50-300	(3)
tiagabine	Gabitril	4-12	(3)

[1]Lithium levels are expressed in mEq/l, carbamazepine and valproic acid levels express in mcg/ml.
[2]Serum monitoring may not necessary [3]Not yet established [4]Available in: 6/25, 6/50, 12/25, and 12/50mg formulations

ANTI-OBSESSIONAL

NAMES		
Generic	Brand	Dose Range[1]
clomipramine	Anafranil	150-300 mg
fluoxetine	Prozac[1]	20-80 mg
sertraline	Zoloft[1]	50-200 mg
paroxetine	Paxil[1]	20-60 mg
fluvoxamine	Luvox[1]	50-300 mg
citalopram	Celexa[1]	10-60 mg
escitalopram	Lexapro[1]	5-30 mg

[1]often higher doses are required to control obsessive-compulsive symptoms than the doses generally used to treat depression.

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PSYCHO-STIMULANTS

NAMES		
Generic	Brand	Daily Dosage[1]
methylphenidate	Ritalin	5-50 mg
methylphenidate	Concerta[2]	18-54 mg
methylphenidate	Metadate	5-40 mg
methylphenidate	Methylin	10-60 mg
methylphenidate	Daytrana (patch)	15-30 mg
dexmethylphenidate	Focalin	5-40 mg
dextroamphetamine	Dexedrine	5-40 mg
lisdexamphetamine	Vyvanse	30-70 mg
pemoline	Cylert	37.5-112.5 mg
d- and l-amphetamine	Adderall	5-40 mg
modafinil	Provigil, Sparlon	100-400 mg

[1]Note: Adult Doses. [2]Sustained release

ANTIPSYCHOTICS

NAMES Generic	Brand	Dosage Range[1]	Sedation	Ortho[2]	EPS[3]	ACH Effects[4]	Equivalence[5]
LOW POTENCY							
chlorpromazine	Thorazine	50-800 mg	high	high	+ +	++++	100 mg
thioridazine	Mellaril	150-800 mg	high	high	+	+++++	100 mg
clozapine	Clozaril	300-900 mg	high	high	0	+++++	50 mg
mesoridazine	Serentil	50-500 mg	high	mid	+	+++++	50 mg
quetiapine	Seroquel	150-600 mg	mid	mid	+/0	+	50 mg
HIGH POTENCY							
molindone	Moban	20-225 mg	low	mid	+++	+++	10 mg
perphenazine	Trilafon	8-60 mg	mid	mid	++++	++	10 mg
loxapine	Loxitane	50-250 mg	low	mid	+++	++	10 mg
trifluoperazine	Stelazine	2-40 mg	low	mid	++++	++	5 mg
fluphenazine	Prolixin[5]	3-45 mg	low	mid	+++++	++	2 mg
thiothixene	Navane	10-60 mg	low	mid	++++	++	5 mg
haloperidol	Haldol[5]	2-40 mg	low	low	+++++	+	2 mg
pimozide	Orap	1-10 mg	low	low	+++++	+	1-2 mg
risperidone	Risperdal	4-16 mg	low	mid	+	+	1-2 mg
paliperidone	Invega	3-12 mg	low	mid	+	+	1-2mg
olanzapine	Zyprexa	5-20 mg	mid	low	+/0	+	1-2 mg
ziprasidone	Geodon	60-160 mg	low	mid	+/0	++	10 mg
aripiprazole	Abilify	15-30mg	low	low	+/0	+	2 mg

[1]Usual daily oral dosage
[2]Orthostatic Hypotension Dizziness and falls
[3]Acute: Parkinson's, dystonias, akathisia. Does not reflect risk for tardive dyskinesia. All neuroleptics may cause tardive dyskinesia, except clozapine.
[4]Anticholinergic Side Effects.
[5]Dose required to achieve efficacy of 100 mg chlorpromazine.
[6]Available in time-release IM format.

ANTI-ANXIETY

NAMES Generic	Brand	Single Dose Dosage Range	Equivalence[1]
BENZODIAZEPINES			
diazepam	Valium	2-10 mg	5 mg
chlordiazepoxide	Librium	10-50 mg	25 mg
prazepam	Centrax	5-30 mg	10 mg
clorazepate	Tranxene	3.75-15 mg	10 mg
clonazepam	Klonopin	0.5-2.0 mg	0.25 mg
lorazepam	Ativan	0.5-2.0 mg	1 mg
alprazolam	Xanax, XR	0.25-2.0 mg	0.5 mg
oxazepam	Serax	10-30 mg	15 mg
OTHER ANTIANXIETY AGENTS			
buspirone	BuSpar	5-20 mg	
gabapentin	Neurontin	200-600 mg	
hydroxyzine	Atarax, Vistaril	10-50 mg	
propranolol	Inderal	10-80 mg	
atenolol	Tenormin	25-100 mg	
guanfacine	Tenex	0.5-3 mg	
clonidine	Catapres	0.1-0.3 mg	
prazosin	Minipress	5-20 mg	

[1]Doses required to achieve efficacy of 5 mg of diazepam

HYPNOTICS

NAMES Generic	Brand	Single Dose Dosage Range
flurazepam	Dalmane	15-30 mg
temazepam	Restoril	15-30 mg
triazolam	Halcion	0.25-0.5 mg
estazolam	ProSom	1.0-2.0 mg
quazepam	Doral	7.5-15 mg
zolpidem	Ambien	5-10 mg
zaleplon	Sonata	5-10 mg
eszopiclone	Lunesta	1-3 mg
ramelteon	Rozerem	4-16 mg
diphenhydramine	Benadryl	25-100 mg

OVER THE COUNTER

Name	Daily Dose
St. John's Wort[1, 2]	600-1800 mg
SAM-e[3]	400-1600 mg
Omega-3[4]	1-9 g

[1]Treats depression and anxiety
[2]May cause signifigant drug-drug interactions
[3]Treats depression
[4]Treats depression and bipolar disorder

COMMON SIDE EFFECTS

ANTICHOLINERGIC EFFECTS
(block acetylcholine)

- dry mouth
- constipation
- urinary retention
- blurred vision
- memory impairment
- confusional states

EXTRAPYRAMIDAL EFFECTS
(dopamine blockade in basal ganglia)

- Parkinson-like effects: rigidity, shuffling gait, tremor, flat affect, lethargy
- Dystonias: spasms in neck and other muscle groups
- Akathisia: intense, uncomfortable sense of inner restlessness
- Tardive dyskinesia: often a persistent movement disorder (lip smacking, writhing movements, jerky movements)

Note: The above are common side effects. All medications can produce specific or unique side effects. For a more complete description, please see references listed below

REFERENCES and RECOMMENDED BOOKS

Handbook of Clinical Psychopharmacology For Therapists (2008) Preston, O'Neal and Talaga

Clinical Psychopharmacology Made Ridiculously Simple 5th Edition (2008) Preston and Johnson

Quick Reference • Free Downloads
Website: www.PsyD-fx.com