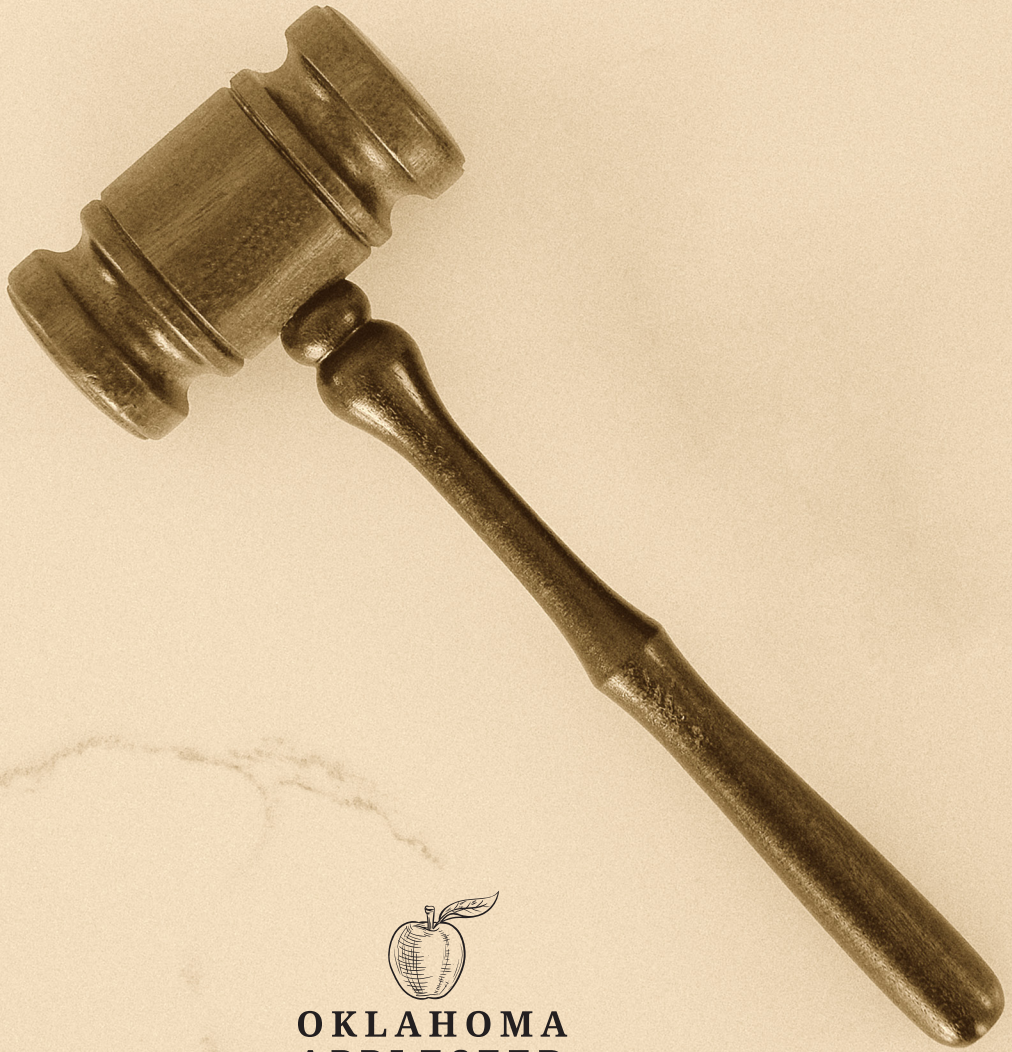
MENTAL ILLNESS, YOUR CLIENT AND THE CRIMINAL LAW

A handbook for attorneys who represent persons with mental illness



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Oklahoma Appleseed presents the information in this handbook as a service to attorneys who represent defendants with mental illness. While we worked to provide accurate and up-to-date information, this handbook is not intended to provide legal advice. Non-lawyers should seek the advice of a licensed attorney in all legal matters. Oklahoma Appleseed makes no warranties, express or implied, concerning the information contained in this handbook or other resources to which it cites.

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A handbook for attorneys who represent persons with mental illness

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About This Handbook

Every year, many people with mental illness come into contact with the criminal justice system in Oklahoma and across the nation. Work to assess the condition of indigent persons in the criminal justice system revealed the special needs of defendants with mental illness and the inadequate representation they sometimes receive. Defense attorneys, like other court officials, often failed to recognize mental illness. Even when attorneys recognize clients as mentally ill, many attorneys are not familiar with the specialized mechanisms, procedures, and laws that apply to persons with mental illness. For instance, many attorneys are unfamiliar with competency statutes and procedures. This lack of knowledge—together with concerns about the time and expense of conducting competency evaluations and, often, the client's desire to get out of jail quickly—may result in a client pleading guilty to an alleged offense when he or she is not competent to do so.

When mental incapacity reduces the defendant's ability to understand what is happening to him or her or to participate in his or her own defense, the basic fairness of the criminal trial process is threatened. In recent years, there is increasing awareness that changes need to be made to the process for identification and treatment of defendants with mental illnesses. These areas include the process of screening defendants, making referrals for further evaluation, and the process of transitioning defendants out of competency to trial or discharge.

However, many shortcomings in the treatment and representation of mentally ill defendants persist. A continued lack of understanding of mental illness and treatment options contribute significantly to delays in competency restoration, harsher sentences, longer stays in jail, and frequent revocations of probation for mentally ill defendants.

This handbook was developed to improve legal representation for criminal defendants with mental illness. It was drafted and reviewed by both mental health professionals and attorneys experienced in criminal and mental health law. However, it is not a comprehensive guide on mental health law or on how to represent a mentally ill defendant. It does not address the law as it relates to juvenile defendants with mental illness. It is designed to give attorneys a starting point for their work with their adult clients who have a mental illness, to alert them to some basic legal options they may want to consider, and to give them some ideas about where to go for assistance.

We hope this handbook encourages attorneys who represent defendants with mental illness to go the extra mile for their clients. It could make all the difference.

Foreword

In 1987, psychology professor and researcher Gary Melton wrote a seminal article on the importance of the process by which legal professionals could become better educated and more receptive to the application of social science research in the legal system. Dr. Melton emphasized how psychological research that was diffused to attorneys and judges in systematic ways was more likely to be used, but he also cautioned that the pace might "creep" along[1]. Decades later, the use of psychological research in the legal system has significantly improved, particularly in the criminal justice system, but research also suggests that the lack of education of attorneys and judges about mental illness persists. Also, it is still the case that attorneys and judges sometimes continue to blur the distinctions between legal constructs such as "insanity" and "competency."

To address this void, practice manuals designed to educate criminal defense attorneys are essential. This Handbook provides the reader with more than the "basics" of mental illness, diagnosis, available treatments, definitions of commonly prescribed psychotropic medications, and instruction about the quasi legal processes of the insanity defense and competence to stand trial. Importantly, it focuses specifically on Oklahoma law. Finally, this Handbook also offers necessary information on how attorneys can learn to interview their clients who may have a mental disorder with the respect and dignity they deserve. Always remember that mental illness is no respecter of persons and can happen to anyone, regardless of social class, race, ethnicity, or gender.

During my career, I have had the opportunity to interview many clients who have suffered from severe mental illness and find themselves in the throes of the criminal justice system, often confused, without support from any family or friends. I hope that this Handbook will be an instant resource to help attorneys see through the eyes of the client who sits across from them in a jail interview room and can move them to a more just disposition of their case when it is clear that they are in need of a different result than jail or prison.

This foreword is dedicated to the memory of Toni Elizabeth Torres Moran and her brother Floyd McKibben who tried to help her successfully navigate the Oklahoma mental health system, but unfortunately, she did not receive the services she needed even with excellent legal counsel. Perhaps this manual will spur on the next generation of criminal defense attorneys to continue the good fight for persons with severe mental illness. Godspeed their efforts.

Thank you, Oklahoma Appleseed for creating this Handbook.

Sincerely,

Kathy LaFortune, J.D., Ph.D.

1 Melton, Gary B. (1987). Bringing psychology to the legal system: Opportunities, obstacles, and efficacy. American Psychologist, 42(5), 488-495.

Top ten things to keep in mind as you represent a client with mental illness

❶ ***Mental illness and intellectual and developmental disabilities are not the same:***

Intellectual or developmental disabilities are permanent conditions characterized by significantly below average intelligence accompanied by significant limitations in certain skill areas, with onset before age 18. Mental illness, on the other hand, usually involves disturbances in thought processes and emotions and may be temporary, cyclical, or episodic. Most people with mental illness do not have intellectual deficits; some, in fact, have high intelligence. It is possible for a person with an intellectual or developmental disability to also have a mental illness. Many of the Oklahoma statutes that address mental illness also address intellectual and developmental disabilities, and you should look carefully at those statutes for the differences in how the two are addressed. This handbook does not address intellectual and developmental disabilities.

❷ ***You owe your client a zealous representation:***

You have the ethical obligation to zealously represent your client, which may include exploring your client's case for mental health issues. It may also include bringing appropriate motions if your client's mental illness has affected his or her case in any of the ways discussed in Section 1 of this handbook.

❸ ***If your client is incompetent, stop and order an evaluation:***

If your client is incompetent, he or she may not be able to make informed decisions about fundamental issues, such as whether or not to enter into a plea bargain agreement or, instead, proceed to trial. Do not allow your client to accept a plea bargain, or make any other decisions regarding the case, when you have reason to believe that he or she is incompetent. Instead, immediately request a competency evaluation.

❹ ***Mental illness and incompetence are not synonymous, and you should be concerned about both:***

Keep in mind that competence to stand trial is distinct from mental illness. Some clients who are fit to proceed to trial may still have serious mental illness. Even if your client does not have a competence issue, there may still be significant mental health issues in the case that you should explore. Remember, however, that if your client is competent to stand trial, he or she makes the final decision about how to proceed with the case, whether or not to explore mental health issues, and whether treatment should be part of a disposition.

❺ ***A mental illness (formerly insanity) defense may be appropriate:***

By taking the time to properly inquire about your client's mental illness and to explore various legal and medical options, you may obtain information that will help you decide if you should explore an insanity defense. If your client receives a not guilty by reason of mental illness, he or she will avoid receiving an unjust conviction. However, as discussed further in Section 7 of this handbook, there may be disadvantages to pursuing the mental illness defense, and you should discuss all of the pros and cons with your client.

❻ ***Mitigate, mitigate, mitigate:***

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

❼ ***Ineffective assistance of counsel and reversible error:***

An attorney's failure to request the appointment or otherwise obtain the assistance of qualified mental health or mental rehabilitation professionals when indicated can be a violation of a defendant's Sixth Amendment right to effective assistance of counsel. This certainly applies to capital cases but also to other homicide cases and any alleged offense that suggests mental aberration. A defendant's prior history of mental impairment may indicate that you need the assistance of a professional evaluation. *Ake v. Oklahoma,* 470 U.S. 68 (1985). *Ake* also confirms the right of indigent, convicted defendants to the assistance of mental health professionals at sentencing proceedings. An appellate judge may find reversible error if a client is truly incompetent or insane and the issue is not raised in court.

❽ ***Overcome your own prejudices before you hurt your client and his or her case:***

A popular misconception is that mental-state defenses are attempts by the defendant to "get off" or deny responsibility for their behavior. Many people are skeptical that persons with mental illness, in contrast to those with intellectual and developmental disabilities, are in some circumstances unable to fully appreciate the nature of their acts and control them. This denial of psychiatric disability can deeply influence the attitudes of both judges and juries toward expert witnesses and mental health defenses. Part of your job, if you are representing a person with mental illness, is to overcome cynicism toward mental health issues in criminal cases. Mental illnesses are neurobiological brain diseases. A mental illness is a medical illness, not "hocus pocus," and the people who experience it suffer profoundly. Mental illness can be diagnosed, treated, and sometimes even cured. You do your client a disservice by representing him or her any other way.

❾ ***Incarceration is particularly harmful to people with mental illness:***

Jails can be very damaging to the stability, mental health, and physical health of individuals with mental illness. Numerous studies show that placing mentally ill persons in single cells, isolation, or "lock down" can worsen their schizophrenia, depression, and anxiety. Individuals with mental illnesses or intellectual and developmental disabilities are also more likely than others to be victimized by other inmates or jail staff. They are at high risk for suicide. They may get inadequate, if any, medication and treatment while in jail. As set out in Section 5 of this handbook, you should seek to get your client's case dismissed quickly and, if appropriate, try to get your client released on bond.

❿ ***Do not let your client get caught in the "revolving door":***

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

Mental Health Checklist for Defense Attorneys

INITIAL STEPS

1) Ask the client questions to determine the mental illness diagnosis.

   - Interview the client as soon as possible.
   - Ask about the facts of the case.
   - Ask the client whether he or she has been treated for any type of mental illness.
   - Review medical records if available. You have a right to these.
   - Ask whether he or she took special classes in school.
   - Talk to the family.
   - Interview witnesses.
   - Inform the client of his or her right to a jury trial before the court and the right to be present at hearings.

2) Get the client out of jail on bail, if possible. Review Okla. Stat. tit. 59 § 1334 (Bail on Personal Recognizance).[1]

3) Familiarize yourself with options available in your community. Talk to mental health professionals, public defenders that specialize in mental health, etc.

4) Refer to Okla. Stat. tit. 43A § 1-110 (2020). It allows the Oklahoma Department of Mental Health and Substance Abuse Services the ability to securely transport individuals experiencing a mental health crisis in a more trauma-informed manner.[2] However, law enforcement is still able to transport people if the treatment facility is within 30 miles.[3] Jail personnel may have the authority to divert the client to a mental health facility. Ask detention personnel if the client can be moved to a medical facility, if appropriate.

5) Familiarize yourself with civil commitments if applicable. Okla. Stat. tit. 43A § 5-410.

6) Familiarize yourself with "Duties of Attorney and Counselor." Okla Stat. tit. 5 §5-3 (2014).

7) Explain your client's absence to the court at meetings or hearings. Determine if you need an independent psychiatric evaluation.

COMPETENCY

Consider an evaluation for competency. In Oklahoma, competency is defined as "the present ability of a person arrested for or charged with a crime to understand the nature of the charges and proceedings brought against him or her and to effectively and rationally assist in his or her defense."[4]

The current competency restoration statute is found in Okla. Stat. tit. 22 § 1175.6a. If the person is found to be incompetent but able to be restored to competency within "a reasonable amount of time," then treatment is ordered.[5] A person cannot be subject to criminal procedures once a person is determined incompetent. Okla. Stat. tit. 22 § 1175.2 (2014). Under 22 O.S. §1175.1(6), a "reasonable amount of time" is defined as a period not to exceed the lesser of a) the maximum sentence for the crime which the person is charged with, or b) a maximum of two (2) years."

Once a bed becomes available, the individual requiring treatment is transferred to the custody of Oklahoma Department of Mental Health and Substance Abuse Services ("ODMHSAS") to receive services at the Oklahoma Forensic Center.

Once the individual has regained competency, a hearing is supposed to be scheduled within 20 days.[6] In practice, a timely hearing does not always occur which can result in the individual again losing competency. If the individual is not able to restore competency within the allotted amount of time and is not capable of doing so, then the Court will initiate civil commitment proceedings and dismiss the criminal case without prejudice.[7]

INSANITY

Consider an evaluation for insanity. Review Section 1176 of Title 22 of the Oklahoma Code of Criminal Procedure. If the client was mentally ill or insane at the time of the offense, give timely notice of intent to raise the defense to the State no later than 30 days after formal arraignment.[8]

1 "Any person in custody before a court or magistrate of the State of Oklahoma subject to discretion of the court may be admitted to bail on his personal recognizance subject to such conditions as the court or magistrate may reasonably prescribe to assure his appearance when required."

2 *Alternative Transport Model for Mental Health Emergencies Marks One Year*, Oklahoma Mental Health & Substance Abuse (Dec. 6, 2022), https://oklahoma.gov/odmhsas/about/public-information/press-releases-and-other-news/2022/alternative-transport-model-for-mental-health-emergencies-marks-.html.

3 *Id.*

4 Okla. Stat. tit. 22 § 1175.1 (1) (2011).

5 *Id.*

6 Okla. Stat. tit. 22 § 1175.6a (C) (2019).

7 Okla. Stat. tit. 22 § 1175.6a (D) (2019).

8 Okla. Stat. tit. 22 § 22-1176 (2021).

SECTION 1

What is mental illness and why should you care?

WHAT IS MENTAL ILLNESS?

The Oklahoma Mental Health Code, set out in 43 Okla. Stat. §1-103, defines mental illness as "a substantial disorder of thought, mood, perception, psychological orientation or memory that significantly impairs judgment, behavior, capacity to recognize reality or ability to meet the ordinary demands of life."

Many of the pertinent criminal statutes include a cross-reference to this definition.

Mental disorders are quite common. In fact, one in four Americans has some type of mental disorder in any given year.[1] About 8% and 15% of all people with mental illness and serious mental illness, respectively, will have a co-occurring substance abuse disorder,[2] although the percentage in the criminal justice system is much higher. About 50-60% of the jail and prison population has a significant mental illness (schizophrenia, bipolar disorder, or major depression) at any given time;[3] this far exceeds the rate for these disorders in the general population. There is a myth that persons with severe mental illness are significantly more violent than other people. Research shows this is not true.[4] In fact, the vast majority of persons with mental illness in jail are arrested for nonviolent offenses. Often, it is when people with mental illness are undiagnosed and untreated, or when they stop taking their medication, that they get in trouble with the law.

1 "Ronald Kessler et al., *Prevalence, Severity, and Comorbidity of Twelve-month DSM-IV Disorders in the National Comorbidity Survey Replication*, 62 ARCHIVES OF GEN. PSYCHIATRY 617-25 (2005)."

2 "These estimates [of mental illness in the population] represented 56% of State prisoners, 45% of Federal prisoners, and 64% of jail inmates." DORIS J. JAMES & LAUREN E. GLAZE, BUREAU OF JUSTICE STATISTICS, MENTAL HEALTH PROBLEMS OF PRISON AND JAIL INMATES 1 (2006), available at https://bjs.ojp.gov/content/pub/pdf/mhppji.pdf.

3 "These estimates [of mental illness in the population] represented 56% of State prisoners, 45% of Federal prisoners, and 64% of jail inmates." DORIS J. JAMES & LAUREN E. GLAZE, BUREAU OF JUSTICE STATISTICS, MENTAL HEALTH PROBLEMS OF PRISON AND JAIL INMATES 1 (2006), available at https://bjs.ojp.gov/content/pub/pdf/mhppji.pdf.

4 Henry J. Steadman et al., *Violence by People Discharged From Acute Psychiatric Inpatient Facilities and by Others in the Same Neighborhoods*, 55 ARCHIVES OF GEN. PSYCHIATRY 393-401 (1998)

SERIOUS MENTAL ILLNESS

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

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

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

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

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

WHY SHOULD YOU CARE IF YOUR CLIENT HAS A MENTAL ILLNESS?

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

- the voluntariness of your client's statements. Statements that are the product of mental illness or intellectual and developmental disabilities will not be excluded from evidence in the absence of impermissible coercive official conduct. However, conduct that is not coercive when used with nondisabled persons may impair the voluntariness of the statements of persons who are mentally ill;
- your client's ability to understand the rights explained to him or her, including Miranda rights;

- the reliability of your client's statements;
- your client's memory, ability to make decisions, reasoning, judgment, volition, and comprehension;
- your client's ability to understand cause and consequence or learn from prior mistakes;
- your client's ability to waive rights in a knowing, intelligent, and voluntary manner, including the right to counsel, right to be present, right to trial and appeal, and right to testify; *and*
- your client's ability to meaningfully participate in trial preparation and at trial.

DEFENDANT'S DECISIONS, ATTORNEY'S DECISIONS

Even if your client has a mental illness and impaired capacity, it is important to remember that the client still retains final decision-making authority over key aspects of the case, namely:

- What plea to enter.
- Whether to waive a jury trial.
- Whether to testify in his or her own behalf.
- Whether to appeal.
- Whether to represent himself or herself.
- The objective and general methods of representation (i.e., counsel is required to consult with the defendant on "important decisions" regarding overarching defense strategy).

Some strategic decisions to be made by the lawyer after full consultation:

- Which witnesses to call.
- Whether and how to conduct cross-examination.
- What trial motions to make.
- All other strategic and tactical decisions.

SECTION 2

Oklahoma indigent defense act

HOW DOES THE OKLAHOMA INDIGENT DEFENSE ACT AFFECT YOU?

The Oklahoma Indigent Defense Act, among other things, provides trial, appellate, and post-conviction criminal defense services to indigent clients at the State's expense.

If you have any questions about when your representation of your client ends, you should contact the county's appointing authority.

HOW DOES THE INDIGENT DEFENSE ACT HELP MENTALLY ILL DEFENDANTS?

The Oklahoma Indigent Defense Act created the Oklahoma Indigent Defense System Board in Okla. Stat. tit. 22 § 1355.1. The Board consists of 5 members appointed by the Governor for 5-year terms.[1] The Board meets every other month and is responsible for developing standards and policies, reviewing claims, authorizing contracts, consulting with indigent defenders and defense lawyers who represent indigent clients, among other responsibilities.[2]

Finally, the Oklahoma Indigent Defense Act provides for the reimbursement of reasonable and necessary expenses, including for mental health experts and other experts.

1 Okla. Stat. tit. 22 § 1355.1 (2021)

2 Okla. Stat. tit. 22 § 1355.1 (2021)

SECTION 3

The initial interview

HOW CAN YOU TELL IF YOUR CLIENT HAS A MENTAL ILLNESS?

Here are some things you should look for when trying to spot a mental illness:

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

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

Circular nature of your client's conversation. While talking with your client, you may note that your client doesn't follow a logical train of thought. In other words, your client may be unable to get from point A to point B.

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

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

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

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

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

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

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

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

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

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

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

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

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

- Have you ever been treated for a mental or emotional issue?
- Have you ever been treated for substance abuse?
- Are you currently receiving treatment? If so, from whom?
- Do you know your diagnosis?
- What types of medication are you taking? Have you taken medications in the past? What were those medications?
- Have you ever been hospitalized for a mental health issue? If so, when and where? Did a court or judge order that you be hospitalized?
- Are there doctors, friends, or family members I can talk to who are familiar with your treatment?

Be familiar with the names of public mental health clinics in your area (such as a local mental health authority or psychiatric hospital), state mental hospitals (e.g., Griffin Memorial, Oklahoma Forensic Center, and Children's Recovery Center (for juveniles)), and jail mental health pods (e.g., Oklahoma County and Tulsa County Mental Health Pods). It may be helpful to ask specifically, for example: "Have you been to Griffin or OFC/Vinita? Do you go to Parkside (Private Mental Health Hospital in Tulsa)? Were you ever on the mental health pod in Tulsa County jail?"

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

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

- Are you on any medications and, if so, what are they?
- Have you had any previous medical treatment and, if so, what was it?
- Do you have a juvenile record and, if so, for what types of offenses?
- Were you in any special classes in school and, if so, do you know why?
- Do you receive disability or Supplemental Security Income (SSI) benefits?
- Have you ever felt depressed?
- Have you ever been a patient at the Veterans' Administration (VA)?
- Have you ever been hospitalized?
- Have you ever had any dealings with a local mental health authority? (You may want to tailor this question using the name of the local mental health authority, ODMHSAS)
- Are there doctors, friends, or family members I can talk with about your case?

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

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

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

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

Do not worry about malingering. It is the mental health evaluator's role, not yours, to determine who might be faking mental illness. While it is true that some defendants try to fake mental illness in order to avoid prosecution or to get a reduced sentence, defendants who actually have a mental illness often try to hide their condition.

SECTION 4

Helpful hints to obtain information

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

WHERE DO YOU LOOK FOR MORE MENTAL HEALTH INFORMATION?

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

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

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

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

If your client is being treated while in jail or is housed in a special cell, serve a Request for Medical Information on jail staff. Usually jail staff has some information on persons in the jail who exhibit mental illness or take medications.

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

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

If your client has been in court before, investigate whether prior competence proceedings were conducted.

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

WHAT RECORDS WOULD BE HELPFUL?

Medical records from doctors or clinics. Under Oklahoma law, mental health and drug/alcohol abuse information is privileged and confidential. Okla. Stat. tit. 43A § 1-109 sets out the elements of a valid written release for disclosure of mental health, drug, or alcohol abuse treatment information.

Prior hospitalization records. Has your client been hospitalized multiple times? Does he or she have a history of involuntary civil commitments? How long were the hospital stays typically?

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

School records. Your client may have been enrolled in special education classes or may have been in special programs while in school. Look for the designation of an emotional disturbance on these special education records.

Employment records. Mental illness may have interfered with your client's ability to hold down long-term, stable employment. Look at your client's employment history. Has he or she had trouble keeping jobs? Has your client ever been a client of the Oklahoma Commission for Rehabilitation Services or other job training programs?

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

VA records.

Military records.

Child Protective Services records.

Because many local agencies and departments may not be willing to release records, it is a good idea to have your client sign

a records release form at the time of your first interview if your client is competent and able to do so. Some facilities may accept the letter of appointment, but others will require a signed release. Even better, call the institution from which you are seeking records and request a copy of its records release form. If your client cannot sign a medical records release form because he or she is incompetent or his or her competency is in question, you may be able to obtain the needed records by sending to the institution a certified copy of the order appointing you to the case. If none of these methods work, you may be able to obtain the records by getting a subpoena or a court order.

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

Note: Legislation around extending HIPAA privacy protections, passed in 2011, has created additional obligations for attorneys and law firms that handle sensitive health information[1].

1 Dan Bowman, "HIPAA Compliance Checklist--How to Keep Your Law Firm Compliant," Vol. XIII National L. Rev. 117 (Apr. 27, 2023). Available at: https://www.natlawreview.com/article/hipaa-compliance-checklist-how-to-keep-your-law-firm-compliant

SECTION 5

Pretrial Process And Options

Confirm that an actual case has been filed against your client

Your client's case may be delayed by the fact that formal charges were never filed against your client. While this does not happen often, there are circumstances where "defendants" are placed in jail without any charges actually being filed. In many counties, without direct filing, a person may languish for a long period with no charge having been filed, yet a competency exam is ordered and, on many occasions, the person is sent to the state hospital—to be "restored" with regard to a case that does not yet exist! Please confirm that a case has been filed to avoid delays.

Try to get the case dismissed

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

Talk with the prosecutor

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

Talk with the complaining witness

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

Talk with the arresting officer

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

Release on a personal bond

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

There may be a memorandum of understanding between ODMH and the jail in your community to divert low-level, nonviolent mentally ill offenders from jail into a mental health facility. If there is a memorandum of understanding in your county, you should bring this to the attention of jail personnel who have the authority to divert your client to a mental health facility.

Involuntary commitment

There may be rare situations in which you want to explore this option with your client if your client meets the commitment criteria. See 43A Okla. Stat. §§ 5-410. In this scenario, the district court would determine whether the person requires treatment.[1] If the person needs treatment, the person will receive the least restrictive treatment necessary.[2]

1 John Wylie, *Requiring Mental Health Treatment and Involuntary Commitment*, OKLAHOMA BAR ASSOCIATION (Sept. 2020), https://www.okbar.org/barjournal/september2020/obj9107wylie/#:~:text=The%20process%20to%20place%20a,least%20restrictive%20appropriate%20treatment%20required

2 *Id.*

SECTION 6

Competence Evaluations And Hearings

THE BASICS

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

Your client is "incompetent" to stand trial on criminal charges if he or she does not have:

1) the present ability to understand the nature of the charges and proceedings brought against him or her
   or
2) the ability to effectively and rationally assist in his or her defense.[1]

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

- Does your client understand his or her legal situation?
- Does your client understand the charges against him or her?
- Does your client understand the legal issues/procedures in his or her case?
- Does your client understand the available legal defenses?
- Does your client understand the dispositions, pleas, and possible penalties?
- Can your client appraise the likely outcomes of his or her case?
- Can your client appraise his or her role and the roles of defense counsel, prosecutor, judge, jury, and witnesses in his or her case?
- Can your client identify and locate witnesses?
- Does your client trust you and communicate relevant information to you, including pertinent facts, events, and

states of mind?

- Does your client comprehend instructions and advice?
- Can your client make decisions after receiving advice?
- Is your client able to collaborate with you on developing legal strategy?
- Can your client follow his or her own testimony and the testimony of others for contradictions or errors?
- Can your client testify about relevant information and be cross-examined if necessary?
- Can your client help you challenge prosecution witnesses?
- Can your client tolerate the stress of the trial process?
- Can your client refrain from irrational and unmanageable behavior in court?
- Can your client disclose pertinent facts about the alleged offense?

A defendant is presumed competent to stand trial unless proved incompetent by clear and convincing evidence.[2]

COMPETENCE EXAMINATIONS

→ ***When is it appropriate to motion for a competency assessment?***

Generally, issues relating to your client's competence to stand trial should be resolved before the trial on the merits. However, you can request a competency examination at any point during the proceedings at which you believe your client is not competent to stand trial—even if you are in the middle of trying your client's case on the merits. You should note that the American Bar Association (ABA) has resolved that it is improper to use competence procedures for purposes unrelated to the determination of competence, such as obtaining mitigation information, obtaining favorable plea negotiations, or delaying proceedings.[3]

Many attorneys find themselves in an ethical bind when their client objects to having the competence issue raised. Some clients facing misdemeanor charges just want to plea to the charges, spend a short time in jail, and then get out. Often getting a psychiatric examination means that the client will spend more time in jail pending the examination, plus a lengthy time at the state hospital if he or she is found incompetent. Be aware, however, that a defendant cannot be committed under the competency statutes for a cumulative period that exceeds the maximum term for the offense charged or up to two years, whichever comes first.[4] Additionally, the ABA stresses a lawyer's professional responsibility toward the court and the fair administration of justice as the paramount obligations in such an instance, and expects an attorney to advance

1 Okla. Stat. tit. 22 § 1175.1 (1) (2011).

2 *Cooper v. Oklahoma,* 517 U.S. 348 (1996).

3 STANDARDS RELATING TO COMPETENCE TO STAND TRIAL § 7-4.2(e) (1989).

4 22 O.S. 1175.1(6).

the issue even over a client's objection whenever a good faith doubt arises about a defendant's competence to stand trial.[5] Of course, if your client is competent to stand trial, he or she makes the final decision about how to dispose of his or her case regardless of whether you agree with this decision.

If a defense attorney, judge, or prosecutor in a criminal case has doubts about the competency of a defendant, they may file an application to have the defendant's competency evaluated.[6]

You should also seek to get your client's case dismissed as discussed in Section 5 of this Handbook, but if the case is not dismissed, you should know that competency examinations and hearings can be conducted even if your client is on bond or otherwise out of jail.

→ ***Requesting the competency examination***

File an application with the court requesting a determination of competency, if you believe your client is not competent to stand trial, whether your client is in jail or out on bond. Even though defense counsel usually files such an application, the court itself or the prosecutor may raise the issue of incompetency to stand trial.

Considerations regarding the mental health expert: When an application that the defendant may be incompetent to stand trial is filed, a mental health professional will meet the individual and conduct an evaluation as to whether the person is competent. The mental health professionals that conduct the evaluations must be either a psychiatrist with forensic training and experience, a psychologist with forensic training and experience, or a licensed mental health professional whose forensic training and experience enable him or her to form expert opinions regarding mental illness, competency and dangerousness and who has been approved to render such opinions by the court.[7]

→ ***Your responsibilities regarding the examination:***

- You may want to tell the evaluator why you think your client is unable to assist you or participate in his or her defense. The defendant is able to challenge results of the competency evaluation, but if the judge finds the individual competent, the proceedings will resume. If the individual is found not competent, the person will go to the Oklahoma Forensic Center (OFC) to receive competency restoration services.
- You should also obtain and submit to the examiner any record or information that the examiner regards as necessary for conducting a thorough evaluation on the matters referred.

5 STANDARDS RELATING TO COMPETENCE TO STAND TRIAL § 7-4.2(c) (1989).

6 *Okla. Stat. tit. 22 § 1175.2 (A) (2000).*

7 Okla. Stat. tit. 22 § 1175.1 (5) (2011).

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

→ ***Preparing the client for the examination***

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

- the purpose and nature of the examination;
- the potential uses of any disclosures made during the examination;
- the conditions under which the prosecutor will have access to reports and other information obtained for the examination and the reports prepared by the evaluator;
- the conditions under which the examiner may be called to testify during sentencing; and
- that your client will be sent to a state hospital for the examination if he or she refuses to cooperate with the court-appointed expert during the examination.

→ ***Can you be present during the competency examination?***

Counsel should consider whether or not to be present during an examination. Some courts allow an attorney to watch but not to speak. Your presence at the examination enables the evaluating professional to observe the attorney-client relationship and get a better idea about what your client may be asked to do to assist with his or her defense. If the prosecutor initiated the examination, and it is likely that the examiner will be a State's witness at trial, you may be better able to cross-examine the mental health examiner at trial if you are present during, or have viewed or listened to, the examination. However, your presence at the examination may inhibit your client from speaking candidly with the evaluator and may also make the examination vulnerable to a prosecutor's challenge on cross-examination or a prosecutor's claim that your presence influenced the examination. If you are not allowed to be present during the examination, or decide not to attend, you should inquire about videotaping or audiotaping the interview as an alternative.

→ ***What to expect in competency reports***

The competency report should contain

1) if the person is able to appreciate the nature of the charges,
2) if the person is able to consult with a lawyer and rationally assist in his or her defense,
3) if it is determined that the person is unable to do either of those, then whether the person can attain competency as set out in Okla. Stat. tit. 22 § 1175.1 with training,

therapy, or treatment
4) if the person requires treatment as defined by Okla. Stat. tit. 43A § 1-103,
5) if the person is incompetent due to an intellectual disability as set out in Okla. Stat. tit. 10 § 1408,
6) if the defendant is not a person requiring treatment or one with an intellectual disability, then the report must explain why the defendant is incompetent, and finally
7) if the person is released, whether the person would be presently dangerous as defined in Section 1175.1. Okla. Stat. tit. 22 § 1175.3.

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

Your three means of challenging the results of the report are

1) cross-examining the doctor,
2) putting on your own expert, and
3) building opposition to the doctor's opinion using your client's medical records.

In some cases, the examiner may draw conclusions about your client's competency by your client's refusal to cooperate with the examination. Be mindful that you have the right to challenge an examination.

The competency report should not contain information or opinions concerning either your client's mental condition at the time of the alleged crime or any statements made by your client regarding the alleged crime or any other crime. If the expert determines that your client is competent to proceed, issues concerning insanity or culpability at the time of the offense should be included in a separate report and not in the competence report. You should seek to ensure that the competence report does not include any offense-related information or express the opinion of the examiner on any questions requiring a conclusion of law or a moral or social value judgment properly reserved to the trier of fact.

→ ***Can your client "regain" competence?***

Whatever the particular diagnosis or disorder, your client can most probably be restored, though not cured, through hospitalization, other treatment, and/or psychotropic medication. The best indicator of whether your client is restorable, and in what time frame you can expect this restoration, is your client's history of response to

treatment. If, however, the examining expert has determined that your client is incompetent but unlikely to be restored within a reasonable amount of time, the Court will proceed with civil commitment proceedings and dismiss the criminal case without prejudice. Be aware of your role as an advocate to challenge whether your client meets civil commitment standards.

THE INCOMPETENCY TRIAL

→ ***How the results could affect your client's case***

The competence determination may affect how you proceed on the merits of your client's case. A hearing is supposed to be held within thirty (30) days after the examiner has made a determination.[8] The judge makes the determination based on a preponderance of the evidence, but if the court finds it necessary, or another person demands, the court will schedule the competency hearing as a jury trial within 72 hours of the request, not counting weekends and legal holidays.[9] The jury will be composed of six people. The person whose competency is in question has the right to appear unless it makes it impossible to conduct the hearing in a reasonable manner. The witnesses shall be subject to cross-examination and no "statement, admission or confession made by the person whose competency is in question obtained during the examination for competency may be used for any purpose except for proceedings under this act."

- ***If your client is determined to be competent:*** Again, if you have documented evidence that your client suffers from a mental illness that may have impaired his or her judgment at the time of the alleged offense, you should explore the dismissal options set out in Section 5.

- ***If your client is determined to be incompetent to stand trial***: The court can civilly commit the defendant if the individual is found incompetent to stand trial and either two years have passed or the maximum sentence for their index offense, whichever is lesser. If the person is incompetent but not dangerous, then proceedings are suspended and conditional release is possible under DHS supervision.

If, after regaining competence, your client decides to go to trial, you should be ready to try the case quickly so that your client does not deteriorate and become incompetent again before you get to trial. You should also take steps to assure that, once your client has returned to the jail from the treatment facility, any medications that were begun or prescribed at the hospital also are made available at the jail. The head of the facility providing competency restoration must document the medications and dosages

8 Okla. Stat. tit. 22 § 1175.3.

9 *Id.*

that were prescribed in their report to the court. Frequently, without continued effective medication, a defendant with a serious mental illness will deteriorate, perhaps to the point of no longer being competent.

If your client is found incompetent, he or she may receive court-ordered compelled medication treatment. In *Sell v. United States*, 123 S. Ct. 2174 (2003), the United States Supreme Court held that the Government may administer anti-psychotic drugs to a criminal defendant involuntarily solely to render him competent to stand trial, at least in those cases meeting the criteria set out by the Court.

The four-factor test to determine whether forcible medication is permissible is

1) Is there an important governmental interest in bringing the person to trial?
2) Is there a substantial likelihood that the medication will render the person competent to stand trial and not have side effects that will interfere significantly with their ability to assist their counsel?
3) Is involuntary medication the least intrusive treatment that can achieve the same results?
4) Is administering the medication medically appropriate?[10]

Unlike a *Harper*[11] hearing, a *Sell* hearing requires that a court, not an administrative body, make the determination of whether the *Sell* factors are satisfied. Additionally, the Tenth Circuit reasoned in *United States v. Morrison*[12] that during Sell hearings the court should consider civil commitment for incompetent defendants in lieu of forced medication in jail, a solution that would serve the dual purpose of lowering the jail population as well as the waiting list for competency restoration.

- ***If the head of the facility to which your client has been committed determines and reports to the court that your client is not likely to attain competency in the foreseeable future***, the state "must either institute the customary civil commitment proceedings that would be required to commit indefinitely any other citizen, or release the defendant." This can happen before the end of the competency restoration period.

If the court determines that your client is not competent to stand trial and still requires treatment, but is not dangerous, criminal proceedings are suspended. The person is referred to the Department of Human Services (DHS) for "consideration of voluntary assistance" or conditional release under DHS supervision.[13] You should know, however, that just because your client is mentally ill

10 504 U.S. 127 (1992).

11 *Washington v. Harper,* 494 U.S. 210 (1990)

12 415 F.3d 1180 (10th Cir. 2005).

13 Okla. Stat. tit. 22 § 1175.6(B)

does not mean he or she will necessarily meet the requirements for civil commitment.

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

To reiterate, you should be aware that if a person is still incompetent after receiving competency restoration services for either two years or the maximum sentence they could serve for their offense, and they are found to be a person requiring treatment, the case is dismissed and the person is civilly committed. However, if at the end of the time period a person requires treatment but is not dangerous, proceedings are suspended, and pursuant to 22 O.S. 1175.6b(B), the person is referred to the Department of Human Services for "consideration of voluntary assistance" or conditional release under DHS supervision. This creates additional issues if the person is not compliant with their treatment plan, as 22 O.S. 1175.7 precludes the court from involuntarily committing the person to an inpatient facility.

SECTION 7

Mental Impairment As A Defense

THE SUBSTANTIVE LAW OF MENTAL IMPAIRMENT DEFENSES

A criminal defendant's mental impairment at the time of the acts constituting a crime may provide a defense to the criminal charges in two ways.

SHOWING THE DEFENDANT LACKED CULPABLE MENTAL STATE

The evidence must show the lack of this culpable mental state with some specificity, undermining the State's claim of proper mens rea. A defendant is not entitled to the diminished capacity defense, arguing that merely because he or she was impaired, the required culpable mental state was lacking.

Ake v. Oklahoma, 470 U.S. 68 (1985) held that expert testimony regarding mental impairment is absolutely required in a case where the defendant raises the insanity defense. It is hard to understand how a serious effort could be made to prove impairment without expert testimony explaining why and how the defendant's impairment suggests the defendant lacked the required culpable mental state.

Since the burden of proving the culpable mental state is on the State, a defendant's evidence need only—at least in theory—raise a reasonable doubt as to the sufficiency of the State's proof.

If the defense evidence suggests that the defendant, despite the impairment, did have the culpable mental state required for a lesser included offense of the charged crime, the jury may be instructed on that lesser included offense at the guilt phase of the trial or assess a lower punishment at the sentencing phase. The jury may thus use the evidence of impairment to reduce but not eliminate the seriousness of the defendant's criminal responsibility

An example of such a defense would be presenting evidence of the defendant's impairments that does not directly negate the defendant's mental state at the time of the offense, but rather suggests a general level of impairment. Also, trial court judges have frequently used the Rule of Evidence 403 to bar the introduction of evidence during the guilt/innocence phase of the trial if the judge concludes that it would create unfair prejudice, confusion of the issues, or mislead the jury. The last two concerns have

come up in the context of evidence raising a "diminished capacity" defense rather than challenging mens rea.

❧ affirmative defense of mental illness (formerly an insanity defense)

Evidence of mental impairment has traditionally been used defensively to establish the defense of mental illness, previously known as insanity, as an affirmative defense. This means the defendant must prove he or she was "insane," although only by a preponderance of the evidence.

If the defendant prevails on an insanity defense, the person cannot be tried, sentenced, or punished for the offense.[1]

To prevail on insanity/mental illness, the defendant must persuade the jury that as a result of severe mental disease or defect, the defendant did not know the conduct constituting the crime was wrong. This is a purely cognitive standard, so evidence of the defendant's ability to control his or her conduct is irrelevant.

Two major terms in the insanity defense are not defined: "know" and "wrong." In fact, defining either term might well be a prohibited comment on the weight of the evidence. In any case, trial judges never include definitions of the terms in jury charges.

Usually an accused's impairment will not have prevented the accused from realizing that authorities would regard the conduct constituting the crime as legally impermissible. Thus, in the usual case, the accused knew the conduct was legally wrong.

In these cases, the defense task is to persuade the jury, first, that "wrong" as used in the legal standard means legally or morally wrong. Then the defense must convince the jury that proper application of the standard so defined requires the conclusion that the accused's impairment caused him to believe the conduct was morally acceptable in some sense and thus the accused did not know it was *morally* wrong.

Many lawyers believe that jurors come to the courtroom with a misperception that such a verdict means the defendant is immediately a free person. Often the jurors will be convinced that the defendant, responsible or not, is a real danger to society. Their understandable concern that the defendant not be free to return to the community quite likely makes them resistant to even a well-based claim of mental illness.

❧ procedural considerations

→ *Notice and examination of the defendant*

A defendant must give the court notice of the defense's intention to introduce evidence of mental illness or insanity at the time of the offense no later than thirty (30) days after formal arraignment.[2]

1 Okla. Stat. tit. 22 § 1161.

2 Okla. Stat. tit. 22 § 1176.

If the defendant is financially unable to obtain services of a mental health professional, the defendant should simultaneously file an application while giving notice of insanity defense. If the court finds that sanity is a significant factor and the defendant is unable to pay, the court must authorize services for a professional to conduct an examination and help with evaluation, preparation, and presentation of a defense, which will be paid by the court fund as set out in Okla. Stat. tit. 20 § 1304.[3]

→ ***The Defense's Right to Expert Advice***

If a defendant may have been non-responsible by reason of mental impairment, defense counsel is often better off seeking the evaluation and advice of an expert whose allegiance is to the defense. Under *Ake v. Oklahoma*, 470 U.S. 68 (1985), due process requires under some circumstances that defense counsel have access to such assistance. A defendant is entitled to such assistance upon the making of a preliminary showing that the defendant's mental condition is "likely to be a significant factor at trial."

Unlike a court-appointed expert, the right to have a mental health professional employed under the *Ake* procedure is part of the defendant's right to counsel. Unless the expert testifies at trial, the State is not entitled to the expert's opinion or even granted access to the expert.

CONSEQUENCES OF AN INSANITY ACQUITTAL

The procedure for processing a criminal defendant found not guilty by reason of insanity is covered in Title 22 of Oklahoma's Code of Criminal Procedure.

Upon acquittal, the court is to make a finding whether the charged conduct indicates the defendant is dangerous to others. Specifically, Okla. Stat. tit. 22 §1161 directs the court to determine whether:

1) The person is presently dangerous to the public peace or safety because the person requires treatment as defined by Okla. Stat. tit. 43A § 1-103; *or*

2) The person needs continued supervision due to treatment noncompliance or untreated mental health issues.

If a defendant is found not guilty by reason of mental illness ("NGRMI"), a hearing is held within 45 days to determine whether a person is dangerous to public peace or safety because they are a person requiring treatment, or if not dangerous, is in need of continued supervision as a result of unresolved symptoms of mental illness or a history of treatment noncompliance.[4] The person

3 Okla. Stat. tit. 22 § 1176.

4 Okla. Stat. tit.. 22 § 1161(B)(2) (2019)

found NGRMI must be transported to OFC immediately following the acquittal. During this 45-day time period the person is hospitalized at the Oklahoma Forensic Center ("OFC") for examination. During their hospitalization, their treating psychiatrists or psychologists will prepare a report for the court regarding the person's mental illness, competency, dangerousness, and criminal responsibility. After these reports are submitted, the court holds a hearing to determine whether the person is a danger to the public peace or safety because they are a person requiring treatment or if they are in need of continuing supervision. If the court finds that the person is not dangerous or in need of continued supervision, they are to be immediately discharged from hospitalization. In practice, however, NGRMI acquittees are almost universally committed to OFC for further treatment indefinitely.

Once an NGRMI acquittee has been committed to OFC for treatment, their case is reviewed at least once a year by the Forensic Review Board ("FRB"). After this review, the FRB may make a recommendation to the district court where the index offense occurred. The FRB may recommend further treatment, conditional release, or full discharge from Department of Mental Health and Substance Abuse supervision. The recommendations of the FRB are not binding, and often district courts are reluctant to release NGRMI acquittees.

It should be noted that courts routinely desire to utilize incarceration as a remedy for failure to conform to the court's conditions, including medication compliance.

JURY TRIALS AND AGREED ACQUITTALS

Despite some conventional wisdom to the contrary, neither a jury trial nor a trial of any sort is necessary to a determination that a criminal defendant is not guilty of a charged offense by reason of insanity. This result can be reached by agreement through plea bargaining with the prosecutor.

Upon entry of such an order of dismissal, the court is to proceed as if the defendant was found not guilty by reason of insanity in a contested trial. A hearing must be held within 45 days to determine if the person is dangerous to public peace or safety and require treatment, or if the person is not dangerous, if the individual is in need of continued supervision due to treatment noncompliance or not treated mental illness.

Once an individual is committed for treatment at Oklahoma Forensic Center, the FRB reviews the case yearly. The FRB can recommend further treatment, conditional release, or complete discharge by the Department of Mental Health and Substance Abuse Supervision. However, recommendations by the FRB are not binding and NGRMI acquittees are rarely released.

A contested insanity defense is clearly a long shot. A jury—or judge—is quite unlikely to buy the defense, particularly if the prosecution can produce at least one expert who assures the jury that, despite the impairment, the defendant knew the conduct was "wrong."

Even worse, the defense may backfire. The evidence that supports a claim of insanity almost always also suggests the accused is a serious danger to others. A jury—or judge—that has heard this evidence and rejected the defense may be moved by this same evidence to be hard on the defendant at sentencing. This is a particular concern if the defense elects to go forward with a jury trial.

The defense is clearly hampered by its inability to explain to the jury the procedural hurdles an acquitted defendant faces before that defendant can return to the community. In Oklahoma, it is considered invading the province of the jury to discuss the implications of sentencing or imprisonment.[5]

A defense lawyer with a client who may want to rely upon mental impairment at trial should begin preparation early. If the defendant has a serious mental illness and acted and appeared bizarre at the time of the crime, those symptoms are likely to be effectively reduced by pretrial treatment. Yet many lawyers believe that a judge or jury will be receptive to a mental impairment defense only if the defense can effectively demonstrate what the defendant was like at the time of the charged conduct.

For this reason, defense counsel should have a mental health professional interview the defendant in one or more recorded sessions as soon after the offense as possible. Ideally, such interviews should begin within a day or two of the offense. Even if the case never reaches trial, defense counsel can provide the recordings to experts later appointed by the court or employed by the prosecution.

If the case does go to trial, a major problem for defense counsel is how to focus the defense presentation. One way is to emphasize the legal standard and how the defendant's symptoms caused the defendant not to know the conduct was wrong. Another is to stress the certainty and severity of the impairment in more general terms, and assume that if the jury is persuaded it should acquit, the jury will find the necessary lack of knowledge that the conduct is wrong. The best approach, of course, is probably to combine the two approaches, seeking first to establish the certainty and severity of the impairment and then to carefully demonstrate specifically how this caused the defendant to meet the legal standard.

5 *Williams v. State*, 1969 OK CR 997; *Williams v. State*, 1973 OK CR 106.

SECTION 8

Use of expert mental health witnesses, mitigation, and sentencing strategies

EXPERT MENTAL HEALTH WITNESSES

→ *How They Can Help You*

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

- the manner in which you relate to your client;
- your client's competence to proceed;
- your client's mental state at the time of the offense;
- plea negotiations;
- jury selection;
- whether or not your client should testify;
- medical treatment or other services for your client while the case is pending;
- what types of assessments or evaluations are needed; and
- the selection of witnesses for the trial, including the penalty phase.

→ *How Can You Get Them?*

The incremental approach set out below may not always be practical. Some judges may determine that a misdemeanor case does not warrant the use of an expert witness or that one expert is all you get. This may even be true in some felony cases. Consult with attorneys in your community about how to get experts appointed in your case. There may be some standard form motions that you can use. Also, remember that the Oklahoma Indigent Defense Act provides for the reimbursement of reasonable and necessary expenses, including mental health experts. Be sure to make a record if you cannot get the experts or resources you need.

THE INCREMENTAL APPROACH: START WITH A MITIGATION SPECIALIST

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

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

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

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

Mitigation investigations should be thorough and extensive, especially in capital cases where the whole of the defendant's life needs to be judged in order to determine whether to spare her or him from execution. Moreover, the U.S. Supreme Court has held that failure to investigate such matters in a capital case can constitute ineffective assistance of counsel. See *Wiggins v. Smith,* 123 S. Ct. 2527 (2003). On the other hand, if your client is charged with a misdemeanor, it may be enough simply to use the social worker mitigation expert, or another qualified investigator, as your only expert in the case.

→ ***Consider using a consulting psychologist***

The mitigation expert may then confer with a consulting psychologist, who will review the records and be able to determine what kinds of expert witnesses you may need and what role you want them to play. In some cases, you need a professional with specialized expertise in testing intellectual functioning. Other cases may require a specialist in personality testing or you may want

someone trained in the area of sexual trauma to interview your client. The consulting psychologist will only refer specific aspects of your client's case to the testifying experts, who will interview your client in preparation for courtroom testimony.

→ ***Focus on your testifying experts***

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

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

- For testimony related to personality or behavioral disorders, intellectual or cognitive functioning, or administering and interpreting tests, you should obtain a psychologist as your testifying expert witness.
- If your client has a brain injury or has problems with memory, language, or orientation functions, you may want to obtain a neuropsychiatrist or a neuropsychologist.

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

Local mental health professionals may not have the expertise you need. Also, some experts may feel beholden to local authorities for future income. If any circumstances arise that cause you to question the objectivity of the local health professional in question, you should seek expert assistance elsewhere. Many practitioners consider this incremental approach to developing mental health evidence superior to the "complete psychological evaluation" that attorneys often request, particularly in capital cases. This suggested approach may be more cost efficient, more likely to produce information that will advance your theory of the case, and less likely to generate information that will be of no use or, worse, will harm your theory and your client. Ideally, the same professional should not fill more than one role (evaluator, consultant, or treatment provider). STANDARDS RELATING TO GENERAL OBLIGATIONS TO DEFENDANTS WITH MENTAL ILLNESS § 7-1.1 (1989).

MITIGATION

→ *Why is mitigation important?*

Mitigation is not a defense to prosecution. It is not an excuse for committing the crime. It is not a reason the client should "get away with it." Instead, it is evidence of a disability or condition that invites compassion. Mitigation is the explanation of what influences converged in the years, days, hours, minutes, and seconds leading up to the crime, how information was processed by a person with a mental disability, and the behavior that resulted.

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

SENTENCING STRATEGIES

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

→ *Mental health information as mitigation can sometimes hurt you.*

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

→ ***If you decide to raise your client's mental illness at the punishment phase, be sure you have sufficient evidence and expert help.***

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

→ ***You may be better off advising your client to waive a jury and take the mental health evidence directly before the judge.***

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

→ ***Make sure your client receives an accurate and complete mental health evaluation.***

If you are going to bring your client's mental illness before the judge or jury for sentencing purposes, make sure that the experts you use do more than conduct a mental status examination and offer a diagnosis. You should work with the expert to ensure that he or she conducts a wider-ranging inquiry into your client's mental health history and its implications. For example, your client may have suffered a head injury at an early age, causing brain damage. Or, there may be a familial history of mental illness or a generational pattern of violence and abuse in the home. It is important to interview outside sources such as family members, former teachers, physicians, etc., as well as to request all available records. A comprehensive mental health examination should include:

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

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

→ ***Many mentally ill offenders have co-occurring substance abuse problems.***

Many persons with mental illness have addictions to drugs and/or alcohol; others "self-medicate" the symptoms of their mental illness with drugs or alcohol. Under either scenario, it is likely that this type of client will have problems staying clean and/or being successful on probation. Both substance abuse and mental illness are chronic, relapsing illnesses that need treatment. If your client has a substance abuse problem and also a serious mental illness, you should look into the availability of dual diagnosis treatment programs in your community. Facilities may treat persons with dual mental health and drug and/or alcohol addictions, but generally have long waits to get in. Some clients would rather accept a plea bargain agreement for jail time than wait to get into substance abuse or dual diagnosis treatment. Your client makes the ultimate decision about whether to get treatment, but you should talk candidly with your client about it. Try saying something like, "Look, you have this problem and you're probably not going to make it on probation. You're going to end up in the penitentiary—but we can get you some treatment to help you avoid that." Talk to your client about doing what is best for him or her over the long term rather than the short term.

→ ***Your client's mental illness should be factored into decisions about probation.***

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

→ ***The judge can amend the conditions of probation***

For example, if the judge mandates that a person be treated in an inpatient setting, but his or her condition improves greatly, the court can then modify the order to authorize outpatient treatment. Judges have a great deal of flexibility to tailor appropriate conditions of treatment for offenders suffering from mental illness. Although mental health treatment may include medication, attorneys and judges are generally not in the best position to make judgments about specific medication options. However, you should advocate for the best available treatment for your client.

→ ***Specialized probation caseloads:***

You may want to ask for your client to be placed on a specialized probation caseload. These are special units set up for adults with serious mental illnesses. The officers who work in these special units usually have received extra training about mental illness and monitor a smaller number of clients. Bring your client's problems to the attention of both the judge and probation department. Tell the probation department that your client has special needs and seek accommodations for your client through the probation department. If you think that your client may deteriorate soon after being placed on probation, ask the probation department if it will authorize a psychological examination; sometimes this can be done before the plea and you can use the results of this examination to further negotiate probation terms for your client.

→ ***Be especially careful if your client is considering deferred adjudication probation***

Under Okla. Stat. tit. 22 § 991cv2, a court can condition a deferred sentence on mental health treatment. However, if your client cannot successfully complete the conditions of his or her deferred adjudication probation, the judge can convict him or her, and the judge will have the **full range** of punishment under which to impose a sentence. On the other hand, if your client successfully completes his or her deferred adjudication probation, he or she will avoid a criminal conviction and will still be eligible for certain housing and job opportunities that are closed to people with felony convictions.

→ ***Your client may not want treatment.***

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

of any plea bargain agreement for your client. If your client is considering straight jail time, you should tell him or her the possible benefits of taking probation with conditions that require treatment. Tell your client what you believe the chances are of him or her staying out of trouble if he or she does not get treatment, and what penalties might await your client if he or she re-offends.

→ ***Go the extra mile for your client.***

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

APPENDIX A

Glossary of common mental health terms

ADD – *see attention-deficit hyperactivity disorder*.

ADHD – *see attention-deficit hyperactivity disorder*.

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

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

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

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

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

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

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

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

Atypical antipsychotics – *see second generation antipsychotics*.

Auditory hallucination – voices or noises that are experienced by an individual that are not experienced by others.

Autism spectrum disorder – a mental disorder, first evident during early childhood, in which the child shows significant deficits in communication, social interaction, and bonding and play activities, and engages in repetitive behaviors and self damaging acts. Established in DSM-V, autism spectrum disorder incorporates the former DSM-IV diagnoses of autistic disorder, Asperger's disorder, childhood disintegrative disorder, or the catch-all diagnosis of pervasive developmental disorder not otherwise specified.

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

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

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

Bipolar disorder – a mood disorder in which people experience episodes of depression

and mania (exaggerated excitement) or of mania alone. Typically the individual alternates between the two extremes, often with periods of normal mood in between. Also called manic-depression.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Dissociative identity disorder – *see multiple personality disorder*.

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

Electroshock therapy – *see electroconvulsive therapy above*.

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

Fetal alcohol syndrome – abnormal development of the fetus and infant caused by maternal alcohol consumption during pregnancy. Features of the syndrome include retarded growth, small head circumference, a flat nasal bridge, a small mid- face, shortened eyelids, and an intellectual or developmental disability.

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

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

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

Hypomania – an affective disorder characterized by elation, over-activity, and insomnia.

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

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

Intellectual or developmental disability (IDD) – a permanent condition usually developing before 18 years of age that is characterized by significantly sub average intellectual function accompanied by significant limitations in adaptive functioning in other areas such as communication, self-care, home living, self-direction, social/interpersonal skills, work, leisure, and health.

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

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

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

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

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

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

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

Mental retardation – older term still in some statutes based on historical usage; current term is intellectual or developmental disability. See *intellectual or developmental disability*.

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

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

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

Nervous breakdown – a non-technical term

used by the lay public, usually referring to an episode of psychosis.

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

New generation antipsychotics – *see second generation antipsychotics*.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Psychologist – a person with a Ph.D., Ed.D., or Psy.D., and a license in psychology, the study of mental processes and behavior. Psychologists can specialize in counseling and clinical work with children and/or adults who have emotional and behavioral problems, testing, evaluation, and consultation to schools or industry, but cannot prescribe medications.

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

Psychosis (pl. psychoses) – a severe mental

disorder in which thinking and emotion are so impaired that the person is seriously out of contact with reality.

Psychosomatic disorder – physical illness that has psychological causes.

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

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

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

Second generation antipsychotics – a newer group of medications, as distinct from older typical antipsychotics, used primarily to treat schizophrenia with broader effectiveness and fewer side effects.

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

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

Shock therapy – *see electroconvulsive therapy*.

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

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

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

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

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

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

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

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

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

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

APPENDIX B

Commonly prescribed psychotropic medications

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

ANTIDEPRESSANTS

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

GENERIC NAME	BRAND NAME	OTHER USES/NOTES
amitriptyline	Elavil, Endep	
amoxapine	Asendin, Asendis, Defanyl, Demolox	
bupropion	Wellbutrin	also used to treat ADHD in children
bupropion	Zyban	used to decrease cigarette smoking in adults
citalopram	Celexa	
clomipramine	Anafranil	also used to treat obsessive-compulsive disorder
desipramine	Norpramin, Pertofrane	also used to treat ADHD and tic disorders in children
desvenlafaxine	Pristiq	
doxepin	Silenor	sometimes used to encourage sleep
duloxetine	Cymbalta	
escitalopram	Lexapro	
fluoxetine	Prozac	approved for use with children; higher doses used for obsessive-compulsive disorder
fluvoxamine	Luvox	also used for obsessive-compulsive disorder
imipramine	Janimine, Tofranil, Melipramine	also used to treat bed-wetting in children
isocarboxazid	Marplan	
maprotiline	Ludiomil	

ANTIDEPRESSANTS (CONTINUED)

GENERIC NAME	BRAND NAME	OTHER USES/NOTES
mirtazipine	Remeron	
nefazodone	Serzone	
nortriptyline	Aventyl, Pamelor	also used to treat anxiety disorders in children
paroxetine	Paxil	contradicted for use in all children under 18 years of age; also used to treat anxiety disorders
pheneizine	Nardil	
protriptyline	Triptil, Vivactil	
reboxetine	Edronax	
selegiline	Depreny	also used with children to treat ADHD in Tourette's syndrome
sertraline	Zoloft`	also used to treat anxiety disorders and obsessive-compulsive disorders in children
tranylcypromine	Parnate	also used to treat ADHD and anxiety disorders in children
trazodone	Desyrel	also used to treat insomnia
trimipramine	Rhotrimine, Surmontil	
venlafaxine	Effexor	

ANTI-ANXIETY OR ANTI-PANIC

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

GENERIC NAME	BRAND NAME
alprazolam	Xanax
buspirone	Buspar
chlordiazepoxide	Libritabs, Librium
clonazepam	Klonopin
clorazepate	Azene, Tranxene
diazepam	T-Quil, Valium
flurazepam	Dalmane
halazepam	Paxipam
hydroxyzine	Atarax, Vistaril
lorazepam	Ativan
oxazepam	Serax
prazepam	Centrex
temazepam	Restoril

ANTIPSYCHOTIC

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

GENERIC NAME	BRAND NAME	OTHER USES/NOTES
aripiprazole	Abilify	
chlorpromazine	Largactil, Thorazine	
chlorprothixene	Taractan	
clozapine	Clozaril	new generation (atypical) medication; requires blood tests every three days when initiating treatment, then weekly blood tests
fluphenazine	Prolixin, Permitil, Modecate	comes in longer-acting injectable form
haloperidol	Haldol	comes in longer-acting injectable form
iloperidone	Fanapt	
loxapine	Loxapac, Loxitane, Daxolin	
lurasidone	Latuda	new generation (atypical) medication
mesoridazine	Serentil	
molindone	Lidone, Moban	
olanzapine	Zyprexa	new generation (atypical) medication
paliperidone	Invega	new generation (atypical) medication
perphenazine	Trilafon, Etrafon	
Pimozide	Orap	also used to treat Tourette's syndrome in children
quetiapine	Seroquel	new generation (atypical) medication; also used as a mood stabilizer
risperidone	Risperdal	new generation (atypical) medication
thioridazine	Mellaril	
thiothixene	Navane	
trifluoperazine	Stelazine	
trifluprom azine	Vesprin	
ziprasidone	Geodon	new generation (atypical) medication

MOOD STABILIZER

Medications used to treat acute manic episodes and to prevent relapse of manic-depressive symptoms. Most of the follow- ing except lithium and the new generation (atypical) medications are also anti-seizure medications.

GENERIC NAME	BRAND NAME	OTHER USES/NOTES
carbamazepine	Epitol, Tegretol	also used with children
divalproex Sodium	Depakote, Epival	also used with children
gabapentin	Neurontin	
lamotrigine	Lamicta	Not for use with children
lithium carbonate (lithium)	Carbolith, Duralith, Eskalith, Lithane, Lithizine, Lithobid, Lithonate, Lithotabs	
lithium citrate	Cibalith-S	also used to treat hyper-aggressive behavior in children
olanzapine	Zyprexa	new generation (atypical) medication
oxcarbazepine	Trileptal	
tiagabine	Gabitril	
topiramente	Topamax	
Valproate (valproic acid)	Depakene, Valrelease	also used with children
quetiapine	Seroquel	also used as an antipsychotic

ANTI-OBSESSIONAL

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

GENERIC NAME	BRAND NAME
clomipramine	Anafranil
fluoxetine	Prozac
fluvoxamine	Luvox

MEDICATIONS USED TO TREAT ADHD (ATTENTION DEFICIT/HYPERACTIVITY DISORDER) IN CHILDREN

GENERIC NAME	BRAND NAME	OTHER USES/NOTES
clonidine	Catapres	also used to treat Tourette's syndrome, ADHD, aggression, self-abuse, and severe agitation in children
dextroamphetamine	Dextrostat, Dexedrine	
dextroamphetamin, amphetamine	Adderall	
guanfacine	Intuniv, Tenex	also used to treat Tourette's syndrome
atomoxetine	Strattera	
dexmethylphenidate	Focalin	
lisdexamfetamine dimesylate	Vyvanse	
methamphetamine	Desoxyn	
methylphenidate	Concerta, Ritalin, Methylin	
methylphenidate patch	Daytrana	
pemoline	Cylert	
propranolol	Inderal	also used to treat Tourette's syndrome, aggression/self-abuse, intermittent explosive disorder, and severe agitation in children

ANTI-SIDE EFFECT MEDICATIONS

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

GENERIC NAME	BRAND NAME	OTHER USES/NOTES
amantadine	Symmetrel	
benztropine	Cogentin	
propranolol	Inderal	also used to treat some children's behavior disorders
trihexythenidyl	Artane	

ANTI-SEIZURE MEDICATIONS

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

GENERIC NAME	BRAND NAME	OTHER USES/NOTES
carbamazepine	Epitol, Tegretol	
clonazepam	Klonopin, Rivotril	also used to treat anxiety disorders, psychosis, mania, severe agitation, severe insomnia and Tourette's syndrome in children
divalproex sodium	Depakote, Epival	also used to treat bipolar disorder
ethosuximide	Zarontin	
lamotrigine	Lamictal	Also used to treat bipolar disorder
phenytoin	Dilantin	
primidone	Mysoline	
topiramate	Topamax	
Valproate (valproic acid)	Depakene, Valrelease	also used with children

MEDICATIONS USED TO TREAT ALCOHOLISM

Medications used to help people resist drinking.

GENERIC NAME	BRAND NAME	OTHER USES/NOTES
calcium carbimide	Temposil	
disulfiram	Antabuse	
naltrexone	ReVia	also used to block the effects of opioids; also used to treat self-injurious behavior

MEDICATIONS USED TO TREAT INSOMNIA

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

GENERIC NAME	BRAND NAME	OTHER USES/NOTES
chloral hydrate	Noctec, Somnos, Felsules	
diphenhydramine	Benadryl	Also used with children
flurazepam	flurazepam	
oxazepam	Serax	
temazepam	Restoril	
trazodone	Desyrel	Also used for children
triazolam	Halcion	
zaleplon	Sonata	
zolpidem	Ambien	

APPENDIX C

Resources for help

Mental Health Association Oklahoma
5330 E. 31st Street, Suite 1000
Tulsa, OK 74135
918) 585-1213
400 N. Walker Ave., Suite 190
Oklahoma City, OK 73102
info@mhaok.org
https://mhaok.org/

Hope Community Services
4720 S. Shields Blvd.
Oklahoma City, OK 73129
(405) 226-6200
https://www.hopecsi.org/

NAMI Oklahoma
3037 NW 63rd St. #104
Oklahoma City, OK 73112
(800) 583-1264
https://www.namioklahoma.org/

NAMI Tulsa
708 S. Boston Ave.
Tulsa, OK 74119
(918) 587-6264
https://www.namitulsa.org/

DBSA
3000 United Founders Blvd., Suite 104
Oklahoma City, OK 73112
(405) 254-3994
office@dbsaok.org
https://dbsaok.org/

CALM Center
6126 E. 32nd Pl.
Tulsa, OK 74135
(918) 587-6264
(918) 394-2256
info@crsok.org
https://www.crsok.org/the-calm-center/

NorthCare
2617 General Pershing Blvd.
Oklahoma City, OK 73107
(405) 858-2700

APPENDIX D

Health Information Release Form

OKLAHOMA STANDARD AUTHORIZATION TO USE OR SHARE PROTECTED HEALTH INFORMATION (PHI)

I. INDIVIDUAL INFORMATION (FOR PERSON WHOSE INFORMATION WILL BE SHARED)

Name	Date of Birth	
Address	City	
Area Code & Telephone Number	State	Zip

II. SCOPE & PURPOSE FOR SHARING INFORMATION

I understand protected health information is information that identifies me. The purpose of this authorization is to allow _____ to share my protected health information.

III. AUTHORIZATION & INFORMATION TO BE SHARED

I authorize _____ as set forth below, to share my protected health information for reasons in addition to those already permitted by law.

A. Person/Organization Receiving Information and Purpose for Sharing

Persons/Organizations Authorized to Receive My Information (Name, Address, Phone & Fax)	Relationship	Purpose

B. Information to be Shared

1. Check one or more boxes below.

- ☐ Psychotherapy Notes (if checking this box, no other boxes may be checked)
- ☐ Mental Health Records
- ☐ Entire Medical Record (includes all records except Psychotherapy Notes)

☐ Pathology Report	☐ History and Physical	☐ Operation Report(s)
☐ Progress Notes	☐ Consultation Report(s)	☐ Discharge Summary
☐ EKG Report(s)	☐ Laboratory Report(s)	☐ Radiology Report(s)
☐ Physician's Orders	☐ Radiology Films	☐ Alcohol or Drug Abuse Records

☐ Other_____

2. Covering Services Between _____ and _____ (Insert either date(s) or "all.")

IV. EXPIRATION & REVOCATION

A. This Authorization will Expire (must choose one):

☐ 12 months from the date signed in Part V.B. ☐ Other (insert date or event): _____

B. Right to Revoke
I understand I may change this authorization at any time by writing to the address listed at the bottom of this form. I understand I cannot restrict information that may have already been shared based on this authorization.

V. ACKNOWLEDGEMENTS & SIGNATURES

A. Acknowledgements

1. I understand this authorization is voluntary and will not affect my eligibility for benefits, treatment, enrollment, or payment of claims.

2. ☐ If checked and initialed, _____ is authorized to share my protected health information for the purpose of marketing. I understand _____ may receive either direct or indirect compensation for sharing my information in this case. Individual initials _____

3. I understand if the person/organization authorized to receive my protected health information is not a health plan or health care provider, privacy regulations may no longer protect the information.

4. I understand I may inspect or obtain a copy of the protected health information shared under this authorization by sending a written request to the address listed at the bottom of the form.

5. I acknowledge information authorized for release may include records, which may indicate the presence of a communicable or noncommunicable disease.

B. Signature

This document must be signed by the individual or the individual's legal representative.

Signature (Patient or Legal Representative)	Date
Printed Patient or Legal Representative Name	**Capacity of Legal Representative (if applicable)**

Company Address:

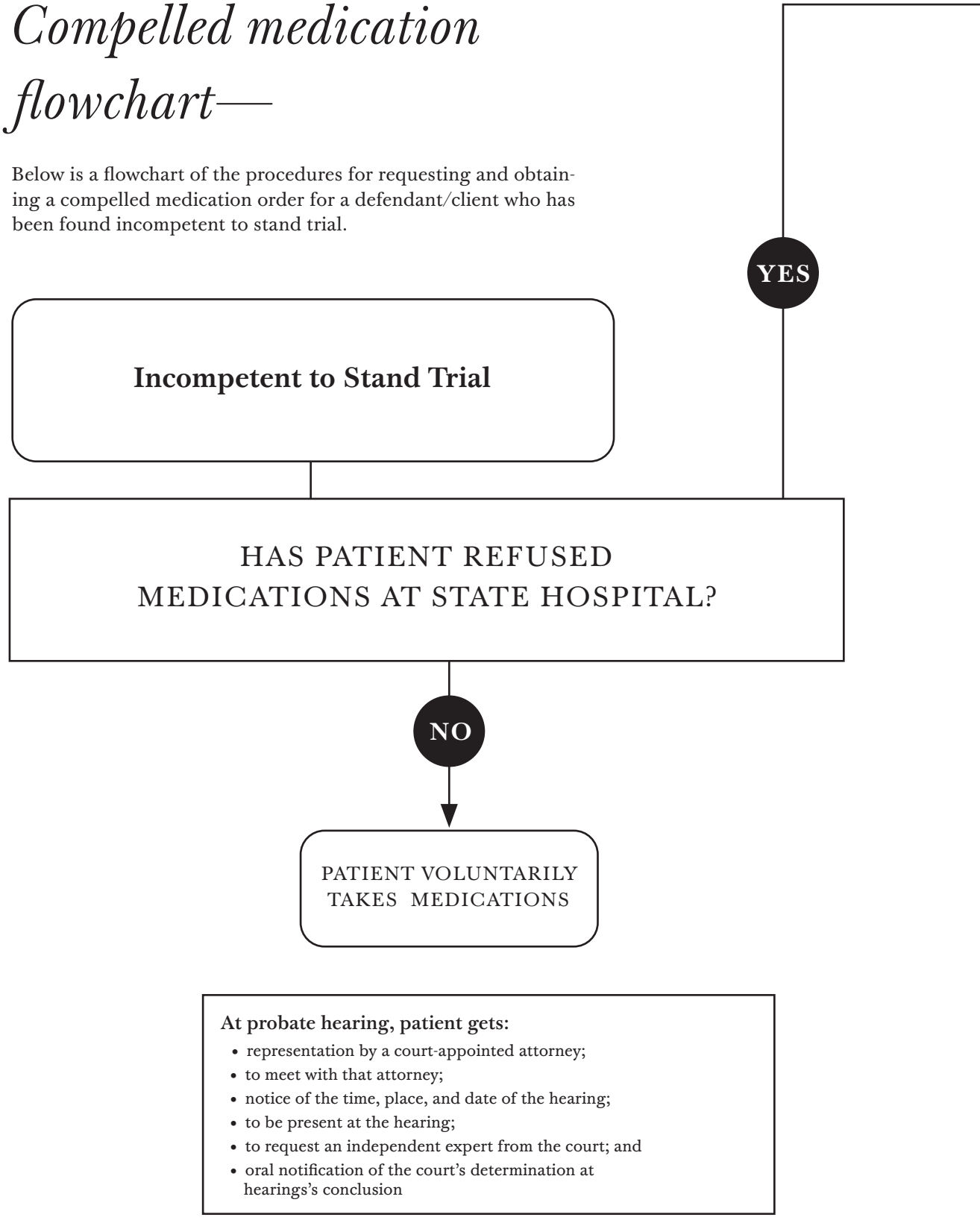
The following information may only be completed by

☐ If checked by _____ — disclosure of Alcohol or Drug Abuse Records is subject to the following restrictions under 42 C.F.R. Part 2:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Compelled medication flowchart—

Below is a flowchart of the procedures for requesting and obtaining a compelled medication order for a defendant/client who has been found incompetent to stand trial.



HEARING at probate court

Dr. files application that states:

- Patient lacks capacity and reasons for that belief
- Reasons Dr. believes patient is dangerous, if basing application on that
- Each medication Dr. wants compelled
- Diagnosis of patient
- Proposed method of administration
  - If not customary, justification for departure

DOES PATIENT HAVE CAPACITY TO MAKE A MEDICAL DECISION?

YES

Dangerousness

Court must determine if patient is a danger to self or others in the mental health facility as determined by:

- whether patient has inflicted, attempted to inflict, or made a serious threat of inflicting substantial physical harm to self or others while in the facility AND within the six months preceding the date the patient was placed in the facility

* *order expires after 6 months*

NO

Trial Competency — Hearing at Criminal Court

Court must find:

- that there is clear and compelling interest in the defendant obtaining and maintaining competency to stand trial;
- that no other less-invasive means of obtaining and maintaining the defendant's competency exists;
- that the prescribed medication will no tunduly prejudice the defendant's rights or use of defensive theories at trial;
- that the treatment is medically appropriate; and
- that the treatment is in the best medical interest of the defendant, and does not present side effects that cause harm to the defendant that is greater than the medical benefit to the defendant.

The hearing must be held within the fifteenth (15th) day after probate medication hearing and must be heldwithin five (5) days of defendant returning to criminal court.

YES

Can Medicate

NO

Can't Medicate

NO

Best Interests

Court must consider patient's:

- expressed preferences regarding treatment with medications;
- religious beliefs;
- risks and benefits;
- consequences if the medications are not administered;
- prognosis if treated with medications
- alternative, less-intrusive treatments that are likely to produce the same results as treatment with medications; and
- less-intrusive treatments to secure agreement to take medications.

YES

OKLAHOMA
APPLESEED

CENTER FOR LAW & JUSTICE

OKLAHOMA APPLESEED

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Tulsa, OK 74120
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Website: www.okappleseed.org