I. Introduction: Competent Mental Health Evaluations are Critical

A persistent problem in the defense of criminal (and especially capital) cases, is incomplete, inadequate and unreliable evaluations regarding the defendant’s mental state at the time of the offense and at trial. I constantly review trial records where a mental health professional, called by the state (or even at times by the defense), testifies that a defendant was competent to stand trial, not insane at the time of the offense, not under the influence of an extreme emotional disturbance and met all the criteria for the diagnosis of antisocial personality disorder. Another frequent scenario I encounter is to review a trial record where no mental state evidence was put on at all by the defense at trial. Then, either in reviewing trial counsel’s file or in talking to trial counsel, I learn that no evidence was presented because there was a “bad” pretrial mental health evaluation.

Over the years, I have learned through experience to view with skepticism all previous mental health evaluations and expert trial testimony. I do so for the simple reason that many of the conclusions reached are either incomplete or wrong. The errors occur because, as will be discussed shortly, these evaluations do not meet existing standards in the mental health profession delimiting the adequacy of forensic mental state examinations. However, as tragic as the consequences of an incomplete or incompetent mental state evaluation might be, the situation is not necessarily irredeemable. An unreliable mental health evaluation often serves as the basis for a constitutional violation with a legal remedy. Furthermore, bringing the true facts to light regarding your client’s mental impairments in post-conviction proceedings may establish a viable claim of ineffective assistance of counsel as well as other federal constitutional violations.

The importance of a competent mental health evaluation in criminal and capital litigation cannot be overestimated. I can provide powerful evidence on a range of mental health issues in addition to traditional questions concerning sanity at the time of the offense, competency to stand trial, and mitigation. It can offer a basis for challenging the validity of prior offenses and convictions, for disproving specific intent for underlying felonies as well as the murder itself, and for defending against premeditation and malice. Diminished capacity, extreme emotional disturbance, duress, domination by others, and non-accomplice status are all factors that can be addressed by mental health professionals. A defendant’s mental status has obvious implications for defense challenges to events surrounding the arrest and its aftermath such as consent to search, Miranda waiver, voluntariness of confessions, and reliability of confessions. A thorough and reliable mental health evaluation is also relevant to any waivers, i.e., of counsel, specific defenses, right to be present at all stages of trial, mitigating circumstances or a jury trial, as well as to any determination of competency at the various stages of litigation from the preliminary hearing to an execution. The point is clear: defense counsel should not be precluded from pursuing viable avenues of defense by an incomplete, incompetent or unreliable mental health evaluation. It is also the purpose of this article to provide counsel with practical steps to follow to secure a competent evaluation at any stage of a case.

II. The Constitutional Framework

In Ake v. Oklahoma, 470 U.S. 68 (1985), the United States Supreme Court held that "the Constitution requires that an indigent defendant have access to the psychiatric examination and assistance necessary to prepare an effective defense based on his mental condition," when the defendant's mental health is at issue. Id. at 70. The Court, after discussing the potential help that might be provided by a
psychiatrist, stated:

We therefore hold that when a defendant demonstrates to the trial judge that his sanity at the time of the offense is to be a significant factor at trial, the state must, at a minimum, assure the defendant access to a competent psychiatrist who will conduct an appropriate examination and assist in evaluation, preparation and presentation of the defense. That is not to say, of course, that the indigent defendant has a constitutional right to choose a psychiatrist to his personal liking or to receive funds to hire his own. Our concern is that the indigent defendant have access to a competent psychiatrist for the purpose we have discussed, and as in the case of the provision of counsel, we leave to the states the decision on how to implement this right. Id. at 83 (emphasis added).

This holding recognized the entitlement of an indigent defendant, not only to a "competent" psychiatrist (i.e., one who is duly qualified to practice psychiatry), but also to a psychiatrist who performs competently – who conducts a professionally competent examination of the defendant and who on this basis provides professionally competent assistance.

The rationale underlying the holding of Ake compels such a conclusion, for it is based upon the due process requirement that fact-finding must be reliable in criminal proceedings. Id. at 77-83. Due process requires the state to make available mental health experts for indigent defendants, because "the potential accuracy of the jury’s determination...is dramatically enhanced" by providing indigent defendants with competent psychiatric assistance. Id. at 81-83. In this context, the Court clearly contemplated that the right of access to a competent psychiatrist who will conduct an appropriate examination would include access to a psychiatrist who would conduct a professionally competent examination. To conclude otherwise would make the right of "access to a competent psychiatrist" an empty exercise in formalism.¹

Some courts have explicitly or implicitly recognized this aspect of Ake holding that the due process clause entitles an indigent defendant not just to a mental health evaluation, but also to a professionally valid evaluation. See, e.g., Mason v. State, 489 So.2d 734 (Fla. 1986). Because the psychiatrists who evaluated Mr. Mason pretrial did not know about his "extensive history of mental retardation, drug abuse and psychotic behavior," or his history "indicative of organic brain damage," and because the court recognized that the evaluations of Mr. Mason’s mental status were flawed if the physicians had “neglec[ed] a history” such as this, the court remanded Mr. Mason’s case for an evidentiary hearing. Id. at 735-37; see also Sireci v. State, 536 So.2d 231 (Fla. 1988),² but see Waye v. Murray, 884 F.2d 765 (45th Cir.), cert. denied 492 U.S. 936, 110 S.Ct. 29, 106 L.Ed.2d 634 (1989).

Similarly, in Blake v. Kemp, 758 F.2d 523 (11th Cir. 1985), the court recognized that the defendant’s right to effective assistance of counsel was impaired by the State’s withholding of evidence “highly relevant, or psychiatrically significant, on the question of [defendant’s] sanity” from the psychiatrist who was ordered to evaluate the defendant’s sanity. 758 F.2d at 532. Even though that evidence was disclosed to the psychiatrist on the witness stand at trial, “[o]bviously, he was reluctant to give an opinion when confronted with this information for the first time on the witness stand. This was hardly an adequate substitute for a psychiatric opinion developed in such a manner and at such a time as to allow counsel a reasonable opportunity to use the psychiatrist’s analysis in the preparation and conduct of the defense.” Id. at 532, n. 10, 533.³

Additionally, there have been numerous cases where counsel has been found to have rendered ineffective assistance of counsel for failing to adequately develop and present evidence regarding a client’s mental state, even in cases in which counsel retrained expert assistance. See, e.g., Baxter v. Thomas, 45 F.3d 1501, 1514-15 (11th Cir. 1995) (Counsel was ineffective for failing to investigate petitioner’s long history of mental illness and resulting psychiatric commitments. Information was readily available had counsel only obtained records. Counsel’s omission was prejudicial because “[p]sychiatric mitigation evidence ‘has the potential to totally change the evidentiary picture.’”); Hill v. Lockhart, 28 F.3d 832, 835 (8th Cir. 1994) (Counsel was ineffective at penalty phase for failing to present in coherent fashion evidence regarding capital defendant’s mental state at the time of the offense, history of psychiatric

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hospitalizations and failure to take anti-psychotic medications); Deutscher v. Angelone, 16 F.3d 981 (9th Cir. 1994) (Counsel was found ineffective in successor habeas petition for failing to develop and present mitigating evidence regarding petitioner's history of mental illness. Counsel failed to discover petitioner's history of mental illness; diagnosis of schizophrenia and organic brain damage and his commitments to mental institutions. There was also evidence, which was available and not presented, that petitioner had been severely abused as a child); Lloyd v. Whitley, 977 F.2d 149 (5th Cir. 1992), cert. denied, 113 S.Ct. 2345 (1993) (Counsel was ineffective for failing to obtain adequate independent mental health evaluation which would have discovered “mental defects” and organic brain damage).

The purpose of this article, however, is not to discuss in detail the legal bases of a challenge to an inadequate evaluation but rather to attempt to outline what is an adequate evaluation.

III. The Elements of a Complete, Competent and Reliable Mental Health Evaluation

As the Ake Court held, the due process clause protects indigent defendants against incompetent evaluations by appointed psychiatrists. Accordingly, the due process clause requires that appointed mental health professionals render that level of care, skill and treatment which is recognized by a reasonably prudent similar health care provider as being acceptable under similar conditions and circumstances. In the mental health areas, as in other medical specialties, the standard of care is the national standard of care recognized among similar specialists, rather than a local, community-based standard of care.

A. The Proper Standard of Care Involves a 5 Step Process Before Diagnosis

In the context of diagnosis, exercise of the proper level of care, skill and treatment requires adherence to the procedures that are deemed necessary to render an accurate diagnosis. On the basis of generally agreed upon principles, the standard of care for both general mental health and forensic mental health examinations reflects the need for a careful assessment of medical and organic factors contributing to or causing psychiatric or psychological dysfunction. H. Kaplan & B. Sadock, Comprehensive Textbook of Psychiatry, 543 (4th ed. 1985). The recognized method of assessment, therefore, must include, at a minimum, the following five steps:

1. **An accurate medical and social history must be obtained**

   Because “[i]t is often only from the details in the history that organic disease may be accurately differentiated from functional disorders or from atypical lifelong patterns of behavior,” R. Strub & F. Black, Organic Brain Syndromes 42 (1981), an accurate and complete medical and social history has been called the “single most valuable element to help the clinician reach an accurate diagnosis.” Kaplan & Sadock, supra at 837.

2. **Historical data must be obtained not only from the patient, but from sources independent of the patient**

   It is well recognized that the patient is often an unreliable and incomplete data source for his own medical history. “The past personal history is somewhat distorted by the patient's memory of events and by knowledge that the patient obtained from family members.” Kaplan & Sadock, supra at 488. Accordingly, “retrospective falsification, in which the patient changes the reporting of past events or is selective in what is able to be remembered, is a constant hazard of which the psychiatrist must be aware.” Id. Because of this phenomenon,

   [i]t is impossible to base a reliable constructive or predictive opinion solely on an interview with the subject. The thorough forensic clinician seeks out additional information on the alleged offense and data on the subject's previous antisocial behavior,
together with general "historical" information on the defendant, relevant medical and psychiatric history, and pertinent information in the clinical and criminological literature. To verify what the defendant tells him about these subjects and to obtain information unknown to the defendant, the clinician must consult, and rely upon, sources other than the defendant. Kaplan & Sadock supra at 550.


3. **A thorough physical examination (including neurological examination) must be conducted**

See, e.g., Kaplan & Sadock supra at 544, 837-38 & 964. Although psychiatrists may choose to have other physicians conduct the physical examination, albeit psychiatrists:

[s]till should be expected to obtain detailed medical history and to use fully their visual, auditory and olfactory senses. Loss of skill in palpation, percussion, and auscultation may be justified, but loss of skill in observation cannot be. If the detection of nonverbal psychological cues is a cardinal part of the psychiatrists' function, the detection of indications of somatic illness, subtle as well as striking, should be part of their function. Kaplan & Sadock supra at 544.

In further describing the psychiatrist's duty to observe the patient s/he is evaluating Kaplan and Sadock note in particular that "[t]he patient's face and head should be scanned for evidence of disease.... [W]eakness of one side of the face, as manifested in speaking, smiling, and grimacing, may be the result of focal dysfunction of the contralateral cerebral hemisphere." Id. at 545-46.

4. **Appropriate diagnostic studies must be undertaken in light of the history and physical examination**

The psychiatric profession recognizes that psychological tests, CT scans, electroencephalograms, and other diagnostic procedures may be critical to determining the presence or absence of organic damage. In cases where a thorough history and neurological examination still leave doubt as to whether psychiatric dysfunction is organic in origin, psychological testing is clearly necessary. See Kaplan & Sadock supra at 547-48; Pollack supra at 273. Moreover, among the available diagnostic instruments for detecting organic disorders, neuropsychological test batteries have proven to be critical as they are the most valid and reliable diagnostic instruments available. See Filskkov & Goldstein, Diagnostic Validity of the Halstead-Reitan Neuropsychological Battery, 42 J. of Consulting & Clinical Psych. 382 (1974); Schreiber, Goldman, Kleinman, Goldfader, & Snow, The Relationship Between Independent Neuropsychological and Neurological Detection and Localization of Cerebral Impairment, 162 J. of Nervous and Mental Disease 360 (1976).  

5. **The standard mental status examination cannot be relied upon in isolation as a diagnostic tool in assessing the presence or absence of organic impairment**

As Kaplan and Sadock have explained, "[C]ognitive loss is generally and correctly conceded to be the hallmark of organic disease," and such loss can be characterized as "(1) impairment of orientations; (2) impairment of memory; (3) impairment of all intellectual functions, such as comprehension, calculation, knowledge, and learning, and (4) impairment of judgment." Id. at 835. While the standard mental status examination (MSE) is generally used to detect and measure cognitive loss, the standard MSE – in isolation
from other procedures – has proved to be very unreliable in detecting cognitive loss associated with organic impairment. Kaplan and Sadock have explained why:

When cognitive impairment is of such magnitude that it can be identified with certainty by a brief MSE, the competent psychiatrist should not have required the MSE for its detection. When cognitive loss is so mild or circumscribed that an exhaustive MSE is required for its recognition then it is likely that it could have been detected more effectively and efficiently by the psychiatrist's paying attention to other aspects of the psychiatric interview.

In order to detect cognitive loss of small degree early in its course, the psychiatrist must learn to attend more to the style of the patient's communication than to its substance. In interviews, these patients often demonstrate a lack of exactness and clarity in their descriptions, some degree of circumstantiality, a tendency to perseverate, word-finding problems or occasional paraphasia, a paucity of exact detail about recent circumstances and events (and often a lack of concern about these limitations), or sometimes an excessive concern with petty detail, manifested by keeping lists or committing everything to paper. The standard MSE may reveal few if any abnormalities in these instances, although abnormalities will usually be uncovered with the lengthy MSE protocols. The standard MSE is not, therefore, a very sensitive device for detecting incipient organic problems, and the psychiatrist must listen carefully for different cues. Id. at 835.

Accordingly, “[c]ognitive impairment, as revealed through the MSE, should never be considered in isolation, but always should be weighed in the context of the patient's overall clinical presentation – past history, present illness, lengthy psychiatric interview, and detailed observations of behavior. It is only in such a complex context that a reasonable decision can be made as to whether the cognitive impairment revealed by MSE should be ascribed to an organic disorder or not.” Id. at 836.

In sum, the standard of care within the psychiatric profession which must be exercised in order to diagnose is concisely stated in Arieti’s American Handbook of Psychiatry (1986):

Before describing the psychiatric examination itself, we wish to emphasize the importance of placing it within a comprehensive examination of the whole patient. This should include careful history of the patient's physical health together with a physical examination and all indicated laboratory tests. The interrelationships of psychiatric disorders and physical ones are often subtle and easily overlooked. Each type of disorder may mimic or conceal one of the other type.... A large number of brain tumors and other diseases of the brain may present as “obvious” psychiatric syndromes and their proper treatment may be overlooked in the absence of careful assessment of the patient leading him to the diagnosis of physical illness. Indeed, patients with psychiatric disorders often deny the presence of major physical illnesses that other persons would have complained about and sought treatment for much earlier. Id. at 1161.

IV. Common Deficiencies in Forensic Evaluations

It can be readily seen that many, if not most, of the mental health evaluations conducted in criminal cases do not satisfy the applicable standard of care. This is not surprising because, as in many other areas, the indigent defendant receives short shrift in the criminal justice system. Most state institutions do not have the funds or staff to follow the above five steps. Furthermore, since many defendants are sent to these institutions for a very limited purpose – in most cases only to determine if the defendant is competent to stand trial – the staff may not believe it is necessary to do a complete evaluation. Additionally, in many cases defense counsel are not sufficiently conversant with the elements of a complete, reliable mental health evaluation to educate the court regarding that to which the client is legally entitled. In other instances, some mental health professionals, used to working on forensic cases
without adequate resources, fail to follow the above five steps. However, in this section of the article, I will focus in on the elements of an evaluation which are generally most deficient and result in the most unreliable results. My experiences since I first published this article in 1990 have only confirmed the basic weaknesses in many forensic evaluations detailed below.

A. Client's History

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

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

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

It is for this reason that it is essential that a mental health professional obtain as much information as possible regarding a client's social and medical history to reliably determine what genetic, organic, environmental, and other factors may have played a role in the client's mental state at the time of the offense. Thus all available records for both the client and significant members of his family should be obtained. These records include, but are not limited to:

- Client's and siblings' birth records
- Client's medical records and family medical records
- Any social services records relevant to client or his family
- Client's and siblings' school and educational records
- All jail and/or department of corrections records, including medical records
- All records relevant to any prior psychiatric treatment or psychological evaluation for client or family members including grandparents, siblings, etc., including the evaluating professional's raw data (do not be content with obtaining the discharge summary or final report)
- Death records for any immediate family members
- Any military records, including medical records
- All police or law enforcement records regarding the arrest, offense, and any prior offenses
- All records relevant to any co-defendants
- Family court records for parents and client
- Attorney files, transcripts, and court files for any prior offenses by the client or his family members

Reviewing these records will often lead to additional records, documents and materials which should be obtained. You must ensure that this time consuming process is meticulously followed because it is impossible, before an investigation is complete, to determine what will be the fruitful sources of information thus creating the risk of an additional skewed evaluation.

However, you cannot prepare the history solely from talking with your client and obtaining records. Other family members, friends and persons with knowledge about your client must be interviewed. These people, especially family members, should not be talked to in a group, but individually. It is important to bear in mind, for example, that any family member or caretaker you interview may have abused your client. This information will rarely come out in a family gathering, and will even more rarely come out the first time you talk with the individual. In addition to family members, your client's friends,
prior counsel, teachers, social workers, probation and parole officers, acquaintances, neighbors, employers, spouses (current or former), and any witnesses preceding, during and after the offense, should be interviewed. Any or all of these persons may have critical information relevant to your client's mental state.

An excellent discussion of the needed investigation can be found in Lee Norton’s article “Mitigation Investigations,” The Champion, Vol. 16, No. 4 (May 1992) at 43.

B. Inadequate Testing for Neurological Dysfunction

While not all of our clients have organic brain damage, many do. Due to poverty, abuse and neglect which characterizes so many of our clients' lives, a substantial percentage of our clients have mothers who abused alcohol and drugs during their pregnancies and who received poor or no prenatal care. Inadequate medical attention to head injuries and other illnesses is also common, as is exposure to various neurotoxins (e.g., lead based paint and pesticides). Long histories of substance abuse, including the use of organic solvents, is also not unusual. These, and other factors, predispose our clients to varying degrees of neurological impairment. Organic brain damage can and does affect behavior. It can impair judgment and rob an individual of the ability to make decisions in crises rationally and responsibly. It can destroy or diminish a person's ability to learn, to carry out a plan of action, to understand long term consequences of actions, to appreciate cause and effect, and to mediate impulse-driven behavior. However, despite its obvious relevance in mental health evaluations in criminal cases, neurological impairment is often not diagnosed.

Another very common deficiency in state forensic evaluations is the inattention to the possibility of organic damage, other neurological dysfunction, or a physiological basis for psychiatric symptoms. Based on my experience, many of our clients are at risk for organic brain damage. They have a history of serious head injuries from chronic childhood physical abuse, car accidents, and falls. Their developmental years are plagued with chronic illness and fevers, frequently untreated, and malnutrition. Poor or non-existent prenatal care and/or birth trauma are routinely found in their histories. Many clients had mothers who drank large amounts of alcohol or used drugs during their pregnancies, now well recognized as a cause of permanent and sometimes devastating mental disabilities in the developing fetus. Most of our clients are chemically dependent, and their early and prolonged use of drugs and alcohol, including organic solvents, can cause permanent brain damage.

However, as a result of inadequate histories, or for other reasons, inadequate attention is frequently given to the possibility of neurological impairment. For example, very few of my clients have ever been examined by a neurologist, despite indications in their histories that warrant neurological consultation. Occasionally, the extent of the neurological evaluation may be an EEG, which was likely conducted without any specific leads or without having the client sleep during the test thus making it an inadequate study. It is also a rare case in which any meaningful neuropsychological testing has been conducted, even though neuropsychological testing is one of the best ways to determine the presence of more subtle brain damage prevalent in our clients. The extent of the testing, if any testing at all is done, may be a few neuropsychological screening tests such as the Bender-Gestalt or the trail making test. This, however, is often inadequate and will yield unreliable results. A complete neuropsychological battery is often the only way to rule out the possibility of neurological damage. Unfortunately, I have been involved in numerous cases where it was only discovered after the trial the defendant had a serious organic deficit. For example, in one case, we only discovered during the federal habeas corpus proceedings that our client had a brain tumor exerting pressure on critical brain structures, which was present at the time of the offense. While this is a dramatic example, in countless other cases we have discovered that our clients have serious neurological impairments that went undiagnosed in earlier evaluations.

This can have tragic consequences. It can deny your client a concrete way to reduce his blameworthiness. It is a fact of death penalty life that juries, and judges, are often less impressed with psychosocial explanations for violent behavior than they are with organic explanations. While this is changing somewhat due to our better understanding of the long term effects of various types of trauma,
see, *e.g.*, Judith Herman, *Trauma and Recovery*, it is still true. Organic deficits, however, frequently have their origin in events and situations over which the defendant had no control, such as Fetal Alcohol Syndrome, temporal lobe epilepsy, measles, encephalitis, or prolonged exposure to neurotoxins such as those found in lead-based paint. These factors can be presented in an empathy-provoking manner, as part of a constellation of factors that affected your client's behavior. While we may appreciate psychosocial diagnoses such as post-traumatic stress disorder, in some cases it is not compelling enough unless it is accompanied by a physical explanation. For example, if you can show that part of your client's brain is literally missing, most jurors and judges can understand that such an impairment might affect an individual's behavior. The same presentation can be made with less dramatic or "softer" neurological impairment, *e.g.*, diffuse brain damage. The important thing is to insure that the evaluation your client received at trial, or receives in connection with post-conviction litigation, fully takes into account the possibility of neurological impairment.

This cannot be done without a reliable history and appropriate testing and examination. A competent neurologist, psychiatrist, or neuropsychologist will recommend a complete neurological examination when indicated by physical symptoms such as one sided paralysis or weakness, facial asymmetry, seizures, headaches, dizziness, blurred vision, or imbalance. Laboratory tests, including blood and endocrine workups, may also be necessary to determine the presence of diseases that affect behavior. Magnetic Resonance Imaging (MRI), Electroencephalogram (EEG), and CT scans can also be useful in this regard. However, it is important to note that a negative (or normal) result on a CT scan, EEG, or MRI does not rule out the possibility of neurological impairment. While a positive finding establishes organicity, a negative finding does not rule brain damage out.11 Organicity may still be discerned through more sensitive neuropsychological testing and/or a neurological evaluation.

V. Choosing Experts

There are a number of different types of experts you may need in any particular case. However, you will not know exactly what type of experts you will need until the social-medical history is completed. As I have stressed throughout this article, this must *always be* the first step. I cannot stress this point enough as it is virtually always the basic flaw in forensic mental health evaluations. You must resist the temptation to hire a psychologist or psychiatrist immediately upon being appointed or retained.12 Without first conducting the necessary life history investigation, your expert may well overlook significant factors and come to premature or erroneous conclusions.

Furthermore, it is critical that you obtain the assistance of a social worker, or someone with similar skills, to assist in compiling and understanding the social and medical history. Social workers are specially trained not only in gathering the type of information you need – both from documents and individuals – but also in organizing and interpreting the data in coherent themes. See Arlene Andrews, *Social Work Expert Testimony Regarding Mitigation in Capital Sentencing Proceedings*, 1991 Social Work 36. While you or someone in your office can collect most documents and interview the witnesses, you may not be attuned to significant facts in the records, or be less able to obtain information from the client, the client's family and friends, and other persons with relevant knowledge about your client than someone with special expertise in this area. Thus, you should always attempt to obtain funds for the assistance of an individual with a social work background in the investigation, compilation and assimilation of the social and medical history.

If the court resists funds for this type of assistance, educate the judge, via affidavit or testimony, as to the critical nature of this aspect of the mental health evaluation.13 For example, a psychiatrist or psychologist with whom you have a collegial working relationship may be willing to provide you with an affidavit laying out specific factors in the "known" social history warranting further exploration by a person with specialized training and discussing the need for full and reliable background information. Furthermore, many of the sources discussed in this article will also be of use in establishing the need for the assistance. It is also important to be adamant about the need for specialized social history assistance in
cases where the client's ethnic or cultural background impairs your ability to obtain accurate and complete information.

Depending on the results of the social history, it is then time to obtain your own experts. In doing so, you should search for professionals with expertise in the themes that have developed in the social history, e.g., abuse (physical, emotional and sexual trauma); alcoholism and/or substance abuse; familial or genetic predisposition to certain mental illnesses; head injuries or other indicators of organicity, mental retardation or all of the above. It is important to keep in mind that one mental health professional can very rarely help you with all of these things. See Clark, Veltkamp & Monahan, The Fiend Unmasked: The Mental Health Dimensions of the Defense, 8 ABA Criminal Justice 22 (Summer 1993).

Thus it is almost always necessary to put together a multidisciplinary team of professionals, including a social worker, to determine the client's mental state reliably. For example, if the social history indicates a history of chronic child maltreatment and abuse, it may be best to begin with a full psychological battery including neuropsychological testing. This testing may confirm or deny the presence of posttraumatic stress disorder, organic impairment or other diagnoses resulting from the abuse. Similarly, in many cases involving child abuse, the individual will often have a long history of substance abuse. Thus, it may be necessary to retain a pharmacologist to explain the nature of the substances abused, their effects on an individual's judgment, impulse control, cognitive functioning, etc., and to explain the long-term effects of these drugs on a person's brain. Furthermore, depending on the results of the neuropsychological examination, a neurological consultation will often be in order.

Other types of experts may also be necessary. We have enlisted the assistance of audiologists, mental retardation experts, special education teachers, toxicologists and a variety of other types of experts, in addition to social workers, psychologists, neurologists, neuropsychologists, pharmacologists, and psychiatrists.

The important thing, however, is to assemble the necessary mental health professionals on the basis of the history as you uncover it. Furthermore, it is frequently necessary to have one professional, generally a forensic psychiatrist, who can "bring it all together." In other words, many of your experts may be testifying as to only one piece of the mental health picture, for example, your client's history of substance abuse. It is useful to have one person who, in consultation with all the other members of the team, is prepared to discuss all the history, testing, and diagnosis and give the fact-finder and sentencer a comprehensive picture of the individual's mental state at the time of the offense, and, if relevant, at trial.

VI. Meaningfully Presenting Expert Testimony

Regardless of which phase of the trial expert testimony is presented, and even regardless of what type of criminal case it is, persuasive expert testimony must have one element: it must enable the jury to see the world from your client's perspective, i.e., to appreciate his subjective experience. Most people have no idea, for example, what it is like to suffer from schizophrenia or other major mental illnesses, or what it means to be psychotic or to have auditory, visual or tactile hallucinations. It is often not enough for your expert to tell the jury or judge that your client is schizophrenic and was out of touch with reality at the time of the offense. Rather, she must attempt to explain, in common sense, persuasive, concrete terms, what schizophrenia means, and what the world looks like to a person with this mental illness. Similarly, it is not enough to have the expert testify that your client is plagued by auditory command hallucinations. Without an adequate explanation a juror may react as follows: "Big deal, I don't care, if someone told me to kill somebody I wouldn't do it."

You and your expert(s) must look for ways to convey what it is truly like to be mentally ill, mentally retarded or brain damaged, and how confusing and frightening the world is to your client as a result of his impairments. In other words, you have to give the fact-finder a view of the crime from the defendant's perspective. If you don't, you run the risk of making your client seem "otherly," frightening and thus expendable. What you are striving for is to enable the fact-finder to look through your client's eyes and to walk, at least for a few minutes, in his shoes. If you can accomplish this through your expert
testimony, you can facilitate understanding rather than fear.

It takes time and energy, but the key is to avoid jargon and words that ordinary people don’t understand. It may be useful to have someone not connected with the case, preferably not a lawyer, sit in on a meeting with your expert witness and see if s/he understands the explanation of your client’s mental state as well as its relevance to the facts of your case.

VII. Attacking Anti-Social Personality Disorder

Many of our clients are diagnosed by mental health professionals, employed by either the state or the defense, as having an anti-social personality disorder. This diagnosis is not only very harmful but, unfortunately for many of our clients, it is often arrived at erroneously. In my opinion, anti-social personality disorder is the lazy mental health professional’s diagnosis. The criteria for the disorder are essentially a description of people’s behavior. It may describe what the client has done, but never why. For example, one of the characteristics is that the individual engaged in sexual activity at a young age, or began using substances at an early age.

Besides the fact that many of these characteristics are economically and racially biased, the diagnosis is often erroneously arrived at because of an inadequate history and lack of other adequate testing and evaluations. DSM-IV specifically states that “the diagnosis may at times be misapplied to individuals in settings in which seemingly antisocial behavior may be part of a protective survival strategy.”14 In other words, the clinician is obligated “to consider the social and economic context in which the behaviors occur.” Id. at 647. This is another area where a thorough and reliable social history can have a significant impact. For example, to qualify for the diagnosis of Anti-Social Personality Disorder, the client must have met the criteria, prior to age fifteen, for a DSM-IV diagnosis of Conduct Disorder. Conduct Disorder has a number of criteria including a history of running away from home, truancy, etc. Thus, it is critical, to an accurate diagnosis, to know why your client ran away from home. If he ran away because he was being physically, sexually or emotionally abused, then the diagnostic criteria would not be satisfied. Similarly, if the child was truant because his caretakers would not allow him to go to school, or if he broke into people’s houses because his father was a thief and forced him to do so to further the family enterprise, the diagnosis of Conduct Disorder, and correspondingly Anti-Social Personality Disorder, would be inappropriate. Thus once the dysfunctional nature of most of our clients’ environments is exposed, the diagnosis can be defeated.

Similarly, if there is an organic or other cause such as mental retardation for some of the behaviors, then the diagnosis should, in many cases, not be given. In this regard, it is useful to look at and study the decision trees published in the American Psychiatric Association’s Diagnostic and Statistical Manual-III. These “trees” indicate a number of other diagnoses that preempt the diagnosis of anti-social personality disorder. However, because all many psychologists do is talk to the client, and look at his or her criminal record and other behaviors, the diagnosis is often arrived at despite other factors which would either prevent the diagnosis or move it sufficiently far down on an axis as to make it irrelevant to the other more significant diagnoses in explaining the individual’s behavior.

Finally, it is important to note that the diagnosis cannot be given unless your client is at least eighteen years old, and if there is clear evidence that a diagnosis of Conduct Disorder was warranted before your client was fifteen years old. In other words, if the alleged “anti-social” behaviors began after your client was fifteen, the Anti-Social Personality Disorder would not be an appropriate diagnosis. Thus, if some neurological impairment or other contributing condition occurring after age fifteen explains your client’s actions, the diagnosis is not correct. In the same vein, DSM-IV states that if the antisocial behavior occurs during the course of schizophrenia or manic episodes, the diagnosis is not appropriate. Id. at 650.

The point of this discussion is that you should never accept at face value any professional’s, including your own, determination that your client has anti-social personality disorder. It is always critical, for diagnostic purposes, to know why the seemingly anti-social behavior occurred. While in some cases the diagnosis may be unavoidable, in many it is not. If the steps outlined previously in this article are followed,
you dramatically increase your chances of avoiding a diagnosis that establishes aggravating factors, and obtaining one instead that offers a compelling basis for mental health related claims.

VIII. Considering Prior Diagnoses

In many cases, you will be confronted with a client who has been previously evaluated, in some cases on many occasions. If this is true, it is also likely that different professionals have arrived at different diagnostic conclusions. In examining the prior evaluations, it is important to know when the prior conclusions were reached, and, more specifically, what version of the Diagnostic and Statistical Manual of Mental Disorders was in effect at the time any prior diagnosis was rendered. See K. Wayland, “The DSM: Review of the History of Psychiatric Diagnosis in the U.S.,” Capital Report #40 (Nov/Dec 1994). For example, it was not until the late 1970's and early 1980's that depression emerged as a diagnosis to be seriously considered in children and adolescents. Thus, prior to that time, a child with a history of suicide attempts and other depressive symptoms would almost certainly not have been diagnosed as suffering from depression. Similarly, Posttraumatic Stress Disorder (PTSD) was not officially recognized as a diagnosis until the publication of DSM-III in 1980. Thus, while there may be clear support for PTSD in descriptions of your client's behavior in a pre-1980 evaluation, the diagnosis of PTSD would likely not have been given.

This indicates – again – the critical need for a detailed history and review of all information regarding your client's life. For it may be that the mental health records contain descriptions of your client's behavior which warrant a different (and more favorable) diagnosis today than was available using previous diagnostic criteria.

IX. Don't be Fooled by the Client

Many times when I consult with lawyers, I hear them say, when we are discussing the possibility that their client is mentally ill or mentally retarded, that "Well, I've talked to him and he seems pretty sharp to me." Or they say “Well, he seems normal to me." Sometimes they describe their client as manipulative, evasive, hostile, or street smart. It is crucial to remember that as lawyers we are not trained to recognize signs and symptoms of mental disabilities. It is equally important to keep in mind that many mentally retarded, mentally ill or brain damaged individuals are quite adept at masking their disabilities. For example, one skill that mentally retarded people typically master is some degree of hiding their disability. One client of mine sat in his cell for hours at a time pretending he could read because he thought, if people thought he could read, they wouldn't believe he was mentally retarded. Other clients with severe mental illnesses are often good at masking their illness for short periods of time. This is especially true when they are in a structured setting, such as prison or jail, which may minimize many of the symptoms of their impairments.

Unfortunately the quality of many attorney-client conversations does not allow probing into the client's mind to determine delusional or aberrational thought processes. However, this does not mean that they are not there. Many ill people, for example, know that other people don't think like they do, and may need to get to know you before they share their thoughts. Similarly, many people with brain damage may not appear dysfunctional when engaged in casual conversation. The important thing is that neither you nor any mental health professional should prejudge a client's mental state based upon casual contact. It is only through the assistance of competent mental health professionals who recognize the importance of a documented social history, and who are trained in appropriate testing, that you can reliably and adequately determine your client's mental state.

X. Essential References
Because of the pivotal role of mental health issues in criminal and capital litigation, counsel must gain a working knowledge of behavioral sciences. Whether an attorney has only one criminal or capital case or several, it is essential to become familiar with the diagnosis and treatment of psychiatric disorders. Two publications need to be on the shelves of attorneys in criminal litigation and studied: *Comprehensive Textbook of Psychiatry, Fifth Edition*, edited by Harold L. Kaplan, M.D. and Benjamin J. Sadock, M.D. (Williams & Wilkins, 1989) and *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)*, published by the American Psychiatric Association in 1994. These references offer a guide through the labyrinth of mental health information and allow counsel to participate fully in developing appropriate mental health claims.

**XI. Conclusion**

Defense counsel in criminal, especially capital, litigation can and should insure that their clients receive complete, competent and reliable mental health evaluations. In order for a mental health evaluation to meet the nationally recognized standard of care in the psychiatric profession it must involve a multi-step process that requires far more than a clinical interview. A thorough and documented social history, physical examination and appropriate testing are necessary components of any psychiatric diagnosis. Mental health professionals must consider whether there is an organic cause for behavior before reaching any psychiatric diagnosis. Counsel has a responsibility to ensure that mental health evaluations reflect this multi-step process.

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**Endnotes**

1. See also *Youngberg v. Romeo*, 457 U.S. 307 (1982) (recognizing that psychiatrist’s performance must be measured against a standard of care when due process demands adequate performance).

2. Other cases involving similar claims associated the effect of the actions by the state court, the prosecution and psychiatric witness with the issue of effective assistance of counsel. Courts have recognized a particularly critical interrelation between expert psychiatric assistance and minimally effective assistance of counsel. *United States v. Edwards*, 488 F.2d 1154, 1163 (5th Cir. 1974).

3. Although the *Blake* court analyzed the impairment of the psychiatrist’s ability to conduct a professionally adequate evaluation in terms of its impact on the right to effective assistance of counsel, it recognized that its analysis was “fully supported” by *Ake*. In support of this conclusion, the court gave emphasis to *Ake’s* requirement that “the state must at a minimum, assure the defendant access to a competent psychiatrist who will conduct an appropriate examination and assist in evaluation, preparation, and in presentation of the defense.” 758 F.2d at 530-31 (quoting *Ake*, 470 U.S. at 83). Thus, *Blake* recognized that if an appointed psychiatrist’s ability to “conduct an appropriate examination” is impaired, due process is violated.


5. A national standard of care is important to insure that your client receives a complete, competent mental health evaluation. If a local standard of care applied, for example, your client could conceivably be deprived of available diagnostic studies, *e.g.*, a MRI scan on the ground that such a study is not readily available in the local
community. The same may be true of neuropsychological testing if there are not trained neuropsychologists. However, your client’s right to a trial conducted in conformity with the Sixth Amendment and the Due Process Clause demands a national standard as opposed to a local standard of care.

6. Thus, if your primary mental health professional is a psychologist, it is critical that you obtain the services of a physician to complete a physical examination. If your client is indigent and the court has only approved funds for a psychologist it is important to bring to the court’s attention (and to litigate if necessary) the need for a complete physical examination.

7. Neuropsychological test batteries were developed as a method for assessing cognitive deficits and involve an assessment of specific cognitive functions, such as memory, attention, and fluency of thinking. The two most widely used neuropsychological batteries are the Halstead-Reitan and the Luria Nebraska. A clinician assessing patients neuropsychologically will often use tests from both batteries as well as other neuropsychological instruments to tailor the assessment to the types of problems that the specific patient is having and to try to identify whether a specific area of deficit is present. When a grouping of neuropsychological tests such as those described above is administered to an individual, the clinician obtains some sense of the person’s overall patterns of abilities and deficits.

8. The determination of whether a defendant is competent—whether he has a rational and factual understanding of the charges and is able to assist counsel—is a limited inquiry which a mental health professional may, under some circumstances, be able to make without following all of the steps outlined in this article. Even in the competency context, however, the failure to obtain a complete and reliable history may skew the results. Unfortunately, in many cases, a mental health professional who only evaluated the defendant for competency purposes, and often conducted a limited examination, proceeds, at the request of either the prosecution or the defense, to testify regarding a wide array of forensic issues such as criminal responsibility and mitigation. While a detailed discussion of the various types of mental health evaluations is beyond the scope of this article, any time a mental health professional fails to follow the steps outlined in this article, there is a corresponding risk that the conclusions reached will be erroneous.

9. There are many excellent, more detailed life history records’ checklists which can be obtained from various post-conviction defender organizations and public defender agencies including the Kentucky Post-Conviction Defender Organization.

10. The reasons organicity so often goes undiagnosed are varied. One reason has to do with the complexity of so many of our clients’ histories. For example, when confronted with a substantial history of abuse and poly-substance abuse, a mental health professional may too quickly conclude that the interaction of the trauma and the intoxicants caused the behavior, failing to adequately pursue any existing neurological impairment. Another reason has to do with the circumstances of the evaluation; many people with organic brain damage respond very well to a structured environment such as prison. Thus, when confined and removed from the complexities and temptations of life on the outside, the symptoms of their impairment are significantly less pronounced and may be overlooked. In some cases, the damage is missed because the particular mental health professional retained by counsel has inadequate training in the diagnosis of brain damage, e.g., a psychologist without any experience in neuropsychological testing.

11. Furthermore, if the CT scan or MRI film has not been reviewed by an expert you have confidence in or was conducted at the request of the state or state psychiatric hospital, I would recommend that you have a neurologist or neuroradiologist retained by the defense review the actual film. I have been involved in a number of cases in which the initial hospital report indicated for example that the MRI was “normal” when it was not. Erroneous CT scans and MRI readings occur for a variety of reasons, a discussion of which is beyond the scope of this article, but counsel should obtain the film and have it reviewed by your own expert.

12. Many times counsel do so, reasoning that it is important to have the defendant seen as soon by a mental health professional as possible after the offense. There may be some limited circumstances where this is true, i.e., if
you are appointed or retained within a few hours of the offense and upon consulting with the client, you
determine he is floridly psychotic. Such situations are, however, few and far between, and the temptation to
conclude that your case falls in this category must be resisted.

13. A detailed discussion of how to secure funds for investigative and expert services is beyond the scope of this
article. As a general matter, I would advise you to review Ed Monahan’s articles: Funds for Resources:
Persuading and Preserving, The Advocate, Vol. 16 No. 6 at 82 (January 1995); and Confidential Request or
Funds for Experts and Resources, The Advocate, Vol. 17, No. 1 (February 1995) at 31. As an initial matter, you
should always vigorously assert your client's right to an ex parte hearing, and it is important to assert your
client's right to confidentiality in connection with funds requests. Furthermore, in developing the argument for
funds it is important to be as specific as possible and to build the case for funds “from the ground up.” For
example, a detailed showing of factors in your client's life suggesting neurological impairment is much more
likely, than a general assertion, to result in the approval of funding. This is especially true if you can convince a
neurologist to submit an affidavit, based on the facts in the history which you have developed, detailing the need
for a neurological evaluation. It is also helpful to submit a similar affidavit from a forensic psychiatrist or
psychologist, and possibly even a social worker, expressing the need for a neurological consultation. A similar
process should be followed in attempting to obtain funds for other types of expert assistance. The affidavits
from other professionals is useful in convincing the court that you are not on a fishing expedition.

14. This was also true of DSM-IIIR.