SUFFOLK ACADEMY OF LAW
The Educational Arm of the Suffolk County Bar Association
560 Wheeler Road, Hauppauge, NY 11788
(631) 234-5588

Representing Individuals with Developmental Disabilities

FACULTY
Anthony M. LaPinta, Esq.
Hon. Richard I. Horowitz, Esq.
Guy Arcidiacono
Deborah J. Chard-Wierschem, Ph.D. NYS OPWDD
Marybeth Anderson, Esq.
Kate Termini

Program Coordinator: Amy Hsu, Esq.

Thank you to Patrick McCormick, Esq., Campolo, Middleton & McCormick, LLP as Benefactor of this program.

December 14, 2017
Suffolk County Bar Center, NY

REPRESENTING INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES

THURSDAY, DECEMBER 14, 2017

5:30 - 5:45 PM	Amy Hsu – speaker introductions and program history
5:45 PM	ADA Guy Arcidiacono: overview of the statute/law
6:15 PM	Dr. Katie Termini: will discuss diagnosis and the risk factors
6:45 PM	Ms. Deborah Chard-Wierschem: type of services provided by OPWDD and the differences between OHM and OPWDD
6:45 – 7:00 PM	BREAK
7:00 PM	Anthony La Pinta, Esq.: practitioner's point of view and defenses
7:30 PM	Mary Beth Anderson, Esq.: Ethical issues for attorneys and judges
8:00 PM	Judge Richard Horowitz: judicial perspective
8:15 P.M.	Q & A

Guy Arcidiacono

Deputy Bureau Chief, Appeals Bureau
Attorney-in-Charge
Forensic Psychiatric Litigation Unit
Suffolk County District Attorney's Office
Criminal Courts Building
200 Center Drive
Riverhead, New York 11901
(631) 852-2444
guy.arcidiacono@suffolkcountyny.gov

Guy Arcidiacono is a Deputy Bureau Chief in the Appeals Bureau of the Suffolk County District Attorney's Office. He is also the Attorney-in-Charge of the Office's Forensic Psychiatric Litigation Unit, which is responsible for hearings to determine defendants' competence to stand trial, evaluation of possible not responsible defenses at trial, post commitment retention proceedings and civil commitment information requests. He previously served as the Attorney-in-Charge of the Office's East End Unit, the Office Unit which covered the North and South Forks of Long Island including the Hamptons.

Mr. Arcidiacono is a member of the New York State District Attorney's Association, and is currently Chairman of that Association's Mental Health Sub-committee. He is a member of that organization's Legislative Committee and serves as a Legislative Secretary, as well as a member of the Best Practices Subcommittee. He is also on the Board of Directors of the Suffolk County Criminal Bar Association.

In 2012 he was named to the American Bar Association, Criminal Justice Section Mental Health Standards Task Force. In 2013 he was appointed the Criminal Justice Section's Liaison to the ABA's Commission on Disability Rights, and in July, 2015 was appointed as Co-Chair of the Criminal Justice Section's Mental Health Committee.

He has lectured extensively for the Suffolk County District Attorney's Office and for the New York Prosecutor's Training Institute on a variety of criminal law topics. In 2010 and 2011 he presented lectures for the Division of Criminal Justice Services to police officers around the state on the new Identification Procedures developed by the NYS District Attorney's Association. In 2006 he authored a short article for the Empire State Prosecutor, "'Civil Commitment: Using Existing Law To Mandate In-Custody Psychiatric Treatment for Sexually Violent Predators.'"

Mr. Arcidiacono graduated cum laude from Hamilton College in 1978, and received his law degree in 1982 from Washington and Lee University School of Law, where in his third year he was a Burks Scholar Teaching Fellow. In 1999 he received a Distinguished Advocacy Award from the Suffolk County District Attorney's Office, and in 2001 his office presented him with a Distinguished Service Award for his work as Attorney-in-Charge of its Forensic Unit. In 2008 he received the New York Prosecutor's Training Institute's Appellate Prosecutor of the Year Award. Mr. Arcidiacono is married and the proud father of three boys.

Dr. Kate Termini

Dr. Termini received her undergraduate degree in psychology, with a minor in criminology from Duke University. She returned to graduate school to earn her doctorate in clinical psychology, with a specialty in neuropsychology, from Yeshiva University/Albert Einstein College of Medicine. She underwent training in facilities including Bellevue Hospital Center, the Manhattan Campus of the Veteran's Affairs Hospital, and NYU Medical Center. She completed her clinical psychology internship, with a specialty in neuropsychology, at North Shore University Hospital and then a post-doctoral fellowship in neuropsychology. She has extensive training in neuropsychological assessment, as well as psychological assessment, in both the forensic and clinical realms. She has performed several hundred forensic evaluations on both the state and federal level. She serves as a consultant and psychologist to Brooklyn's Mental Health Court. She is an adjunct faculty member at Albert Einstein College of Medicine/Ferkauf Graduate School of psychology as an instructor of clinical assessment to doctoral students.

Bio for Deborah Chard-Wierschem, Ph.D.

Dr. Deborah Chard-Wierschem is currently the Director of the Bureau of Intensive Treatment Services, -the forensics-related bureau, at the **NYS Office for People with Developmental Disabilities (OPWDD).** She has a long history in state service, initially working at the **NYS Department of Corrections and Community Supervision (DOCCS)** where she conducted research in a variety of areas, including research on female offenders, recidivism and substance abuse treatment; the **NYS Division of Criminal Justice Services (DJCS)** where she was Director of the Domestic Violence Research Unit, which was tasked with evaluating the NYS Mandatory Arrest policy on domestic violence and developing the Domestic Incident Report (DIR) that is mandated for use by police departments across the state. More recently, prior to her work at OPWDD, Dr. Chard-Wierschem worked at the **NYS Office of Mental Health (OMH)** where she was Director of the bureau that oversaw services to individuals on CPL statuses. Her work at OMH also included work on various forensic-related projects, including screening and training for officers on suicide prevention in local correctional facilities, police officer and county mental health department training, community reentry, focus group research and performance indicator development. Dr. Chard-Wierschem has dual master's degrees in Criminal Justice and Social Work, and a doctorate in Criminology from the State University at New York, at Albany.

ANTHONY M. LA PINTA

Anthony La Pinta has been a federal and state criminal defense attorney for over 25 years. He has achieved the "Preeminent-AV" rating by Martindale-Hubbell and has also been selected to the 2014, 2015, 2016 and 2017 editions of "Super Lawyers Magazine" New York Metro Edition.

Mr. La Pinta has successfully defended many high profile cases that have drawn national media attention. Some of his past clients include law enforcement officials, financiers, politicians, attorneys and physicians.

Mr. La Pinta is an adjunct professor at Touro Law School where he teaches Criminal Procedure and Criminal Trial Advocacy. He is also a routine lecturer for the Nassau and Suffolk County Bar Associations and the National Institute for Trial Advocacy (NITA). He is a current member of the New York State Grievance Committee for the Tenth Judicial District and a member of the Board of Directors for the New York State Association of Criminal Defense Lawyers. He is a former President of the Suffolk Criminal Bar Association, and past Chairperson of the Ethics and Professionalism Committee of the Suffolk Bar Association. Mr. LaPinta has also been a contributor and legal commentator for Court TV, Fox News, Newsday and News 12 – Long Island.

Mr. La Pinta was born in Brooklyn, New York and raised in West Islip, Long Island. He is a graduate of The State University of New York College at Oswego and Temple University Law School. He is currently the Managing Partner of Reynolds, Caronia, Gianelli & La Pinta, P.C., located in Hauppauge, New York.

Mary Beth Anderson

Mary Beth Anderson is the director of the Urban Justice Center Mental Health Project. From 2011-13, she was the Director of Social Work and Investigation at Brooklyn Defender Services. Before that, she had a 21-year career at the Legal Aid Society criminal practice where she held many positions, including founding a city-wide project that teamed social workers and attorneys to provide comprehensive services for clients with mental health and substance abuse issues. Mary Beth has devised and participated in many training programs on mental health and criminal justice issues, and serves on the NYPD's mental health/criminal justice advisory board. She graduated from St. John's University School of Law and obtained her master's in social work at Hunter College School of Social Work. Mary Beth is a member of The Stability Network, a coalition of professionals living with mental health concerns, who are willing to share their stories of recovery to help others recover faster and stay well longer.

Hon. Richard I. Horowitz – Suffolk County Supreme Court

Richard Horowitz was appointed to the Court of Claims by Governor Andrew Cuomo in 2015. He currently sits as an Acting Supreme Court Justice in the dedicated Guardianship Part of Suffolk County. Judge Horowitz's prior judicial positions include District Court Judge, Acting County Court Judge and Supervising Judge of the District Court. He has presided in virtually all of the various civil and criminal parts of the District Court, including the Drug Treatment Court and the Mental Health Court. In 2013 he was tasked with creating and presiding over the Human Trafficking Intervention Court.

Judge Horowitz began his legal career as a public defender at the Legal Aid Society of New York. He served as a Senior Staff Attorney for nineteen years and specialized in representing individuals living with mental illness and chemical addiction.

Richard Horowitz had a hiatus from the bench from 2014 until 2015. During that time, he served as the Deputy Bureau Chief of the Special Investigations Bureau of the Suffolk County District Attorney's Office. His Bureau was responsible for combating gang and gun violence, animal cruelty and human trafficking.

Judge Horowitz is a Special Professor of Law at Hofstra University School of Law, where he teaches a course, of his own design, entitled *Mental Health Issues in the Criminal Justice System*. He also serves as guest lecturer at Touro Law Center and at the Suffolk Academy of Law.

He is a Past President of the Suffolk County District Court Judges Association and a Past Vice-President of the New York State District Court Judges Association. He currently serves as a Co-Chair of the Neuroscience and the Law Committee of the Suffolk County Bar Association.

Judge Horowitz is the recipient of the Suffolk Criminal Court Bar Association's Judge of the Year Award, Hofstra University's George M. Estabrook Distinguished Service Award and the Long Island Business News' 50 Around 50 Award.

He is a graduate of Binghamton University and Hofstra University School of Law.

Representing Individuals With Developmental Disabilities – The Prosecution Perspective

Suffolk County Bar Association
December 14, 2017

Guy Arcidiacono
Deputy Bureau Chief, Appeals Bureau
Attorney in Charge, Forensic Psychiatric Litigation Unit
Suffolk County District Attorney's Office

Power Point, Materials and Presentation By
Guy Arcidiacono

Introduction

- Mental States
- Competency – CPL Article 730
- Interrelationship between Competency and Mental Defense Issues
- Psychiatric Examinations
- Capacity for self-representation
- Evidentiary and Ethical considerations

The Practical Approach

Is there a basis in the record for conducting an examination?

What are the consequences of contesting an examination?

Should you take a position?

Fact
vs.
Expert Opinion

Is defendant mentally ill?
If so, what is his mental illness?
Does that mental illness cause him to lack capacity?
Was defendant not responsible at the time of the crime?

Inherent tension between lawyers' (or law enforcement) interpretation of psychiatric evidence and psychiatric professionals' interpretation of that evidence.

Buck v. Bell, 274 U.S. 200 (1927)

"...It is better for all the world, if instead of waiting to execute degenerate offspring for crime, or to let them starve for their imbecility, society can prevent those who are manifestly unfit from continuing their kind. The principle that sustains compulsory vaccination is broad enough to cover cutting the Fallopian tubes. *Jacobson v. Massachusetts,* 197 U.S. 11. Three generations of imbeciles are enough."

-Oliver Wendell Holmes

Foucha v. Louisiana, 504 U.S. 71 (1992)

"...the state now claims that it may continue to confine Foucha, who is not now considered to be mentally ill, solely because he is deemed dangerous, but without assuming the burden of proving even this ground for confinement by clear and convincing evidence. The court below gave no convincing reason why the procedural safeguards against unwarranted confinement which are guaranteed to insane persons and those who have been convicted may be denied to a sane acquittee, and the State has done no better in this Court "

- Byron White

OVERVIEW

Mental Illness alone is not sufficient to establish competency, insanity or current dangerousness

Developmental Disability [as defined in the DSM V], [formerly Mental Retardation],and Mental Illness are Medical Terms

Competency, Mental Disease or Defect, and Mental Retardation [as defined in CPL 400.27 (12) (e)] are legal concepts

While the legal concepts may overlap with the medical concepts, they are not the same.

The Insanity Defense and Extreme Emotional Disturbance concern a defendant's mental state at the time of the crime

Fitness to proceed (a/k/a competency/capacity) refers to defendant's mental state from arraignment through imposition of sentence.

-CPL § 730.30

Post Adjudication proceedings under CPL § 330.20 concern the defendant's current (post plea/verdict) mental condition

Selected Definitions

"'Mental illness' means an affliction with a mental disease or mental condition which is manifested by a disorder or disturbance in behavior, feeling, thinking, or judgment to such an extent that the person afflicted requires care, treatment and rehabilitation." Mental Hygiene Law §1.03(20) [*see also,* Corrections Law §508 (3)(b)(ii) – same definition, minus "and rehabilitation"].

Fitness to Proceed – CPL Article 730

"'Incapacitated person means a defendant who as a result of mental disease or defect lacks capacity to understand the proceedings against him or to assist in his own defense" – CPL §730.10(1)

Mental Disease or Defect [Insanity Defense] Penal Law §40.15

"In any prosecution for an offense, it is an affirmative defense that when the defendant engaged in the proscribed conduct, he lacked criminal responsibility by reason of mental disease or defect. Such lack of criminal responsibility means that at the time of such conduct, as a result of mental disease or defect, he lacked capacity to know or appreciate either:

1. The nature and consequences of such conduct; or
2. That such conduct was wrong."

Fitness to Proceed

Fitness to Proceed – CPL Article 730

"'Incapacitated person means a defendant who as a result of mental disease or defect lacks capacity to understand the proceedings against him or to assist in his own defense" – CPL §730.10(1)

Competency is a Constitutional Right- an individual has a due process right to assist in his own defense and understand the nature of the charges against him.

Medina v. California, 112 S.Ct. 2572 (1992)
Pate v. Robinson, 383 U.S. 375, 378 (1966)

Competency under Article 730 applies from time of initial charging through sentencing [CPL 730.30]

One 730 exam may not suffice - defendant may slip in and out of competency during the course of hearings, trial, penalty phase and sentencing

Don't Ignore the Obvious

If the Court has reason to believe defendant may be an incapacitated person, it must order an exam
-CPL 730.30 (1)

People v. Tortorici, 92 N.Y.2d 757, 765 (1999)
People v. Armlin, 37 N.Y.2d 167 (1975)

- defendant is presumed competent

- not entitled as of right to a hearing if Court is satisfied from available information that there is no proper basis for questioning defendant's capacity

- a prior history of psychiatric illness does not, in itself, call into question defendant's competence

- whether to order a hearing rests in the sound discretion of the trial court.

People v. Tottorici, 92 N.Y.2d 757 (1999)

The Court does not have to order an Article 730 exam simply because defendant requests one.

People v. Gensler, 72 N.Y.2d 239 (1988), *cert.denied*, 488 U.S. 932 (1988)
People v. Greco, 177 A.D.2d 648 (2nd Dept. 1991), *app. denied,* 79 N.Y.2d 857 (1991)
People v. Kontis, 159 A.D.2d 590 (2nd Dept. 1990)
People v. Salladen, 50 A.D.2d 765, 766 (1st Dept. 1975), *aff'd,* 42 N.Y.2d 914 (1977)
See, People v. Tortorici, 92 N.Y.2d 757 (1999)

The CPL §730 Examination

Article 730 - Psychiatric Examiners

"'Qualified psychiatrist' means a physician who (a) is a diplomate of the American board of psychiatry and neurology or is eligible to be certified by that board; or (b) is certified by the American osteopathic board of neurology and psychiatry or is eligible to be certified by that board. - CPL §730.10(5)

"'Certified psychologist' means a person who is registered as a certified psychologist under article one hundred fifty-three of the education law. - CPL §730.10(6)

"'Psychiatric examiner' means a qualified psychiatrist or a certified psychologist who has been designated by a director to examine a defendant pursuant to an order of examination" - CPL §730.10(7)

Experts

Psychiatrists v. Psychologists

The Goldstein/Crawford Problem

People v. Goldstein, 6 N.Y.3d 119 (2005)

- Psychiatrist may testify to opinion, even if based on hearsay from third parties

- Psychiatrist established third party information accepted practice in the profession

But

- Confrontation Clause prohibits testimonial hearsay – Expert can not testify about the third party hearsay statements

- Statements to People's expert were "formal" statements made to government officers

Conducting the Examination

Conducting the Examination

- Place of Examination
- Layout of examination room
- Transcription of the proceedings
- Security Concerns
- Presence of the Attorneys
- Role of the Attorneys

The Examination

Director of Community Mental Health Services designates two qualified Psychiatric Examiners to conduct the Examination.

The court may authorize psychiatric examiner retained by defendant to be present at exam

The Examination

If defendant is in custody at the time of the examination order, the exam must be conducted at the place where defendant is being held

But

If director determines that hospital Confinement is necessary for an effective Exam, the sheriff must deliver defendant to a hospital designated by the director – CPL § 730.20

Exam may not be held in the District Attorney's Office – *People v. McCabe,* 87 A.D.2d 852 (2nd Dept. 1982); see CPL 730.20 (3).

The Examination

If the psychiatric examiners are not unanimous in their opinion, the Director must designate another Psychiatric examiner.

The Director must deliver the reports to the Court.

CPL § 730.20

THE EXAMINATION

•Competency is a judicial, not a medical determination.
People v. Phillips, 16 N.Y.3d 510 (2011)

•Information obtained for the 730 exam can only be used on the issue of competence, it can not be used at trial CPL 730.20 (6)

•Court may subsequently direct additional examinations if after a hearing it is not satisfied.

•If the reports are old, consider requesting an updated exam

•Parties may also move to hire their own experts

•Exam may not be held in the District Attorney's Office – *People v. McCabe,* 87 A.D.2d 852 (2nd Dept. 1982); see CPL 730.20 (3).

Both Prosecution and Defense Can Request an Opportunity To Have Defendant Examined By An Examiner Of Their Own Choosing

- *See, People v. Del Rio,* 220 A.D.2d 122 (2nd Dept. 1996)

THE COMPETENCY HEARING

- Burden of Proof - People have the burden to show by a fair preponderance of the evidence that defendant is not incapacitated

People v. Tortorici, 92 N.Y.2d 757,770 (1999)
People v. Christopher, 65 N.Y.2d 417, 424-425 (1985)

Issue:

What happens if prosecution is satisfied Defendant is incompetent but Defense counsel asserts defendant is competent?

Standard and factors to consider

Dusky v. United States, 362 U.S. 402 (1960)

People v. Francabandera, 33 N.Y.2d 429, 436 (1974)

see also, People v. Picozzi, 106 A.D.2d 413 (2nd Dept. 1984), *lv. denied,* 64 N.Y.2d 1137 (1985).

The Court should consider the following factors:

- whether defendant is oriented as to time and place
- is able to perceive, recall, relate
- has an understanding of the process of the trial and the roles of Judge, jury, prosecutor and defense attorney
- can establish a working relationship with his attorney
- has sufficient intelligence and judgment to listen to advice of counsel, and, based on that advice, appreciate (without necessarily adopting) that one course of conduct may be more beneficial to him than another
- is sufficiently stable to enable him to withstand the stresses of the trial without suffering a serious prolonged or permanent breakdown.

People v. Picozzi, 106 A.D.2d 413 (2nd Dept. 1984), *lv. denied,* 64 N.Y.2d 1137 (1985).

Standards and Factors

"The key inquiry in determining whether a criminal defendant is fit for trial is whether he or she has sufficient present ability to consult with his or her lawyer with a reasonable degree of rational understanding – and whether he or she has a rational as well as factual understanding of the proceedings against him or her' *(People v. Phillips,* 16 N.Y.3d 510, 516 [2011][internal quotation marks, brackets and citation omitted]"

People v. Babcock, ___ A.D.3d ___ (3rd Dept. 2017), 2017 WL 3080582 (July 20, 2017).

Standards & Factors

"In making this determination, a court may take into account the findings of any competency examination as well as its own observations of the defendant' [quoting *People v. Kendall,* 91 A.D.3d 1191, 1192 (3rd Dept. 2012)][citations omitted]..."

People v. Babcock, ___ A.D.3d ___ (3rd Dept. 2017), 2017 WL 3080582 (July 20, 2017).

Medication Induced Competency - a defendant does not have to be competent independent of medication

People v. Williams, 144 A.D.2d 402 (2nd Dept. 1988) - Defendant was diagnosed with chronic paranoid schizophrenia and was receiving anti-psychotic drug Thorazine which suppressed his psychosis. Since defendant could assist in his own defense, trial court did not err by finding him competent.

See also, People v. Lopez, 160 A.D.2d 335 (1st Dept. 1990, *app. denied,* 76 N.Y.2d 791 (1991)

A New Standard For
Medication Induced Competency?

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

- Medicated competence by psychotropic drugs does not violate 5th Ad. Due Process, but only if
  - -treatment medically appropriate
  - -substantially unlikely to have side effects that might undermine fair trial
  - -necessary to further important trial-related government interests

Is medication induced "synthetic sanity" "cognitive censorship?"

Although Defendant may properly be medicated to achieve capacity, Court may order him or her cycled off medications during trial so that jury may observe defendant's condition when not on medication.

See, *Riggins v. Nevada,* 504 U.S. 127 (1992)

Developmentally Disabled defendants found incompetent

***See, e.g. Jackson v. Indiana,* 406 U.S. 715 (1972);**
***People v. Villanueva,* 139 Misc.2d 751 (N.Y. Sup. Ct. 1988);**
***People v. Santos,* 127 Misc. 2d 63 (N. Y. Sup. Ct. 1985)**

Mildly Developmentally Disabled defendant found competent

***see, e.g.,People v. Bronson,* 115 A.D.2d 484 (2nd Dept. 1985)**

Procedure Following Determination of Unfitness to Proceed

Misdemeanors

Court signs final order of observation [CPL 730.40]

- Charge is dismissed by operation of law
- Order of protection not obtainable
- Defendant confined in a hospital for up to 90 days
- Any subsequent proceedings are civil
- People must forward to Comm. Of Mental Health names of PIVs (Potentially Identified Victims)
- If defendant is discharged, released, or placed in a less restrictive confinement District Attorney may apply for hearing [CPL 730.60 (6)(c)]

Potentially Identified Victims (PIV)

- Who is a PIV?
- What information must be forwarded?
- Who makes the determination?
- Can a PIV opt out?

Felonies
Pre-Indictment

•Court issues a temporary order of observation
- CPL 730.40(1)

•At expiration of temporary order of observation, proceeding in local criminal court terminates but People may still present charges to Grand Jury within six months of expiration of temporary order of observation - CPL 730.40 (2), (5)
•Accusatory Instrument is dismissed

•Case may be presented to Grand Jury during defendant's incompetency, and Grand Jury need not hear defendant pursuant to CPL 190.50
-CPL 730.40 (3)

CPL 730.40 (3)

"When a local criminal court has issued an order of examination or a temporary order of observation, and when the charge or charges contained in the accusatory instrument are subsequently presented to a grand jury, such grand jury need not hear the defendant pursuant to section 190.50 unless, upon application by defendant to the superior court that impaneled such grand jury, the superior court determines that the defendant is not an incapacitated person."

Felonies - Post Indictment

- Court issues Order of Commitment committing defendant to custody of the Commissioner of Mental Health for a period not to exceed one year - CPL§730.50(1)

- If Defendant is still incompetent at expiration of Order of Commitment, court may issue retention order and subsequent retention orders of two year periods - CPL §730.50(1)

- The aggregate period of the retention orders "must not exceed two-thirds of the authorized maximum term of imprisonment for the highest class felony charged in the indictment or for the highest class felony of which he was convicted.

- When defendant has been retained for 2/3 of the maximum time, the Commissioner must certify that defendant is in their custody . The indictment is dismissed. The Commissioner may or may not seek civil commitment.

•While defendant is in the custody of the Commissioner of Mental Health, the pending criminal action is suspended - CPL 730.60 (2)

•If psychiatric reports find defendant fit, People may not be able to argue good cause for extension of CPL §180.80 when defendant is brought back for further proceedings – See *People v. Smith,* 143 Misc. 2d 100 (NY City Crim. Ct. 1989).

•At the expiration of the last authorized retention order, the Court must dismiss the indictment and the dismissal is a bar to any further prosecution of the charge or charges in the indictment - CPL 730.50 (4)

•Commissioner of Mental Health may recommend Civil Commitment.

The Statute Does Not Define 2/3 of Death or 2/3 of Life without Parole

Speedy Trial

CPL § 30.30 (4)(a)

4. In computing the time within which the people must be ready for trial pursuant to subdivisions one and two, the following periods must be excluded:

(a) a reasonable period of delay resulting from other proceedings concerning the defendant, including but not limited to: proceedings for the determination of competency and the period during which defendant is incompetent to stand trial;.....and the period during which such matters are under consideration by the court...

Grand Jury Proceedings

People v. Lancaster, 69 N.Y.2d 20 (1986)

•Prosecutor does not have a duty to instruct Grand Jury about mitigating defenses.

•Consideration of the insanity defense is not within the province of the Grand Jury, but rests exclusively with the petit jury.

•People are not required to instruct the Grand Jury about evidence tending to negate intent, but are "free to seek an indictment for the highest crime the evidence will support..."
[quoting *People v. Valles,* 62 N.Y.2d 36, 39]

Jackson Issues

- If defendant is incompetent, and the court determines that he will not, in the near future become competent, and is not making progress towards that goal, the court must Order that the Commissioner either release defendant or move to civilly commit him pursuant to Mental Hygiene Law Article 9 or 15

  Jackson v. Indiana, 406 U.S. 715 (1972)
  People v. Schaffer, 86 N.Y.2d 460 (1995)

- Release under *Jackson* does not *per se* affect the pendency of the indictment.

  People v. Schaffer, supra at 468

- Prosecution may still proceed if defendant becomes competent

Jackson Issues

- Dismissal of charge because defendant is incompetent is not a ground for dismissal under CPL 210.40

  People v. Shaffer, 86 N.Y.2d 460, 464 (1995)

- Court may entertain a *Jackson* motion immediately upon determination of incapacity under Article 730

  Shaffer, supra

- *Jackson* time does not count towards 2/3 dismissal rule

  People v. Lewis, 95 N.Y.2d 539 (2000)

Are there separate standards of Competency for each stage in the Proceedings?

- Self-Representation
- Pre-trial hearings
- Plea
- Trial
- Sentencing

Competency for self-representation at trial

Defendant may be competent to Proceed to trial but lack capacity for self-representation

- *People v. Stone,* 22 N.Y.3d 520 (2014)
- *People v. People v. Reason,* 37 N.Y.2d 351 (1975)

Self Representation

People v. Stone, 22 NY3d 520 (2014)

- Defendant's mental capacity can be taken into account
- Court does not have to hold a special Hearing
- Court must make a searching inquiry to clarify that defendant understands the ramifications
- Defendant can be competent to Proceed but not competent to Voluntarily and intelligently waive Right to counsel.

People v. Stone, 22 N.Y.3d 520 (2014)

- Defendant asked to be relieved of counsel and proceed *Pro Se.*
- Court granted motion and defendant represented himself
- Defendant became incapacitated prior to sentencing
- After he was restored to competence, he was represented by counsel and sentenced
- Defendant argued the Court should not have granted his motion for self-representation because he was not competent.

New York's Insanity Defense

Mental Disease or Defect [Insanity Defense] Penal Law §40.15

"In any prosecution for an offense, it is an affirmative defense that when the defendant engaged in the proscribed conduct, he lacked criminal responsibility by reason of mental disease or defect. Such lack of criminal responsibility means that at the time of such conduct, as a result of mental disease or defect, he lacked capacity to know or appreciate either:

1. The nature and consequences of such conduct;

or

2. That such conduct was wrong."

Insanity Defense Reform Act

- Current Law was partially a result of Hinkley and Adam Berwid cases.
- Changed the defense to an affirmative defense
- Statistically, the defense is rarely successful

Insanity Defenses

- McNaughten
- Irresistible Impulse
- Durham Rule (Product Rule)
- Guilty But Mentally Ill (GBMI)

- **Presumption of Sanity**
- **Affirmative Defense**
- **The jury must determine that defendant committed the underlying crime before it considers the insanity defense.**
- **The prosecution must still prove intent if it is an element of the crime *People v. Kohl,* 72 N.Y.2d 191 (1988)**
- **Admissible Evidence - see CPL 60.55**
- **Required charge to jury - see CPL 300.10 (3)**

Insanity Defense In Grand Jury Proceedings

***People v. Lancaster,* 69 N.Y.2d 20 (1986)**

- **Prosecutor does not have a duty to instruct Grand Jury about mitigating defenses**
- **Consideration of the insanity defense is not within the province of the Grand Jury, but rests exclusively with the petit jury**
- **People are not required to instruct the Grand Jury about evidence tending to negate intent, but are "free to seek an indictment for the highest crime the evidence will support..."**
  [quoting *People v. Valles,* 62 N.Y.2d 36, 39]

CPL 60.55 (1)

Rules of Evidence; Psychiatric Testimony In Certain Cases

Psychiatrist or psychologist must be permitted to make statement about

- **Nature of the examination**
- **Diagnosis of defendant's mental condition**
- **Opinion about whether defendant's ability to know or appreciate nature and consequences or wrongfulness of his actions was impaired by mental disease or defect at time of crime**

CPL 60.55 (1)

- **Psychiatrist or psychologist must be permitted to make explanation to clarify diagnosis and opinion**
- **Expert may be cross-examined about any matter concerning his credibility or competency or validity of opinion and diagnosis**

CPL 60.55 (2)

Statements by defendant to psychiatrist or psychologist during examination "inadmissible in evidence on any issue other than that of the affirmative defense...The statement shall, however, be admissible upon the issue of the affirmative defense...whether or not it would otherwise be deemed a privileged communication."

CPL 60.55 (2)

"Upon receiving the statement in evidence, the court must instruct the jury that the statement is to be considered only on the issue of such affirmative defense and may not be considered by it in its determination of whether the defendant committed the act constituting the crime charged."

CPL 300.10 (3)

"...the court must, without elaboration, instruct the jury as follows 'A jury during its deliberations must never consider or speculate concerning matters relating to the consequences of its verdict. However, because of the lack of common knowledge regarding the consequences of a verdict of not responsible by reason of mental disease or defect, I charge you that if this verdict is rendered by you there will be hearings as to the defendant's present mental condition and, where appropriate, involuntary commitment proceedings.'"

Types of Psychiatric Exams

- *Rufus Lee* examination
- Competency examination
- CPL 330.20 examination

In our discussion, there are common elements to all three types of examinations.

A well conceived examination by a prosecution expert will insure your ability to consider the consequences of opposing or acquiescing in the affirmative defense.

Matter of Rufus Lee v. County Court of Erie County, 27 N.Y.2d 432 (1971)

- Prosecution may ask permission of Court To have defendant examined by their own expert.

Notice of Intent to Proffer Psychiatric Evidence and examination by People's psychiatrist or psychologist CPL §250.10. [Cf. CPL §400.27 (13)(b), (c)]

"psychiatric evidence" means -

- "Evidence of mental disease or defect to be offered by the defendant in connection with the affirmative defense of lack of criminal responsibility by reason of mental disease or defect." CPL§ 250.10(1)(a).

- "Evidence of mental disease or defect to be offered by the defendant in connection with the affirmative defense of extreme emotional disturbance as defined in paragraph (a) of subdivision one of section 125.25 of the penal law and paragraph (a) of subdivision two of section 125.27 of the penal law." CPL §250.10 (1)(b)

- "Evidence of mental disease or defect to be offered by the defendant in connection with any other defense not specified in the preceding paragraphs." CPL §250.10 (1)(c)

The evidence is inadmissible unless defendant serves upon people and files with court written notice of intention to present psychiatric evidence CPL §250.10(2).

•The notice "must contain enough information to enable the prosecution and the court to discern the general nature of the alleged psychiatric malady and its relationship to a particular proffered defense." *People v. Almonor,* 93 N.Y.2d 571 (1999); *see also,* Preiser, Practice Commentaries, 1999

•notice applies to any defense or affirmative defense – *People v. Berk,* 88 N.Y.2d 257 (1996)

•notice must be before trial

•no more than 30 days after entry of plea of not guilty to the indictment

•later filing if in the interest of justice and good cause shown
-court's discretion, but discretion not absolute _ *People v. Berk, supra.*

• Caveat - Federal Courts may potentially find violation of 6th Adm. right to present a defense. [See, *Almonar*]

When defendant gives notice, People may apply to court, upon notice, for an order directing *Rufus Lee* examination by People's psychiatrist or psychologist CPL §250.10(3).

- defendant has right to have counsel present
- district attorney may also be present
- counsel may not take active role and are merely passive observers

- People may have defendant independently examined, even if defendant not examined by psychiatric examiner for guilt phase of capital case and will not present expert testimony at guilt phase – *People v. Irwin,* 182 Misc. 2d 113 (Sup.Ct. Sullivan Co. 1999).
- Psychiatrist or psychologist must prepare a report and make it available to both sides. CPL §250.10 (4)
- Transcript or recording of examination is not required but if made, must be available to both parties prior to trial

- **Some examiners may prefer that the proceedings not be transcribed or recorded.**

- **Transcript helpful to prepare cross-examination and if ultimately defendant is found not responsible, transcript useful for post-adjudication proceedings under CPL 330.20.**

- If defendant "willfully refused to cooperate fully" court may preclude testimony by defendant's psychiatrist or psychologist. CPL §250.10 (5)

- If defendant has other proof of affirmative defense, which is otherwise competent it is admissible but court must instruct jury of defendant's non-cooperation and "such failure may be considered in determining the merits of the affirmative defense."

- Psychiatric Exam may toll CPL section 30.30 time – *People v. Boda,* 28 A.D.3d 379 (1st Dept. 2006).

The Goldstein/Crawford Problem

People v. Goldstein, 6 N.Y.3d 119 (2005)

- Psychiatrist may testify to opinion, even if based on hearsay from third parties
- Psychiatrist established third party information accepted practice in the profession

But

- Confrontation Clause prohibits testimonial hearsay – Expert can not testify about the third party hearsay statements
- Statements to People's expert were "formal" statements made to government officers

Conducting the Examination

- Place of Examination
- Layout of examination room
- Transcription of the proceedings
- Security Concerns
- Presence of the Attorneys
- Role of the Attorneys

The Report

- Contents – CPL 250.10 does not specify what must be in the report.
- Conclusions
- Ramifications

Insanity Plea
CPL §220.15

•Requires consent of Court and Prosecution

•Prosecution must indicate their satisfaction that defense would be proven by defense by a preponderance of the evidence

•Defense counsel must state its opinion that defendant has capacity to enter the plea

Insanity Plea
CPL §220.15

- Court must advise defendant of his rights
- Court must determine that there is a factual basis for the plea and that the prosecution would prove each element of the crime beyond a reasonable doubt
- Court must further find that defendant's plea was knowing and voluntary
- Court must find that acceptance of the plea is required in the interest of the public in the effective administration of justice

Insanity Plea
CPL §220.15

- Consider whether defendant will concede dangerousness as part of plea
- Consider whether defendant will provide HIPAA waiver for medical & psychiatric records at all subsequent CPL 330.20 proceedings
- Defendant is entitled to effective assistance of counsel at initial hearing -
Matter of Brian HH, 39 A.D.3d 1007 (3rd Dept. 2007).

Insanity Plea or Verdict

- **Trial Record Should Include Crime Scene Photos, Statements, Tape Recordings, Psychiatric Reports [from both parties], Videotapes, Police Reports**
- **Put together an exhibit packet and have it entered as a Court Exhibit**
- **Plea Minutes or Trial Transcript**

POST INSANITY ADJUDICATION PROCEEDINGS

"'Mental illness' means an affliction with a mental disease or mental condition which is manifested by a disorder or disturbance in behavior, feeling, thinking, or judgment to such an extent that the person afflicted requires care, treatment and rehabilitation." Mental Hygiene Law §1.03(20) [*see also,* Corrections Law §508 (3)(b)(ii) – same definition, minus "and rehabilitation"].

CPL §330.20 – Psychiatric Examiners

"'Qualified psychiatrist' means a physician who (i) is a diplomate of the American board of psychiatry and neurology or is eligible to be certified by that board; or (ii) is certified by the American osteopathic board of neurology and psychiatry or is eligible to be certified by that board." – CPL §330.20 (1)(q)

CPL § 330.20- Post Acquittal Proceedings

CPL §330.20 (1)(c) - "'Dangerous mental disorder' means: (i) that a defendant currently suffers from a 'mental illness' as that term is defined in subdivision twenty of section 1.03 of the mental hygiene law, and (ii) that because of such condition he currently constitutes a physical danger to himself or others."

CPL §330.20 – Post Acquittal Proceedings

CPL §330.20 (1)(d) – "'Mentally ill' means that a defendant currently suffers from a mental illness for which care and treatment as a patient, in the in-patient services of a psychiatric center under the jurisdiction of the state office of mental health is essential to such defendant's welfare and that his judgment is so impaired that he is unable to understand the need for such care and treatment..."

Post Insanity Adjudication Proceedings

Examination Order -CPL §330.20 (2),(3) and (4)

- **Initial Examination -30 days unless additional 30 days granted**
- **at least two psychiatric examiners**
- **Prosecution can hire its own doctor [CPL §330.20(15)]**
- **Court may appoint one or more additional examiners if not satisfied with the reports**
- **Court must furnish reports to DA, Defendant's Attorney and MHLS**
- **People have the burden to prove defendant is dangerously mentally ill or mentally ill by preponderance of the evidence *People v. Escobar,* 61 N.Y.2d 431 (1984)**

The Initial Hearing

Determination of Dangerousness - *Matter of George L.,* 85 N.Y. 2d 295 (1995)

Court must look to surrounding factors to determine whether defendant is dangerous. Synthetic sanity does not by itself, demonstrate lack of dangerousness

- **nature and recency of crime**
- **potential victims**
- **risk of relapse or returning to dangerous behavior**
- **compliance or lack of dangerousness in a facility does not necessarily mean defendant is not dangerous**

Results of Initial Hearing

Three possible results [tracks]:

Track 1 - Defendant is dangerously mentally ill [CPL §330.20 (6)]
- **confinement in a secure hospital for six months**
- **first retention for one year**
- **second and subsequent retentions for up to two years each**
- **District Attorney remains a party**
- **possible future confinement in non-secure facilities – See *Matter of David B.,* 97 N.Y.2d 267 (2002).**
- **possible future furloughs**
- **hearings are generally held in county where defendant is confined.**

Track 2

- **Defendant is mentally ill but not dangerous [CPL §330.20 (6),(7)]**
- **prosecution is essentially no longer a party**
- **defendant is confined in a civil [non-secure] facility**
- **future release or confinement of defendant is a matter for court and hospital to decide**
- **defendant can revert to track one if he is released but becomes dangerously mentally ill**

Track 3

•Defendant is neither mentally ill nor dangerous and is immediately released- either conditionally or subject to an order of conditions [CPL §330.20 (7)]

CPL §330.20 - Additional Provisions

•Furlough Orders - subd. 10
•Order of Conditions - subd. (1)(0)
-see *Matter of Oswald N.,* 87 N.Y.2d 98 (1995)
•Recommitment Order - subd.14 - see *People v. Stone,* 73 N.Y. 2d 296 (1989)
•Rehearing and Review - subd.16
•Escape from custody [elopement]- see *Ortega*
•Appeals - subd.21

Forensic Assessment of Individuals with Developmental Disabilities

Dr. Kate Termini

Topics

- Definition
- Etiology
- Diagnoses
- Components of a forensic neuropsychological evaluation
- The forensic neuropsychological assessment process
- The forensic neuropsychological report
- Competencies

Definition of Developmental Disability

- Developmental Disabilities are a group of conditions that result in an impairment in physical, learning, language and/or behavioral abilities. These conditions originate at birth or during the developmental period, substantially restrict the individual's functioning in several major life activities, and are expected to continue throughout the person's lifespan.
- Not all developmental disabilities result in cognitive impairment. For the purpose of this presentation, the focus will be on those disorders that affect cognitive functioning.

Etiology

- There are multiple etiologies for developmental disabilities. Some potential causes include:
  - Genetic or chromosomal disorders – ie., Down syndrome, Fragile X syndrome, Tay-Sachs disease
  - Birth/pre-natal complications – anoxic events, cerebral palsy, hydrocephalus, fetal alcohol syndrome
  - Acquired injury – epilepsy, traumatic brain injury, heavy metal poisoning
- Sometimes DD is the result of multiple factors and sometimes there is no clear etiology. Intellectual disability (previously mental retardation) often has no clear, singular cause. Autism is believed to be a combination of multiple factors.

Diagnoses

- In the DSM-V, within the heading of Neurodevelopmental Disorders is:
  - Intellectual Disabilities
  - Communication Disorders
  - Autism Spectrum Disorder
  - Attention Deficit/Hyperactivity Disorder
  - Specific Learning Disorder
  - Motor Disorders
  - Other Neurodevelopmental Disorders

Intellectual Disability

- Also known as Intellectual Developmental Disorder.
- A disorder with onset during the developmental period that includes both intellectual and adaptive functioning deficits in conceptual, social and practical domains.
- Must meet the following criteria:
  - Deficits in intellectual functions, such as reasoning, problem-solving, planning, abstract thinking, judgment, academic learning and learning from experience, and practical understanding, confirmed by both clinical assessment and individualized, standardized intelligence testing (two sd's below the mean)
  - Deficits in adaptive functioning that result in failure to meet developmental and sociocultural standards for personal independence and social responsibility. Without ongoing support, the adaptive deficits limit functioning in one or more activities of daily life. Must be in at least one domain: conceptual, social and practical.
  - Onset of intellectual and adaptive deficits during the developmental period.
  - Can be qualified as mild, moderate, severe, and profound.

Communication Disorders

- Language Disorder
  - Persistent difficulties in the acquisition and use of language across modalities due to deficits in comprehension or production including reduced vocabulary, limited sentence structure and/or impairments in discourse.
    - Language abilities are substantially and quantifiably below the expected age, resulting in functional limitations.
- Speech Sound Disorder
- Stuttering
- Social (Pragmatic) Communication Disorder
  - Persistent difficulties in the social use of verbal and nonverbal communication. These individuals can seem autistic but the deficits are isolated to speech/communication.

Autism Spectrum Disorder

- Persistent deficits in social communication and social interaction across multiple contexts, as manifested by:
  - Deficits in social-emotional reciprocity
  - Deficits in nonverbal communicative behaviors used for social interaction (ie – verbal/nonverbal communication integration, eye contact, use of gestures, facial expression)
  - Deficits in developing, maintaining, and understanding relationships.
- Restricted, repetitive patterns of behavior, interests, or activities as manifested by:
  - Stereotyped or repetitive motor movements
  - Inflexible adherence to routines or ritualized patterns
  - Highly restricted, fixated interests that are abnormal in intensity or focus
  - Hyper or hypo-reactivity to sensory input or unusual interest in sensory aspects of the environment.
- Symptoms must be present in the developmental period and cause clinically significant impairment.
- Qualifiers – with or without accompanying intellectual impairment, with or without accompanying language impairment. Can be level 1, 2 or 3 depending on the level of support required (any support, substantial support, or very substantial support.)

ADHD and Specific Learning Disorders

- Attention Deficits/Hyperactivity Disorder
  - Persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development. Can have combined presentation or predominantly inattentive or predominantly hyperactive.
- Specific Learning Disorder
  - Difficulties learning and using academic skills, as indicated by difficulties with reading, reading comprehension, spelling, written expression, mastering numbers/calculation, mathematical reasoning.

Other Specified or Unspecified Neurodevelopmental Disorder

- Symptoms characteristic of a neurodevelopmental disorder that cause impairment in social, occupational or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the neurodevelopmental disorders diagnosis class. The clinician can choose to specify the reason.
  - Example: Neurodevelopmental disorder associated with prenatal alcohol exposure.

Neuropsychological research and criminal offenders

- Incarcerated individuals overall have a lower average IQ and higher prevalence of intellectual disability than the general population. Studies have shown that sexual offenders with offenses towards children have an even higher prevalence of cognitive deficits.

- Studies done to date suggest that there might be some connection between impairment found within certain areas of brain. Brain damage may also contribute to an inability to control anger or disorganized thought. Brain structures/areas commonly associated with violent behavior include:
  - Prefrontal cortex (primarily medial and ventromedial sections)
  - Amygdala and Hippocampus
  - Temporal lobe
  - And, to a lesser extent: Corpus Callosum and Angular Gyrus

Developmental Disabilities and Crime

- Those with developmental disabilities are significantly more likely to be the victims of crimes (4 to 10 times more likely than those without a disability).
- Approximately 5-10% of the prison population has an intellectual disability, versus 2-3% of the general population.
- Individuals with DD are frequently used by other criminals to assist in law-breaking activities without understanding their involvement in a crime or the consequences of their involvement.
- They may also have a strong need to be accepted and may agree to help with criminal activities in order to gain friendship.
- Many individuals unintentionally give misunderstood responses to officers, which increase their vulnerability to arrest, incarceration and possibly execution, even if they committed no crime.
- Once in the criminal justice system, these individuals are less likely to receive probation or parole and tend to serve longer sentences due to an inability to understand or adapt to prison rules.

Defendants with DD

- Individuals with DD in police custody may respond in certain ways because they may:
  - not want their disability to be recognized (and try to cover it up)
  - not understand their rights but pretend to understand
  - not understand commands, instructions, etc.
  - be overwhelmed by police presence
  - act upset at being detained and/or try to run away
  - say what they think officers want to hear
  - have difficulty describing facts or details of offense
  - be the first to leave the scene of the crime, and the first to get caught
  - be confused about who is responsible for the crime and "confess" even though innocent

Cautions with Low Functioning Clients

- Expect poor time frames
- Expect inconsistent estimations of frequency or number of occurrences
- Inconsistent information may be a function of the person trying to be compliant rather than being misleading.

What is Neuropsychology?

- Neuropsychology is the study of the structure and function of the brain as they relate to specific psychological and cognitive processes and behaviors.
- It aims to understand how behavior and cognition are influenced by brain functioning and is concerned with the diagnosis and treatment of behavioral and cognitive effects of neurological disorders.
- We utilize a large array of neuropsychological tests to determine how behavior/cognition correlates to neuroanatomical functioning.

Forensic-Neuropsychological Evaluation

- Preparation for the Case
- Psychiatric Examination
- Mental Status Examination
- Psychological testing and Neuropsychological assessment
- Collateral interviews
- Data Analysis
- Forensic Report
- Testimony

Preparation for the Case

- Identify the issue – What's the referral question?
- Expectations / Purpose
- Set Fee – work vs. testimony
- Provide all relevant materials / data source
- Relevant legal statutes

Collateral Sources

- Legal Discovery
- ACS/CPS records
- Prior medical/psychiatric records
- Current medical/psychiatric records
- Academic records – if someone had an IEP (Individualized Education Plan) in school, they must at some point have had cognitive assessment.
- Occupational evaluations
- Military records

Components of the Neuropsychological Examination

- Evaluations are comprised of multiple sources of information, not simply that provided by the client during interview. Sources of information include:
  - Review of History
  - Collateral interviews
  - Extensive client interview/direct examination
  - Mental status exam
  - Neuropsychological and psychological assessment
  - Data analysis
  - Written report of results and professional opinion

Areas assessed during neuropsychological assessment

- General intellectual ability
- Pre-morbid cognitive ability
- Malingering of cognitive symptoms
- Learning and memory
- Language abilities
- Executive Functioning
- Attention and concentration
- Visuo-spatial abilities
- Academic Abilities
- Adaptive functioning
- Emotional Functioning and social cognition

How is this done?

- Extensive clinical interview
- Mental status examination
- Neuropsychological assessment battery
  - This will vary from client to client depending on the referral/diagnosis in question. It will almost always include a WAIS-IV.
- Review of relevant records, including neuroimaging

Information obtained during Interview

- Self report of cognitive symptoms
- Family medical history
- History of mother's pregnancy/delivery
- Developmental milestones
- Substance use, both self and family
- Medical history, including history of head injury or loss of consciousness
- Educational history
- Employment/financial/housing problems
- Interpersonal functioning
- Psychiatric history

Current Review of Problems/Symptoms

- Symptoms commonly described by individuals with DD:
  - Poor memory – often related to attentional problems/focus
  - Trouble communicating appropriately, word finding problems
  - Difficulty with self-care
  - Difficulty maintaining employment
  - Feeling like no one understands them/they don't fit in anywhere
  - Getting lost easily
  - Requiring an escort for appointments
  - Poor judgment/decision making

Data Analysis

- Review raw data – all test scores are normed by age and sometimes by education as well.
- Integrate data with presentation and prior history/records
- Diagnose
- Apply to relevant statutes
- Formulate conclusion and opinion

Forensic-Neuropsychological Report

- Referral data
- Past personal history
- Review of Incident
- Collateral Sources
- Mental Status
- Neuropsychological test results
- Formulation and Diagnosis
- Opinion

Prepping?

- Honesty is the BEST policy
- Clients should not be made familiar with the testing instruments
- If a client is found to be malingering, that can often lead to a worse case scenario. Thus, honest responding is critical

Criminal Competencies

- To stand trial
- To waive Miranda Rights
- To plead guilty
- To be sentenced
- To be executed
- To represent himself/herself, i.e. going Pro Se

Civil Competencies

- Informed consent
- Competence as witness
- Competence to enter contract
- Competency to make a will

The Disorders Associated with Incapacity under Article 81

- Dementia and disease-related dementia
  - Alzheimer's
  - Vascular dementia
  - HIV
  - Traumatic Brain Injury (head trauma)
  - Parkinson's
  - Huntington's
- Developmental Disabilities
- Intellectual Developmental Disorder

NEW YORK STATE OF OPPORTUNITY. | Office for People With Developmental Disabilities

Navigating Justice for Individuals with Developmental Disabilities

by Deborah J. Chard-Wierschem, Ph.D. Director,
Bureau of Intensive Treatment Services (BITS), NYS OPWDD

"Representing Individuals with Developmental Disabilities"
Suffolk Academy of Law, New York

Date: December 14, 2017

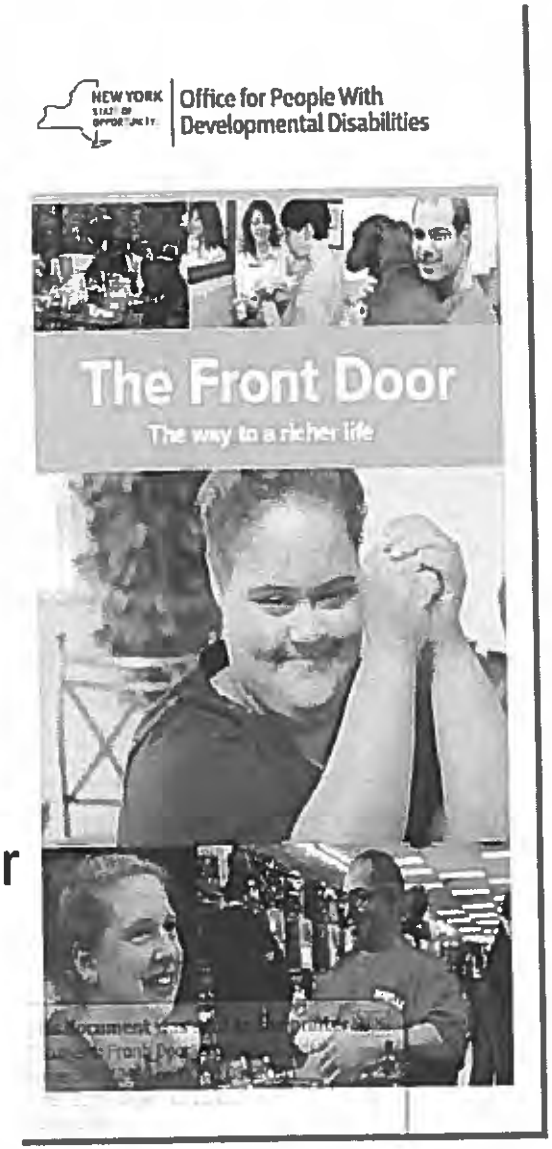
Outline

1. OPWDD: Who Are We?
2. OPWDD Eligibility and Services
3. OPWDD Response to CPL Orders
4. Tips for Attorneys
5. Appendix A: OPWDD forensics
6. Appendix B: Overview of CPL

OPWDD: Who are we?

OPWDD: Overview

- NYS Office for People With Developmental Disabilities (OPWDD)
- Responsible for *coordinating services* to >130,000 individuals with intellectual and developmental disabilities
- Certifies and oversees **approximately** 700 voluntary agency providers
- MHL Article 15 admissions to campuses
- By law, can only provide services to individuals who have been found eligible for services
- OPWDD's "Front Door" process guides request for services; eligibility is key



OMH and OPWDD: Two Agencies

NYS Office of Mental Health (OMH) and the

NYS Office for People With Developmental Disabilities (OPWDD)

are two separate agencies.

NEW YORK STATE OF OPPORTUNITY. | Office for People With Developmental Disabilities

NYS OMH: Description

- 22 psychiatric hospitals (includes 4 forensic; 3 children's)
- 5 Field Offices (each one with a Forensic Liaison)
- MHL Article 9 & 10 admissions
- Many forensic initiatives and programs due to size of population served and funding
- Provides MH services to state prison system; DOCCS and OMH oversee discharge planning
- OMH contact info: Forensics Bureau; 518-549-5068

OPWDD Mission

OPWDD helps people with developmental disabilities live richer lives

NEW YORK STATE OF OPPORTUNITY | Office for People With Developmental Disabilities

OPWDD VISION

People with developmental disabilities have a chance to…

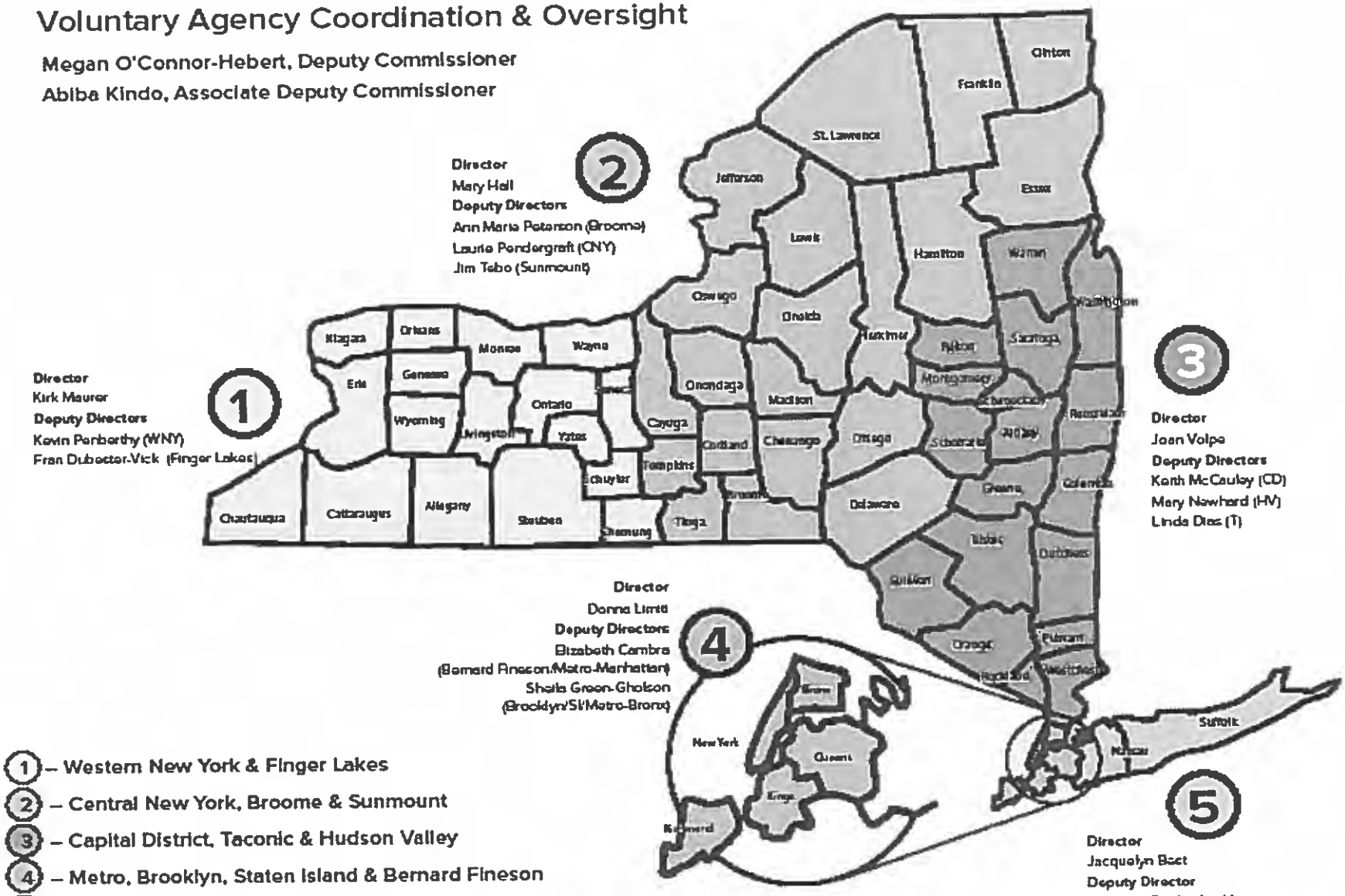
- ❑ enjoy meaningful relationships with friends, family and others in their lives
- ❑ experience personal health and growth
- ❑ live in the home of their choice
- ❑ fully participate in their communities

Updated: 09/17

5 Developmental Disabilities Regional Offices

Voluntary Agency Coordination & Oversight

Megan O'Connor-Hebert, Deputy Commissioner
Abiba Kindo, Associate Deputy Commissioner



1 – Western New York & Finger Lakes
2 – Central New York, Broome & Sunmount
3 – Capital District, Taconic & Hudson Valley
4 – Metro, Brooklyn, Staten Island & Bernard Fineson
5 – Long Island

Find your Regional Office

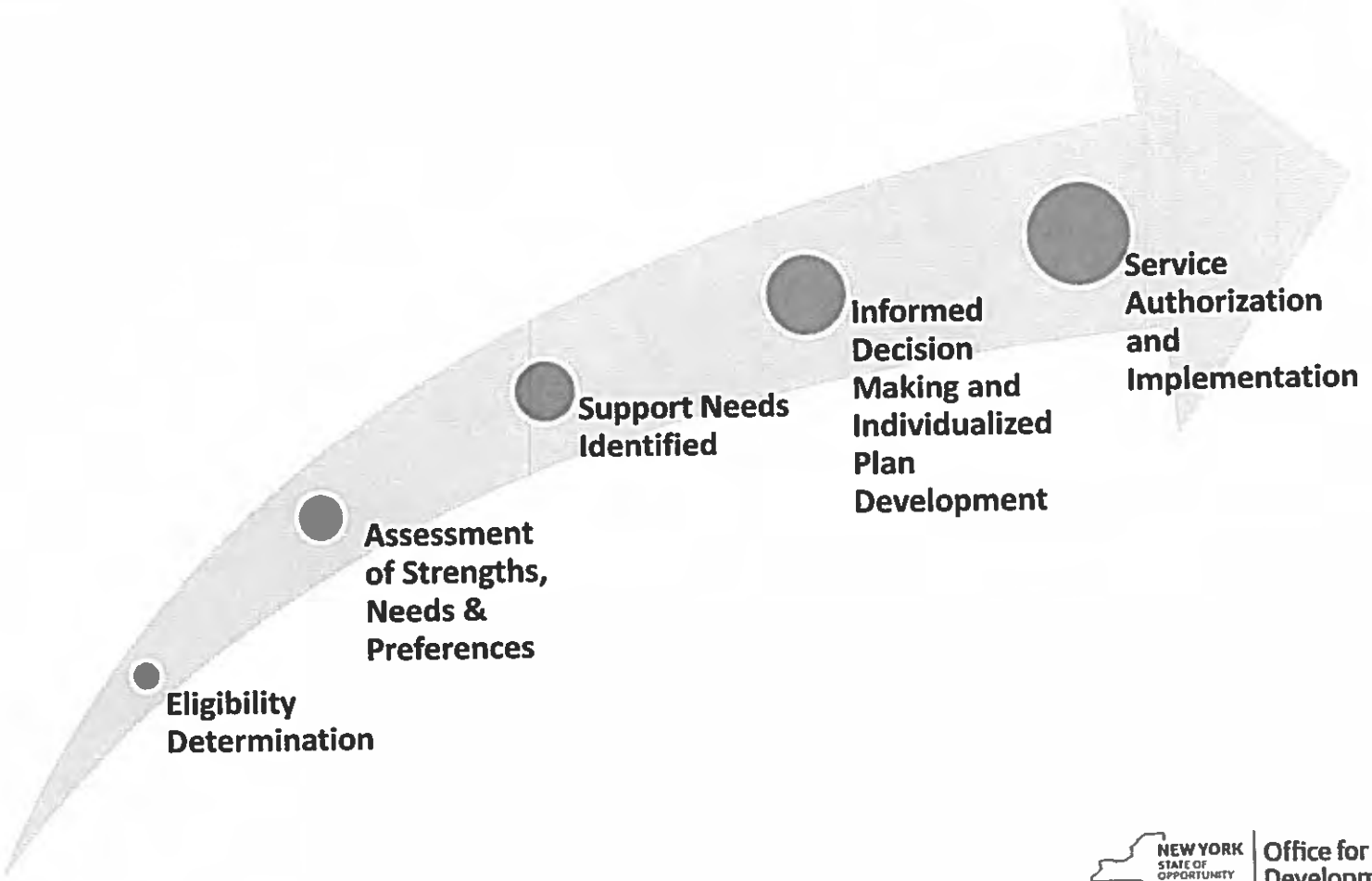
- Unless an individual is already being served by an OPWDD state-operated program, OPWDD-certified services are handled by OPWDD Regional Offices. (https://opwdd.ny.gov/welcome-front-door/Front_Door_Contact_Numbers)

- **Region 1**
  - *Finger Lakes:* Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne, Wyoming, Yates
  - *Western:* Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans
- **Region 2**
  - *Broome:* Broome, Chenango, Delaware, Otsego, Tioga, Tompkins
  - *Central:* Cayuga, Cortland, Herkimer, Lewis, Madison, Oneida, Onondaga, Oswego
  - *Sunmount:* Clinton, Essex, Franklin, Hamilton, Jefferson, St. Lawrence
- **Region 3**
  - *Capital:* Albany, Fulton, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, Washington
  - *Hudson Valley:* Orange, Rockland, Sullivan Westchester
  - *Taconic:* Columbia, Dutchess, Greene, Putnam, Ulster
- **Region 4** *Queens/ Kings (Brooklyn)/ Manhattan/ Bronx/ Staten Island*
- **Region 5** *Long Island: Nassau, Suffolk*

OPWDD Eligibility and Services

NEW YORK STATE OF OPPORTUNITY. Office for People With Developmental Disabilities

ACCESSING OPWDD SERVICES



NEW YORK STATE OF OPPORTUNITY | Office for People With Developmental Disabilities

OPWDD Eligibility and MHL Law §1.03

(22) "**Developmental disability**" means a disability of a person which:

(a) (1) is attributable to intellectual disability, cerebral palsy, epilepsy, neurological impairment, familial dysautonomia, Prader-Willi Syndrome or autism;

OR (2) is attributable to any other condition of a person found to be closely related to intellectual disability because such condition results in similar impairment of general intellectual functioning or adaptive behavior to that of intellectually disabled persons or requires treatment and services similar to those required for such person;

OR (3) is attributable to dyslexia resulting from a disability described in subparagraph (1) or (2) of this paragraph;

AND....

OPWDD Eligibility and MHL Law §1.03

…AND

(b) originates before such person attains **age 22;**

AND

(c) has continued or can be expected to continue **indefinitely**;

AND

(d) constitutes a **substantial handicap** to such person`s ability to function normally in society.

OPWDD Eligibility Review

- What's the qualifying diagnosis?
- What's the evidence (documentation) for the diagnosis?
- How does the diagnosis impact the person's ability to function in society (impact on adaptive functioning)?
- What evidence is there that disability existed before age 22?
- Is this likely to continue indefinitely?

REQUIRED DOCUMENTS

- **Psychological reports** which include an assessment of intellectual functioning ("IQ test")
- For conditions other than Intellectual Disability, **a medical or specialty report** that includes health status and diagnostic findings to support the qualifying diagnosis
- A recent **general medical assessment** report should be included in all eligibility requests
- A developmental/ psychosocial history report, or other **report that shows that the person became disabled before age 22** (this is required for all eligibility requests)
- **Adaptive behavior functioning assessment**
- In some cases, the DDRO may **require additional information to determine eligibility**

3 STEPS IN DEVELOPMENTAL DISABILITY ELIGIBILITY DETERMINATION

1st Step Review

- DDRO clinical staff review the eligibility request to determine eligibility.

2nd Step Review

- If eligibility request is forwarded for a 2nd Step Review, a committee of DDRO clinicians evaluate the referral materials and any additional information that has been provided by the person.

3rd Step Review

- 3rd Step Reviews are done by an independent Eligibility Review Committee of licensed practitioners not involved in the 1st and 2nd Step Reviews.

After Eligibility: Assessment

Why is Assessment important?

The purpose of doing an assessment is to determine a person's current strengths, needs and the natural/community supports available to that individual. This information will then be used to identify additional service needs and develop a **person-centered plan.**

After Assessment: SERVICES

- Medicaid Service Coordination (MSC)
- Vocational Services
  - Prevocational Services (e.g., hygiene, work skills)
  - Pathways to Employment (e.g., exposure to volunteer opportunities)
  - Supported Employment and Employment Training Programs (paid)
- Day Habilitation or Community Habilitation
- Residential Service Options
  - Housing Subsidies (for individuals living on their own)
  - Family Care
  - Individualized Residential Alternatives (IRA); supervised group home
  - Support for individuals living independently in apartments/houses
- Self-Directed Services (authority to choose)
- Family Support Services (for those living with family)
- Adaptive and Assistive Technology
  - Also includes environmental modification

OPWDD Response to CPL Orders

OPWDD (BITS)

Bureau of Intensive Treatment Services (BITS):

- Provides guidance to Regional Offices re: justice-involvement
- Oversees admissions and designations to campus based developmental centers
- ***What is a designation?*** The commissioner determines the facility or regional office that is responsible for complying with a court order.
- BITS processes orders from Criminal and Family Court:
  - CPL §730.40 Final Orders
  - CPL §730.40 Temporary Orders of Observation
  - CPL §730.50 Commitment Orders
  - CPL §330.20 Examination or Commitment Orders
  - Family Court orders pertaining to competency (FCA §322 or §353.4)

OPWDD Response to CPL §730 Final Orders

- Since *Ritter*, OPWDD has interpreted Final Orders as Referrals for Services, unless, upon initial evaluation, it is determined by an OPWDD clinician that a 2 PC under Article 15 of the MHL is needed.

- An initial evaluation is critical to determine (1) OPWDD eligibility and (2) clinical needs. Per statute, OPWDD can only provide services to eligible individuals.

- OPWDD typically designates a Regional Office to provide the Referral for Services.

- Services are voluntary.

OPWDD Response to CPL §730 Orders, requiring Restoration

- After evaluation, designation is made to one of two facilities: Sunmount or Valley Ridge
- OPWDD's Statewide Admissions Committee, in consultation with OPWDD BITS and the facilities, decide on the most appropriate level of care
- Individuals participate in programming to address competency as well as other clinical needs
- As ICF facilities, community inclusion (furloughs) opportunities are part of the program

OPWDD Response to CPL §730 Outpatient Orders

- Individuals are served in state-operated Individualized Residential Alternatives (IRA), with 24/7 supervision
- Individuals have treatment goals and risk management plans, and if needed, rights restrictions to ensure personal and public safety
- OPWDD will ask the court to convert an outpatient order to inpatient, if needed

OPWDD Response to CPL §330.20 Orders

- Track 1: Designated to secure facility
- Track 2: Designated to non-secure facility (only at Sunmount)
- Track 3: Community designation, to state-operated IRA (engaged in community services)
- Treatment on OPWDD campuses: Escorted Community trips (furloughs), with an order; Treatment Goals, Risk Management Plans, Behavioral Support Plans

Justice-Involvement: Tips for Attorneys

(from the perspective of a Program Administrator)

NEW YORK STATE OF OPPORTUNITY. | Office for People With Developmental Disabilities

Tip #1

Resource: *Individuals with Intellectual and Developmental Disabilities Who Become Involved in the Criminal Justice System: Guide for Attorneys, 2014. by The Arc of New Jersey, Criminal Justice Advocacy Program.* ***Suggestions:***

- Use "**Person First Language**" (e.g., individual with a disability v. disabled person)
  - Organizations are removing the older "R" word term and replacing it with "intellectual disability"
- ***Understand how a developmental disability (DD) is defined***
  - *Not all developmental disabilities involve an intellectual disability*
  - *Not all intellectual disabilities qualify as a developmental disorder will qualify as having a developmental disability under MHL §1.03*
- ***Misconceptions to Avoid***
  - Not all individuals with DD are alike; they don't all look a certain way;
  - They are not more likely to commit a crime but are more likely to be victims;
  - IQ scores do not give the whole picture
- ***Consider the difficulties individuals may have***: communication, reading, writing,
- difficulty concentrating, easily influenced, poor impulse control, easily diverted, inappropriate social skills → *how can you adjust your interaction to address*?
- ***Distinguish between Mental Illness and DD***

Tip #2

Understand the different types of court orders and implications for liberty

*(e.g., CPL **§730;** CPL §330.20; FCA 322 orders)*

- **Legal infirmities in orders to watch for**
  - Misdemeanors→ CPL 730.40 Final Order
  - Do the exams support incompetency?
  - Out-defendants: may not need a jail remand
  - Felony Commitments -> check **2/3**rds sentence
- **Should outpatient restoration be considered?**

(Defer to OPWDD BITS (or OMH) for direction)

Tip #3

***There are several local criminal justice programs in your community that may benefit your client*:**

- Mental Health Courts
- Alternatives to Incarceration (ATI) or diversion
  - OPWDD is not a diversion program
- NYS DCJS Reentry Task Forces (http://www.criminaljustice.ny.gov/crimnet/ojsa/initiatives/offender_reentry.htm)
- Other programs/agencies that may be relevant:
  - NYS Office of Alcoholism and Substance Abuse (OASAS)
  - NYS Department of Health (DOH); Traumatic Brain Injury
  - NYS Office of Aging (OA)
  - NYS Office of Probation and Correctional Alternatives

Tip #4

It is useful to be knowledgeable about NYS Department of Correctional and Community Supervision (DOCCS) programs:

- **Comprehensive Reception screening with OMH**
  - MH levels assigned (1 through 6)
- **Appropriate facility and program identified**
  - Special Needs Units (SNU)
  - Correctional Alternative Rehab (CAR)
  - Intermediate Care Program (ICP)
  - Intensive Intermediate Care Program (IICP) [SMI]
  - Transitional Intermediate Care Program (TriCP)
  - Residential Mental Health Unit (RMHU).....*and several other programs*
- **Comprehensive Discharge Planning**

Tip #5

Yes, individuals with DD can be found fit to proceed!

Tip #6

If you are not sure which agency a CPL order should be issued to, please feel free to reach out to BITS.

- A stipulation agreement from J.S. v. Stone (1996) outlined protocols for jurisdictional decision-making for CPL cases.
- Even after orders are issued, OMH & OPWDD can confer and if there is agreement, request that the court re-issue the order to a different agency.

Tip #7

When anticipating time-served sentences or immediate release of a defendant ***post-case disposition,*** *ensure that all appropriate parties (i.e., jail discharge planner/administrator/mental health, DA, defense, community services) are* ***collaborating on reentry planning.***

- If a plea-deal has been offered and may be accepted, thereby effectuating an immediate release, work with collaborative partners to ensure that the partners are aware and are working on a supportive reentry plan.
- Example: Plea-deal -> immediate release of defendant IN THE COURT ROOM after court disposition

Appendix:

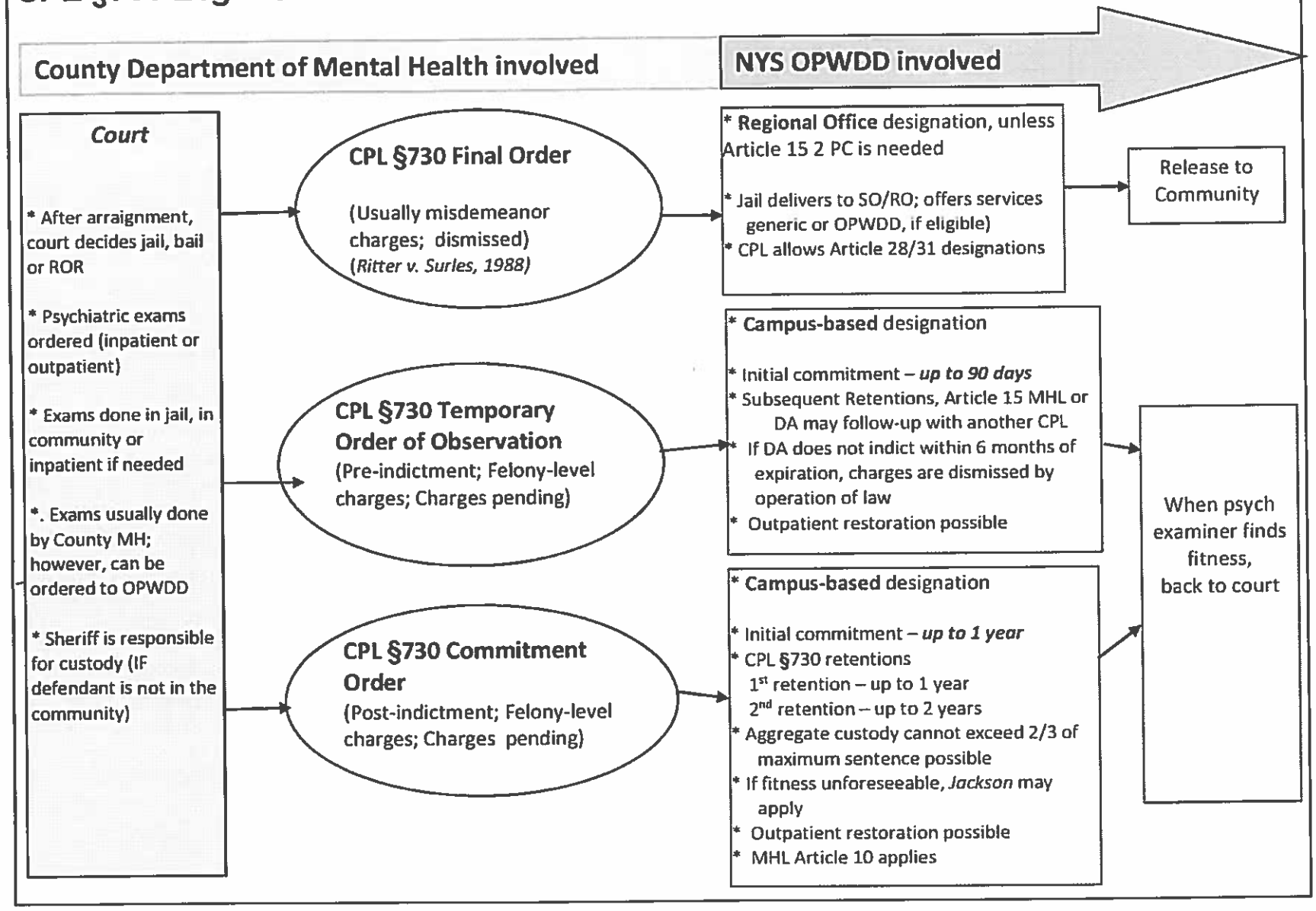
Overview of CPL §730 & CPL §330.20

Overview of NYS CPL §730

- CPL §730 defines an incapacitated person as someone who, "as a result of mental disease or defect lacks capacity to understand the proceedings against him or to assist in his own defense." (*Dusky* standard)

- There are basically **3 types** of CPL §730 statuses, dictated in part, by whether the defendant is charged with a misdemeanor or felony, and the presence or absence of indictment.

CPL §730 Legal Statuses and NYS OPWDD



ities

CPL §730: Final Orders

(1) CPL §730.40(1-2) Final Orders of Observation

- Misdemeanor level defendants although with the consent of the DA, can be issued for a felony
- Charges are immediately dismissed
- The official forms are not accurate with regards to custody "not to exceed 90 days" because of *Ritter* .

- **Ritter v. Surles** (1988). State Supreme Court ruled that you can't treat differently persons whose charges are dismissed v. persons who are dangerous and civilly committed. Therefore, must use MHL civil commitment standards to admit (MHL; clear and convincing), not CPL. Both OMH and OPWDD modified their CPL 730.40 Final Order protocols to respond to issues raised by the court's ruling. (OPWDD: Most Final Orders are "Referrals for Services.")

NEW YORK STATE OF OPPORTUNITY. | Office for People With Developmental Disabilities

CPL §730: Final Orders

- ***Out-defendants do NOT have to be remanded to jail!***

- *Ask about* ***Pre-Designations*** *or* ***Final Order templates with out-defendant language:***

> "___ *if the defendant is not in detention*, having previously been released on bail or on his/her own recognizance, resulting in the 730 examination being conducted on an out-patient basis, the defendant shall be allowed to continue his/her community release, pending notice by the appropriate Commissioner of (OMH)(OPWDD) of the designated facility, whereupon, the defendant will be responsible for transportation to the designated facility at a date and time to be determined."

CPL §730: Temporary Orders

(2) CPL §730.40 (3-5) Temporary Orders of Observation

- Defendant accused but not indicted of a felony offense
- Issued by LOCAL CRIMINAL COURT
- Commitment is for a period of **up to 90 days**
- Charges against the defendant are pending, not dismissed
- After 90 days, need a new basis for retention (e.g., Article 9 or 15 of MHL, CPL)

CPL §730: Commitment Orders

(3) CPL §730.50 Orders of Commitment

- Felony charges which are pending, not dismissed
- Issued by SUPERIOR COURT
- Commitment for a period of **up to** 1 **year**
- Continued retentions via CPL §730, for up to 2/3 of the maximum sentence that the person would have received if convicted, with periodic review of the status.
- Return to court when we find they are FIT to Proceed
- For persons not restorable in foreseeable future, *Jackson* possible, with MHL retentions

CPL §730: Outpatient Orders

- District Attorney consent is *required*
- No defendant should receive outpatient restoration without OPWDD approval
- If a defendant may be appropriate for outpatient restoration, contact NYS OPWDD BITS
- Orders of Condition will be added to outpatient orders
- Defendants are served in state-operated community residences
- Outpatient orders can occur even after inpatient

Jackson Relief

- *Jackson* applies to CPL §730.50 Commitment Orders
- According to Jackson v. Indiana (1972), persons incapable of attaining fitness in the foreseeable future must be released or converted to civil commitment status (*via MHL Article 9 or Article 15*).
- MHLS, the Defense, OMH or OPWDD, or even the DA can initiate a Jackson application. In practice, OPWDD defers to MHLS with regards to Jackson applications.
- Statements re: a dismissal of charges may or may not accompany a Jackson Relief order

CPL §330.20 and the NYS Insanity Defense Reform Act of 1980

- **The Standard (PL §40.15):**

  Not responsible IF "at the time of such conduct, as a result of mental disease or defect, he/she lacked the substantial capacity to know *or* appreciate either the nature of such conduct or that such conduct was wrong."

- Affirmative defense (since 1984) (NYS DA's had advocated for this to reduce skyrocketing insanity defense pleas)

CPL §330.20 and the NYS Insanity Defense Reform Act of 1980

CPL §220.15 : Procedures re: Plea Not Resp.

- Defendant enters plea with court/DA consent
- Defendant understands implications of plea (with likelihood of conviction if move forward)
- Defendant has capacity to assist in defense
- Defendant voluntarily made plea
- There is a factual basis for the plea
- Supporting psychiatric evidence
- Acceptance of plea is required in the interest of the public and for the effective administration of justice

CPL §330.20: Post Verdict

- CPL §330.20 outlines procedures to be followed by the courts, OPWDD/OMH and DA after a plea of Not Responsible

- **OPWDD/OMH are not involved until the disposition (post verdict)**

- BITS is responsible for overseeing protocols pertaining to defendants found Not Responsible

NEW YORK STATE OF OPPORTUNITY. | Office for People With Developmental Disabilities

CPL §330.20: Post Verdict

Note the bifurcated process:

- ***Before* the** verdict, the reference is to a defendant's state of mind ***at the time of the instant offense***

- ***After*** the verdict, CPL §330.20 requires additional psychiatric evaluation re: an individual's *current* mental status***, at the time of the acquittal/verdict***

CPL §330.20: Post Verdict

- CPL §330.20 Exam Order. Commissioner has **30 days** to conduct the exam
  - **Purpose** of (inpatient or outpatient) exam: DMD?
  - **Components of** exam: determine
    - the patient's *present* mental condition and
    - determine the level of treatment needed
    - Level of dangerousness (past, present, future risk)
- **Commissioner** submits findings to court
- Court issues Track 1, 2 or 3 CPL § 330.20 Order

CPL §330.20: Post Verdict

Court makes legal determination (informed by clinical) re: "Tracks":

Track 1: Dangerous Mental Disorder

Track 2: Mentally ill, but not dangerous

Track 3: Not mentally ill, and not dangerous

(What's missing?)

CPL §330.20: Post Verdict

Track 1: Dangerous Mental Disorder (DMD)

- **DMD** means "that a defendant currently suffers from 'mental illness' [as defined by MHL, meaning needing an inpatient setting]…**and** that because of such condition he currently constitutes a physical danger to himself or others."
- Designated to a secure facility
- Initial commitment 6 months; first retention order (1 year); subsequent retention orders (2 years).
- All subsequent changes to a less restrictive setting or in level of freedom (privileges) must be requested via application to the court

CPL §330.20: Post Verdict

Track 2: Mentally Ill but not dangerous

- Mentally Ill (per CPL §330.20[1d]) means requiring inpatient retention
- Court issues an inpatient CPL Order of Conditions
- Designated to a non-secure facility
- MHL Article 9 (OMH) or Article 15 (OPWDD) initial commitment of 6 months; apply for additional retentions

CPL §330.20: Post Verdict

Track 3: Not dangerous, not mentally ill

- Patient may still need community services, but does not need inpatient retention at OPWDD/OMH
- Can be released conditionally (outpatient CPL Order of Conditions) or unconditionally
- Most Track 3's are released with conditions

Questions?

For more Information:

Deborah J. Chard-Wierschem, Ph.D.
Director, Bureau of Intensive Treatment Services

NYS Office for People With Developmental Disabilities
44 Holland Avenue, Albany, NY 12229

Secretary: (518) 474-6309
Fax: (518) 474-3599
E-mail: Deborah.J.ChardWierschem@opwdd.ny.gov
Bureau E-mail: Central.Statewide.BITS@opwdd.ny.gov

NEW YORK STATE OF OPPORTUNITY. | Office for People With Developmental Disabilities

NEW YORK STATE OF OPPORTUNITY.
Office for People With Developmental Disabilities

ANDREW M. CUOMO
Governor

KERRY A. DELANEY
Acting Commissioner

Frequently Asked Questions about CPL §730 and CPL §330.20

(April 10, 2017)

NYS Office for People with Developmental Disabilities (OPWDD)
Bureau of Intensive Treatment Services (BITS)

The NYS OPWDD Bureau of Intensive Treatment Services (BITS) is the administrative unit responsible for coordinating the delivery of OPWDD services to individuals in New York State who require admission to a developmental center, and/or who become involved with the criminal justice system. Individuals who become justice-involved may be court-ordered to OPWDD pursuant to various sections of the Criminal Procedure Law (CPL) or the Family Court Act (FCA). Specifically, these populations include:

- Defendants found incompetent to stand trial pursuant to CPL §730
- Defendants found Not Responsible for Criminal Conduct due to Mental Disease or Defect pursuant to CPL §330.20
- Juveniles found incompetent to stand trial pursuant to FCA §322

Contact information for BITS: (518) 474-6309; Central.Statewide.BITS@opwdd.ny.gov [1]

Frequently Asked Questions about CPL §730: Incompetent to Stand Trial

1) **When an individual is found incompetent to stand trial, what are the associated court orders?**
Article 730 of the NYS Criminal Procedure Law (CPL) provides the statutory authority for determining competency. The *county* mental health department is responsible for conducting the CPL §730 examination to determine competency. The state agencies (OPWDD or OMH) typically do not get involved until *after* an individual is declared unfit and a CPL §730 order is issued. There are three basic types of CPL §730 orders.
    - **CPL §730.40(1-2) Final Order of Observation**: Court order committing a defendant who has been found to be an incapacitated person to the care and custody of the Commissioner. Final Orders of Observation usually pertain to misdemeanor level offenses, although with consent of the district attorney, they may be issued for a defendant with a felony level offense. With these types of orders, the charges are immediately dismissed. While CPL §730 states that Final Orders are valid for up to 90 days, *Ritter v. Surles (1988)* modified agency protocols such that an admission, if needed, must be made on the basis of Mental Hygiene Law (MHL). *Out-defendants do not need to be remanded to jail, pending designation by the Commissioner.* (Call BITS for more information.)
        - **Designations:** OPWDD designates its Regional Offices to respond to Final Orders. Unless an assessment recommends the need for an intensive treatment setting (i.e., a developmental center) and this recommendation is reviewed and approved by the BITS

[1] The contact information for the forensics bureau at our sister agency, the NYS Office of Mental Health (OMH), is 518-549-5000.

Statewide Admissions Committee , Regional Office staff provide assessment, offers and/or referrals for services.

- **CPL §730.40(3-5) Temporary Order of Observation:** Court order committing a defendant accused, but not indicted of a felony offense who has been found to be an incapacitated person to the custody of the Commissioner. Temporary Orders are valid for 90 days. If an individual is not restored within that time period, the agency must evaluate and, if appropriate, convert the admission to a civil status as provided by Mental Hygiene Law (MHL), or discharge. If the district attorney fails to obtain an indictment within six months of the expiration date, the charges are dismissed by operation of law. At times, Temporary Order cases result in indictment and are followed by CPL §730.50 Commitment Orders or some Temporary Order cases result in the issuance of Final Orders.
    - **Designations:** OPWDD designates Temporary Orders to developmental centers. The county mental health department pays for approximately 50% of the costs associated with retention.

- **CPL §730.50 Commitment Orders**: Court order committing a defendant accused and indicted of a felony offense who has been found to be an incapacitated person to the custody of the Commissioner. This type of order can include convicted, non-sentenced defendants. Commitment Orders are valid for up to one year; additional CPL retentions can be sought for up to two years each. Total aggregate retention time can extend up to 2/3rds of the maximum sentence that the defendant would have received if convicted.
    - When there is belief that an individual is incapable of attaining fitness in the foreseeable future, *Jackson Relief* can be sought from the court (per *Jackson v. Indiana, 1972*). If granted, the defendant must be released or converted to a civil commitment status.
    - In 2012, CPL §730.50 was modified to allow for outpatient restoration. District Attorney consent is required; however, OPWDD also requires prior notice, review and consideration. Defendants on outpatient restoration orders are served in 24/7 supervised community residences operated by OPWDD.
    - **Designations:** OPWDD designates Commitment Orders to developmental centers, unless outpatient restoration is ordered. When the individual is found fit to proceed, OPWDD gives notice to the court and applies for an Order to Produce, so that the individual can be remanded to jail (unless the order is outpatient). The county mental health department pays for approximately 50% of the costs associated with retention.

2) **What is the notice provisions of CPL §730.60?**
CPL §730.60 requires that when an individual who is retained on a CPL §730 legal status is released from custody or placed on a less restrictive status, notification must be given to the district attorney, police, sheriff, a reasonably anticipated victim and any other person or entity identified by court. For CPL §730 Temp and Commitment Orders, four days advance notice is required. However, per the *Ritter* decision, advance notice for Final Orders is not required, although it is preferred. The legislature also amended CPL §730.60 in 2013 to require OPWDD/OMH to provide certification of notice to the court. It also required that district attorneys transmit to the Commissioner the names and contact information of persons who may reasonably be expected to be a victim, upon release of an individual on a §730 legal status. (This information can be provided to OPWDD BITS.)

Frequently Asked Questions about CPL §330.20: Not Responsible by Reason of Mental Disease or Defect

1) **What is the legal definition for the lack of criminal responsibility? How and when does the Commissioner (of OPWDD or OMH) get involved?**
A finding of Not Responsible by Reason of Mental Disease or Defect is based on the premise that an individual is not criminally responsible for his/her conduct *"if at the time of such conduct, as a result of mental disease or defect, he/she lacked the substantial capacity to know or appreciate either the nature of such conduct or that such conduct was wrong"* (PL §40.15). It is an Affirmative Defense, with preponderance of the evidence as the standard of proof. CPL §220.15 delineates the procedures to be followed. By statute, the Commissioner (of OPWDD or OMH) becomes involved only after a finding of Not Responsible.

2) **What is the difference between the psychiatric exams that occur *prior* to the acceptance of a CPL §330.20 plea and the exams that occur *after* the acceptance of a CPL §330.20 plea?**
Prior to the court accepting a CPL §330.20 plea, CPL §220.15 requires that defense counsel state, in detail, the psychiatric evidence supporting a CPL §330.20 plea. Thus, defense counsel will submit a psychiatric evaluation to support the plea. This pre-plea (CPL §220.15) examination is focused on the mental condition of the defendant *at the time of the instant offense*. The pre-plea psychiatric exam does not involve the Commissioner (of OPWDD or OMH). After a court accepts a Not Responsible plea, CPL §330.20 requires that a court issue an examination order for the Commissioner to determine the defendant's present mental condition and determine the subsequent level of treatment needed. Thus, the post-plea (CPL §330.20) examination is focused on the *current mental condition* of the defendant. District attorneys are asked to submit all pre-plea (CPL §220.15) examinations and any available documentation related to the charge and adjudication to the Commissioner as soon as possible, to ensure an accurately informed and comprehensive CPL §330.20 psychiatric examination.

3) **What happens after the post-plea (CPL §330.20) psychiatric exams are completed?**
After the Commissioner completes the CPL §330.20 psychiatric examinations, the court conducts an Initial Hearing to review the exams and make a determination about the course of treatment. The hearing is a critical stage for the defendant because it has considerable impact on a defendant's liberty and course of treatment with an agency. There are four possible determination outcomes of the CPL §330.20 Initial Hearing, three of which include continued involvement by the Commissioner. These are referred to in practice, as "Track" determinations:
    - <u>**Track 1: Dangerous Mental Disorder (DMD)**</u>: A court must issue a Track 1 Commitment Order if it finds that a defendant has a dangerous mental disorder, which CPL §330.20(1)(c) defines as a defendant who *"currently suffers from 'mental illness' as that term is defined in subdivision 20 of section 1.03 of the mental hygiene law and that because of such condition he currently constitutes a physical danger to himself or others."* District attorneys are only parties to post-plea legal actions for Track 1 determinations.
        - **Retention:** Track 1 cases are retained initially for six months, under a CPL §330.20 Order of Commitment. If dangerousness is still a consideration, additional CPL retentions can be requested from the court. The first retention request is for an additional year, while subsequent requests are for up to an additional two years.
        - **Designations:** Track 1 determinations result in designation to a secure facility. Individuals on a Track 1 status must remain until a Transfer Order to a non-secure setting and non-DMD retention are applied for or are otherwise, issued by the court.

- **Track 2: Mentally Ill (Inpatient Status):** If a court finds that a defendant does not have a dangerous mental disorder, but is mentally ill as defined by CPL §330.20[1d], requiring a non-secure inpatient setting, then it will issue a Track 2 Civil Commitment Order. The court must also issue (inpatient) CPL §330.20 Order of Conditions, which are valid for up to five years. District attorneys are not parties to post-plea legal actions for Track 2 determinations.
    - **Retention:** Individuals on a Track 2 status are retained initially for six months under Article 9 (OMH) or Article 15 (OPWDD) of the Mental Hygiene Law (MHL), not CPL. Additional MHL retentions can be requested from the court. The first retention request is for an additional year, while subsequent retention requests can extend to up to an additional two years. The director of the facility can authorize release when clinically indicated.
    - **Designations:** OPWDD designates Track 2 determinations to a non-secure setting, intensive treatment setting at a developmental center.

- **Track 3: No DMD, Not Mentally Ill (Outpatient Status):** If a court finds that a defendant does not have a dangerous mental disorder and does not need an inpatient setting for mental illness (or a developmental disability), but would like the Commissioner (of OPWDD or OMH) to monitor treatment, then it will issue a Track 3 Conditional Discharge Order. This order allows the individual to receive agency services while residing in the community. Track 3 Discharge Orders also include a CPL §330.20 Order of Conditions, which are valid for up to five years. District attorneys are not parties to post-plea legal actions for Track 3 determinations.
    - **Retention:** Not applicable. Track 3 cases are not ordered to an inpatient setting; they begin their CPL §330.20 status as outpatients.
    - **Designations:** OPWDD State Operations offices oversee services and monitoring of Track 3 designations.

- **No Track: Unconditional Discharge:** If the court determines that a defendant does not have a mental illness for which Commissioner (of OPWD or OMH) monitoring is necessary, it can unconditionally discharge the defendant to the community.

4) **How do defendants with a Track 1 CPL §330.20 legal status regain their liberty?**
Individuals on a Track 1 CPL §330.20 status regain their liberty only upon court order. They receive an intensive treatment regimen (at OPWDD or OMH), followed by an extensive period of gradual reintroduction of privileges so that careful clinical monitoring and decision making can occur at every level. Several layers of review are involved (e.g., treatment team, psychologists, director, forensic committee reviews, Central Office review) before court application is sought for transfer, furlough, release or unconditional discharge.

5) **What happens when an individual on a CPL §330.20 status, whether in a non-secure setting or in the community, begins to present with dangerousness again?**
At any point during the time period covered by an inpatient or outpatient Order of Conditions, CPL §330.20(14) states that an application can be made by the Commissioner or the district attorney, requesting a recommitment order *if it is believed that the individual is currently suffering from a dangerous mental disorder.* If the court issues a recommitment order, the individual must be designated to a secure facility setting. Regardless of the initial track determination, once a recommitment order is issued, the individual's track becomes Track 1, and he or she will be subject once again to significant liberty restrictions.

STATE OF NEW YORK
_____ COURT OF _____ County

FINAL ORDER OF OBSERVATION AND DISMISSAL OF ACCUSATORY INSTRUMENT

PEOPLE OF THE STATE OF NEW YORK
-against-
_____, DEFENDANT

Docket #: _____
Indictment #: _____

The above-named defendant, having been charged with _____, in violation of _____, and having been examined pursuant to a court order by two psychiatric examiners, qualified in accordance with law, and examination reports thereon having been made to this Court, and the District Attorney and counsel for the defendant having been given copies of such examination reports, and the Court having examined such examination reports, copies of which are hereto attached,

AND: *(check one)*
__ no motion for a hearing having been made,
__ a hearing having been held on the _____ day of _____ and the following persons having appeared _____

AND it appearing to my satisfaction that the said defendant as a result of mental disease or defect lacks capacity to understand the proceedings against him/her/ or to assist in his/her own defense,

AND it further appearing that: *(check one)*
__ the local criminal court accusatory instrument filed against the defendant is other than a felony complaint. ·
__ the indictment filed against the defendant does not charge a felony. ·
__ the defendant has been convicted of an offense other than a felony. ·
__ although a felony complaint has been filed against the defendant, the District Attorney has consented to the entry of a final order of observation.

NOW, it is ORDERED, that the above named defendant be committed to the custody of the Commissioner of the New York State *(select one)* (OMH) (OPWDD) for care and treatment in an appropriate facility of the (OMH) (OPWDD), to be designated by said Commissioner for a period not to exceed ninety days from the date of this order, and it is further

ORDERED, that the defendant: *(check one)*
__ *if the defendant be in detention*, he/she be continued in detention at _____, pending designation of an appropriate facility by the Commissioner of (OMH) (OPWDD) and, upon notice by the appropriate Commissioner of the designated facility, be delivered thereto by the (Sheriff) (Commissioner of Correction of the City of New York)
___ *if the defendant is not in detention*, having previously been released on bail or on his/her own recognizance, resulting in the 730 examination being conducted on an out-patient basis, the defendant shall be allowed to continue his/her community release, pending notice by the appropriate Commissioner of (OMH)(OPWDD) of the designated facility, whereupon, the defendant will be responsible for transportation to the designated facility at a date and time to be determined.

AND it is further

ORDERED, that the accusatory instrument filed in this court against such defendant is hereby dismissed.

Dated: _____

_____
Judge or Justice

ATTACHMENT ONE

FORENSIC-PSYCHIATRIC EVALUATION INTERIM REPORT: NOT RESPONSIBLE BY REASON OF MENTAL DISEASE/DEFECT

ALEXANDER SASHA BARDEY M.D.
FORENSIC AND CLINICAL PSYCHIATRY

FORENSIC-PSYCHIATRIC EVALUATION

INTERIM REPORT
December 30, 2004

Anthony M. La Pinta, Esq.
35 Arkay Drive, Suite 200
Hauppauge, NY 11788

Dear Mr. La Pinta,

At your request, and as ordered by the Honorable Michael Mullen, J.S.C., I have performed a psychiatric examination of in order to answer the following questions:

1. Does suffer from a severe mental disease or defect?

2. At the time of the offense, was . suffering from a mental disease or defect?

3. If the suffered from a mental disease or defect at the time of the offense, did he lack substantial capacity to know or appreciate either the nature and consequence of his conduct, or that such conduct was wrong?

I examined at the Suffolk County Jail on October 27, 2004 and on November 11, 2004. During those interviews, I reviewed his personal and psychiatric history, and I reviewed his understanding of the circumstances that led to his crime. I performed a mental status examination in order to assess his intelligence, thought processes, cognitive functioning, memory, orientation, judgment, insight, and impulse control.

150 EAST 58TH STREET, NEW YORK, NY 10155
Telephone: (212) 223-1983 Fax: (212) 223-2390 E-Mail: DrSashaBardey@aol.com

In addition to my examination, I reviewed the following collateral information in making my assessment:

1. Central Islip Psychiatric Center Medical Records, dated 4/3/66-6/21/66
2. Suffolk Psychiatric Hospital Medical Records, dated 8/26/68-9/17/68
3. Suffolk Psychiatric Hospital Medical Records, dated 4/28/69-5/29/69
4. Suffolk Psychiatric Hospital Medical Records, dated 4/14/70-5/10/70
5. Suffolk Psychiatric Hospital Medical Records, dated 5/10/70-5/28/70
6. Suffolk Psychiatric Hospital Medical Records, dated 6/10/70
7. Central Islip Psychiatric Center Medical Records, dated 4/14/72
8. Suffolk Psychiatric Hospital Medical Records, dated 5/10/72-7/14/72
9. Central Islip Psychiatric Center Medical Records, dated 4/26/74-7/5/74
10. Central Islip Psychiatric Center Medical Records, dated 7/24/74-7/31/74
11. Central Islip Psychiatric Center Medical Records, dated 11/10/76
12. Brunswick Psychiatric Hospital Medical Records, dated 2/8/77-4/11/77
13. Central Islip Psychiatric Center Medical Records, dated 4/11/77-4/25/77
14. Central Islip Psychiatric Center Social Service Record, dated 4/13/77
15. Central Islip Psychiatric Center Medical Records, dated 5/9/79-6/13/79
16. Central Islip Psychiatric Center Medical Records, dated 4/20/80-6/10/80
17. Letter from to of Central Islip Psychiatric Center, dated 4/22/80
18. Suffolk County 730 Report, dated 1/14/81
19. Central Islip Psychiatric Center Medical Records, dated 1/19/81-2/26/81
20. Central Islip Psychiatric Center Medical Records, dated 3/4/81-4/22/81

21. Patchogue Aftercare Clinic Medical Records, 5/11/81-9/1/82

22. Kings Park Psychiatric Center Medical Records, dated 9/7/82-9/22/82

23. Kings Park Psychiatric Center Medical Records, dated 10/5/82-10/18/82

24. Kings Park Psychiatric Center Medical Records, dated 6/7/83-7/6/83

25. Kings Park Psychiatric Center Medical Records, dated 7/21/83-8/11/83

26. Kings Park Psychiatric Center Medical Records, dated 8/23/83-10/24/83

27. Southside Hospital Medical Records, dated 4/14/86-4/22/86

28. Kings Park Psychiatric Center Medical Records, dated 6/21/87-6/24/87

29. Kings Park Psychiatric Center Medical Records, dated 6/25/88-7/1/88

30. Southside Hospital Medical Records, dated 4/14/86-4/22/86

31. Southside Hospital Medical Records, dated 10/05/92-10/08/92

32. Southside Hospital Medical Records, dated 3/1/93-3/11/93

33. Southside Hospital Medical Records, dated 3/15/93-3/30/93

34. Southside Hospital Medical Records, dated 6/12/93-6/23/93

35. Southside Hospital Medical Records, dated 7/8/93-7/9/93

36. Brookhaven Memorial Hospital Records, dated 11/17/94

37. Brookhaven Memorial Hospital Records, dated 5/27/99-6/7/99

38. Brookhaven Memorial Hospital Records, dated 6/5/00-6/13/00

39. Brookhaven Memorial Hospital Records, dated 1/11/01-2/15/01

40. Pilgrim Psychiatric Center Medical Records, dated 2/15/01-4/17/01

41. New York State Office of Temporary and Disability Assistance, Division of Disability Determinations, Medical Questionnaire sent to doctor, dated 4/10/01

42. Peconic Center Medical Records, dated 4/19/01-10/24/02

43. Brookhaven Memorial Hospital Records, dated 6/30/02-7/1/02

44. St. Catherine of Sienna Medical Center Medical Records, dated 7/1/02-7/29/02

45. St. Catherine of Sienna Medical Center Medical Records, dated 8/22/02-10/24/02

46. Pilgrim Psychiatric Center Medical Records, dated 10/24/02-3/12/03

47. Pilgrim Psychiatric Center Medical Records, dated 5/6/03

48. Oral Statement of , dated 5/6/03

49. Written Statement of , Police Department, County of Suffolk, NY, dated 5/7/03

50. Summary Report of Autopsy Findings, dated 5/8/03

51. Indictment of , County Court: Suffolk County

52. 730.20 – Form 2, Examination Report, State of New York Suffolk Court, dated 8/13/03

53. 730.20 – Form 2, Examination Report, State of New York Suffolk Court, dated 8/14/03

54. Model Report in Support of Competency Restoration made pursuant to CPL 730.60(2), dated 2/24/04

55. Notification of Fitness to Proceed, State of New York County Court, County of Suffolk, dated 3/18/04

PAST PERSONAL HISTORY

Fifty-three year old was born on Williamsburg, Brooklyn into an intact family. Other than a botched circumcision, he reported no significant problems at birth or as an infant. He reported reaching developmental milestones in a timely manner.

mother, . was born in New York to Italian immigrant parents. His father, , was also born in New York to an Italian immigrant mother and an American born father. worked as a steel-rule die maker, producing corrugated products, stuffed animals, and cutting dies. He died in 1976 by accidentally falling off a fire escape, although suspected suicide. . worked in a King Kullen grocery store as a Deli worker and manager fill-in for 15 years. She died at the hands of her son, has one full brother, . who is 51 years old.

was raised in a middle class home. He described his parents as "normal," raising him to be Catholic and enrolling him in a Catholic School, St. Marten of Tours in Brooklyn. He did well in elementary school, earning A's and B's on his report cards and reporting no disciplinary problems. did state that he was a little scared of school and that, at one point, a nun reported to his mother that she suspected physical abuse in the home.

parents began to have marital problems when he was a very young boy. Reportedly, his mother had very flamboyant, rich tastes. aunt was apparently wealthy, making his mother yearn for the expensive items that her sister had. His father had no desire to support his mother's tastes, eventually leading to their separation when was five years old and eventually to their divorce six or seven years later. As a result of his parents' separation, festyle changed drastically, beginning with his moving from his comfortable house into a railroad apartment with his mother and brother.

When was in the 2nd grade, his mother met his future stepfather, . She had been babysitting for a couple and reportedly initiated an affair with the father of the children she was looking after. After entering a relationship with asserts that his mother began neglecting and abusing him and his brother. She no longer provided food for them and would often leave them home alone for most of the day. He received most of his food and care from the nuns at his school. also reported frequently witnessing his mother and stepfather having sex, which left him angry, as he believed his mother should only have been involved with his biological father. . claimed that his aunts began calling his mother a "whore", as a result of information they received from . estranged wife. also reportedly used to physically abuse his ex-wife.

When was eight years old, his mother moved him and brother to South Amboy, New Jersey, in order to live with and create distance between themselves and his ex-wife. After the move to New Jersey, began attending a public school where he did very poorly. His grades and behavior in school quickly deteriorated. He attributed this decline to the poor care he was receiving at home. He described his time in New Jersey as "devastating."

After living in New Jersey for six months, returned to Brooklyn for Christmas. During this trip, he refused to return to New Jersey. The entire family agreed to stay and so they moved to a poor area of Brooklyn and he enrolled in St. Leonard's Parochial School. He described his new school as "pretty bad" at first, reportedly having Puerto Rican kids throw rocks at him regularly.

recalled his life in the new home was deplorable. His mother and stepfather still failed to provide food for him and his brother, and his stepfather was often abusive. reported being thrown around and hit with an open hand by his stepfather two or three times per week. The house was always filthy, with and his brother being the only ones who made any effort to keep it clean. Although he was constantly mistreated at home, , stated that neither his mother nor his stepfather drank alcohol. The only joy reported having as a child was when he was playing ball or on the occasional weekend when his paternal grandmother would take him to see his father and would feed him.

When was in the 5th or 6th grade, he recalled his mother having two illegal abortions in their home. He vividly recalled hearing her crying and screaming throughout the procedures, in addition to overhearing his aunts criticizing his mother for her actions. These memories were very disturbing to During this time, earned barely passing grades in school. He claimed that he was never fed breakfast or dinner, surviving by eating a large lunch at school. In the 7th grade a nun took a special interest in him. She began helping him study and disciplining him, resulting in his achieving honors by the 7th and 8th grades. He first attended Bushwick High School. At this time, he began drinking alcohol, smoking marijuana and sniffing glue.

When was 15 years old, his family moved to Selden, Long Island where his mother purchased a house with a loan she received from his uncle. began Newfield High School, entering in the 10th grade. He reportedly did poorly at his new school, where he claimed the teachers did not like him because he was from Brooklyn. He recalled being called a "Brooklyn bum" by his teachers and peers. While in school, he acquired a part-time job and earned enough money to buy himself a car.

When living in Selden, because of the house's configuration, often witnessed seeing his mother walking around her bedroom naked through his bedroom door. He reported masturbating to the vision of his mother nude.

In 1966, when , was in the 10th grade, he recalled arriving home one day with a pain on the right side of his groin. He informed his mother of his problem and told her he needed to see a doctor. His mother reportedly did not take him to see a doctor for two days because, according to , "she hated" her son. When

he finally saw a doctor, he was diagnosed as having a "queasy stomach" without the doctor performing any type of exam. A few days later, mother reportedly had a dream that he was going to die, resulting in her taking him to the doctor the following day. was consequently diagnosed with a ruptured appendix and was immediately taken to the hospital for surgery.

After the surgery, began to experience a loss of appetite and poor sleep for two or three weeks. He stopped attending school, never slept, and began to harbor bizarre thoughts. He saw a doctor in Farmingdale who stated that was only a drug addict. No further treatment was offered. Weeks later, as the symptoms did not remit, mother and stepfather took him to Central Islip State Hospital. Upon arriving there, recalled believing that he had been sent to Russia, due to the institutional appearance of the facility. He reportedly "flipped out" because he believed "the Russians were after him." He was given Ativan and Thorazine on his first night there, providing him with his first nights sleep in weeks. He recalled waking up shaking in the morning as a result of the Thorazine. Throughout his 3-month stay at Central Islip State Hospital, parents visited him every Sunday. He also resumed playing the drums, a hobby he had learned as a child. The other patients in the hospital apparently enjoyed his music, making him feel accepted. Upon being released, he reported no longer experiencing delusions; however, he recalled being depressed about the prospect of returning home where he did not feel the same acceptance he had in the hospital.

After being discharged, claimed that he did not receive any follow-up care because he did not wish to continue taking his medication. He returned to high school where he worked at catching up on the work he missed. He dropped out of Regents classes, opting for an easier level of courses in which he earned a B+. At this time, he reported playing the drums with the , recalling that there was a strong Mafia presence in Shirley, NY. He stated that the infamous family told his mother that he was a talented musician and that they wished to "make" him. His mother reportedly declined the offer.

Around this time, at the age of 16, was given a new car by his grandmother, that he enjoyed racing. His cousin gave him part-time employment working in a machine shop. Unfortunately, 's home life had not improved. His stepfather took to insulting him, calling him a "fag." stated that he still holds fear in his head that he is a homosexual, reporting that the insults he received from his stepfather was "like putting poison in someone's mind."

One night in 1968, attended a party at a friend's house, at which he consumed a few beers and then borrowed a friend's car. He drove the car to pick up his grandfather, after which he got into a car accident, resulting in his grandfather falling into a coma.

Later that year, _ _ s situation at home worsened. His parents had no money, causing them to lose their house in Selden and to move into "a shack" in Shirley, Long Island, where he transferred to Longwood High School in Middle Island. He graduated from high school in 1968. At this time, his stepfather was constantly calling him a "fag" and a "queer." His mother would often talk about his problems with mental illness. She would torment him by constantly asking, "Do you think you are going to be sick again," as if she thought he had control over his illness.
met his first girlfriend, Linda, at the age of 18; however, she broke up with him, he claimed, because of his mental illness.

After graduating high school, . _ . paternal grandmother told him that his father wished to see him. He had not seen his father for four years because his father had relocated to California with his second wife, a marriage that had produced two half-sisters. _ _ and his mother flew to California to see his father who reportedly looked terrible and was experiencing his own psychiatric difficulties. At this point, according to his father had been hospitalized psychiatrically on four occasions. began to believe that his mother's abuse had caused both his and his father's mental illnesses. He reportedly always felt like the "black sheep" in his mother's home.

spent the summer of 1968 with his father in California. While there, he reportedly became depressed, paranoid, and confused. Consequently . father sent him back to New York where he was hospitalized again at Central Islip State Hospital. He remained on their inpatient service for six to eight weeks and was treated with Triavil.

After leaving the hospital, . spent three months in his room, paranoid and scated to leave. He claimed that, although compliant with his medication, it did not help his paranoia. In his mind, his paranoia was the result of constantly being called a "fag" and that his friends had heard the rumor that he was gay, making him confused and fearful of facing the outside world. He began to think that maybe he was gay and that "the time had come" for it to manifest itself.

During the summer of 1969, began to fear that he was physically ill. As his physical and mental complaints escalated, his mother brought him back to Central Islip State Hospital on at least three occasions. In between hospitalizations, continued taking his medications; however, he was consumed by thoughts and fears of homosexuality. He felt his manhood was being questioned.

In 1969, _ . took a job at White's Department Store. It was there that he met his first wife, . . She apparently had a poor reputation in neighborhood. He believed that . was a virgin, when in fact she was not. After he started dating she got a job as a stenographer at Central Islip State Hospital . grew to believe that was having sex with the entire staff of the hospital.

He claimed that the attendants there informed him that she was having sex with, "everyone at the hospital." , stated that drove him "crazy. His delusional beliefs about 's infidelities eventually led him to physically abuse her. He believed that his mother knew about behavior, yet pushed him into the relationship regardless. This made him feel "set-up" by his mother. He described himself as going from one abusive relationship, from his mother to

In 1970, was hospitalized psychiatrically on numerous occasions. He blamed his lack of improvement on his knowledge of what was doing behind his back. He committed violent acts while in the hospital as a result of his paranoia. The thoughts and rumors regarding "drove him crazy" and caused him to become delusional. He was living at home at this time, which displeased his mother. He believed that his mother hated him and wanted him out of her house. During that same year, brother was accused of committing rape.

Throughout 1971, reported experiencing the same thoughts and delusions as the previous year. He was paranoid and insecure. On one occasion, recalled attending a concert with , during which he became convinced that she had sex with the band At this time, was seeing a psychiatrist, . He treated with psychotherapy and suggested he be placed in a group home. A week after making this referral, believed that his mother was involved with death. To this day, he is still unsure as to his mother's involvement in his doctor's death. asserted that hiss mother convinced the doctors to administer Electro-Convulsive Therapy (ECT). After three rounds of ECT, he forgot about promiscuous reputation.

In 1972, married He began working in father's ice cream business. He reported having fun with at this time because the ECT blocked out his thoughts about her sexuality. He believed he was on a new track and moved into an apartment with in Middle Island. His mother gladly told "good luck, he's your problem."

, began having troubles with as he developed the delusional belief that was taking money out of their bank account without telling him. While rushing to the bank to catch her, got pulled over for speeding. The police, apparently realizing that he was delusional, had him committed to Central Islip State Hospital once again. One year into their marriage, got sick again psychiatrically. He was first taken to Pilgrim, and then back to Central Islip State Hospital. While there, he believed he heard that was "a whore" and was still engaging in sex with everyone in the facility. He believed dressed in too sexy a manner, further convincing him of her sexual promiscuity.

In 1973, was injured doing concrete work. He was hospitalized at Mather Hospital and treated for 3rd degree burns on his legs. Throughout that year, he worked on and off between his multiple hospitalizations for mental illness. also reported gaining a significant amount of weight.

In 1974, returned to California to see his father for two weeks, bringing with him. Upon returning to New York, he bought a house with . At that time, reported that was spending a lot of time with his sister-in-law while his brother was serving time for the rape charge he pled guilty to. believed that his sister-in-law and would go out and have sex with various men. He recalled returning and informing him that she had had sex with other men in his car. Apparently, after hearing this information, struck giving her a bloody lip. As a result of such delusional beliefs and violent outbursts, was repeatedly hospitalized psychiatrically in 1974.

In 1975, gave birth to the couple's daughter . At that time, was working for Cypack, a German machine company, as a field technician. His work at Cypack inspired a strong interest in electrical, mechanical, and automobile repair. While working there, he developed the delusion that was having an affair with his boss. eventually quit his job at Cypack after one year because a new manager reassigned him to work in the parts room, depriving him of the fieldwork he enjoyed previously.

reported attending a cousin's christening in 1975 at which his mother's entire family was in attendance. He recalled his mother stating, "I'm the boss, I'm taking over." believed that this statement was proof that his mother and her family were "connected," and had ties to the Mafia.

In 1976, was hired by Estee Lauder to set up packaging machinery. While working there, he reportedly began cheating on with a woman named . His philosophy was "she did it, so why couldn't I." eventually found out about the affair and broke off his relations with husband contacted and , reportedly calling a "fag." After this incident, was hospitalized at Brunswick.

While in the hospital, was informed that his father had died. Although it is not certain, it is believed that his father committed suicide, although suspected foul play. Psychiatrically institutionalized at the time, he was not able to attend the funeral.

and began fighting frequently, resulting in their discussing filing for a divorce. The two agreed to separate and moved out of their house with their daughter. began bodybuilding and had a series of good-looking girlfriends. claimed to have had a threesome with and his

girlfriend. After I moved out, believed she told his girlfriend that he was homosexual. His girlfriend attended the same gym as he did, and he grew certain that she was passing on the rumor of his sexuality to his friends at the gym. Although he was never abusive towards his daughter, has not had contact with her for the past eleven years. After left, continued bodybuilding and started a construction/painting business that was prosperous throughout the 1980's.

In 1980, was arrested for manifesting irrational and delusional behavior in public. He reportedly took an overdose of Lithium, then went walking outside barefoot in the middle of the winter. He asked a man for a ride and when the man declined, assaulted the stranger. Upon his arrest, he claimed he was in the CIA and that his mission was to save hostages from Khomeni. He reported that President Carter had sent Marines to save the hostages, but the mission had been aborted. He explained that he was trying to get to Gruman's to fly an F-14 jet to Iran. His mission was to bomb Iran with atomic weapons and save the hostages. While trying to get a ride to his jet at Gruman's, was arrested for assault. He was first sent to jail, and then committed to Central Suffolk Hospital. According to , while he was in custody, President Reagan made a deal with the hostage takers and the hostages were released. felt that he had played a part in the freeing of the hostages. stated that although his story may "sound crazy, it's true."

Later that same year, married his second wife, s 10 years younger than he and was reportedly very attractive. He stated that was extremely promiscuous and had been told before they married that he was a "faggot." He described her as cold, not wanting sex but thoroughly enjoying men's attention: a "fatal attraction." He speculated that father had raped her and that she married him because she desperately wanted to move out of her house. Their marriage supposedly became a financial arrangement.

In 1982, assaulted his stepfather after his stepfather reportedly accused him of being gay. The incident led to a three-week stay on the inpatient psychiatric service of Central Islip State Hospital. In 1983, while married to , was hospitalized at Kings Park also as a result of paranoia and delusions. He believed that was having sex with other men while he was hospitalized. He was treated with Lithium and Prolixin. A new delusion that was insisting on becoming part of his business so that she could write checks led to yet another hospitalization that same year.

described his marriage to as worse that his previous marriage to . He recalled that would go out with her sister frequently, causing him to fear she was cheating on him. This led to many arguments, some of which resulted in physically abusing his wife. He claimed that, although he was the only one inflicting physical abuse, she mentally abused him. He believed

that _ : knew how to make him paranoid and that because her mother was a Registered Nurse, _ knew how to trigger his illness and would do so at her will.

_ _ _'s relationship with _ fluctuated while he was in and out of the hospital over the next few years. He had trouble remaining well because he would not always take his Prolixin.) managed to keep his illness under control during some of his time with _ _. While married to her, his business did well, leading to many happy times in their relationship. He described them as having "lots of normal times," partly due to the fact that kept _ away from his mother. However, when . : would want to go out, he would get scared that she was going to cheat on him. He reportedly abused her out of fear of losing her.

_ _ explained that his relative financial success led feelings of jealousy from his family members because of the expensive items that he was able to purchase, such as cars, boats, and a large house. He believed that his mother eventually tried to break up his relationship with by spreading rumors that . was having various affairs. This led _ _ to a breakdown, and his checking into Kings Park Hospital.

In the mid-1980's,) was seeing his daughter .. every other weekend. This caused problems in his marriage because while he was with would go out She had no desire to be involved with his daughter. . believed that _ was jealous of , and stated; "my life was getting destroyed by , " : was eventually diagnosed with Bipolar Disorder.

In the late 1980's, _ called , causing to reportedly erupt in a jealous rage. proceeded to have a big argument with _ in front of At that time, feared that . might be cheating on him. He admitted to cheating on her a few times, which upset his wife. Looking back, , now fears that . may not have been cheating on him as his mother rumored.

In 1992, _ _ s mother and stepfather informed him that they were going to move to Florida and that he and should accompany them. He now believes that his mother had no intention of moving and tricked him in order to destroy his relationship. His mother and stepfather did not move to Florida until many years later. However, as a result of his parents' persuasion, _ and : moved into a home he had purchased in Royal Palm Beach, Florida. After the move, : began going out frequently, causing a return of depression and paranoid beliefs. again acted out violently as a result of his mental illness and was arrested and incarcerated while in Florida; however, he claimed that he was not given any medication. _ bailed him out, but he believed that while he was incarcerated she had sex with another man. After bailing him out, she informed him that she wanted a divorce and wished to move back to New York.

. remained in Florida for six or eight months thereafter by himself, eventually selling his house. At that time, out of funds and with no credit, he declared bankruptcy. Upon returning to New York, he reunited with and moved in with her and her mother. He began attending Suffolk Community College, earning a 3.75 GPA. After six months, reportedly gave an ultimatum, informing him that in order to stay married to her, he would have to agree to never seeing his daughter again. rejected her offer and moved out of her mother's house in 1992. Their divorce was finalized in 1994. He moved in with his mother and stepfather for four days, at which point an argument with his parents led to his leaving home.

After moving out of his parents' home, moved in with a female friend named was also mentally ill, suffering from Bipolar Disorder with Rapid Cycling. He tried to help her by fixing up her house and bringing her to his doctor for treatment. He did not have a job and was living off of Social Security checks he had been collecting since 1980. Throughout his eight-month stay with was in and out of hospitals constantly, checking into both Central Hospital of West Suffolk and St. John's Hospital for his paranoia. As a result of his multiple hospital stays, he was forced to drop out of school. felt that all of his plans had fallen to pieces, a realization that would take him years for to recover from.

During one of his stays at Central Hospital of West Suffolk, met his present wife, , who was a fellow patient. reported that they shared a common experience in that they were both abused as children. Although was married at the time of their meeting, reported that she was extremely attracted to him. They engaged in a long courtship that eventually led to an affair. ended his relationship with in 1994 because of his feelings for . Around the same time, husband found out about the affair and left her. She later reunited with her husband in 1996, but and continued to see each other. formed a close relationship with mother, taking trips with her to South Carolina.

In 1994, attempted to commit suicide. At this time, he did not know the whereabouts of his ex-wife, , and daughter. had moved without providing him with any new contact information, making him unable to see his daughter for a long period of time. believed that his mother was keeping his daughter hostage because of a recent fight he had had with his stepfather. His stresses over his failed marriage, the absence of his daughter, and a perceived intervention by his mother drove to take 70 pills of Lithium. He was taken to Southside Hospital where his stomach was pumped.

In 1996, obtained Section 8 housing in Florida. He wanted to escape New York for a while because he was unsure of his situation with . He drove his car down to Florida to visit his mother and stepfather and was glad to see them as it had been a few years since their last meeting. After his arrival, was informed that his stepfather had terminal cancer. He began to become involved in his stepfather's illnesses: cancer and diabetes. He stood by his stepfather through his illness, until he died in 1998.

began attending college in Florida; however, because of multiple hospitalizations and psychotropic medication, he had trouble maintaining his grades. During one of his hospitalizations, made a friend named At the suggestion of his new friend, began taking classes for social work. Reportedly, he later found out that was a homosexual. became concerned that was spending time with a gay man, so she left her husband to come see him in Florida. stated that because was able to find his unlisted number in Florida, he believes that she is also connected to the Mafia. When arrived in Florida, she immediately took to disliking and married in 1999. Not long after their marriage, their mental health began to deteriorate, resulting in them both becoming paranoid and delusional.

They both resided in Florida until the summer of 1998, at which point returned to New York. After the move, he started a home improvement business with his brother. Reportedly, his brother began the business with him, but did not maintain an interest in the company for long. His brother was abusing alcohol and drugs frequently, leaving with the full weight of the business on his shoulders. As a result, the business failed.

During this time, mother came to live with him while she was recovering from an injury. After living with him for two months, told him that she wanted his mother out of the house. told his mother to leave, forcing her to move in with his brother. After business failed, began putting pressure on him to work. At this point, he stated he was working for the CIA, unbeknownst to his wife. The stress she placed on him he believes resulted in his psychiatric hospitalization at Brookhaven Hospital. While there, hit a staff member that was talking tc was angry at the time because he felt that because he was being forced into the hospital because he was in the CIA.

From 1999-2003, was hospitalized an additional five times, despite complying with his medications. He stated that he was having trouble functioning because his mother and his wife were placing Zyprexa in his coffee every morning. He found it hard to work while on his medications, causing him to become depressed. Over that four-year period, called the police frequently reporting domestic disputes. stated that he never placed a hand on his wife.

In 2003, following a fight with [redacted] took money out of his bank account and got in his car with the intention of driving to the South. Upon leaving, he stated, "I am going to run this country." [redacted] says that at the time, [redacted] threatened to kill the President; however, [redacted] denies the allegation, stating that he would never hurt the President.

While driving south, [redacted] stopped in Maryland and placed a call to his brother Mark who informed him that his wife had contacted the authorities and the Secret Service was now looking for him. [redacted] checked into a hotel in Maryland tried to get some rest. At the time, he was not taking his Lithium pills and was reportedly a little manic. While trying to sleep, at approximately 11 pm, [redacted] received a knock on his door. He opened the door and was reportedly confronted by the Secret Service. [redacted] recalled denying to the Secret Service that he intended to harm the President or anyone else. He showed his prescription bottles and offered to have them search his room and car. Eventually, [redacted] reported, the Secret Service backed off and let him go. After the incident, [redacted] returned to New York.

ACCOUNT OF THE INCIDENT

When [redacted] arrived back at his home in New York, he found his home empty so he went to his brother's house. [redacted] was reportedly spending time with her children. [redacted], in a manic state, went to a Chevy dealership in Port Jefferson, NY with the intention of purchasing a Corvette. Although he had no money at the time, [redacted] believed that because he was in the CIA, he would be getting money shortly. He thought that his mother, because of her Mafia ties, would give him some money in the mean time. After leaving the car dealership, he went to pick up his mother and a pizza pie. She informed him that [redacted] was with [redacted] and his girlfriend, a friend of [redacted] that [redacted] was not fond of.

During this time while [redacted] was with [redacted] reportedly started hallucinating that the train running behind his house was being used to transport Jews to prison camps. He began to believe that his mother was responsible for killing Jews. He also became very frightened of his icemaker, a machine that made frequent loud noise. He also became very fearful of ghosts at this time. He believed "they" were trying to drive him out of his house. He began staying in hotels in order to get out of his house.

[redacted] was hospitalized at St. Catherine's Hospital in late 2002 where he engaged in frequent fights. As a result, he was placed in a seclusion room in the hospital. He was off of his Lithium at the time because of problems he was having with his kidney. His delusions and hallucinations worsened. He believed he had to fight as a CIA agent in order to "straighten people out." He took part in what he

believed to be detailed and disciplined assaults that he was ordered to perform as part of his CIA work. He believed the staff and patients were all either part of the Mafia or were Jewish. He described the hospital as "connected." He believed the Jews were working together with the Sicilians and that his mother was part of it. He reported that because of his mother's involvement with the Jews and the Mafia, she tried to have him put away for a long time so he could not interfere.

After St. Catherine's, was taken to Brookhaven Hospital. While there, decided that he was "going to save the country," using his role in the CIA. While at Brookhaven, placed a Jewish patient in a chokehold. He was consequently sent to Pilgrim Psychiatric Center (PPC). While at PPC, his mother and reportedly visited on occasion. He recalled his mother and brother coming to visit him at Christmas time. He stated that his mother would taunt him frequently and was controlling him through her Mafia connections. His feelings regarding his mother's role and connections to the Mafia intensified over this period. He stated that the Sicilians would often use reverse psychology, a strategy that his mother also used against him.

was discharged from PPC under an Assisted Outpatient Treatment order (Kendra's Law) into the care of an Assertive Community Treatment team, or ACT. Under such a law, because had a history of non-compliance with treatment for a severe mental illness that had resulted in repeated hospitalizations or acts of violence, he was compelled to accept psychiatric treatment and medications, or face forcible hospitalization. As a result, he continued to see doctors at his brother's home, while his brother promised to supervise his compliance with the prescribed medications. His brother had agreed to let him stay in his home for $500/month. He slept on a couch in his brother's den, a room that had no doors or privacy. He recalled his brother's two sons often bringing home their girlfriends. He did not like having them see him sleeping on the couch. He grew to believe that his brother's wife was having a hard time because brother would often hit her. He stated that he also believed that his brother's wife began to flirt with him. , as a result of these growing concerns and developing delusions, left his brother's house and the supervision he was providing him in April 2003.

now off some of his medications, traveled to see his uncle , a gay teacher living in Manhattan. delusional beliefs intensified, he believed that "the Jews were out to make him (me) gay." He described himself as both depressed and manic.

began to stay at his other brother's house when his brother told him he thought he should be hospitalized. refused. The next day, reportedly met with his ACT or AOT doctor, and informed the doctor that he was "connected," and that his mother was working with the Jews and the Mafia. believed that the AOT doctor telephoned brother

reportedly told the doctor that had choked his wife some time prior to the call. reportedly did not like because she was very close with his mother and because she was half Jewish.

began harboring delusions regarding the AT&T telephone company. His cell phone would often lose service or drop calls; a phenomenon he thought was caused by his mother and scheming to put the company out of business. He believed that his mother and did not like AT&T because the company was part of his father's side of the family. This scenario frightened greatly, causing his tensions with his mother to build. He reportedly warned her, telling her, "You're looking for it." As a result of his paranoid concerns, began carrying a pair of scissors with him one week prior to the incident. He was worried that someone was going to try to kill him.

believed that he had been approved and given credit to purchase a Mustang automobile at the time; however, stated that the dealer rescinded the offer. He knew that his mother and brother were responsible for this and that they had called the dealer in order to prevent him from getting the car.

On July 11, reportedly met with his AOT doctor who decided not to have him hospitalized. He continued his daily activities such as doing laundry, listening to Led Zeppelin, and concerning himself with his mother's role in the Mafia and the music business.

reported that around this time, the insurance and title of his car had been transferred to his mother's name illegally. He reported that Puerto Ricans working at the Department of Motor Vehicles had transferred the title of the car without his authorization, because they were working with the Sicilians and Jews. He knew that his mother had Spanish people working on her side.

reported that his mother began calling him daily, aggravating him with questions regarding his insurance. He believed that she ran the insurance company. On the day of the alleged incident, phoned his mother and she informed him that he had just received a letter from the insurance company regarding his insurance so he went over to her house. While he was there, he reportedly heard a voice telling him, "Take the scissors out of your pocket and do it, you're doing the right thing." He believed that she was ruining the country and destroying everything. He kept hearing, "go ahead and do it,," and "you're doing the right thing." He recalled stabbing her with the scissors. believing himself still a CIA agent, believed that his just mission was to kill the Mafia operative, in the form of his mother. As far as knew, his mother was controlling a number of different agencies that were conspiring to harm him, his father's family and the nation. The orders he received in the form of the command auditory hallucinations were his order to execute his duties.

left his mother's house, went to his home to change his clothes, and then drove to Middle Island where he threw his bloody sweater into a dumpster. He parked his car near a barber, at which time a police officer approached his car. He reportedly told the officer that he was intoxicated and wished to sleep it off before driving again. That night, still thought that what he had done was right, but he knew that it was a serious offense, as his mission had been a secret. He believed that the police would eventually know that he was an important figure and would let him go.

He spent the night on North Fork, where his wife was originally from. The following morning, went to a deli for a coffee and bun, at which point a police officer approached him. Reportedly, at that point, four or five unmarked cars showed up, the officers all drawing their guns. began speaking with the police, but did not tell them that he was in the CIA. He was subsequently arrested. He later led the police officers to Middle Island to retrieve his bloody sweater.

MENTAL STATUS EXAMINATION

presented for the initial examinations in arm and leg irons, wearing only a correction-issued apron. On the last examination, he was clad in regular prison garb only wearing handcuffs. His manner improved as the examinations progressed, in that he was initially guarded and suspicious and frankly paranoid and disorganized in his thinking. He attempted unsuccessfully to relate to this examiner, but was often overwhelmed with internal thought processes and paranoid delusions. During later examinations, he appeared better organized, less psychotic, and better able to relate to this examiner and give a coherent account of his life history and of the events that led to his arrest. Paralleling the gradual improvement in his thinking was his grooming and physical appearance. He was initially poorly groomed, unshaven, uncombed and malodorous. Subsequently, he appeared better dressed, neatly groomed and washed.

remained animated with mild to moderate psychomotor agitation throughout the examinations. He made intense eye contact at times and became anxious or tearful at different times. Oddly, issues that brought to tears were often anecdotes about his childhood, adolescence or young adulthood. Especially difficult for to talk about was the fear his stepfather had instilled in him that he was homosexual. He spoke about the treatment he had received at the hands of this man, as though it had occurred yesterday, rather than decades ago. In fact, throughout the examination, gave equal emotional importance to issues that could be separated in time by decades and that might seem inconsequential to anyone else. It was almost as if every detail of every instant in his life shared equal importance and would be responded to as if it had just occurred.

. speech was rapid and abundant. He spoke spontaneously without appearing to censure any content whatsoever. There was no indication that he was reflecting on his answers or that he was trying to portray himself in a specific light. There was no evidence that he was malingering or exaggerating any of his responses. He appeared sincere and often overwhelmed. His speech tended to be circumstantial and tangential in that he was over inclusive of detail and often veered off track and off subject. associations were loose and fraught with paranoid and illogical statements. He drew inferences from what he witnessed around that were incoherent and idiosyncratic. Through his paranoid and delusional lenses, he made associations and created conspiracies and alliances that warped his understanding of the world around him.

reported a number of delusions involving his mother and others since he was a teenager. During these evaluations, eported, although he recognized that he has no evidence for this theory, that his mother, as a member of the Mafia, had played an important role in the deaths of John F. Kennedy, Robert F. Kennedy, Malcolm X, and Martin Luther King Jr. He believed that the Mafia killed all of those men and that his mother was involved in their deaths. He recalled that after President Kennedy was shot, he was watching the news coverage when his mother told him that President Kennedy was "a bum" because of what he had done to Marilyn Monroe. His mother used to say that President Kennedy was "a friend of niggers." He stated that because she spoke of politicians with such insight and authority, she had to "be connected."

In addition, his mother also often spoke of her hate for English people, confirming in mind that she was involved in the death of Princess Diana. He also remarked on the coincidence that three famous British rock drummers that he had liked had all died of accidental overdoses. He believed that his mother, who was running the music business, had also played a part in their deaths.

reported that he recently noticed a scar on his chest that he had never noticed before. He speculated that the scar was the result of an electronic device that was implanted inside him. He held the Mafia, and his mother, responsible for the devise and the scar.

at the time of the offense, as well as during my examinations, believed that it was right to kill his mother because of her role in the Mafia. He saw her as "another Al Capone, the Godmother of New York." As a member of the CIA, he understood that it had been his job to kill her. He believed his mother was "ending this world." "I thought it was right to go ahead and do what I did." As a CIA agent, elieved that he was only following orders.

He also reported that the "walls have ears" and therefore, he could not talk loudly. During these examinations, he still maintained that he was in a branch of the government. He believed that the CIA could hear everything he was saying during this evaluation; and therefore, nothing was private or confidential. He expressed the belief that he had no case because the CIA was hearing and controlling everything.

COLLATERAL SOURCES OF INFORMATION

Central Islip Psychiatric Center Medical Records, dated 4/3/66-6/21/66

was admitted to the hospital in a mental state characterized as "homicidal, suicidal, disturbed, depressed." He was diagnosed with Schizophrenia, Catatonic Type. Upon his admission, his mother explained that he had become "withdrawn and fearful. He feels medication will make him a drug addict. He has been unable to sleep and had loss of appetite. His time sense is disturbed."

In a mental status exam administered on 4/7/66, was described as a 15-year old boy brought in by his mother because of a preoccupation with morbid thoughts, fearing for himself and his mother. The patient's answers were seen as vague and he was said to be preoccupied. He reported delusions, auditory hallucinations, and ideas of reference. His mood was described as depressed with fear. Patient believed that he was in the hospital because he was bleeding internally and that he was suffering from brain damage from medication he was given in the hospital. He recalled hearing voices that told him he would die. He expressed hostile feelings towards both of his parents. He had great difficulty with recall, unable to remember his address and names of his parents and siblings.

In a psychological evaluation performed on 4/26/66, was described as a boy "who was hospitalized following a psychotic episode characterized by delusions, auditory hallucinations, preoccupation with death, and marked psychomotor retardation. He was viewed as struggling with hostile and aggressive impulses resulting from feelings of rejection. He was described as viewing his mother as "a rejecting, threatening person who fails to satisfy his strong dependency needs because of greater interest in younger siblings." The patient was also seen as feeling a great deal of guilt over masturbatory behavior and a fear of sexual intercourse, stemming from a fear of further rejection from his mother. He was reported as having shown much improvement since his admission.

Suffolk Psychiatric Hospital Medical Records, dated 8/26/68-9/17/68

mother brought him to the hospital after he returned from visiting his father in California unexpectedly early. He was complaining of feeling butterflies in his stomach, seemed depressed and upset, distracted, withdrawn, and

unable to sleep. He was reportedly very unhappy in California. also stated that she felt her son blamed her for his parents' divorce and that he had accused her of sleeping with his father's friends, an allegation she denied. She remarked that her son "appears very sensitive and responds hostilely to any kind of criticism or even non-critical approaches." He was described as restless and unaware of his environment. He reported feeling that since his return, people were acting against him. He was lacking in insight and his judgment was impaired. He was treated with the antipsychotic medication Taractan and Cogentin.

was described in Progress Notes on 9/3/68 as having been extremely paranoid, extremely hostile and out of contact with reality. He was confused, irrelevant and rambling. He was treated with Taractan and improved progressively. He reportedly adjusted well to hospital routine and had several successful home visits with his mother. His psychotic symptoms subsided.

Suffolk Psychiatric Hospital Medical Records, dated 4/28/69-5/29/69

was described as anxious and visibly apprehensive. He complained that he had just broken up with his girlfriend and could not seem to get over it. He was diagnosed with Schizophrenia, Chronic, Undifferentiated Type and treated with Librium.

Suffolk Psychiatric Hospital Medical Records, dated 4/14/70-5/10/70

was admitted in a depressed state, remarking that "he hates everything and everybody." He admitted to using hallucinogenic drugs occasionally since the age of 13. His insight and judgment were seen as poor, but he harbored no suicidal or homicidal ideations. He was diagnosed as having Adult Adjustment Reaction. He was ordered to receive Convalescent Care.

Suffolk Psychiatric Hospital Medical Records, dated 5/10/70-5/28/70

was re-hospitalized after receiving 2 weeks of convalescent care. He complained of feeling pressure around his head, and of feeling confused. He was described as mildly depressed, angry, and hostile. He was diagnosed with Drug Dependence and Adult Adjustment Reaction. He was again treated with Taractan.

Suffolk Psychiatric Hospital Medical Records, dated 6/10/70

came to the hospital accompanied by his mother and his father. He reported experiencing auditory and visual hallucinations on a nightly basis and reported using LSD and marijuana. He was unable to control his emotions, was angry and hostile, and had been disagreeable with his parents. He was reportedly mumbling to himself during his intake interview. He was described as lacking in insight and

judgment and his emotional reaction was angry and hostile. The original impression listed by the doctor was of a Drug Addict with Psychosis. He was diagnosed with Drug Dependence.

Central Islip Psychiatric Center Medical Records, dated 4/14/72

attended the day clinic at Central Islip, and complained that he is afraid of homosexuality. He was described as being obsessed with his fear of homosexuality and masculinity. He also claimed to sometimes be suspicious of his job. He suffered from "insistent intrusion of unwanted thoughts and fears of homosexuality which distresses him and makes him depressed." He was diagnosed with Schizophrenia, Residual Type with Obsessive Compulsive Thinking. It was recommended he receive psychotherapy and medication.

Suffolk Psychiatric Hospital Medical Records, dated 5/10/72-7/14/72

came to the hospital accompanied by his father, complaining that he was unable to sleep due to auditory hallucinations. He reportedly lacked insight and sound judgment. His speech lacked spontaneity and his thinking was moderately depressed. He was diagnosed with Schizophrenia, Undifferentiated Type. He was treated with a course of Electro Convulsive Therapy (ECT).

Central Islip Psychiatric Center Medical Records, dated 4/26/74-7/5/74

was admitted with a mental state described as, "agitated, overactive, pressured speech, flight of ideas and delusional thoughts related to his wife's infidelity, as well as to the Chinese plot at Stony Brook." He had reportedly stopped taking his medication and had become violent and assaultive, running out of the building, having to be retrieved by staff members. He reportedly had stopped taking his medication in recent weeks and had become hyperactive, sleepless, with overproductive speech. He had reportedly telephoned the White House. His attitude upon admission was withdrawn, inappropriate and suspicious. His affect was slightly flat and inappropriate. He was reported as having homosexual impulses and delusions of grandeur. He was diagnosed with Manic Depressive Illness, Manic Type and treated with the antipsychotic medications Haldol and Taractan.

In a Progress Report form dated 4/29/74, was described as experiencing grandiose ideas, poor impulse control, and homosexual obsessions. On 5/3/74, he reported grandiose delusions that he was a genius and should be attending MIT. He also displayed homosexual impulses and paranoid beliefs.

While hospitalized, on 4/30/74, was administered a computerized Mental Status Examination Record. The program diagnosed the patient with Schizophrenia, Paranoid Type, or possible Manic Depressive Illness, Manic Type. The

patient tested strongly in the following areas: Unusual Thoughts-Delusions, Violence Ideation, Excitement, with moderate Cognitive Disorganization and Suspiciousness.

The patient was discharged with a mental state described as coherent, relevant, and logical, though he still had mild pressure of speech and irritability. He no longer reported delusional ideas.

Central Islip Psychiatric Center Medical Records, dated 7/24/74-7/31/74

chief complaint upon admission was that he "can't function." He reported feeling "roboty, and mechanical, feels nervous and can't sleep." He was reportedly abusing the sedative Valium prior to this hospitalization, taking 100 mg for several nights prior to his admission. He was diagnosed with Manic Depressive Illness, Manic Type, and treated with the mood stabilizer Lithium Carbonate, the antipsychotic Haldol, and Cogentin. During the hospitalization, his temper was volatile, and he manifested several episodes of violence. He reportedly punched his fist through a window and threw an ashtray during an angry outburst. The patient was transferred from CIPC to Brunswick Psychiatric Hospital.

Central Islip Psychiatric Center Medical Records, dated 11/10/76

was seen as an outpatient, and stated that he felt "the world was coming to an end, had jealous feelings that his wife was involved with other men, and had difficulty sleeping." He was diagnosed as Manic Depressive, Manic Type. He was treated with Lithium.

Brunswick Psychiatric Hospital Medical Records, dated 2/8/77-4/11/77

Upon admission, admitted to having auditory hallucinations and expressed referential and paranoid ideation. The patient was described as tense, anxious, apprehensive and quite hostile. His insight and judgment were deemed markedly impaired. His thinking was described as delusional and obsessed with persecutory themes. His perception of himself "as an emasculated masculine figure generates accompanying fears of homosexuality which often precipitates strong feelings of panic. Patient's perception of members of the opposite sex is distorted and strongly ambivalent about heterosexual feelings." He was diagnosed with Schizophrenia, Paranoid Type.

Following his admission, was treated with psychotherapy and psychotropic medications. He was prescribed the antipsychotics Thorazine and Haldol, as well as Cogentin. While hospitalized, was assaultive, verbally abusive, and threatening to patients and staff. Consequently, he remained in a closed ward. He slowly showed improvement and became less violent, at which point he was moved to an open ward. He was discharged on the antipsychotic Mellaril.

Central Islip Psychiatric Center Medical Records, dated 4/11/77-4/25/77

was transferred to CIPC from Brunswick Hospital and presented himself with severe agitation, complaining of being depressed, experiencing thoughts of homosexuality and of inadequacy. He believed he was transferred because the doctors at Brunswick were "drugging him up." He admitted to feeling afraid of people and that they will think he is inadequate and a homosexual. "He mentions some upset concerning his mother's relationships with others. He has, in the past, been jealous of the possibility of his wife running around with other men on the job." The patient was also experiencing delusions that a doctor, his wife, or someone else can read his thoughts. He was diagnosed with Manic Depressive Illness, Circular, Depressed Type, R/O Schizoaffective Disorder and R/O Paranoid Schizophrenia.

In Discharge Summary, his history of illness stated that he and his wife had been separated for three months prior to his admission. He said that in the previous years, they had been having marital difficulties and financial stresses that led him to have extramarital affairs. This led to frequent arguments that eventually led to a separation. This caused him to feel extremely guilty and inadequate. He stated that he is very dependent on his wife, claiming "without my wife I don't feel secure, I have nothing, she's my other half." The patient reportedly would become violent at times, punching holes in walls and assaulting his wife. "He's been running around restless, confused, and 'wanting to make it big in music.'" He had stopped taking his medications because he reportedly felt he did not need them anymore. After being placed back on Lithium, showed a rapid improvement in his symptoms.

Upon being discharged, was described as pleasant, alert, and cooperative, showing no signs of agitation, hyperactivity, catatonia, or psychomotor retardation. His insight and judgment were fair, and he showed no signs of delusions or thought disorder.

Central Islip Psychiatric Center Social Service Record, dated 4/13/77

was reportedly brought to Central Islip Psychiatric Center on 4/11/77 after a 2-month stay at Brunswick Hospital. He was described as agitated and complained of thoughts of homosexuality and extreme feelings of inadequacy. He felt that in the past people could "control my feelings." Patient's history listed him as having abused hallucinogenic drugs intermittently since the age of 13.

Central Islip Psychiatric Center Medical Records, dated 5/9/79-6/13/79

was brought to the hospital by the police and described as experiencing persecutory ideas and paranoid delusions, elated mood, increased productivity of speech with hyperactivity and inappropriate and uncooperative

behavior. He reportedly attacked his father-in-law, giving him a black eye and knocking out several of his teeth. He also had pulled the telephone off of the wall of his home because of "mysterious calls" he was receiving. He described these phone calls as unusual and threatening. He stated, "There are forces working against me," and believed that his cousin had put a time bomb in his car. He also reported that he had not slept in 3 weeks. He had reportedly been experiencing hallucinations since the age of 13. He was described as assaultive, uncommunicative, shaky and refusing to eat and drink. He was deemed a danger to himself and to others. He had no insight and his judgment was impaired. His mood was described as suspicious. He was diagnosed with Manic Depressive Illness, Manic Type and treated with Lithium and Haldol, which was later changed to Mellaril.

In the patient's Application for Admission, his wife . described him as having "unpredictable outbursts of violence directed at the people in his immediate environment (a few days ago, the patient attacked his father-in-law). She stated that he had a negative view of women and was unable to discriminate between his wife and his mother. She was in the process of applying for legal separation. His Social Service Record stated, "following his wife's decision to leave the home, the patient went on an alcoholic drinking binge and stopped taking his medication." The patient's Examination for 72 Hour Conversion listed the patient as feeling "people talk about him and call him a homosexual...He states that his mother thinks he is sick but that he does not feel ill." He also stated that he desired to reconcile with his wife with whom he was separated from at the time.

At the time of discharge, was described as cooperative, pleasant, and showing no evidence of violent and suicidal tendencies. He was less confused and was no longer causing any problems on the ward.

Central Islip Psychiatric Center Medical Records, dated 4/20/80-6/10/80

. was brought to the hospital by the Police Department. He was pulled over for speeding on his motorcycle, and was then found to be uncooperative, resisting arrest and becoming assaultive. It was reported that he had harassed and threatened to kill his wife, tried to steal his daughter, and attempted to assault a police officer. Upon admission, he was described as uncooperative, suspicious, angry, hostile and at times appearing to be in a catatonic stupor. His mood appeared depressed and his insight and judgment were listed as poor. He was diagnosed with Schizophrenia, Catatonic Type and treated with Thorazine and Lithium Carbonate. Upon admission, the patient was found to have a fracture of his fifth metacarpal bone and was consequently fitted with a cast.

, required placement in seclusion many times during his first several days in the hospital, because of his agitation and violence. , did not seem to improve on the Thorazine, so he was prescribed Prolixin, another antipsychoptic

medication. At that point, he was "extremely unmanageable and was transferred to the Crisis Unit Building one week after admission. He was placed back on Thorazine.

During his hospitalization, he placed frequent phone calls to his wife, threatening her life repeatedly. He was also threatening and assaultive towards other patients. After four weeks, his Lithium and Thorazine were increased at which point he finally began improving. He was discharged with a diagnosis of Manic Depressive Illness, Circular and Manic Type. When he was released he was described as doing very well, being pleasant, cooperative, alert and apologetic for his previous behavior.

Letter from to of Central Islip Psychiatric Center, dated 4/22/80

In this letter, requested to be informed as soon as was discharged from the hospital. She stated that he had been abusive towards her in the past and that on 4/14/80, he came to her apartment, "threatened to kill me and was physically abusive and tried to take out daughter from the house." She reported that she was under a temporary order of protection from her estranged husband and that she felt " . is quite capable of hurting me and/or my daughter." She asked that her request not be taken lightly, and stated her concern that in the past, she has learned that " ... is capable of convincing a doctor that he is not dangerous, and then within hours I have taken the brunt of his violence."

Suffolk County 730 Report, dated 1/14/81

was charged with harassment. He had reportedly engaged in bizarre and aggressive behavior such as throwing food, attacking a Correction's Officer, exposing himself, and displaying psychotic symptoms. He was described as showing marked impairment of insight and judgment and reportedly would not discuss his case as he said it is of no interest to anyone else. He was diagnosed as suffering from Bipolar Disorder, Mixed Type. He was declared unfit to stand trial.

Central Islip Psychiatric Center Medical Records, dated 1/19/81-2/26/81

was arrested and detained for harassment at the Suffolk County Correctional Facility and then brought to the hospital to be examined for a 730 examination. His facial expression was described as angry, irritable and anxious. The patient's Examination for 72 Hour Conversion reported that was unable to be examined because he was assaultive at the time. The patient had reportedly been refusing to eat and refusing to give any information. He reportedly became agitated whenever anyone came close to him. He was described as assaultive, threatening and a danger to himself, as well as uncooperative, slovenly, untidy, and negativistic. His insight and judgment were severely impaired. His affect was flat, and his mood was suspicious and irritable. It was impossible upon admission to ascertain if he was experiencing hallucinations or delusions due to his uncooperativeness. He was

diagnosed with Bipolar Disorder, Mixed Type and his medications at the time were Thorazine and Cogentin. He was also diagnosed with gonorrhea upon entering the hospital.

On 1/11/81, while being accompanied to the bathroom, attacked a staff member who sustained a laceration on his thumb as a result of the attack. Similarly, on 1/31/81, the patient, for no apparent reason, attacked a deputy and attempted to gouge out his eyes, inflicting a laceration on the deputy's nose. On 2/25/81, the patient threw chairs and bedside articles around his room. He was deemed unfit to stand trial and released the following day to Suffolk Correctional Facility. It was recommended that the patient receive further inpatient care. His mental condition was recorded as "slightly improved."

Central Islip Psychiatric Center Medical Records, dated 3/4/81-4/22/81

was transferred to Central Islip from Suffolk County Correctional Facility as a result of being found unfit. Upon admission, he was negativistic and uncooperative. His affect was flattened, and his mood was anxious and angry. He reportedly appeared suspicious and guarded. He was diagnosed with Bipolar Disorder, Manic Type and treated with Thorazine and Lithium Carbonate.

In a progress report dated 3/24/81, the patient reportedly stated, "I am not going to eat so I can die, give my blood to someone else and they will die." He was reportedly depressed, aggressive, and distressed. He was eventually discharged on a regimen of Thorazine, Cogentin, and Lithium. When he was released, he was reportedly alert, pleasant, and cooperative with no agitation or hyperactivity.

Patchogue Aftercare Clinic Medical Records, 5/11/81-9/1/82

..as an outpatient at the Patchogue Clinic following his 2-month stay at CIPC. In a session on 8/27/81, expressed concern to the doctor that there is no "cure" for his problem and that is "chemical," and repeats itself every "winter season." At that time he was described as functioning well. On 12/10/81, the patient was still reportedly doing well. He spoke of his divorce and his relationship with his girlfriend, as well as financial pressures he was experiencing. At that time, he was most concerned with staying out of the hospital.

On 1/21/02, was reportedly having problems with his girlfriend and discussed the fears he had about separating from her. He stated that he has a problem dealing with "controlling personalities." On 2/18/02, the doctor reported that mother called him to say that she was concerned about her son. She stated that he was having business problems and had broken up with his girlfriend. She asked the doctor not to tell that she called. On 4/1/82, called his doctor to say that he wanted to come in for his medication, but that he did

not wish to continue therapy. He stated, "he dislikes all women." When he arrived he was angry and confused. The doctor concluded that behavior, and his low Lithium levels, were signs that he was not taking his medication. The doctor noted that if he continued to be noncompliant, he would have to return to the hospital. The doctor increased his Lithium dosage. On 9/1/82, was removed from Patchogue Aftercare Clinic and readmitted to CIPC because of a "recurrence of his mental symptoms."

Kings Park Psychiatric Center Medical Records, dated 9/7/82-9/22/82

was brought to the hospital by Suffolk County Police and diagnosed as suffering from a Schizoaffective Disorder. He reportedly had had a fight with his girlfriend on the day he was brought in and was abusive towards her. He was described as uncooperative, negativistic, and belligerent. He refused to answer any questions, "just pacing back and forth and stares into space, singing often." His mood was described as blunted and he reportedly appeared to be suffering from persecutory delusions with impaired insight and judgment. He was prescribed Lithium and Thorazine.

On the patient's Application for Admission his mother wrote that had not shown any improvement with his medication. She stated that, "he has shown a lot of hostility in him and also is violent towards his family and people he knows and also strangers." She reported he had hit his brother and sister-in-law and had attacked his stepfather.

At the time of discharge, he was reportedly no longer hostile or belligerent, as well as no longer demonstrating inappropriate or bizarre behavior. His mood was described as pleasant, his speech was spontaneous, coherent, and relevant.

Kings Park Psychiatric Center Medical Records, dated 10/5/82-10/18/82

was brought in by his mother and girlfriend and was admitted with the diagnosis of Schizoaffective Disorder. On his Application for Admission, his mother wrote, "he has shown he has a lot of hostility in him and also violent to us his family and people he knows and also strangers...He gets violent with me and my husband. He has attacked my husband." Upon admission, he was described as suspicious, guarded and delusional. His judgment was poor and his affect was inadequate. He reportedly believed his sister-in-law was trying to take over the country. He admitted to explosive, agitated behavior, punching the walls, and hearing voices. He was described as angry and unable to control his temper. He threw chairs and reportedly had hit his brother and sister-in-law. He was ruled as a danger to himself and to others.

The patient reported that he had been taking his medications, Lithium and Thorazine, regularly, but he reported being unable to sleep for a few nights prior to his hospitalization. He was placed on the antipsychotic Navane, Lithium and Cogentin. Upon discharge, ___ was described as neat, clean, attentive, cooperative and pleasant.

Kings Park Psychiatric Center Medical Records, dated 6/7/83-7/6/83

was admitted to the hospital and diagnosed with Bipolar Disorder, Mixed Type. He appeared exhausted and showed psychomotor retardation. He complained of having trouble sleeping and feeling restless. His mood was described as mildly anxious and his affect was restricted. He was treated with Lithium, Navane, and Cogentin. He reportedly seemed to be improving once medicated.

On 6/12/83, during a home leave, the patient reportedly attempted to stab his wife three times. He believed that she was part of a conspiracy against him. He stated, "A lot of doctors are against me. They are trying to give me a hard time. I heard voices. Something inside me said that I had to stab my wife. I knew that knife would not hurt her, but I wanted to scare her. She had put me through a lot." The patient was delusional with a flat affect. Once improved and no longer psychotic, he reportedly felt very remorseful for having stabbed his wife. He reported that he had been hearing voices and that he felt "a lot of pressure on his mind." He also expressed a belief that a lot of doctors were against him. The following day, reportedly punched another patient, because he believed the man was talking about his wife.

By 6/17/83, was reportedly less delusional and seemed to be getting along with his wife. He was granted another home leave on 6/24/83, which reportedly went very well. The hospital did not receive any complaints from his relatives; therefore, his home leave was extended to 7/5/83.

Kings Park Psychiatric Center Medical Records, dated 7/21/83-8/11/83

was admitted to the hospital and diagnosed with Schizoaffective Disorder. He complained that he needed rest due to marital difficulties. He stated, "being that society is in crisis, I need a rest." He admitted to thought broadcasting, thought control, and thought insertion. He was experiencing auditory hallucinations. His mood was described as angry, hostile and irritable and his affect was constricted. He had no insight and impaired judgment. He reportedly provided very little information, stating, "I have nothing to say," and seemed suspicious of everyone.

Upon admission, was placed on Lithium Carbonate and Thorazine. In Progress Notes dated 7/22/83, Mr. Sancimo was described as "walking around hitting other residents in the mouth for no apparent reason." He was very

suspicious and angry, and was pacing the ward, refusing to talk to staff. On 7/23/83, the patient was described as quiet and cooperative, causing no problems. On 7/25/83, reportedly hit another resident with a breakfast tray because he thought that he was talking about him. On 8/1/83, the patient was not expressing delusional ideas, showed improved insight, and was no longer causing problems on the ward. He was approved for home leave.

Kings Park Psychiatric Center Medical Records, dated 8/23/83-10/24/83

was admitted to the KPPC clinic for aftercare following his hospitalization. At his first appointment at the clinic, he reportedly was friendly and cooperative, though somewhat tense and anxious. He was being treated with Lithium Carbonate and Thorazine. He was complying with his medication at that time. He complained of having marital problems, as well as financial stresses. At his last appointment, he reported that communication with his wife had greatly improved, and that he had stopped taking his Thorazine medication. He asked to be discharged because he wished to see at the Bay Shore Mental Health Center.

Southside Hospital Medical Records, dated 4/14/86-4/22/86.

was admitted to the hospital on 4/14/86 and remained there for 8 days. His provisional diagnosis was Bipolar Disorder, Manic Type. Upon being admitted, the patient complained of "being hyper, unable to sit still, unable to relax...and difficulty concentration, feeling that people are against him and after him to hurt him." He also reported being part of the Mafia, as well as the CIA. "These two conflicting emotions were giving him a lot of restlessness and agitation."

The patient's history reported him as complying with prescribed medications, Lithium and Trilafon, for the previous 2-3 years. These medications "apparently kept him from decompensating to acute psychotic state which required previous admissions in the past." He reported previously having been admitted to the hospital for paranoia, believing that people were talking about him. His history also listed a "questionable history of mood disorder on his father's side."

Upon admission to the hospital, was reportedly anxious, tense and apprehensive, admitting to having bizarre delusions, but no hallucinations. "His affective responses were being determined by his content of thought." He was consequently prescribed the mood stabilizer Lithobid and the antipsychotic Trilafon. Tegretol, a mood stabilizer, was later added to his treatment to help his "marked delusional perception." At that point, the patient reported feeling a "subjective and objective improvement in his thought process. He became free of delusional perceptions and ideations." was released with a final diagnosis of Bipolar Disorder, Manic Type, as well as with prescriptions for the medications he was being treated with.

Kings Park Psychiatric Center Medical Records, dated 6/21/87-6/24/87

arrived at the hospital with his wife and mother and was admitted with a diagnosis of Bipolar Disorder, Manic. He reported having recently experienced marital problems, feeling depressed, and experiencing a deterioration of his mental condition. He reported thinking that his wife was using cocaine because she sneezed frequently. He also expressed a belief that he could read people's minds. Prior to his admission he had been taking Trilafon, Lithium, and Tegretol.

In Progress Notes from 6/22/87, was described as appearing anxious and suspicious of the ward and area. He reportedly stated that his family was the cause of his problems. By 6/23/87, the patient was described as pleasant and cooperative with the ward and staff, as well as being compliant with medications. He was discharged the following day.

reportedly improved rapidly. After being treated with Trilafon, Tegretol and Lithobid, the patient's mood quickly improved, and he was no longer depressed or angry.

Kings Park Psychiatric Center Medical Records, dated 6/25/88-7/1/88

came to the hospital by himself, complaining that he felt paranoid that his wife and the Mafia were plotting against him. He also reported feeling pressured by his wife to get a job and that this disturbed him. At the time, he was reportedly taking Lithium and Tegretol. He was preoccupied with ideas of the Mafia and other imaginary enemies. His insight and judgment were impaired, and his mood was despondent. He was reportedly cooperative, pleasant, and coherent, but was exhibiting paranoid ideations and persecutory delusions. He was diagnosed with Delusional Disorder. Upon being discharged, the patient had reportedly responded well to hospitalization and treatment. He requested to be discharged and was urged to stay a few more days; however, he insisted that he be discharged on 7/1/88.

Southside Hospital Medical Records, dated 10/05/92-10/08/92

was admitted to the hospital on 10/05/92 and remained there for only 3 days. His admitting diagnosis was Bipolar Disorder, Manic Type. Upon being admitted to the hospital, the patient was reportedly "extremely anxious, tense and depressed." He reported feeling that way since a motor vehicle accident that occurred approximately 2 weeks before his admission. He described the accident as a "very traumatic experience for him and since he has been feeling extremely anxious and unable to relax." He reported feeling panic-ridden when entering intersections, experiencing marked perspiration and anxiety, sleeplessness and nightmares of the accident, and fear of the future. , progress record also listed his recent

separation from his wife as a stressor in his life. He "expressed anger towards her, having difficulty letting go."

history reported him as complying with his medications, Tegretol, Lithium Carbonate and Prolixin based on his mental status, since his last hospitalization in 04/88. The patient was reportedly currently living in an apartment alone in Shirley. His father was listed as suffering from Mood Disorder.

In his Mental Status Examination, reported feeling he was going to have a psychotic breakdown as a result of the tension he was experiencing. "He denied any suicidal or homicidal ideations...Insight and judgment were superficial."

It was recommended to that he remain in the hospital for 1-2 weeks. He remained there for only three days. On his 3rd day in the facility, the patient received a telephone call from a friend telling him that his truck was going to be repossessed by his estranged wife). was released with a final diagnosis of Bipolar Disorder, Manic Type and Post Traumatic Stress Syndrome. His condition upon being discharged was described as "satisfactory."

Southside Hospital Medical Records, dated 3/1/93-3/11/93

was admitted to the hospital on 3/1/93 and remained there for 10 days. His admitting diagnosis was Bipolar Disorder, Manic Type. Upon being admitted, the patient complained of being anxious, tense, and agitated as a result of his "increasing delusional perception which has been the reason for his bizarre behavior." He reported not being able to relax for days prior to his admission. The patient's symptoms were attributed to his noncompliance with his prescribed medications, Tegretol and Prolixin. He was taking Lithium at the time of his admission; however, since ceasing to take his other medications, he began having marked difficulty functioning. also complained of stress associated with his current divorce proceedings.

s was described as anxious, tense, apprehensive, and superficially cooperative. His mood was anxious, and his affect inappropriate. His "thought content showed marked delusional ideation. Patient denied any suicidal or homicidal ideations. His intellectual functions were fair, insight and judgment were impaired." Treatment Plan reported him as being unable to cope due to racing thoughts, as well as paranoid and delusional beliefs. The patient reportedly felt that everybody was judging him. His Physical Examination reported the patient as having thyroid masses and tremors in his hands.

Throughout his stay in the hospital, remained delusional and apprehensive. One week into treatment, the patient was described as paranoid, delusional and feeling everybody was judging him. As a result, he was treated with

Lithium Carbonate, the sedative Klonopin, Prolixin, and Cogentin. At that point, the patient began to show improvement and stabilization of his mental condition. His final diagnosis was Bipolar Disorder, Manic Type.

Southside Hospital Medical Records, dated 3/15/93-3/30/93

, was admitted to the hospital on 3/15/93 and he remained there for 15 days. His diagnosis upon admission was Bipolar Disorder, Manic Type. The patient complained of being anxious, tense and depressed due to his inability to sleep, to think rationally or to function. He complained of a severe tremor of his body and trunk. The patient had recently discontinued his Lithium, Tegretol, and Trilafon. reported abusing marijuana and alcohol recently after 13 years of sobriety. He was in the middle of a divorce, and attributed much of his stress to his lack of employment and housing. His history listed his father as suffering from Bipolar Disorder.

On Mental Status Examination was described as "anxious, tense, and quite agitated, tremulous...unable to sit still or relax." He showed marked tremors in his hands and was reported as delusional and impulsive. His speech was pressured and his thought processes were marked with "delusional ideation of persecutory nature. The patient portrayed a desire to '"blow up my brains,' if he had a gun;" however, he denied any homicidal ideation. His insight and judgment were viewed as markedly impaired. He was diagnosed with Bipolar Disorder with Marked Psychotic Features.

The Treatment Plan reported as "talking about hurting himself and others," expressing vague suicidal ideation. He was deemed possibly assaultive. As a result, he was placed on close observation. He was prescribed Librium, Thorazine, Lithium Bicarbonate, and Tegretol. The patient began to show a lessening of his psychotic systems, allowing him to be taken off close observation after three days. His Treatment Plan also listed him as being delusional and paranoid. He was described as suffering from Sensory Perceptual Alteration. His final diagnosis was Bipolar Disorder, Manic Type. His condition upon release was described as "satisfactory."

Southside Hospital Medical Records, dated 6/12/93-6/23/93

was admitted to the hospital on 6/12/93 and remained there for 11 days. His diagnosis at admission was Bipolar Disorder, Mixed Type. He complained of being anxious, tense and depressed "with marked impulsivity and agitation and inability to function."

Medical History described him as in the process of divorcing his second wife. The document also stated that the patient had recently received an order

of protection from his daughter. His Intake Summary listed a personal conflict as "lost daughter in court battle." He was currently residing with his girlfriend. His father was listed as having suffered from depression.

was described as anxious, tense and depressed "with marked frustration intolerance," and slightly pressured speech. His thought content "showed ideations that went into delusional proportions. He voiced some destructive ideation on account of his agitation and recurrent manic episodes." The patient's insight was markedly impaired. The patient's Treatment Plan described him as wanting to hurt himself, thus having vague suicidal ideations and paranoid delusions. He was diagnosed with Bipolar Disorder, Mixed Type. He was treated with Thorazine, Tegretol, Lithium, the tranquilizer Sodium Amytol, and the sedative Ativan. As a result of treatment, anxiety and agitation decreased, as did his paranoid delusions. His final diagnosis was Bipolar Disorder, Manic Type.

Southside Hospital Medical Records, dated 7/8/93-7/9/93

was driven to the emergency room by his sister-in-law after attempting to kill himself with an overdose of Lithium (60-70 tablets) at 6 AM on 7/8/93. He reported vomiting four times before reaching the hospital. The patient admitted to wanting to end his life. The patient's Intake Summary described him as angry, agitated, and still expressing suicidal thoughts. His impulse control and insight were said to be markedly poor. He was described as paranoid, particularly in regards to his doctor, s, and the hospital staff. He requested to see another psychiatrist, regardless of the fact that had been treating him for at least 10 years. Prior to his overdose, the patient had been taking Lithium and Tegretol.

After being admitted, was not remorseful regarding his overdose. The patient stated that he was having difficulty coping with his impending divorce, custody issues, unemployment, and chronic mental illness. He had planned his overdose for 3 days and still expressed suicidal thoughts. He was released after a one-night stay in the hospital.

Brookhaven Memorial Hospital Records, dated 11/17/94

was admitted to the hospital and treated for fever sores around his mouth, a symptom he had reportedly been suffering from for 4 days. He also had a low-grade fever.

Brookhaven Memorial Hospital Records, dated 5/27/99-6/7/99

was admitted to the hospital with a diagnosis of Bipolar Disorder, Depressed with Psychotic Features. He was experiencing auditory hallucinations, paranoid ideations, and suicidal ideations. He reported being angry with his wife,

whom he had married only three weeks prior to his admission. He felt that she was after him "in some unclear, suspicious fashion." He also reported having conflicts with his brother, who was his business partner at that time. In his Application for Admission, the patient stated, "I feel people are fighting and I don't have any trust in people." The patient showed symptoms of paranoia, believing that people were talking about him and were after him. He reported being able to read people's minds and displayed thought insertion. He reported that when he talks to others, "he has the sense they are talking to him and someone else at the same time." At the time of admission, was taking Lithium, Tegretol, the antipsychotic Zyprexa, and the antidepressant Celexa.

attitude and behavior were described as "rather surly, with hostile, aggressive edge, and superficial cooperation," as well as serious, irritable, and over-controlled. His mood was depressed and his activity "hypoactive." His insight was minimal and his judgment was poor. He was judged a danger to himself and therefore placed under close supervision. In Progress Notes from 5/28/99, the patient reported that he did not think he could get well in the unit he was in because "the patients are too bizarre." He reported feeling threatened by his community and his wife, and stated that the voices he hears are "intolerable." In Notes from 5/30/99, obsessed about "racial conflicts," and his unhappiness with his wife since they got married.

In Progress Notes from 6/2/99, denied still having feelings of self-harm or of hearing voices. His chief complaint was of his wife and her bipolar related outbursts. He "states his wife is bipolar also and often breaks objects in the house and he has to sit back and watch for fear of restraining her and being arrested." He was described as pleasant and cooperative. On 6/4/99, the patient's mood was described as "brighter," and he stated that he wanted to work things out with his wife. The patient's final assessment stated that he "lost his active psychosis and became much more realistic." At the time of discharge, he was taking Lithium Carbonate, Tegretol, Cogentin, and Haldol.

Brookhaven Memorial Hospital Records, dated 6/5/00-6/13/00

was admitted to the hospital and diagnosed with Bipolar Disorder, Depressed, Severe without Psychotic Features as well as Paranoid Personality Disorder. He was described as extremely psychotic, delusional, and paranoid. He reported feeling people were looking at him, watching him, and trying to harm him and that people did not like him. He felt depressed and disorganized and he reported feeling "his mind was racing up and down." His affect was sad and blunted, and his mood was despondent. He was experiencing persecutory delusions and impaired judgment and concentration. The patient was treated with Zyprexa, Tegretol and Lithium Carbonate.

In his Final Assessment, he was described as no longer experiencing mood swings and being less tense, anxious, and having less paranoid ideation. However, he was reportedly still feeling that people were after him.

Brookhaven Memorial Hospital Records, dated 1/11/01-2/15/01

was admitted with the diagnosis of Bipolar Disorder, Manic Type, Severe with Psychotic Features, R/O Schizoaffective Disorder, Bipolar Type, and Paranoid Personality Disorder. He was brought in by his wife and was reportedly agitated, yelling, screaming, disengaged, paranoid, delusional, labile, irritable, and volatile. He was assessed to be a danger to himself and others. While in the Emergency Room, the patient punched a member of the staff. During his stay at the hospital, he choked a patient and a staff member, accusing them of working for the Mafia. The patient claimed that he was working as a government agent and was preoccupied with delusions regarding the Mafia. He also believed people could read his mind and that someone was after him and going to hurt him. He held very poor insight and judgment, stating, "I don't believe I have a mental illness...I am the victim of circumstances." His judgment was impaired and his insight was poor. He was disoriented and his affect was blunted and flat. He was ruled a danger to himself and to others. In his Psychological Assessment, described his mother as distant, stating that he did not feel loved by her.

On a record dated 1/23/01, the patient was reportedly exhibiting homicidal ideation, paranoid delusions and poor impulse control. The patient complained to hospital staff on numerous occasions that he desperately wanted to divorce his wife because they no longer got along and because he believed she was "sabotaging" his care. On 1/24/04, it was noted in his Progress Notes that he was still exhibiting numerous delusions, "believing he is a doctor, lawyer, nuclear physicist, and government employee while also preoccupied with the Mafia and possible need to purchase a gun to protect himself." Another Progress Report from 1/28/01 stated that the "patient believes he is a doctor and a lawyer and is going to Washington DC to be an advisor to the President. Patient discussed his wife and his belief that she is cheating on him...Patient states that he feels wonderful, and has no insight into his illness." In a Report from 2/6/01, patient was reportedly improving, no longer expressing bizarre delusions and stating that his relationship with his wife was getting better.

Upon being discharged, was described as "now aware of the extent of his disability and recognizes delusions are not real, however they are still at the core of his thought processes. He was transferred to Pilgrim Psychiatric Center with a Final Assessment describing him as "still somewhat suspicious and guarded, unpredictable." At the time of his transfer he was taking Zyprexa, the antipsychotic Risperdol, Tegretol, Lithium, Klonopin, Haldol, and Cogentin.

Pilgrim Psychiatric Center Medical Records, dated 2/15/01-4/17/01

reported being angry with his wife, having trouble sleeping, experiencing command auditory hallucinations telling him to attack people. He had not been taking his medication, and just before being brought to the hospital by his wife, Mr. Sancimo had gotten in his car and driven to Maryland, only to turn around and return home after a 15-hour drive. His wife was fearful of him.

Upon admission, was given the diagnosis of Bipolar Disorder with Psychotic Features. He stated that he needed to "kill the elderly," and that he could read people's minds. He expressed believing that the Jews were conspiring against him and he feared people were trying to kill him. He claimed to be a nuclear physicist who was hired by the CIA to choke a woman whose husband was a Nazi. He believed he needed a gun in order to fulfill his mission. He also claimed to be part of the assassinations of President Kennedy and Martin Luther King. While hospitalized he punched a member of the staff and tried to choke another staff member. While in the ER, he was reportedly "paranoid, delusional, grandiose, disorganized (thinking), agitated, yelling, and screaming." The patient's Screening/Admission Note lists his father as being Manic Depressive and his brother as being Manic. After being admitted to the hospital, was placed on Zyprexa, Tegretol, Lithium Carbonate, Klonopin, and Cogentin. He was eventually taken off the Klonopin and Cogentin.

Due to his violent outbursts, was placed in seclusion were he exhibited poor impulse control and no insight into his mental illness. The patient reportedly told a staff member, "come in my room and shut the door because there are people in the hallway trying to kill me." He was also noncompliant with his medications. After approximately two weeks, improved and became compliant with his medications. He became quiet and cooperative.

On 3/23/01, a series of psychological tests were administered to He was given the Millon Clinical Multiaxial Inventory-3rd Edition (MCMI-II), the Minnesota Multiphasic Personality Inventory –2 (MMPI-2), and the Self-Representation Inventory (SRI). An excerpt from the interpretation of those tests follows:

presents as a somewhat strange and peculiar individual who reported difficulties in thinking and concentrating. He is at times delusional, hallucinatory, disorganized, and confused. He expresses unusual and unconventional ideas which he has difficulty integrating with objective reality. He lacks insight concerning the causes of his psychiatric symptoms, as well as his motives and feelings. He seems confused about the causal relation between his problems and behavior and placement in the psychiatric hospital.

Despite his attempts to repress and deny problems, experiences significant psychological distress, including feelings of alienation, social withdrawal, and a general

dissatisfaction with his circumstances. He seeks simple, concrete understandings that do not require self-examination, and thus, may present as naïve, immature, and self-centered. As someone who does not easily experience internal, subjective sources of information, relies on more overt, concrete sources such as bodily concerns, external cues, and other people in order to understand his experiences.

self-concept is quite poor and incohesive. He is often emotionally inappropriate, apathetic, fearful, and expresses feelings of hopelessness. He defends against these feelings with an elevated, grandiose view of himself. He expects others to recognize and praise his special qualities and to focus on him even though he does not reciprocate this social support. He has excessive expectations of entitlement and will exploit and manipulate others without concern for their rights. Because his behavior is guided more by his feelings than his intellectual controls, he is often impulsive, unpredictable, and strange. Perhaps due to this relative weakness of cognitive control, he is frequently tense, anxious, depressed, and indecisive.

While has a strong need for attention and affection, he has difficulty soliciting support from others in a direct, appropriate manner. In times of distress, he may become increasingly demanding of affection and support, and may use indirect and manipulative means to get attention and affection. For example, in response to stress may be especially vulnerable to the development of physical complaints and may use these complaints to avoid responsibility or to gain attention from others. Due to the limitations of his insight into his own experiences, and his tendency to manipulate others to obtain the support he needs, his social relationships are likely to be superficial, immature, and potentially turbulent.

The results of the psychological testing led to a diagnosis of Bipolar Affective Disorder with Psychotic Features. The summary and recommendations for this diagnosis were as follows:

condition had improved and he experiences minimal interference from cognitive distortions. While he is capable of developing trust and establishing a therapeutic alliance, he has only minimal insight into his mental illness and tends to deny psychological problems. Consequently, he is likely to be resistant to psychological intervention and treatment. He may be at risk for becoming noncompliant with aftercare with psychotropic medication, without which he quickly decompensates. When he decompensates, he tends to become paranoid and it is at this time that he becomes at risk for acting out aggressive impulses. Currently he is in control of his impulses and is not manifesting any aggressive tendencies. He is coherent and cooperative and can be considered for discharge. Upon discharge it is recommended that he maintain contact with outpatient professionals who can provide therapy and assist with medication compliance.

At the time of discharge, was described as pleasant and cooperative, no longer displaying any mood lability or aggressiveness. His affect had improved and he denied still having any suicidal or homicidal ideations.

New York State Office of Temporary and Disability Assistance, Division of Disability Determinations, Medical Questionnaire sent to , dated 4/10/01

This form listed as suffering from Bipolar Disorder, most recent episode manic, severe, without psychotic features, with the following symptoms: auditory hallucinations, insomnia, agitation, hyper and physically aggressive, paranoia, grandiose, poor frustration, and impulsivity. His medications were listed as: Ativan, Cogentin, Prolixin, Tegretol, and Lithium Carbonate.

Peconic Center Medical Records, dated 4/19/01-10/24/02

was seen as an outpatient at Peconic Center after being discharged from Pilgrim Psychiatric Center. At his first appointment, he was described as calm and cooperative. His speech was relevant and coherent, and there was no evidence of flight of ideas, paranoid delusions, or hallucinations. He was alert, his affect was appropriate and his mood was euthymic. His insight and judgment were still impaired. He was reportedly doing very well and complying with his medications; however, his symptoms did tend to temporarily become exacerbated whenever he had arguments with his wife. His symptoms would diminish either as the arguing ended, or with a slight adjustment in his medication. was in control of his symptoms until they began to return after he viewed many hours of the 9/11 terrorist attacks on New York City on television. On 9/18/01, reported that after viewing the news footage, he began to feel worried about what people were saying about him and became concerned about the Mafia. His doctor consequently adjusted his medications to treat his symptoms. On 10/29/01, the patient reported that he was doing better. He had been taking his medication and felt calmer. His relationship with his wife was described as satisfactory.

In June or July of 2002, reportedly stopped taking his medication, which resulted in his being hospitalized. He was re-admitted to the Peconic Center on 7/29/02. On 8/13/03, did not show up for his consultation, and therefore the doctor called his mother. His mother informed the doctor that on the previous evening (8/12/02), had been in her home and was agitated and using profanities. He was asked to leave by her daughter-in-law because her children were in the house. He left and went to his brother's house. While there, reportedly tried to choke his sister-in-law. The police were called, but when they arrived had already left the premises. His family did not press any charges. The family did not know where he was, as a result the doctor contacted the police and the Secret Service to report the incident. 's sister-in-law reportedly called the doctor on 8/29/02 and stated that had checked himself into St. Catherine of Sienna Medical Center. He was officially discharged from Peconic Center on 10/24/02.

Brookhaven Memorial Hospital Records, dated 6/30/02-7/1/02

was admitted to the hospital and diagnosed as having a Schizoaffective Disorder. He was described as non-compliant, volatile, disorganized,

and labile. His affect was reportedly flat, and his mood was anxious and irritable. He reported in his Psychosocial Assessment, "I don't have any family." His records noted that in the past, he had been assaultive towards patients and that he came across as very paranoid. While in the hospital, the Police Department called, requesting to speak to They informed the hospital that the patient had made threats to kill the President and was found in the Washington, D.C. area a couple of days prior. He was questioned and released. On 7/1/02, Secret Service Agent Michael Huber came to the hospital to assess

; Patient Information states that "Upon discharge the US Secret Service must be notified," and provides the number of a case agent (#202-406-5000).

St. Catherine of Sienna Medical Center Medical Records, dated 7/1/02-7/29/02

... was admitted to the hospital with a diagnosis of Bipolar Affective Disorder, Manic Type with Psychotic Features. The patient presented himself as an attorney, and complained of insomnia and a low energy level. He was described as non-compliant, guarded, irritable, preoccupied, secluded, hostile, and easily agitated. He demonstrated frequent angry outbursts and his judgment and insight were poor.

In Progress Notes dated 7/2/02, the patient stated that he "has no family," but he did report that he was experiencing conflict between himself and his mother and brother. On 7/5/02, The Secret Service contacted the hospital because the patient had previously stated that he wanted to harm the President. They wanted to know if the patient "verbalizes any threats about the President." During his stay, he punched his roommate without provocation, punched two male peers, attempted to punch a nurse, was repeatedly threatening towards the staff, and engaged in many fights with the staff. On 7/11/02, Progress Notes were taken regarding a meeting with the patient's wife. She stated that her husband had left her three weeks ago and that she wanted a divorce because of the patient's frequent verbal abuse. She stated that , is "usually angry at brother and mother but has been very pleasant towards them."

On 7/17/02, , reported being concerned about being arrested by the Secret Service after being discharged. He denied having made any threats towards the President and "states he thought he was in the CIA in the past but does not believe it at this time." At this time he was reported in Progress Notes as being compliant with his medications and being less irritable. On 7/20/02, he was described as being calm, pleasant, and cooperative. However, on 7/27/02, the Progress Notes stated that became "acutely paranoid again, completely unprovoked became threatening toward doctor, threatened assault." He threatened a male nurse, and was having paranoid delusions, stating, "you'll know it was me when it all goes down" and "f*ck the government." On 7/28/02, he was reported as being back in control. He stated, "I had some problems yesterday," but was cooperative on that day.

By the time was discharged, "he was no longer having angry outbursts, he was agreeing to comply with medications and denied any urges to assault anyone." At the time, he was taking the antipsychotic Seroquel, Lithium Carbonate, Ativan, and Inderol.

St. Catherine of Sienna Medical Center Medical Records, dated 8/22/02-10/24/02

was admitted with a diagnosis of Bipolar Disorder, Manic Type with Psychotic Features. He was described as experiencing agitation, violent outbursts, being non-compliant with medications, angry, and paranoid. He was also guarded and suspicious, and was experiencing command, auditory hallucinations. He refused to disclose his history; however, he did claim to have graduated from Yale University. Upon being admitted to the hospital, the social worker contacted the Secret Service to inform them that Mr. Sancimo was in their care. The doctor received a call back from Agent Roberta Kane #249-0404 requesting the patient's initial evaluation and level of threat to the President. It was reported on 8/29/02 that the Secret Service "continues involvement."

assaulted a male peer and a member of the staff. Consequently, he was placed in seclusion. He continued to experience command auditory hallucinations telling him to attack the staff and patients. On 8/31/02, he punched a male visitor and was again placed in seclusion. As a result of his command auditory hallucinations, he was often threatening to the staff and was easily agitated without provocation. In Progress Notes from 9/13/02, it was noted that the patient was informed that a transfer to Pilgrim Psychiatric Center was being considered. He was described as pleasant and conversational at times, but at times becoming tense. He complained that his medications interfered with his activities. "His commitment to med compliance is doubtful." On 9/20/02, reported experiencing paranoid delusions that the Irish were following him. He was described as "distracted, grandiose." On 10/8/02, the patient made an angry statement towards the writer of the Progress Notes, stating, "you only help your kind, you only help the Jews." He was described as having "a menacing stare, irritable edge." On 10/23/02, the patient stated, "I'm paranoid, I'm afraid to be around people, I'm afraid they're going to find me out."

was transferred to Pilgrim Psychiatric Center due to his need for continued, long-term care. At that time he was taking the antipsychotic Clozaril, Haldol, the mood stabilizer Trileptal, and Seroquel.

Pilgrim Psychiatric Center Medical Records, dated 10/24/02-3/12/03

was admitted to the hospital and diagnosed as suffering from Schizoaffective Disorder, Bipolar Type. He had been transferred from St. Catherine of Sienna Hospital because he continued to be psychotic and was ruled unable to sustain

himself safely in the community. At the time of admission, he was prescribed Clozaril, Haldol, and Seroquel and Trileptal. He was described as previously being non-compliant and it was reported that he had recently tried to choke his sister-in-law. When asked why he was hospitalized, responded the he "wasn't taking my medication properly." He was experiencing paranoid ideations, delusions, grandiose and disengaged thinking, yelling, swearing, command auditory hallucinations, and paranoid delusions. He was irritable and was experiencing delusions that people wanted to hurt him. He reported last hearing voices "a couple of weeks ago."

Within 2 days of entering the hospital, was described as "pleasant and cooperative to ward routine." On 11/01/02, he reported feeling much better than he had upon admission, stating that his mind felt much clearer compared to before. In notes from 11/05/02, the patient expressed awareness that his decompensations are often associated with his non-compliance with his medication. He discussed "that his life has been negatively impacted by his inability to comply with prescribed medications," however, he also complained of the side effects he experienced form his medications, such as feeling sick and tired. On 12/11/02, he spoke of command auditory hallucinations that he had in the past, and stated that he was aware that at times he did act on those commands. At that time, he denied having any hallucinations and was complying with medication. A Progress Note from 1/9/03 states that , a member of the staff at PPC "spoke to the Secret Service today, Mr. who reported the case is still open. reported his wife called the Police and patient was found in Maryland. When asked at that time also patient denied any threats. Secret Service should be informed before discharge."

was approved for discharge with an accompanying order for Assisted Outpatient Treatment (AOT), thus mandating him into outpatient treatment. He was discharged into his brother's care. Upon being discharged, was described as cooperative, pleasant, well behaved, calm, and verbally relevant. His mood was fine and his affect was appropriate. He denied paranoia, delusions, hallucinations, and hearing voices. His insight into his illness was listed as good.

Pilgrim Psychiatric Center Medical Records, dated 5/6/03

was discharged from PPC on 3/12/03 under AOT supervision. He was reportedly doing well and complying with his medications; however, on 5/8, 's brother, with whom he was living at the time, left a message at PPC regarding his concern for his brother. He reported the "patient was doing very good while he was living with him, he was monitoring his medication and the ACT team visited him twice a week. Patient moved out from his brother's house probably a month ago and his medications were lowered by his psychiatrist. Patient started decompensating and his medications were increased a week ago. He also reported that had an episode of aggressive behavior during a prior weekend towards his other brother but they did not want to press charges."

Oral Statement of *dated 5/6/03*

was questioned by Det. and Det. . He was asked when the last time he took his medications was and he responded, "last night." He was asked about his mother, to which he replied, "my mother is devious, cunning, control freak, always telling me what to do. It never ends. I'm the oldest, always expecting more from me. She pressures me. She stresses me out." He reported that he had been at his mother's house, and that he went there to get a letter she had regarding his car insurance. His mother had been upset because she had been paying his car insurance and he had not reimbursed her. He entered the house, in which his mother lived with his brother, sister-in-law, and their three children. He stated, "Mom was still giving me a hard time about the letter. Mom's so controlling. We went to smoke in the laundry room. Mom started blaming me. I just snapped and started stabbing her with scissors. I had it in my pocket for protection. I carried them for a few days...I stabbed her all over. I stabbed her a lot. I was fighting with her in the laundry room. I had it. I couldn't take it anymore. Mom ran into the living room trying to get away. I went after her and I kept stabbing her. I wanted her dead." After leaving his mother, bleeding on the couch, , went to his apartment to wash up. He then got in his car and drove to Middle Island where he reportedly threw the blue sweater he was wearing into a dumpster. He reportedly slept in his car that night.

Written Statement of *, Police Department, County of Suffolk, NY, dated 5/7/03*

In his statement reporting the events surrounding his mother's death, stated, with regards to the weapon used to kill his mother, that he had began "carrying the scissors with me for the last three or four days for protection." He stated that his mother "was always blaming me about things and I had had it and I snapped." The police allege that, as stated, went over to his mother's to address a situation regarding his car insurance. After arriving at his mother's, he proceeded to get into an argument with his mother. She had been paying his car insurance for some time and was not happy with the amount of time it was taking him to reimburse her. He reportedly took the scissors out of his pocket and began to stab is mother. He stated "I stabbed her everywhere. Just enough to kill her because I couldn't handle it anymore." He then stated that, "She was bleeding a lot and calling my name over and over again. I was scared I couldn't take what I was seeing so I left the house. The scissors that I used to stab mom I left in the house, but I don't remember where...When I was fighting with my mother I was wearing a blue sweater that I got rid of, the blue jeans that I have on, sneakers and tan socks." When I left my mom's house, I went to my apartment and washed up in the sink. I got my leather coat I got into my car and I started to drive around." While driving around, he allegedly threw his glasses out on the side of the road and threw the blue sweater he was wearing into a dumpster.

Summary Report of Autopsy Findings, dated 5/8/03

This document ruled , cause of death to be multiple sharp force injuries and the manner of death to be homicide. "The autopsy revealed approximately 85 sharp force injuries of the face, neck, trunk, wrists, hands, and left leg with internal injuries and hemorrhage."

Indictment of . County Court: Suffolk County

This document stated that the Grand Jury of Suffolk County, "accuse the defendant, , of the crime of Murder In The Second Degree on two counts, committed as follows: The defendant, on or about May 6, 2003, in Suffolk County, State of New York, with intent to cause the death of , caused her death by stabbing her with a sharp instrument." The second count was committed as follows: "The defendant, , on or about May 6, 2003, in Suffolk County, State of New York, under circumstances evincing a depraved indifference to human life, recklessly engaged in conduct which created a grave risk of death to a by stabbing her with a sharp instrument, thereby causing her death."

730.20 – Form 2, Examination Report, State of New York Suffolk Court, dated 8/13/03

This document stated that ., a Qualified Psychiatrist, examined in order to determine if he was an incapacitated person. The findings were as follows: "It is in my opinion that the above-named defendant ( ) is an incapacitated person in that the said defendant as a result of mental disease or defect lacks capacity to understand the proceeding against him or to assist in his own defense."

In his report, I stated, "of note, . discussed his relationship with his own attorney in a delusional manner. The defendant is under the delusional belief that he is a Yale-trained attorney and psychiatrist, and that his current defense attorney is a Harvard-trained attorney and medical doctor. has noted that his legal and psychiatric expertise may be useful in his defense with the court. He also made reference to an apparent chronic paranoid delusional belief of a conspiracy within his family to belittle him and persecute him, and that his current case is part of this conspiracy." Later on in the report wrote that reported "a history of physical abuse by his mother," and also reported that his mother and his siblings would not allow him to attend Yale Law School in a conspiracy effort to persecute him." report also stated that, upon arriving at Central New York Psychiatric Center where he was taken two days after being arrested and remained for one month, "punched the admitting physician in the face and required physical restraint and emergent treatment with antipsychotic medications.

was noted to have auditory hallucinations, delusions of persecution, disorganized thinking, and paranoia. He was noted to act upon his paranoia and delusions in various episodes of assaultive behavior." Over the course of his month at Central New York Psychiatric Center required numerous emergency medications to control his threats and actual acts of violence.

Upon being admitted to Kirby, described as having "symptoms of psychosis such as hallucinations, paranoid delusions, and grandiose delusions of being a 'lawyer and scientist.' He reported feelings of thoughts being placed into his head by 'hypnotism.' He described the nature of the thoughts to be threatening and commanding him to strike others in the hospital. He reported daily experiences of 'hypnotism' with auditory hallucinations." These episodes of "hypnotism" reportedly lasted anywhere from 2 hours to an entire day. He stated that during these episodes, he hears voices telling him to hit people, or else "something bad will happen." When asked during his evaluation with when the last time he heard those voices was, he stated "I am hearing them right now," and added that the voices were telling him to hit the doctor. At that time, informed . . . that they would be taking a break. During that break, summoned additional security personnel to observe the interview. As the interview continued, " notably sat on his hands stating that he could 'control himself.'"

reported that "demonstrated gaps in his insight regarding his illness and need for treatment." For example, he stated that he had stopped medications on many occasions because he couldn't 'play drums' while medicated, and felt 'tired' when medicated. Furthermore he continues to have difficulty separating reality from delusion as evidenced in his seeking career counseling advice regarding his delusion of being a psychiattist in training, or in reporting his expertise in law which he believes may be useful in his own defense."

730.20 – Form 2, Examination Report, State of New York Suffolk Court, dated 8/14/03

This document stated that a Certified Psychologist, examined in order to determine if he was an incapacitated person. His findings were as follows: "It is in my opinion that the above-named defendant) is an incapacitated person in that the said defendant as a result of mental disease or defect lacks capacity to understand the proceeding against him or to assist in his own defense."

In his report, stated that upon admission to Kirby, continued to exhibit symptoms of psychosis including auditory hallucinations, paranoid ideation and grandiose delusions. He noted that frequent complaints had been made regarding hearing command hallucinations to attack others. h reported that, while at Central New York Psychiatric Center,

"exhibited multiple episodes of assaults on staff and other patients in response to paranoid ideation and auditory hallucinations."

reported that was "recently put on one-to-one observation for reporting suicidal thoughts. He is currently diagnosed with Schizophrenia, Paranoid type and being treated with Olanzapine and Haloperidol, Depakote, and Lorazepam. Due to his assaultive and threatening behaviors he has been transferred to Kirby's intensive management unit." He stated, ' reports frequent command auditory hallucinations, telling him to hit others. He also reports being able to communicate with others 'mentally' and with people on TV (thought broadcasting). He also exhibits paranoid ideation that other patients may be 'out to get me because of my crime' and frequently has impulses to hit others. Delusional thinking was evident as he reported being a Yale trained attorney, having worked for the CIA, and being the "Secretary of the Interior.'" He reportedly demonstrated limited insight into his illness. "For example, although he states that he is mentally ill, he believes the auditory hallucinations and his ability to communicate with other mentally to be reality."

Model Report in Support of Competency Restoration made pursuant to CPL 730.60(2), dated 2/24/04

This report stated that upon being admitted to Kirby Forensic Psychiatric Center, was assigned a working diagnosis of Schizophrenia, Paranoid Type. On 8/8/03, the Hospital Forensic Committee reported that he suffered from "paranoid thinking, delusions, auditory hallucinations, and believed that people could read his thoughts. The report of the HFC indicated that the defendant's paranoid thinking, assaultive behaviors, and delusional beliefs that the government was manipulating evidence against him precluded him from working effectively with an attorney...On admission, the defendant was paranoid, delusional, hostile, and assaultive in response to his psychotic symptoms. The symptoms that most adversely affected his/her competence –related abilities were: Psychosis: Paranoid thinking and delusions."

The document reported that showed substantial improvement over the course of treatment. His treatment began with being placed on Olanzapine and Depakote. "He required one-to-one observation to prevent assaultive behavior, as he remained preoccupied with his delusions and had significant paranoia towards people in general. He assaulted two patients early in his hospitalization in response to his psychotic symptoms. His medications were therefore adjusted. Over the course of treatment, with which he was compliant, improved to the point where his paranoia and delusions diminished, he refrained from assaults and was in better control of his behavior, and he was able to think more rationally and flexibly. Although he was still expressing delusional beliefs, including "long-standing paranoid delusions about his mother, he was not preoccupied by them and was "able to tolerate

being challenged about his delusional beliefs about her." It was ruled that these delusions would not affect his ability to proceed with the case.

Notification of Fitness to Proceed, State of New York County Court, County of Suffolk, dated 3/18/04

This is a document notifying the District Attorney of Suffolk County that, after being in the custody of Kirby Forensic Psychiatric Center since 7/18/03, was determined to no longer be an incapacitated person. He was ordered returned to the custody of the court.

DIAGNOSIS AND FORMULATION

As a result of my psychiatric examination and the review of available collateral data done so far, I have come to the following interim diagnostic conclusions regarding

Axis I
(Clinical Syndromes)
Schizoaffective Disorder

Axis II
(Personality Disorders)
Antisocial Personality Traits

Axis III
(Medical Problems)
None

Does suffer from a severe mental disease or defect?

has suffered from a severe and chronic psychotic mental illness since adolescence. As reported by and as verified and confirmed in the voluminous medical records reviewed in preparing this draft report, he has been afflicted with a mental illness that has been characterized by mood symptoms, such as depression and mania, by psychotic symptoms such as command auditory hallucinations, grandiose and paranoid delusions, thought insertion and broadcasting, disorganized and illogical thinking, thoughts of persecution, as well as behavioral symptoms such as impulsivity, agitation, suicidality, destructiveness and assaultiveness.

As a result of the recurrence of these severe and disabling symptoms, has been hospitalized psychiatrically over forty times in as many years. A

review of his mental state at the time of his hospitalizations shows great consistency over time, in that he presents with similar symptoms of his mental illness during each hospitalization. Typically, as a result of either non-compliance with treatment or as a result of a significant life stress, he becomes paranoid and delusional, typically involving conspiracies to harm him to be carried out by family members, fears of homosexuality, or concerns that his mother or significant other women in his life are performing sexual acts behind his back. As these delusional beliefs intensify, he begins to incorporate other delusional material such as being part of the CIA, the Mafia, being a doctor or a lawyer. At a certain point, his fear becomes panic and he lashes out violently, suddenly, and without warning. The medical records are replete with examples of suddenly striking, assaulting, or choking a medical staff member or fellow patient in the days immediately following his admission, while his mental state remains psychotic and disorganized. Once the medications and therapeutic environment have taken effect, then psychotic symptoms recede and eventually disappear, along with any disorganized or violent behaviors. Once his mental illness is stabilized, no longer manifests any of the aggressive or dangerous behaviors that characterize his acute symptoms.

A review of the available records indicates that presentation may have varied slightly over time during different psychiatric hospitalizations. At times, he has appeared more depressed, at times more manic, or more psychotic, or more violent. Despite these varied mental states, the theme of paranoia, sexual insecurity, fears of family-based conspiracies, and involvement with the CIA and FBI remain constant, as does the presence of psychotic violence.

At the time of the offense, was ... suffering from a mental disease or defect?

It is evident that suffered from a mental illness in the days, weeks and years prior to the incident. He was discharged from Pilgrim Psychiatric Center in March 2003 with a Kendra's Law order to comply with outpatient psychiatric treatment. The conditions of his discharge were that he would reside with his brother who would supervise his taking of psychotropic medications and that he would meet regularly with the ACT team who would provide comprehensive psychiatric services.

A review of the records indicate that approximately on month prior to the incident, left his brother's apartment and was no longer being supervised. Records also indicate that he became acutely psychotic and violent during the weeks leading to the incident as evidenced by his assaulting family members and becoming paranoid about his brother and family. Such psychotic behavior is characteristic of when he becomes acutely mentally ill with delusional, paranoid, agitated and psychotic symptoms. Although the records indicate that as a result of the onset of such acute symptoms of his mental illness, the psychiatrist of the ACT team increased the medications, the intervention may have occurred too late, as was

already floridly psychotic and no longer able to function safely in the community. As it takes up to four weeks for antipsychotic medications to take effect, the intervention that may have occurred a week prior to the incident would not have significantly impacted on the acute psychotic symptoms he was manifesting. Obviously as the medical records from the AOT and ACT services become available, I will be better able to assess the effectiveness, if any, of any interventions taken.

The medical records of treatment following his arrest, including psychiatric reports documenting lack of capacity to stand trial, support the finding that for weeks after his arrest he remained acutely psychotic, paranoid, delusional, disorganized in his thinking and repeatedly violent. Despite treatment, his symptoms did not abate for many weeks while he was in custody. He continued to harbor the very same symptoms and psychotic violence that had characterized his presentation during prior hospitalizations. In summary, there is evidence in the medical records that was acutely psychotic in the weeks prior to the incident as well as for weeks following the incident. The symptoms he harbored are consistently described by as well as by mental health providers in the reviewed records. He manifested symptoms of paranoid, delusional and grandiose thinking, fear, panic, agitation and assaultiveness. As a result, there is no doubt that, at the time of the offense, was suffering from the acute psychotic symptoms of his mental illness.

If the suffered from a mental disease or defect at the time of the offense, did he lack substantial capacity to know or appreciate either the nature or consequence of his conduct, or that such conduct was wrong?

At the time of the offense, was acutely psychotic. His thinking was illogical and disorganized. He harbored paranoid delusions that his life was in danger, that he was a member of the CIA and that his mother was connected to the Mafia. As he had in the past, he believed, as told to him by command auditory hallucinations, that it was his responsibility to stop his mother at all costs. As he had many times in the past and since, , in an acutely delusional mental state, began to fear for his well being and lashed out in a psychotic and violent manner in order to defend himself against the threats that seemed very real to him. Having lost contact with reality, truly believed that what he was doing was right and that he was carrying out his duty as an agent against a significant threat to his well-being.

Despite months of treatment, remains delusional to this day, though less intensely, and he still believes that his mother was connected to the Mafia and that she had been involved in various assassinations over time. These strongly held, but distorted beliefs, are at the core of 's mental illness. When acute and severe, the beliefs overwhelm his ability to distinguish reality from fantasy. In such a mental state, his irrational fears no longer seem irrational and the conspiracies

feel like true threats. The actions that takes when acutely ill are symptoms of his mental illness. In his distorted and delusional world, his actions are sensible, justifiable and necessary to contain a perceived threat to his person.

It is therefore my opinion with a reasonable degree of medical certainty that at the time of the offense, was suffering from the acute and severe psychotic symptoms of his mental illness and that, as a result of those symptoms, he lacked the capacity to know and appreciate that what he was doing was wrong.

As additional records become available, specifically the records from Central New York Psychiatric Center, from the Assisted Outpatient Treatment Program and from the ACT team that was providing psychiatric treatment to at the time of the incident, I would make myself available to review them and to incorporate my findings into a final report.

Thank you very kindly for referring this matter to my attention.

Respectfully submitted,

Alexander Sasha Bardey, M.D.
Diplomate in Psychiatry, American Board of Psychiatry and Neurology
Diplomate in Forensic Psychiatry, American Board of Psychiatry and Neurology
Clinical Faculty, New York University School of Medicine
Adjunct Assistant Professor, Department of Psychiatry and Behavioral Health
New York Medical College

ATTACHMENT TWO

FORENSIC-PSYCHIATRIC EVALUATION INTERIM REPORT: FINDING OF SELF DEFENSE DUE TO BATTERED WOMAN'S SYNDROME

ALEXANDER S. BARDEY M.D.
FORENSIC AND GENERAL PSYCHIATRY

FORENSIC-PSYCHIATRIC EVALUATION

Indictment No. ,

March 27, 2015

Attorney At Law

Bronx, NY 10451

Dear

At your request, I performed a psychiatric evaluation of in order to assist you and the Court in gaining a better understanding of her mental illness and/or substance abuse disorder and to gain a clearer understanding of any underlying psychological and/or psychiatric factors directly related to her crime that may impact on the disposition of her criminal charges. Ms. has been charged with Manslaughter in the First Degree and Criminal Possession of a Weapon in the Fourth Degree secondary to an incident that occurred on or about August 16, 2013.[1]

To this end, I conducted a psychiatric examination of Ms. Bellevue Hospital Center in Manhattan, NY on July 18, 2014, during which, I reviewed her personal, social, educational, vocational, and psychiatric histories, and I reviewed her understanding of the circumstances that led to her legal troubles. I performed a mental status examination in order to assess her intelligence, thought processes, cognitive functioning, memory, credibility, orientation, judgment, insight, and impulse control. Ms. monstrated an understanding of the limits of confidentiality inherent to such an evaluation.

In addition to my examinations, I reviewed the following collateral sources of information:

- NYC Health Correctional Health Services, records dated .

[1] Supreme Court of the State of New York, County of Bronx, Indictment, Ind. No. 2638-13, dated 8/22/13

303 FIFTH AVENUE, SUITE 403, NEW YORK, NY 10016
Telephone: (212) 532-2322 Fax: (212) 725219 E-Mail: DrSashaBardey@aol.com

- Narco Freedom, Inc., Methadone Maintenance Program Records, dated

- Videotaped Statement, dated
- Albert Einstein College of Medicine Wellness Center at Melrose, Division of Substance Abuse, Methadone Maintenance Program Records, dated

- University Behavioral Associates
- Supreme Court of the State of New York, County of Bronx, Indictment, Ind. No.

- Bronx County Office of the District Attorney, Notices & Voluntary Disclosure Form,
- Criminal Court of the City of New York, Bronx County, Criminal Complaint, dated
- New York City Police Department records, Patricia Nimmons' Written Statement, dated
- New York City Police Department, Domestic Incident Reports, dated

- New York State Division of Criminal Justice Services, Fingerprint Response, dated

- New York City Office of Chief Medical Examiner Records, dated

- New York City Police Department records, dated
- Lincoln Medical and Mental Health Center Medical Records, dated

- Audio Records of 911 Call, undated
- Autopsy Photographs, undated
- Crime Scene Photographs, undated

PAST PERSONAL HISTORY

is a 56 year-old Black female born on Bronx, NY. Her mother, Lula Nimmons, passed away approximately two years ago secondary to cancer. unable to recall if her mother ever worked outside of the home. Her father, way in 2005 secondary to a stroke. Again, was unable to recall if her father was employed, "I don't remember if he worked…I was young at the time." indicated that there is a history of alcohol abuse in both of her parents and a history of mental health problems on the paternal side of her family.

dicated that she has seven siblings. She reported that she is now the oldest living sibling, but she had an older brother and sister who have passed away.

She explained that her sister passed away secondary to a brain aneurism and her brother passed away from AIDS after contracting the HIV virus from intravenous drug abuse.

lenied experiencing any developmental or serious medical problems as a child. She stated that she was raised with a Protestant upbringing in Bronx, NY in an intact family. She denied suffering from any type of abuse within or outside of the home as a child.

As an adult, experienced an ectopic pregnancy and had to be treated in a hospital. She did not endorse a history of any other serious medical problems.

was unable to recall the names of the elementary and middle schools she attended. She did recall attending where she was enrolled in regular classes. She attended high school until the tenth grade when she dropped out secondary to being pregnant. She denied abusing any alcohol or drugs or experiencing any legal problems during that time.

ndicated that she gave birth to her only son, in 1975. She related that her son is currently "okay" and "working."

After dropping out of high school, worked as a home attendant for about two years. She had extreme difficulty recalling what other jobs she had throughout the years, but reported working at McDonalds at some point. Prior to the instant offense, she reportedly worked as a "Peer Counselor" for nine months at a syringe exchange program. When not employed, supported herself by receiving welfare services and at times, she would buy clothes wholesale to sell on her own.

reported that she began abusing heroin and crack cocaine around 1993 at the age of She stated that she was introduced to heroin by a friend and decided to try it because she was "curious." She reported that she would "just snort" heroin and never abused the substance intravenously. related that she developed a "big [heroin] habit," eventually consuming approximately five bags of heroin a day.

To support her drug habits, in addition to abusing crack cocaine she began selling drugs. indicated that she was arrested for the criminal sale of a controlled substance around 1993 and ultimately served two years "upstate."

Records reveal that had been arrested on 31 occasions prior to the instant offense for various charges including, but not limited to, General Violation of Local Law, False Personation, Petit Larceny, Criminal Sale of a Controlled Substance in the Third Degree, Criminal Possession of a Controlled Substance in the Third Degree, Criminal Possession Stolen Property in the Fifth Degree, Assault in the Third Degree, Menacing in the Third Degree, Harassment in the Second Degree, Robbery in the First

Degree, Loitering: Prostitution Solicitation, Reckless Endangerment in the Second Degree, and Grand Larceny in the Fourth Degree.[2]

The records confirm that Ms. Nimmons was incarcerated at Bedford Hills Correctional Facility from December 21, 1993 to January 24, 1997 when she was released on Parole. was discharged from Parole on January 25, 2001.[3] In addition, on August 7, 1985, was incarcerated at at Rikers Island for 25 days subsequent to charges of Attempted Assault in the Third Degree.[4]

eported that she entered a work release program around 1995 in which she spent "five days out" working for the Parks Department and "two days in." When she finished the program she was released and found a job working at McDonalds.

After her release from Bedford Hills Correctional Facility, Ms. continued to struggle with substance abuse, having periods of sobriety peppered by relapses. larified that she has never received any type of mental health treatment in the past and has never been psychiatrically hospitalized. However, she endorsed receiving both inpatient and outpatient treatment for substance abuse. Ms. was able to recall that she entered a methadone maintenance program, "Narco Freedom," which "worked." She reported that since entering the program she has successfully remained off heroin.

Records were requested from Narco Freedom, Inc., but the only record made available was documentation of a Physical Examination from January 2013. According to those records, sented for her physical examination on January 30, 2013 fully oriented with a depressed mood and a flat, but appropriate affect.[5] These records also indicate that Mr. Nimmons was a patient at their Methadone Maintenance Program from January 22, 2001 through July 12, 2013 when she was transferred to Albert Einstein College of Medicine for continued treatment.[6]

Records from Albert Einstein College of Medicine Methadone Maintenance Program verify that was admitted to their program on July 10, 2013 as a referral from Narco Freedom. She presented with a history of Opioid Dependence, Cocaine Abuse,[7] Alcohol Abuse, as well as symptoms of depression.[8] She was being treated with Methadone and her toxicology screening conducted upon admission came back positive for cocaine.[9]

---

[2] New York State Division of Criminal Justice Services, Fingerprint Response, dated
[3] New York State Division of Criminal Justice Services, Fingerprint Response, dated
[4] New York State Division of Criminal Justice Services, Fingerprint Response, date
[5] Narco Freedom, Inc., Physical Examination, dated
[6] Narco Freedom, Inc., Letter Composed by Brenda Wheat, date
[7] Albert Einstein College of Medicine Methadone Maintenance Program, Discharge Plan, dated
[8] Albert Einstein College of Medicine Methadone Maintenance Program, OTP Admission Exam, dated
[9] Albert Einstein College of Medicine Methadone Maintenance Program, Discharge Plan, date

On August 16, 2013, was discharged from Albert Einstein's Methadone Maintenance Program secondary to her arrest for the instant offense. It was noted that at the time of her arrest she was living in a homeless shelter.[10]

Around the age of 39, net and began dating her deceased husband, The couple dated for 13 years before getting married in 2010. Ms. reported that her relationship with as "bad and good." She explained that Mr. had a history of alcohol and drug abuse, with opiates being his drug of choice. She reported that he drank alcohol every day and would become physically and verbally abusive when intoxicated.

The findings described in autopsy report, dated August 17, 2013, corroborate report of Mr. history of substance abuse, noting evidence of chronic alcoholism.[11]

In 2009, Ms. and her husband rented a room where they stayed for several months before being evicted secondary unpaid rent. reported that from 2010 up until her arrest for the instant offense, she and her husband were homeless and living in various homeless shelters "on and off." She related that part of the reason they got married was so that they could be together in a "family shelter." Ms. commented that their relationship was "better," or less volatile, when they lived in separate shelters.

Ms. related that Mr. would frequently call her names such as "bitch, stupid" and "all kinds of [other] names." She indicated that, "every now and then" Mr. would "hit me, punch me, slap me, knock me down…kick me." Ms. s explained that Mr. ally hit her with his hands, but would also use "sticks" and other objects on occasion. She explained that he was "real controlling" and "jealous." He would frequently accuse her of lying and cheating when this was not the case. If she came home "too late" from being out with her friends, "he would get mad and jealous and accuse me of lying and cheating."

Ms. limitted there were times when she was "scared of him." She indicated that she would try to avoid getting hit or physically injured by leaving the apartment for several hours if she "saw it comin " However, many times Mr. would lock the door and/or block path to leave the apartment. In addition, there were many times he would hit her "out of the blue" with no warning signs that could recognize. recalled an incident during which she called the police because she was "scared" of eving that he was going to "hurt me."

[10] Albert Einstein College of Medicine Methadone Maintenance Program, Discharge Plan, dated 8/16/13
[11] New York City Office of Chief Medical Examiner, Report of Autopsy, dated 8/17/13

: related that she attempted to leave several occasions secondary to the physical and emotional abuse. She reported that family and friends consistently told her to "leave," but "I didn't listen… we got back together." She explained that when she would try to leave, would "come find me. He would go to my job or [just] know where to find me…I couldn't get away."

In the past, two Domestic Incident Reports were filed on behalf of secondary to verbal and physical abuse committed by On December 8, 2005, . was involved in a verbal altercation with her boyfriend, There was no evidence of any physical injuries and no crime had been committed. It was recorded that is wanted her boyfriend to move out of the home. No further details were reported.[12] On May 22, 2011, saulted with a "mop stick," hitting her in the face and on the right side of her back. suffered a laceration to the right side of her face and was taken to Lincoln Hospital for treatment. [13]

ecalled that in 2012 or 2013, she went to Lincoln Hospital for medical treatment after hit me in the head and I was bleeding." She explained that had kicked a door in, forcing his way into the apartment. The door hit her in the head and she fell to the ground. reported that she got up off the floor, grabbed a knife, and swung it at him "and he left."

On May 22, 2011, was brought to Lincoln Hospital by EMS after being physically assaulted by her boyfriend resulting in a laceration on the right side of her face[14] and an "acute right zygomatic arch fracture" revealed by a facial CT scan conducted on May 23, 2011.[15] ad reported that her boyfriend hit her with a mop stick[16] multiple times in the face and the back resulting in a loss of consciousness for a "few minutes." Facial swelling and an abrasion over the zygomatic arch were noted.[17] Ms. as treated and then discharged from Lincoln Hospital on May 23, 2011 in an improved condition.[18]

On August 17, 2013, was arrested for the instant offense on charges of "Murder: Intention," Manslaughter in the First Degree, and Criminal Possession of a Weapon in the Fourth Degree.[19]

---

[12] NYPD Domestic Incident Report, dated 12/8/05
[13] NYPD Domestic Incident Report, dated 5/22/11
[14] Lincoln Medical and Mental Health Center, Emergency Department Triage/Assessment Form, dated 5/22/11
[15] Lincoln Medical and Mental Health Center, Facial CT, dated 5/23/11
[16] Lincoln Medical and Mental Health Center, Emergency Department Triage/Assessment Form, dated 5/22/11
[17] Lincoln Medical and Mental Health Center, ED MD Initial Note, dated 5/22/11
[18] Lincoln Medical and Mental Health Center, Unscheduled ED MD Disposition Note, dated 5/23/11
[19] New York State Division of Criminal Justice Services, Fingerprint Response, dated 8/17/13

Since her arrest, has been incarcerated at Rikers Island. She reported that from August to September 2013, she was kept on the Mental Observation Unit at Rikers Island. From September 2013 up until present time, she has remained in General Population. eported that at the time of the evaluation, she was being treated with the antidepressants Trazodone and Remeron, as well as the benzodiazepine Librium.

THE INSTANT OFFENSE

According to the Supreme Court of the State of New York Indictment, Indictment No dated August 22, 2013, has been charged with one count of Manslaughter in the First Degree and one count of Criminal Possession of a Weapon in the Fourth Degree secondary to an incident that occurred on August 16, 2013. On August 16, 2013, :aused the death of : while acting with intent to cause serious physical injury by stabbing him. In addition, she did possess a knife with intent to use the same unlawfully against another.[20]

Following her arrest, ade several statements to law enforcement officers. On August 17, 2013 at 3:30am, :ated, " nd got into a fight. He hit me with the broom. He punched me a few times. When he made a fist and started punching me again I took the knife off the counter and stabbed him in the stomach. He fell down. I spoke to my friend and we called the police." This statement was initially made orally and was later committed to writing. On August 17, 2013, a videotaped statement was made in which : stated, "That's my written statement. I asked the detective to write it. He came home and we fought. He hit me with the broom and started punching me. I took the knife. I stabbed him in the stomach and he fell. I tried to help him but I couldn't. I spoke to my friend and I called the police. I mopped up the blood because there was blood all over my floor."[21]

According to records, manner of death was ruled a homicide and his cause of death was "stab wound of abdomen with injury of iliac artery and vein." There was a single stab wound in the lower left abdomen and a laceration on the back of the right arm. In addition, it was noted that there was evidence of chronic alcoholism. [22]

At the time of the instant offense, were residing in the " Shelter" in Jamaica, Queens, a "family shelter." reported that they began living at the shelter in July 2013 or one month before the instant offense. Upon moving into this shelter, "things got worse." The couple began fighting

[20] Supreme Court of the State of New York, County of Bronx, Indictment, Ind. No.
[21] Office of the District Attorney, Bronx County, Notices & Voluntary Disclosure Form, dated
[22] New York City Office of Chief Medical Examiner, Report of Autopsy, dated 8/17/13

much more frequently and the physical and verbal abuse continued to escalate over the course of July into August 2013.

recalled that the instant offense took place on August 16, 2013. She reported that she woke up that morning and went to the Narco Freedom program from 9am to 10am. She then went to work as a "Peer Counselor" at "Arm Reduction" from 10am to 5pm. After work she went to see who was selling loose cigarettes on "163rd and Union Avenue" in Bronx, NY. related that was "drunk" and had been "drinking beer probably all day long." went back home and turned home several minutes later "some time before 10pm."

Back at home, the couple began fighting, but "I can't recall why." explained that it started as a verbal argument, but then turned physical when began hitting her with his hands and then with a broom. She recalled being hit twice on the left shoulder with the broom. then punched in the face, knocked her to the floor and began kicking her "everywhere," all over her body including her face. She related that she was trying to block the kicks, especially trying to protect her face. ndicated that had "never hit me like that before and I didn't know if he was going to kill me…I thought he was going to hurt me real bad."

got up off the floor, but "I didn't know what to do." She described feeling "angry" and "scared." She reported that she saw the knife and "grabbed it trying to keep back." She stated that she began swinging the knife in an attempt to keep back. She recalled that she had "hit" or stabbed with the knife in his lower left abdomen, "I did it once and he fell…They said I hit a nerve." believes the knife was approximately six inches in length and reported that she used it for cooking. She explained that she did not carry knives with her or store knives away in the house. She reiterated that she had only made a single stabbing motion, "it was only once."

After fell from his injury, "I was scared." tried to put pressure on the wound and then called her friend from across the street telling her "something happened" and she did not know if would "wake up." then called the ambulance. She reported that taken to the hospital and she was taken into custody by law enforcement officers.

maintained that she did not have any intention to seriously harm or kill he's my husband. I was trying to keep him back…I didn't know that would happen." eported that she believed she would have been able to use the knife to keep harming her, as she had done successfully on one occasion in the past.

Limited records obtained from Rikers Island indicate that was being treated at Rikers Island at the end 2013 with the antidepressant Remeron and

antihistamine Vistaril, which is used to treat anxiety. was diagnosed with Adjustment Disorder with Depressed Mood and various substance-related syndromes (Opioid Dependence, Alcohol Abuse, Cocaine Abuse). By the end of 2014, was also prescribed the antidepressant Prozac, while her diagnoses remained the same.[23] Records from early 2015 allude to the fact that was attending group services, as she made reference to learning about triggers for relapse and she was compliant with her medications.[24] Of note, the aforementioned March 2015 indicates that ntinued to be treated with Remeron, Vistaril, and Prozac. Her mental status exams for the available treatment records were unremarkable.

MENTAL STATUS EXAMINATION

is a Black female who presented for her evaluation well groomed, alert, and fully oriented, and with a cooperative attitude. Of note, was an unreliable historian secondary to difficulties with her memory. Her thought processes were disjointed and disorganized, but logical and free of delusions. There were no signs or symptoms of psychosis, including hallucinations, delusions, and/or illusions. No paranoid ideation had been elicited. exhibited a speech impediment and was soft-spoken, but coherent. While no formal testing was conducted, appears to be operating within the low range of intellectual functioning. Her insight and judgment were limited.

reported that she is currently feeling "bad" and endorsed suffering from difficulties sleeping. She was withdrawn and her mood was depressed with a constricted, but appropriate affect. endorsed one episode of suicidal ideation in the past, but denied any current suicidal and/or homicidal ideation, plan, or intent.

reported experiencing intrusive thoughts, nightmares, and flashbacks of the instant offense, which cause her significant distress. She stated that she has flashbacks of images of "on the floor" and "sometimes" hear oice calling out to her. She also described experiencing episodes of anxiety and nervousness as well as hypervigilance. She explained that she tries to stay busy to distract herself and "block it out," but as soon she "sits" or relaxes "it comes back." She stated, "I try not to think about it (the instant offense) but I'll always remember it." exhibited genuine remorse and regret for her actions. She went on to state, "Sometimes I wonder why…I can't believe it happened. I didn't think uld die."

DIAGNOSIS AND FORMULATION

[23] NYC Health Health Correctional Services, Psychiatry – Medication Reevaluatio date

[24] NYC Health, Health Correctional Services, TPR and MH Clinicians Progress Note, date

Posttraumatic Stress Disorder, (Battered Woman Syndrome)
Adjustment Disorder with Depressed and Anxious Mood Depression?
Opioid Dependence, In Sustained Institutional Remission
Cocaine Abuse, In Institutional Remission
Borderline Intellectual Functioning

is a 56 year-old Black female born on in Bronx, NY. She was raised by her biological parents and denied suffering from any type of abuse throughout her childhood. There is a familial history of substance abuse and mental illness.

to have a serious substance abuse problem as an adult which led to her involvement in crimes related to a substance abuse lifestyle. Her substance and its sequelae appear to be have been major factors in inability to function in the community and her extensive legal history. She has a history of receiving substance abuse treatment for heroin dependence and crack-cocaine abuse verified by the records reviewed, especially in the period of time just preceding her arrest for the instant offense. She met her husband, the victim of the instant offense, at the age of 39. As credibly described by and as correlated by the reviewed materials, was the victim of physical and emotional abuse at the hands of her husband for most of their marriage. She suffered severe, almost life threatening physical abuse, resulting in fractured bones, trips to the hospital, and police involvement.

In addition, years of substance abuse impaired coping skills, emotional maturity, and ability to tolerate stress. In addition, deficits in conflict resolution secondary to her low intelligence left her with an inability to deescalate episodes of domestic violence and to extricate herself from an abusive marriage.

As mentioned earlier, have a history of substance abuse; however, as a result of the years of domestic abuse she suffered at the hands of her husband, she also meets diagnostic criteria for a diagnosis of Posttraumatic Stress Disorder, as evidenced by the results of this examination and as documented in the reviewed records. As a direct result of the abuse she had endured for years, manifests the triad of psychiatric symptoms that typify PTSD. These include symptoms of depression (social withdrawal, hopelessness, helplessness, depressed mood, constricted affect, emotional numbing), symptoms of traumatic re-experience of the trauma (flashbacks, nightmares, dissociative episodes) and symptoms of sympathetic hyperarousal (increased startle, anxiety, panic attacks).

In case, her PTSD took a form specific given her domestic situation and the nature of the trauma that caused the PTSD. Her involvement for years with an emotionally and physically abusive man caused her to suffer from a form a PTSD known as Battered Woman's Syndrome.

The term Battered Woman, coined by Dr. Lenore Walker, refers to a woman who has been repeatedly exposed to any forceful physical and/or psychological behavior by a man in order to coerce her to do something he wants her to do without any concern for her rights. To be classified as a battered woman, the couple must go through a cycle of abuse, also described by Dr. Walker, at least twice. Dr. Walker uses the term Battered Women's Syndrome to describe the development of particular characteristics among victims of prolonged physical and psychological domestic abuse. Dr. Walker believes these women eventually become trapped by their fear, fearing even more brutal attacks if they leave, and eventually exhibit learned helplessness.[25]

. . scribed the typical pattern of domestic abuse and violence seen within couples that is consistent with the "cycle of abuse" theory developed by Lenore Walker in the 1970s. :sed four stages to describe the patterns of behavior frequently seen by the victimizer and victim during abusive relationships. According to the theory, the four stages are the Tension Building Phase, the Acting Out Phase, the Reconciliation/Honeymoon Phase, and the Calm Phase. described experiencing each phase during her relationship with J , as well as the typical escalation of abuse over time and the pattern of physical abuse following emotional, verbal and/or mental abuse.

The Tension Building Phase is what usually precedes an abusive act during which underlying conflict and tension between the couple quickly escalate. Frequently, the victim of the abuser will "walk on egg shells" or modify her behavior to avoid triggering an abusive outburst from their partner. The Acting Out Phase includes the physical, mental or emotionally abusive act while the Reconciliation/Honeymoon Phase is when the abuser will either express affection to the victim, remorse for their behavior, and/or will ignore the act altogether.

As with many other survivors of domestic abuse/violence, had such a great desire for her marriage to work, which led to her remaining in the relationship despite the repeated abuse. It is important to note that the abuser's behavior during the Reconciliation/Honeymoon Phase perpetuates the abuse and encourages the victim to stay, as it provides the victim with the point of view that their relationship and/or partner is not all bad. During the Calm Phase, the relationship is somewhat peaceful yet problems and difficulties ultimately emerge and the cycle starts over with the Tension Building Phase.

Lenore Walker suggested that sustained periods of living in such a cycle may lead to learned helplessness ansd Battered Woman Syndrome.

---

[25] Marybeth H. Lenkevich, *Admitting Expert Testimony on Battered Woman Syndrome in Virginia Courts: How Peeoples Changed Virginia Self-Defense Law*, 6 Wm. & Mary J. Women & L. 297 (1999)

The Battered Woman Syndrome has been introduced in criminal assault and homicide cases in order to help determine and explain the woman's judgment and state of mind at the time of her crime and how her prior years of enduring repeated abuse impacted on her decision-making skills at the time of the instant offense. It further helps determine the "reasonableness" or justification of the woman's decision in using force against her abuser subsequent to her perception of being in imminent harm at the time.[26]

"Battered Woman Syndrome has been found to be relevant to a jury's deliberations regarding 'the perception in the mind of the defendant at the time of the killing as to how a battered woman would perceive danger as being imminent even though her batterer was not then in a position to pose immediate danger'." (*Minnis*, 455 N.E.2d at 215).[27]

involvement in the instant offense, and in the reported assaults that occurred prior to the offense, are an aberration for her in terms of her own life choices and character, but are consistent with actions borne out of her PTSD and Battered Woman Syndrome. The years of abuse she endured gradually deepened the trauma she was experiencing, much like opening a wound over and over again, each time a little deeper. This type of "kindling effect" means that each new bout of abuse is added to each prior event and is experienced as much more severe than that abuse would have been on its own, much like an abused child who eventually flinches when the abuser simply raises his hand. by the time of the instant offense, had suffered so much abuse that her husband yelling, punching, and beating her with a broomstick, made her feel like she was being killed. It is no wonder, in this psychiatrist's mind, that grabbed a knife in apparent self-defense and stabbed her husband. A history of violence on her part, existing independently from the trauma she endured, would have been manifest throughout their relationship. This has not been the case for Instead, when the repeated abuse was kindled over time into an overwhelming history of intolerable trauma, lost the ability to properly gauge the risk she was facing at the hands of her husband and reacted accordingly with deadly force.

At the time of the offense, could no longer separate her husband's actions at that specific moment from the lump sum of all the abuse he had perpetuated until that point. As a result truly felt as though her life were in danger and, and a result, instinctively used deadly force to defend herself. To be clear, her actions were not only borne out of a desire to defend herself against the attack she was facing at that very moment, but were also acts borne out of the psychiatric pathology she was suffering from at the time, causing her to lose the ability to reflect rationally on her behavior, to think consequentially, and to gauge the wrongfulness of her actions. Her

[26] Marybeth H. Lenkevich, *Admitting Expert Testimony on Battered Woman Syndrome in Virginia Courts: How Peeoples Changed Virginia Self-Defense Law*, 6 Wm. & Mary J. Women & L. 297 (1999)
[27] Marybeth H. Lenkevich, *Admitting Expert Testimony on Battered Woman Syndrome in Virginia Courts: How Peeoples Changed Virginia Self-Defense Law*, 6 Wm. & Mary J. Women & L. 297 (1999)

actions, at those points in time, were not guided by a rational and calculating mind, but rather by intense and overwhelming emotionality and fear.

Seen through this lens, suffered from a real, severe, and enduring trauma both through her own eyes, as well as though those of anyone placed in her situation. Her reaction to this trauma, kindled over years and caused by a wave of overwhelming emotion, was unexpected, explosive and sudden. She felt that her life was in mortal danger because of the assaults she had endured in the past and because of the emotional trauma that had built up over time. As a result, she reacted as she did, stabbing her husband a single time and causing his death. In the instant, she lost rational control over her behavior and her actions controlled solely by the intense emotional reactions she was having to yet another bout of abuse at the hands of her husband. It is therefore my opinion, with a reasonable degree of medical certainty that behavior, at the time of the offense was consistent with that of an individual functioning under a diminished capacity. There is no doubt in this psychiatrist's mind that . had no intentions of killing s. Instead, frightened for her life and in the throes of PTSD, she reacted in self-defense to protect herself from mortal injury.

Respectfully submitted,

Alexander Sasha Bardey, M.D.
Diplomate in Psychiatry, American Board of Psychiatry and Neurology
Diplomate in Forensic Psychiatry, American Board of Psychiatry and Neurology
Clinical Faculty, Department of Psychiatry, New York University Medical Center
Adjunct Assistant Professor, Department of Psychiatry and Behavioral Sciences
New York Medical College

ATTACHMENT THREE

FORENSIC-PSYCHIATRIC EVALUATION: FINDING OF MITIGATION DUE TO EXTREME EMOTIONAL DISTURBANCE

1. *Forensic-Psychiatric Examination*

ALEXANDER SASHA BARDEY M.D.
FORENSIC AND CLINICAL PSYCHIATRY
150 EAST 58TH STREET, 25TH FLOOR, NEW YORK, NY 10155
Telephone: (212) 223-1983 Fax: (212) 223-2390 E-Mail: DrSashaBardey@aol.com

FORENSIC-PSYCHIATRIC EVALUATION

Ind. No.

December 11, 2006

Office of the District Attorney
350 Jay Street
Brooklyn, NY 11201

Dear Mr.

At your request, I performed a psychiatric examination of , at the District Attorney's office in Brooklyn, New York on , in order to assist you in gaining a better understanding of his mental state at the time of the events that led to his arrest.

In conducting my examination, I reviewed his personal, social, educational, vocation, and psychiatric history, and I reviewed his understanding of the circumstances that led to his legal troubles. I performed a mental status examination in order to assess his intelligence, thought processes, cognitive functioning, memory, credibility, orientation, judgment, insight, and impulse control.

In addition to my examination, I reviewed the following collateral sources of information in making my assessment:

1. Personalized Description and Success Strategies from the Personal Profile System, dated 3/16/04
2. Divorce Questionnaire, not dated
3. Property Clerk's Invoice, dated 1/21/05
4. Complaint – Follow Up Informational, dated 1/21/05
5. Lutheran Medical Center Medical Records, dated 1/21/05-2/4/05
6. Court Transcripts, dated 1/25/05-1/27/05

7. Office of Correctional Health Services Medical Records, dated 2/19/05-present
8. Psychological Evaluation prepared by

PAST PERSONAL HISTORY

Forty-one year old born on July in Jamaica, West Indies. His father, is currently in his sixties and is a self-employed real estate broker. He previously worked as a schoolteacher and a banker in Jamaica before entering the real estate business when he came to the United States. He is in good health and has no history of mental illness or substance abuse. mother, is also in her sixties and is still living in Jamaica. parents never married. She is self-employed and lives with her current husband, a mechanic. was a young boy when his parents separated, and he was subsequently raised by his paternal great-aunt and paternal grandmother. has three brothers and four sisters. Some of his siblings are half-siblings. has one older sister and one older brother. He and his siblings were raised in a religious environment, in which they attended church and Sunday school on weekends. He described his upbringing as "good, comfortable."

education began in a private school in Jamaica. At the time, he was living with his grandmother. Upon completing the sixth grade in 1977, and his older sister moved to the Brooklyn, New York to live with their father who had moved there previously. recalled adjusting to the move smoothly. His father was extremely strict, perhaps because he had been a school teacher,. He would cane his children if they misbehaved; however, stated that he handled the discipline very well and did not consider the practice abusive.

began the seventh grade in Brooklyn at High School. Although did well academically, he had difficulty behaviorally, something he attributed to cultural differences he experienced upon moving to the United States. Outside of school, made many friends in his neighborhood and played soccer in his free time. He progressed through junior high in a timely manner.

Technical High School in the ninth grade with a strong interest in electronics. Throughout high school, continued to play soccer, and became interested in music, in particular in Jamaican Rap. When asked about using drugs and alcohol, stated, "not really." He attended parties with friends, would dance and perform rap songs. He recalled dating "a little" in high school. He described himself as somewhat of a "nerd" in high school graduated from high school in 1983, and then moved in with his mother who had by then also moved to New York.

After completing high school, began attending the City College of New York, while also working odd jobs to make money. In college, became more

"outgoing, more social." He would go to parties four or five nights a week, were he would often drink alcohol. He dated, but had no serious relationships. In 1986, after three years in college, dropped out so that he could work full time. He and his mother were struggling financially and he felt he would be better off earning a full-time income. He began working for a temporary employment agency, where he did brief stints in many different companies and in many fields, including sales and photography. By his own description, he spent his days working and his nights partying with friends and rapping. He also worked promoting parties as dance halls. He moved out of his mother's home in 1988, and has been living on his own ever since.

In 1988, began working for Company. His job entailed going to supermarkets and ensuring that the products they had ordered arrived. He was given an expense account, as well as a company car. He worked in that capacity until 1996. While working for dated and had girlfriends. In 1990, he met and began dating a woman named At the time, he and his brother were renting a house together. Three months after and began dating, she got pregnant. Though the couple was not using contraception, they had not planned the pregnancy.

married three months after they found out she was pregnant, on August 2, 1990. They moved in together and were "two young people, in debt, starting out." On December 30, 1990, their daughter was born. The couple was thrilled about the birth. After her birth, stated, he began working three jobs in order to support his new family. He was working for Company, delivering papers for the and promoting parties at dance halls. ed until Tiara's birth, at which time she took several months off. When she was ready to return to work, she found a job and began working in a hair salon.

recalled that his relationship with changed after birth. He stated, " had a temper." He added, ". would rant and scream about needing long distance and get up and leave and go back to her mother's. She gets upset and I placate her." At one point, found out that was an illegal alien, forcing him, he stated, to redo all of his taxes.

During their marriage, in the early 1990's, found out that had Chlamydia. He stated that some nights she would disappear and go out to parties. He believed that she was having unprotected sex with other men. saw a doctor, and took be tested. They both tested negative for the disease. After found out about Chlamydia, she reportedly called his mother because was afraid that would leave her. The couple spoke and came to forgive her.

In 1993 or 1994, . opened her own hair salon on Avenue. explained that he wanted to help her in any way that he could. He painted the salon for her,

but. was apparently displeased with his work and got angry with him. He stated, ". didn't like to be told what to do." After that incident, "kept his mouth shut" when it came to her business. The business was not successful and struggled with it for many years. Eventually, according to the defendant, in 2004, she lost her lease due to owed back rent.

Remington left Company in 1996 because he wanted to return to school and earn his degree. He attended full-time for one year in an attempt to earn his Bachelor of Arts. After enrolling in college, got a job at Brooklyn. He worked there during the days, and attended school during the evenings. He stopped attending school after one year, and continued to work for until 2004. He was eventually promoted to supervisor, and eventually to sales manager. In 1998 or 1999, purchased a house for his family on in Kensington.

In the late 1990's, stated, contracted Herpes while having unprotected sex. found out and began packing his belongings in a bid to leave his wife, but begged him to stay. related that he again forgave his wife.

On November 7, 2001, gave birth to the couple's second child, a daughter named . He stated, "Life was good." He was enjoying his job at , doing marketing work for the company. sent him on trips to speak with clients who treated him very well.

After the birth of their second child, stated, his relationship with started to be "up and down." She wanted a different lifestyle and was trying to persuade him to go into the real estate business. believed that he did not make enough money to make happy and to give her the kind of lavish life that she desired. This led to frequent disagreements between them, disagreements that often became heated. He described temperamental" and stated that at times she became violent towards him. When she became violent, he reported, he would always walk away and leave her alone. However, he added that their arguments became increasingly more frequent as time passed. On several occasions, the police were called when their arguments became particularly heated. On a few occasions, witnessed the fights.

In late 2001/early 2002, and , arguing escalated. decided that he wanted to pay back . mother for a loan he had taken from her. gave . money to pay her mother back with, but instead of giving it to her mother, believed that kept the money for herself. Shortly thereafter, became pregnant. Despite strong objections, she had an abortion. was reportedly very upset by this, but he did not speak to anybody about it.

In spring 2004, asked make a business plan because he wanted to use their house's equity to help pay their bills. He then paid off a fifteen thousand dollar bill of using a line of credit. He asked Joyce what she planned to do financially during the upcoming summer, and she stated that she was going to prostitute herself. Remington stated that he took the remark as a joke. In July 2004, Joyce closed down her business, without telling . He was unaware that her business had closed until he came home and saw her unloading a van full of her business supplies. remembered being angry that she would do such a thing without even telling him. The situation caused an escalation of the tension in their relationship.

After losed her business, she began renting a booth at another salon in order to serve her customers. picked her up from work every day. He stated that he began to notice some "puzzling" things. Although she was working all day, he stated that she never had any money. He stated, "Something was going on." He though that perhaps she was sending money to people she knew in Barbados. In August 2004, a friend/client of came by the house asking for thought that was strange, and was supposed to be at work at that time. He began to notice her receiving calls from "strange" phone numbers, and that she would often run for her phone checked her voice mail, and he heard men leaving her intimate messages saying things such as, "I love you...Good seeing you...Dropped you off safely, etc." He believed that she was having a sexual relationship with someone else. He confronted her about the messages and she initially denied it. He then played the messages for her, forcing her, he stated to admit to the affairs. In response, :old her he wanted a divorce. He recalled that as "an emotional time." Following their confrontation, made a copy of the voicemail tape and put it in a safety deposit box. He also sent a copy to his mother in Jamaica.

described being very distraught by infidelities. He stated that if it had been one man, he could understand it, but he believed she had been having affairs with multiple men. He started gathering more information, getting addresses to go with the phone numbers Joyce had received calls from.

On October 10, 2004, went to an individual's house whose address had matched one of the phone numbers he had found in)hone. He reportedly saw come out of the house and get into a cab. then tried to follow the cab, but noticed that he was following her and tried to lose him. The couple then fought, and told him she wanted to have an open marriage. She stated that they could live on separate floors of their house, and remain married. was not amenable to this idea and wanted a divorce.

reportedly wanted an equitable divorce. Through a friend of his who was a divorce lawyer, found a mediator, with whom they met twice. He also obtained information on child support. While proceeding with the divorce,

was still gathering information about adultery. He became afraid that something might happen to him, so he put the deed to their house in a safety deposit box. He recalled that time as being "overwhelming. I didn't know what was going on." He was "confused, disgusted, and overwhelmed." Though was proceeding with the divorce, the couple was still living together and was still sexually intimate.

In late October or early November of 2004, and went to the Poconos for the weekend. While there, they went through paperwork and discussed their various assets, in preparation for divorce. still did not want a divorce, but would not change his mind. While there, found out that had caught another sexually transmitted disease. When they returned, he saw his doctor and was treated for it.

Shortly thereafter, took a trip to Atlantic City to pick up and their children who had been vacationing there. He drove with his friend , a police officer. During the ride, he played the tape for While in the car, he came to the realization that was in fact prostituting herself. He recalled the comment she had made earlier that year, and came to the conclusion that that was what she had been doing. He later confronted about his belief, and she reportedly "clammed up, but the look on her face confirmed it."

One night, after on had accused f prostituting herself, she told him she was going to s. He believed she was acting strangely so, after she left, he began calling the numbers he had gathered from her cell phone, asking for He called one man's phone number, and then called a club and heard the same music playing in the background. He then went to the club and called the same man's number. When he heard the phone ring, he knew which man it was that he had called. asserted that he walked up to the man and the two almost came to blows, had other patrons not intervened.

Later that night, and her husband, brought home. spoke to and he decided to intervene. then sat down with and told her that she "could not have it both ways." confronted her with the list of phone numbers he had compiled, and she again "clammed up." then went upstairs to go to sleep.

After the fight with tried to abstain from having sex with her, but he was unable to. On January 9, 2006, was supposed to attend his cousin's birthday party. He first dropped off at another party before going home to pick up and take her to his cousin's. He and took to the party, during which reportedly left numerous times to be with different men. took his aunt's house after the party and then went home. He then saw being dropped off by a man in a car, while another man pulled up the house. believed the men were "so

called clients." He recalled feeling overwhelmed and confused. He stated that he has no memory of what occurred after that.

first memory after seeing being dropped off by a strange man is of waking up in a hospital. He recalled thinking that he had been in a car accident. He had in fact killed his wife and then gotten in his car and driven into a tanker truck. He remains confined to a wheelchair as the result of injuries sustained during the crash. When he found out that was dead, he stated, he did not believe it until he was shown pictures of her body.

MENTAL STATUS EXAMINATION

At the time of the examination, on presented with an essentially normal mental status examination. Restrained by his injuries to a wheelchair, he was well-dressed and groomed. He cooperated with the examination and maintained great emotional self-restraint throughout the process. He was well spoken, coherent, and logical, though he rambled at times. There was no evidence of a thought disorder or evidence of any psychotic symptomatology. He denied any hallucinations or delusions. His mood was somber and his affect was restrained.

He was alert and oriented in all spheres and grossly intact cognitively. He appeared to function in the above average range of intelligence.

Based on the materials reviewed and on the credible aspects of history, his mental state at the time of the incident was significantly different. Enough accounts exist to suggest that was growing increasingly frustrated, angry and disturbed in the weeks prior to the incident. His attempt to kill himself immediately following his killing his wife and his continued depression while incarcerated support a finding that mental state at the time was dominated with overwhelming feelings of anger, depression, and frustration.

COLLATERAL SOURCES

Personalized Description and Success Strategies from the Personal Profile System, dated 3/16/04

ubmitted himself to this evaluation in the context of a job search. The Behavioral Overview of states the following: " tends to be direct and forceful, innovative and imaginative, analytical and calculating. In fact, his behavior includes two opposing forces. His desire for tangible results may be balanced by his striving

for perfection. His tendency to be aggressive may be balanced by his sensitivity. Quickness of thought and action may be balanced by a desire to explore all options. Although he may not enjoy conflict, he tends to be able to act aggressively, if necessary for his success. He also may tend to expect and accept such aggressive behavior in others. Actually, may tend to be rather restrained in his expression when he initially meets someone. This may give the impression that he is mild-mannered and unlikely to be aggressive. His tendency to prefer to work alone and to deal with activities which limit his contact with people, may contribute to his appearance of being non-aggressive. Yet when the need for confrontation arises, may take up the challenge. This may surprise those who have not previously seen that aspect of his behavior. may seek to be in a position of influence or control, preferably one that is officially endorsed...Being primarily oriented towards tasks, may not always be concerned with people. In fact, he may occasionally cause co-workers to feel more like objects than people. He may not engage in any idle chatter or humor. If he feels that someone is somehow affecting progress, he may be quite blunt in saying so. He may not offer any friendly warning or include any element of humor or support in his message. He may be very specific in pointing out shortcomings so the people involved know precisely what they have done wrong and how to improve. Unfortunately, he may be less likely to acknowledge good performance or individual contributions. If things are not going well or he is unable to achieve the control he desires, may become easily bored with any kind of routine activities. He may also tend to sulk, becoming sullen and aloof, if he is not getting his share of the limelight. If he finds himself in this situation for some time, he may become quite aggressive, losing his natural degree of restraint."

Divorce Questionnaire, not dated

. filled out this questionnaire. He check-marked the following grounds for divorce: "cruelty and inhuman treatment" and "adultery." He requested joint custody of their children, with the children residing with his wife. He wrote that his children were aware that their parents were definitely getting a divorce. He check-marked that he was living with his spouse at that time and wanted a divorce "as quickly as possible." He wrote that he consulted with an attorney regarding the divorce on September 4, and he consulted with a mediator on October 4.

Property Clerk's Invoice, dated 1/21/05

This states that the following items were found on the bathroom floor adjacent to the victim's body: red grick (brick), jogging sweat jacket, miscellaneous papers, and one wooden handled kitchen type knife. One broken audio cassette was vouchered as arrest evidence in a security envelope.

Complaint – Follow Up Informational, dated

was interviewed inside his apartment. He lives on the second floor of the home, renting a room in their house. He had lived there for two and a half years at the time of the incident. His statement stated, "Approximately one month ago moved to the apartment on the third floor. In the past couple of months he has heard the couple arguing. has deep voice. The disputes are verbal only. Witness returned home last night around 2100 hrs...He did not see either or Approximately 0200 hrs knocked on his door. She was excited and stated you have to come downstairs I think on might have done something to and might kill himself. Once downstairs with help they pushed bathroom door open and saw part of a body lying on the floor. asked him to call 911. He tried from first floor but the phone wasn't working so he ran upstairs and called 911."

was interviewed at the She stated that she had worked for the family for about three years as a live-in nanny. She stays on the second floor of the house, across from Both of the children usually sleep with her. She told the police, " ecently started divorce proceedings against his wife. He told her that things were not working. She questioned about it also and she also stated that things were not working. stated that he was bugging her about signing divorce papers. She thinks that she might have signed them last week however. The witness stated that police have come to the house before. She knew of one time for sure...Witness stated that she never saw he deceased. They have strong/loud arguments. Once threw something at her. stated that was cheating on him. Last night around 2225 hrs she was sleeping with kids. called and asked her if stated she was going anywhere and she said no. He told her to go back to sleep. Around 0100 hrs she heard somebody who she things was going up and down stairs from first to third floor quickly. Person then slammed the front door close. It startled her. About ten minutes later called her on her cell phone. He told her to go downstairs and look into the bathroom. I might have killed He stated he wanted to kill himself and told her to tell the children I love them. She tried to keep him on the line but he hung up. She checked the bathroom but door was locked. She used a key to open lock but something was blocking the door. She pushed and saw feet lying on the floor. She tried rocking body back and forth with door thinking was just unconscious. Finally she ran upstairs to tenant and asked him to help her. She also had him call 911."

The police interviewed at the home. " informed me that they were sleeping when around 0130-0140 hrs he picked up ringing telephone. The person on the other end asked to speak with his wife . He did not recognize the voice so he asked who was it and the caller replied . He handed phone to his wife. stated that old her he was having a problem with her sister. He stated she was having different relationships. He tried to talk with her. He said something about 'prosecuting himself.' He then stated 'she's not waking

up. I think she's dead.' called 911 then told what happened. They then called and learned what happened and drove here immediately. additionally informed me that was hard, cold person. He once seemed to get insulted when he kissed his sister in law hello upon seeing at family function. Since that time he made sure not to kiss her hello in his presence."

, the fourteen-year old daughter, was interviewed in her home. "She stated that approximately four months ago when she returned home from vacation to Texas a male friend of her mother's called the house and left a message on answering machine. Since then her mother and father have been having disputes because he things she was cheating. Initially he just stopped talking to her and refused to pick her up after work. Her mother is a hairdresser at She works late, Tues thru Sat until 2300-2400 hrs. The fight escalated and her father stated they were going to get a divorce. Last week her father came home and kicked in bedroom door. He did this because her mother got home late. He was yelling at her saying he was going to call her family. In late Nov, early Dec her father moved out of first floor into third floor attic apt. Last week he told her mother that he wanted custody of the children."

The police interviewed via telephone. "He stated that he met the deceased, because she has a cousin who is his brother's wife. They met in Long Island on 1/20/05 around 2100-2115 hrs. He picked up at work on They drove around in his car talking for about one and a half hours. He then drove her home dropping her off about three houses away from her own. This was her request. He heard about her death in the news."

witnessed. autopsy. He wrote, "The results of the autopsy are as follows, the cause of death is from injuries including blunt trauma to the head and two stab wounds. One stab wound was to the right side of the torso and the other to the front right side of the head. The blunt trauma to the head consists of at least three blows, one to the rear right side of head, one to the right side of head and one to front left side of head. The death is being classified as a homicide. The victim had no defensive wounds. On the fourth finger on left hand was cut and broken nail."

' rrest Report states, "At T/P/O defendant did cause victims death by blunt trauma, brick, to head and stab wounds; knife. Weapons recovered."

Lutheran Medical Center Medical Records, dated 1/21/05-2/4/05

was admitted to Center after crashing his car in an apparent suicide attempt. He was brought in by ambulance with the Chief Complaint, "My leg hurts." His Ambulance Call Report states, "Thirty-three year old male, found supine on scene, patient alert and oriented x3. Patient was driver in vehicle involved in MVA. Major

damage to vehicle. Patient extracted by FD. Patient complaining of pain to right leg in thigh area."

While in the hospital, was diagnosed with the following: GI Injury Nec-Closed, Fracture Acetabulum-Open, Post Trauma Pulmonary Insufficient, Pulmonary Collapse, AS Posthemorrhage Anemia, Thrombocytopenia NOS, Cortex Laceration W/O Coma, Poison-Drug/Medicine NOS. He underwent the following procedures: Partial Small Bowel Resect NEC, Other Skeletal Traction, Insert Endotracheal Tube, Cont. Mech. Ventilation 96+ Hours, Packed Cell Transfusion, and Serum Transfusion NEC.

A Nurse's Assessment upon arrival at the hospital states, "Patient driver of car that hit a gas tanker truck. Patient was extricated by FDNY, c-collar and backboard with traction to tight leg. On arrival, patient placed on cardiac monitor...patient combative and repetitive, c-spine precautions maintained."

A Psychiatry Note from 1/29/05 states, "Thirty-nine year old male who allegedly attempted suicide by driving his car into gastruck. Continued to express suicidal ideation." A Psychiatry Note from the following day states, "He stated that he doesn't have any idea what happened to his wife. When he was asked if he had any arguments with his wife before he ended up in the hospital, patient requested police officer to leave the room. Then stated that he found out that his wife was cheating on him with a few men, but he is not blaming her because he sees all their problems started when she refused to take his advise how to run her business." A Social Work Note on 1/31/05 states, "Patient under police guard – not agreeing to any treatment at LMC – cleared for discharge. Appropriate arrangements to be made by 72nd precinct for patient discharge and transfer out of LMC."

was discharged and transferred on February 4, 2005 to Bellevue Medical Center Prison Ward for follow-up care. His Transfer Note states, "Thirty-nine year old male s/p MVA on 1/21 with multiple injuries including: head injury, pelvic fracture, bladder contusion, bowel injury, right hip dislocation. Initially admitted to ICU and intubated for several days. Had emergent laporotory of small bowel and reduction of hip dislocation. Patient stabilized, had femoral traction pin placed with 35 lbs. traction applied. Head injury resolved, abdominal injuries, bladder also resolved. CT also with fracture (stable) of lower thoratic vertebrae, asymptomatic. Patient subsequently extubated and placed on regular diet, foley catheter discharged, psychological evaluation obtained, reported on chart regarding patient's attempt at suicide after allegedly killing his wife. Patient charged and arraigned for murder by NYPD, has been under their custody for last week now under department of corrections. Patient was booked for IVC filter prior to ORIF of acetabulum, but he refused procedure on day of OR. Patient subsequently refused ORIF of acetabulum surgery by myself. CT scan with minor displaced transverse acetabulum fracture, but with large incarcerated fragment from posterior...Psych reconsulted, patient deemed competent to refuse. Patient continued to refuse ORIF for over a week despite multiple doctors discussion

with patient. Patient resistant getting out of hospital. We discussed with and ortho service at Bellevue, transfer arranged for later today. Traction pin to remain in, should be placed back in traction upon arrival."

patient transfer form states, "Patient very depressed with little eye contact when spoken/speaking. Patient looks at you when talking, but appears like he's looking through you. Patient takes mostly PO Tylenol for pain. Patient has 30 lbs skeletal traction to right leg and needs pin care Bid."

Court Transcripts, dated 1/25/05-1/27/05

On January 25, 2005, was called to the stand. She stated that she worked with the , taking care of their two children. She was at home with the family on January 21, 2005. ame home that night at 7:00 or 7:30. She let him in and went to the third floor of the house where he slept. His wife slept on the first floor. At ten o'clock he asked her if his wife had said "if he was going somewhere." Ms. said no and went back to sleep. At 1:00 am, she awoke to hear footsteps running hard on the third floor and she heard two doors slam. At 1:20 am, her cell phone rang. She answered it and said, "I just killed (his wife). Go downstairs, open the bathroom, you see her. Tell that I love them. Call the cops. I'm on my way to kill myself." Ms. then went to the bathroom and saw the victim lying on her stomach. She then ran upstairs to wake the tenant that lived on the second floor, She said, " .please call the cops for me. just killed ." called the police and the two went downstairs to wait for them to arrive.

Following testimony, was called to the stand. She stated that she was the victim's sister. On the night of the incident, her telephone rang at 1:43 am. Her husband answered the phone and handed it to her. It was He stated, "I've been having problems with your sister. I tried to talk to her. She's been seeing different men or having different men...I have to prosecute myself. I killed I think she's dead. She wouldn't wake up." He told her to call the police.

Detective was called to the stand after He arrived at the scene of the crime at 2:40 or 2:45 am. The officers on scene showed him where the victim was found on the bathroom floor. He saw the victim lying face down in a pool of blood. He saw a stab wound on her right side. He stated that at that time he was beginning to look for the victim's husband.

On January 27, 2005, Lieutenant firefighter, was called to the stand. At 2:00 am the night of the incident, he arrived at the scene of a car accident in which a white Lexus crashed into a gasoline truck at a Mobile gas station. He stated that the situation as extremely dangerous because gasoline was pouring onto the car. Five firefighters

pulled the driver out of the car. They then brought him to an awaiting ambulance.

After Lieutenant . s testimony, Officer was called to the stand. At approximately 2:00 am on the night of the incident, he was called to a scene where a white car was stuck underneath a gas truck. He then saw firemen pull a man from the car. At that time, he heard over his radio that the police were looking for a particular person matching the description of the car's driver .

Office of Correctional Health Services Medical Records, dated 2/19/05-present

Mr. forms state that he was suffering from numerous physical injuries, residual from his car accident. A Note on 2/28/05 states, "patient is requesting to speak with psych about legal and personal matters...Patient was seen briefly without a chart. Patient does not want to see the psychiatrist but just wants to talk. Patient will be seen on 3/3/05 to complete mental health screening." A Mental Health screening from 3/3/05 states that in addition to his physical injuries, he was diagnosed with Adjustment Disorder with Depressed Mood. He was "refused by medical due to wanting to discuss personal matters. Patient will not discuss reason for incarceration...Patient is depressed this is his first incarceration and he has problems handling the environment. Patient is very guarded and refuses to tell writer the reason for incarceration. Patient was in a car crash, that he has no memory of. He is told by his family that this car accident was a suicidal attempt after the crime that he committed. Patient was alert and oriented x3 and cooperative. His mood was depressed and his affect was appropriate to his mood." There was no evidence of suicidal or homicidal ideation or of hallucinations of any kind.

A Note from 3/27/05 states, "'I miss my family on this holiday.' Patient's affect more flat and appears more depressed than usual. Sleeping through the day on and off."

Psychological Evaluation prepared by *dated 11/30/05*

The history recounted in this report coincides with that given to this examiner. He described to . crumbling marriage and the belief that his wife was prostituting herself. However, seemed more intact when he saw He told the doctor that "after he smashed his car into an oil tanker in a suicide attempt, he was hallucinating and thought he saw his late wife."

with mother. She stated that he son had been having problems in his marriage and that his wife had been "selling herself." She advised him to go to a counselor or separate. She stated that her son did not want to leave his marriage because he loved his wife. He had been complaining about their problems for about one year. She stated he had never been violent before. "Something happened that night that really provoked him. He had kept it inside so long. He blew a fuse. He had never had a physical

fight with anyone." also spoke with brother, He stated that his brother was having problems with his wife and that he had moved into a separate bedroom. He stated, "On the night of the incident, the wife had other men dropping her off at the house. She was disrespecting him in front of his family. He didn't say anything. I've never seen him angry. He puts a positive spin on everything. He finally retaliated and went overboard!...There was a wine glass in the sink that night."

administered numerous psychological assessments. The instruments showed no evidence of malingering or exaggerating of symptoms. On the MMPI-II, a personality inventory, reportedly "tended to be self-favorable and moderately minimizing of emotional problems." His profile indicated "that he has transient paranoid and psychotic episodes. His reality testing breaks down...Hostility toward family members is poorly recognized. His hostility is rigidly over-controlled until it erupts in rare but explosive outbursts, most often toward a member of his family....This profile is associated with psychotic episodes with paranoid jealousies and self-righteous temper outbursts." remarked that marital conflicts were common with s "code-pattern." He rested high on the Overcontrolled-Hostility Scale, consistent with a man who has rare but extremely violent outbursts. "The elevated O-H scale indicated the presence of both hostile alienation and excessive inhibition around the expression of hostile impulses – both of which reside outside of awareness." On the MCMI-III, another personality inventory, tended to present himself in a favorable light, slightly under-reporting psychological symptoms. simply stated, "According to the Millon Inventory (MCMI-III), Mr. is experiencing a mental disorder."

described Mr. as unaware of how angry he was with his wife. "It is most probable that on the evening of the Instant Offense, something happened that provoked and pushed him over the edge. likely had been drinking wine of this occasion and this may have been a factor in lowering his normally solid controls against expression of violent urges. description of the events surrounding the incident is entirely consistent with the information related by his mother and brother. It is virtually certain that was in the throws of a psychotic episode when his wife was killed and when crashed his car into an oil tanker in a suicide attempt."

Mr. diagnosis of Brief Psychotic Disorder with Paranoia. He gives the criteria for this diagnosis and stated that qualifies for the criteria, in that he was experiencing delusions and hallucinations, experienced the symptoms for at least one day but less than one month, and his symptoms were not better accounted for by another diagnosis such as Schizophrenia or Schizoaffective Disorder concludes, "In this psychologist's opinion and with a reasonable degree of psychological certainty, Mr. only partially criminally responsible for his conduct." He added tha is not a malingerer, was suffering from brief psychotic disorder, and acted under the influence of extreme emotional disturbance (EED). "The extreme emotional disturbance

(EED) resulted from significant mental trauma that has affected the defendant for a substantial period of time, simmering in the unknown subconscious and then inexplicably coming to the fore."

concluded, "In this examiner's opinion, would benefit most from psychiatric treatment and/or psychotropic medication. s aware that he needs psychiatric help... Clearly, a lengthy incarceration where intensive psychiatric treatment is not available would not serve him or the community well."

In addition to report, this examiner reviewed his raw notes and assessment materials. Mr. MMPI-II results in fact read, "The profile suggests a mixed picture, possible a transient paranoid or hysterical psychotic episode...His item responses would not rule out a partial breakdown of his reality testing...In other cases the clinical picture more closely approximated atypical schizo-affective and manic-depressive disorders. Nevertheless, his average range ego strength score would predict effective practical coping and personal self-sufficiency in many areas."

not address the results of MCMI-III. He simply states that the MCMI-III showed that " is experiencing a mental disorder." The report of his results stresses 'active solicitation of attention and praise and his need for nurturance and security. His fear of autonomy often leads him to seek a responsive partner and to assume an obliging and pleasant manner...When faced with interpersonal tensions, he may try to maintain a superficial air of buoyancy, denying disturbing inner emotions and concealing his true discomfort with short-lived enthusiasm and surface pleasantries...To secure his attentional needs, he may be overly accommodating and responsive to the needs of others...He tends to value himself in terms of surface traits and physical appearance, not in terms of inner values and principles...It is likely that this man has learned to anticipate signs of potential hostility and rejection so that he can minimize the dangers of social indifference and disapproval. Moreover, by paying close attention to the signals of others, he can shape his behavior to conform to their desires....Guilt, illness, anxiety, and depression may be displayed instrumentally to deflect criticism and to transform threats to his security into messages of support and sympathy. More extreme reactions may emerge when his basic needs for praise and security are genuinely threatened."

With regards to clinical syndromes, the MCMI-III profile states, "The restless and apprehensive quality of this man's behavior is not characteristic of him, yet a number of MCMI-III responses suggest a generalize anxiety disorder...These symptoms may be prompted by recent failures or their expectation, an inability to get things to go his way, a feeling that a disparity exists between having things as he is accustomed and the presence of events that now preclude his more usual and successful manipulations." The profile does state, "This man may not admit to weaknesses or emotional difficulties within the context of an impersonal psychological tests, and therefore, the denial of clinical symptomatology may

have resulted."

The MCMI-II suggested the following diagnoses: Generalized Anxiety Disorder, Obsessive Compulsive Personality Disorder with Self-defeating Personality Features and Dependent Personality Features. It should be noted that these diagnoses were relevant to Mr. Watson at the time of the administration of the test and have little bearing on his mental state at the time of the offense.

DIAGNOSIS AND FORMULATION

Axis I
(Clinical syndromes)
Adjustment Reaction with Disturbance of Mood and Conduct

Axis II
(Personality and developmental disorders)
Obsessive-Compulsive Personality Disorder

Axis III
(Medical issues)
Status Post motor vehicle accident

is a forty-one year man with no significant past psychiatric, legal, or substance abuse history. For years, he had been embroiled in a turbulent relationship with , the deceased. Ongoing attempts at securing a divorce in the context of likely infidelities and/or prostitution appeared to have gradually plunged into a state of acute depression on the day of the incident.

Though his memory is vague for his thoughts at the time of the incident, facts about the case give credibility to a claim of his being suddenly overcome with rage, depression, and frustration and that he lost all rational control over his behavior. Attempting to take his own life after having killed his wife only adds, I believe, to the claim that he was overwhelmed with depression and anger at the time.

Direct clinical observations, in addition to the psychological testing, reveal Mr. be a reserved man who keeps his feelings to himself and functions with a great deal of self-control. Other than increasingly angry and bitter exchanges with his wife, there is no evidence of impulsivity, brutality, or abuse in this man's life. His own description of the stresses inherent to his marriage are confirmed by interviewed third parties and appeared credible to this examiner.

I do not, however agree with assessment that was suffering from a psychotic disorder at the time of the incident, as no evidence exists of such symptoms in any of the reviewed materials.

In the end, it is my opinion with a reasonable degree of medical certainty that Mr. on January 20, 2006 was so overcome with emotion that he lost rational control over his behavior. As such, at the time of the offense, he was under the influence of an Extreme Emotional Disturbance.

Thank you very kindly for referring this matter to my attention.

Respectfully submitted,

Alexander Sasha Bardey, M.D.
Diplomate in Psychiatry, American Board of Psychiatry and Neurology
Diplomate in Forensic Psychiatry, American Board of Psychiatry and Neurology
Clinical Faculty, Department of Psychiatry, New York University Medical Center
Adjunct Assistant Professor, Department of Psychiatry and Behavioral Sciences
New York Medical College

ATTACHMENT FOUR

AFFIRMATION AND PROPOSED ORDER FOR APPOINTMENT OF EXPERT WITNESS

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF SUFFOLK

----------X

THE PEOPLE OF THE STATE OF NEW YORK,

-against-

Defendant.

----------X

AFFIRMATION IN SUPPORT OF EX-PARTE APPLICATION FOR APPOINTMENT OF A MEDICAL EXPERT

Ind. No.

I, **ANTHONY M. LA PINTA**, an attorney duly admitted to practice law in the Courts of the State of New York, hereby affirms the following under the penalties of perjury:

1. I am counsel for the defendant who is charged with one count of Murder in the Second Degree involving the death of on June 21, 2011.

2. In order to properly represent the defendant and provide effective assistance of counsel herein, it is necessary to hire a Neurological expert to assist me. This case involves complicated psychiatric and neurological issues relating to background and the facts of this case.

4. Accordingly, I desire to enlist the services of William B. Barr, Ph.D., a forensic neuropsychologist from New York City. Dr. Barr is a product of the University of Michigan and The New School For Social Research in New York City. He has been qualified as an expert in forensic neuropsychology by many New York State trial courts. Attached hereto as **Exhibit A** is his Curriculum Vitae.

5. Due to Dr. Barr's expertise and qualifications, it is requested that the Court allow payment for his services. To accommodate this appointment, Dr. Barr is willing to bill his time in the amount of $400.00 per hour, a reduction from he customary hourly rate. Dr. Barr has explained that he will need, at minimum, 20 hours of time to effectively evaluate. review relevant medical and treatment records, prepare a report, prepare for trial and testify in court. Therefore, it is requested that the

Court approve this expenditure for Dr. Barr's services.

WHEREFORE, it is respectfully requested that the Court approve this expert application granting leave to employ William B. Barr, Ph.D. as a forensic neuropsychologist to assist in the defense herein and that his services be billed at a rate of $400.00 per hour not to exceed forty (20) hours.

Dated: Hauppauge, New York
April 22, 2013

Yours etc.,

ANTHONY M. LA PINTA, ESQ.
Attorney for the Defendant
35 Arkay Drive, Suite 200
Hauppauge, New York 11788
(631) 300-0033

At a term of the Supreme Court held in and for the County of Suffolk, at the Courthouse thereof at 210 Center Drive Riverhead, New York on the _____ day of April, 2013.

P R E S E N T:

The Honorable William Condon, J.S.C.

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF SUFFOLK
----------X
THE PEOPLE OF THE STATE OF NEW YORK,

-against-

ORDER

Ind. No. -

Defendant.
----------X

The defendant, by and through his attorney ANTHONY M. LA PINTA, having moved this Court on April 22, 2013 for an ex-parte order pursuant to Section 722-c of the County Law, granting counsel leave to employ WILLIAM B. BARR, Ph.D., a qualified forensic neuropsychologist to assist the defense in performing a psychiatric evaluation of the defendant. Such expert services will be required to enable counsel to adequately prepare and conduct the defense of the defendant, and the cost of such expert is to be so rendered by and paid by the County of Suffolk; and it appearing that the defendant, , is wholly destitute of means with which to employ and obtain the services of said expert to assist her assigned attorney in the preparation and conduct of the defense of the indictment herein.

NOW, upon motion of ANTHONY M. LA PINTA, ESQ., the attorney for defendant , it is

ORDERED, pursuant to the provisions of the Criminal Procedure Law and the County Law of the State of New York, that ANTHONY M. LA PINTA, ESQ., attorney for the defendant, be hereby given

leave to employ WILLIAM B. BARR, Ph.D. a qualified forensic neuropsychologist in order to adequately prepare assist in the defense of the defendant; and it is further

ORDERED, the cost of such forensic neuropsychologist is hereby declared to a be a charge against the County of Suffolk, not to exceed a hourly rate of $400.00 per hour with a limit of 20 hours, to be paid by the County Treasurer thereof upon the Affirmation of ANTHONY M. LA PINTA, ESQ., attorney for the defendant, that such services are material and necessary to the preparation and conduct of the defense of the indictment herein.

Dated: Riverhead, New York
April ___, 2013

ENTER:

_____
WILLIAM CONDON, J.S.C.

ATTACHMENT FIVE

AFFIRMATION AND PROPOSED ORDER FOR APPOINTMENT OF EXPERT WITNESS, UNITED STATES DISTRICT COURT

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK
----------x

UNITED STATES OF AMERICA

-against-

EXPARTE APPLICATION FOR THE ASSIGNMENT OF A FORENSIC PSYCHIATRIST

CR (ADS)

Defendant.

----------x

I, ANTHONY M. LA PINTA, an attorney duly admitted to practice law in the Federal District Court, EDNY, hereby affirms the following under the penalties of perjury:

1. I am counsel for the defendant who has previously pleaded guilty to attempt to Provide Material Support to Terrorists and Attempt to Provide to Provide Material Support to a Foreign Terrorist Organization.

2. is 18 years old. Since childhood he has been diagnosed with various psychiatric conditions including Autism, Aspergers Syndrome, depression and Kallmann's Syndrome, a serious hormone disorder. Due to these conditions, he is currently prescribed a number of medications currently being dispensed by the staff of the MDC, where the defendant is currently being housed. He has been under the care of a psychiatrist since childhood. Mr. is indigent and has no assets.

3. In order to properly represent the defendant and provide effective assistance of counsel herein, it is necessary to hire a forensic psychiatrist to assist me in the sentencing phase of this

criminal prosecution. This case involves complicated psychiatric issues pertaining to background and the facts and circumstances surrounding his crimes.

4. I desire to enlist the services of Alexander Sasha Bardey, M.D., a clinical and forensic psychiatrist from New York City. Dr. Bardey has previously been qualified as an expert in forensic psychiatry in both Federal Court and New York State Court courts. Attached hereto as Exhibit A is Dr. Bardey's curriculum vitae.

5. Due to Dr. Bardey's expertise and qualifications, it is requested that the Court allow CJA payment for his services at the rate of $300.00 per hour, a reduced hourly rate. Dr. Bardey has explained that he will need, at minimum, 25 hours of time to effectively evaluate and prepare a report. Therefore, it is requested that the Court approve the expenditure of $7,500 for Dr. Bardey's services.

WHEREFORE, it is respectfully requested that the Court approve this expert application granting leave to employ Alexander Sasha Bardey, M.D., as a forensic psychiatrist to assist in the defense herein and that his services be billed at a rate of $300.00 per

hour not to exceed twenty five (25) hours.

Dated: Hauppauge, New York
October 24, 2013

Yours, etc.,

ANTHONY M. LA PINTA, ESQ. (AML-
Attorney for the Defendant
35 Arkay Drive, Suite 200
Hauppauge, New York 11788
(631) 300-0033

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK

----------X

THE UNITED STATES OF AMERICA,

-against-

AFFIRMATION IN SUPPORT OF EX-PARTE APPLICATION FOR APPOINTMENT OF A FORENSIC PSYCHIATRIST EXPERT

CR (ADS)

Defendant.

----------X

AFFIRMATION IN SUPPORT OF EX-PARTE APPLICATION

ANTHONY M. LA PINTA, ESQ.
Attorney for Defendant
35 Arkay Drive, Suite 200
Hauppauge, New York 11788
(631) 300-0033

To:

Attorney(s) for

Service of a copy of the within is hereby admitted.

Dated:

.....
Attorney(s) for

PLEASE TAKE NOTICE

NOTICE OF ENTRY ☐ that the within is a (certified) true copy of a entered in the office of the Clerk of the within named Court on 19 .

NOTICE OF SETTLEMENT ☐ that an Order of which the within is a true copy will be presented to the Hon. one of the judges of the within named Court, at , on 1995, at M.

Dated: October 24, 2013

ANTHONY M. LA PINTA, ESQ.
Attorney for Defendant
35 Arkay Drive, Suite 200
Hauppauge, New York 11788

TO:

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK
----------X
THE UNITED STATES OF AMERICA,

-against- ORDER

, CR

Defendant.
----------X

The defendant, by and through his attorney ANTHONY M. LA PINTA, having previously moved for an Ex-Parte order on October 30, 2013 pursuant to Criminal Justice Act, granting leave to employ ALEXANDER SASHA BARDEY, M.D., a qualified forensic psychiatrist to assist the defense in performing a psychiatric evaluation of the defendant and in preparing a report. Such expert services were deemed necessary to conduct the defense of the defendant herein, and having appeared that the defendant,

is wholly destitute of means with which to employ and obtain the services of said expert to assist his assigned attorney in the preparation and conduct of the defense of the indictment herein.

NOW, upon motion of ANTHONY M. LA PINTA, ESQ., the attorney for defendant, , it is

ORDERED, pursuant to the provisions of the Criminal Justice Act, that ANTHONY M. LA PINTA, ESQ. hereby given leave to further employ ALEXANDER SASHA BARDEY, M.D. a qualified forensic psychiatrist in order to adequately prepare and conduct the defense of the defendant at trial; and it is further

ORDERED, the cost of such forensic psychiatrist is further approved at the hourly rate of $300.00 per hour for an additional period of fifteen (15) hours, and that such services are material and necessary to the preparation and conduct of the defense of the defendant herein.

Dated: Central Islip, New York
November 10, 2015

ENTER:

Denis R. Hurley

THE HONORABLE DENIS R. HURLEY
UNITED STATES DISTRICT COURT JUDGE

Should Coercion Play a Role in the Attorney-Client Relationship?

Mary Elizabeth Hennen-Anderson, Esq., LMSW
Director, Urban Justice Center Mental Health Project

Frequently, attorneys, particularly criminal defense attorneys as well as other attorneys who work with clients with behavioral health needs,[1] find themselves in the position of advising their clients to engage in treatment services in order to obtain a favorable legal outcome. In my more than 25 years of working with such clients, for more than two decades as a public defender, and for the past three years managing a civil legal services organization that provides services to clients with serious mental illness, I've heard clients complain frequently that they feel "coerced" to engage in treatment, that they would prefer to engage in these services voluntarily, rather than under court mandate or because their attorney informs them they are unlikely to receive government disability benefits unless they can show a history of treatment for the disabling condition, or avoid eviction unless they accept treatment services. Sometimes it helps for clients to know that they do have a choice to refuse to engage in treatment, and to point out the consequences of such refusal.

Many lawyers feel uncomfortable advising clients when there is an element that seems coercive within that advice. This short article aims to help attorneys gain confidence in presenting clients with their options to resolve cases by engaging in treatment or to enhance possibilities of achieving a more favorable legal outcome by engaging in treatment.[2]

Advising defendants in criminal cases about treatment alternatives to incarceration

Often, defendants in criminal cases who are candidates for treatment alternative-to-incarceration programs, such as drug or mental health courts, feel they have no options other than to plead guilty and engage in treatment. Lawyers who advise these clients have the obligation to relate plea-bargaining alternatives, and, indeed, must act with constitutional effectiveness in negotiating and advising on plea bargains, as set forth in the United States Supreme Court decisions in Missouri v. Frye[3] and Lafler v. Cooper.[4] All attorneys in New York State are also guided by our Rules of Professional Conduct, which provide that attorneys must be competent to practice in the areas in which they provide legal services (or seek advice if they

[1] "Behavioral health" includes mental illness and substance use disorders.
[2] In that the author is a practitioner in New York State, this article is written for New York practitioners; however, many of the principles set forth would be applicable in other states.
[3] 132 S. Ct. 1399 (2012)
[4] 132 S. Ct. 1376 (2012)

do not have such competence),[5] and in advising clients about their options, lawyers can consider not only the law, but also "other considerations such as moral, economic, social, psychological, and political factors that may be relevant to the client's situation."[6] Regardless of the attorney's advice, in a criminal case, the attorney must abide by the client's choice of whether to enter a plea or pursue trial.[7]

Clearly, if an attorney practices in a jurisdiction that offers alternatives to incarceration to people with treatment needs, the attorney should explore with the client whether to seek a disposition in the form of an alternative to incarceration. That alternatives to incarceration exist in the jurisdiction does not relieve the lawyer's obligation to investigate the case and recommend a trial when the facts demonstrate that a client has a reasonable likelihood of prevailing at trial.

In my experience, defense attorneys are extremely reluctant to advise clients with serious mental health concerns to go to trial. In the latter part of my career as a public defender, I assumed representation of several clients from other attorneys specifically because I saw the possibility of the clients prevailing at trial where the original attorneys either did not see that possibility or did not feel they had the capacity to help a client with serious mental illness navigate the trial process effectively. In each of these cases, the clients were initially reluctant to choose trial as an option. However, careful and extensive discussions – sometimes over the course of many meetings with the clients – helped the clients comprehend the rationale behind my recommendations that the clients go to trial and gave many of them the confidence to choose to go to trial.[8]

Thus, a key take-away for attorneys who are representing clients with mental health concerns is that such representation often requires a greater investment of the attorney's time, in order to provide clients with confidence in their representation as well as to ensure client understanding of the legal proceedings. Lawyers have obligations under the Rules of Professional Conduct to communicate all significant matters relating to a client's case to the client.[9] Thus, attorneys who practice in jurisdictions that offer treatment alternatives to incarceration have an ethical obligation to discuss these options with clients who may qualify for them.

---

[5] Part 1200, Rules of Professional Conduct, Rule 1.1

[6] Id., Rule 2.1

[7] Id., Rule 1.2 (a)

[8] I should note that a number of these clients eventually chose not to go to trial, due to the risk of an increased sentence if they did not prevail at trial, yet many of these cases that moved toward trial resulted in plea bargains that were in line with the clients' actual measures of culpability.

[9] Part 1200, Rule 1.4

Does this mean that, if a client decides to engage in an alternative-to-incarceration program, and later on decides to stop participating in treatment (e.g, stops taking psychiatric medication), the defense attorney may be placed in the position of exercising some form of coercion to ensure the client is in compliance with the terms of the program?

The simple answer to this question is "yes," but the situation can be viewed through a lens that removes coercion from the equation.

All of us face coercion in our lives – whether it be the mild coercion to go to our jobs on a beautiful day that we'd rather spend outside, or having to take medication for diabetes or asthma or high blood pressure or our own mental health concerns, or having to choose between appearing on a trial matter and missing an event at our children's school. Many of us would prefer not to work, but to travel the world or lay in the sun on an exotic island beach. For most of us, these are not realistic options.

When a client has made a decision to accept a plea bargain that requires engagement in a course of treatment, the client has decided not to go to trial and not to pursue other dispositional options. In my practice, I've found it helpful to lay out a client's options in detail before the client accepts a plea to participate in a treatment program. Sometimes it is effective to make a written list of these options, to let the client see how many different options the client has. Most clients have at least four or five, including (1) take a treatment plea, (2) take the case to trial, (3) try to work out a plea that does not include treatment or incarceration, (4) try to work out a plea for the least amount of incarceration possible, (5) engage in motion practice, to see if the grand jury presentation supports the charges, (6) take the case to the hearing stage, and if the hearings are lost, work out a plea before trial. A client may not like these options, but listing them helps the client see there are choices.

If a client complains about the coercive nature of the treatment plea option, emphasize the client does not need to accept it – yet give the client hope as well, by relating that this program may help the client achieve good recovery and help the client find a way out of the criminal justice system. It is generally best for a lawyer not to use the lawyer's own life as a point of comparison regarding coercion. For example, I would not tell a client that I really didn't want to go to work every day but I have to. I would instead tell the client that many people don't want to go to work, that people with illness often don't want to engage in treatment, keeping the comparison diffuse rather than pegged to a particular known person's life issues.

If a client decides upon treatment and then later lets the attorney know that the client would like to stop engaging in the program in total, or in a particular part of the program, ask the

client to explain why. Some clients need encouragement that they can complete the mandated course of treatment; other clients may be experiencing serious side effects of medication and may need help with advocating for a medication change. In some circumstances, clients may be facing other personal circumstances that are making program completion difficult, such as lack of family or other social supports, abusive relationships, difficulties with housing or benefits. In these situations, a social worker could be instrumental in helping the client cope with such obstacles.

There may be times when clients decide they cannot complete treatment and would prefer to receive the sentence alternative. In these circumstances, the attorney should discuss the matter in detail, and, if the client is insistent upon the sentence alternative, the attorney should respect the client's decision and offer to advocate for appropriate services during the sentence and upon completion.

Capacity to stand trial in criminal cases

When representing a client who has any impairment, a lawyer has the obligation to treat the client as any other client without an impairment would be treated, to the extent that is possible, and to take any steps necessary to protect the client with impairments if the nature of the impairment is such that it interferes with the client's ability to participate in legal proceedings or is causing the client to act in a manner that is contrary to the client's legal best interests.[10] In criminal cases, this may require the lawyer to request an examination for capacity, even if the client does not wish to be treated for restoration to fitness.
When clients in criminal matters oppose the defense attorney's request for an examination, this does not mean the attorney is precluded from requesting the examination. The Court of Appeals, in People v. Christopher, 65 N.Y.2d 417 (1985), indicated that the defense attorney at times has to raise the issue of capacity, even if the defendant does not want this issue raised. In my experience, when a defense attorney has significant concerns about a client's capacity to understand the legal proceedings or assist the attorney in the defense of the pending criminal charges, a defense attorney must request an examination for capacity, even though this may subject the defendant to treatment the defendant does not want. The law is clear: a defendant cannot waive the right to be competent to proceed. [11]

If a defendant is found unfit on felony charges, the defendant may be medicated over objection to restore capacity only if the state's interest in restoration outweighs the defendant's right to

[10] Id., Rule 1.14
[11] Pate v. Robinson, 383 U.S. 375 (1966).

refuse medical treatment.[12] In New York, the standard for psychiatric medication over objection is set forth in Rivers v. Katz, 67 N.Y.2d 485 (1986), and roots the right to refuse medication in the New York State Constitution (article I, section 6). The Court in Rivers states that psychiatric medication may be given over a patient's objection in the following circumstances: "Where the patient presents a danger to himself or other members of society or engages in dangerous or potentially destructive conduct within the institution, the State may be warranted, in the exercise of its police power, in administering antipsychotic medication over the patient's objections." (Id., at 496).

Thus, there are times that a defense attorney may be an indirect cause of a client's medication over objection, and thus subject the client to a truly coercive procedure. However, in my experience, many defendants who are found unfit to proceed agree to engage in treatment voluntarily in the more therapeutic hospital setting.

Many attorneys believe that they cannot resume effective representation of clients who have been hospitalized with the lawyer's assent over the client's objection. In my experience, this is rarely true. In such situations it is incumbent upon the attorney to continue to develop the case while the client is hospitalized. An investigation may provide facts that would allow for a good trial defense, or that would provide mitigation for a plea bargain. If the case is one that should go to trial, the lawyer needs to be prepared to move forward with the case promptly upon the client's return as fit to proceed.

The investigation may also provide facts that would warrant a reduction or dismissal of charges. All motion practice that does not require the defendant's active participation can be done (and in my view should be done) while the client is being restored to fitness.[13]

Clients who are returned to court upon fitness restoration are often pleased to find that the attorney assigned to their cases has not forgotten about them, and has moved the case forward to a point where it can be resolved. Indeed, if possible, the attorney should visit the client during the restoration commitment, or arrange to speak by phone with the client. Phone calls can often be coordinated with the assistance of the Mental Hygiene Legal Service (MHLS) attorneys who work in the restoration hospital or developmental center.

Clients with intellectual and/or developmental disabilities can pose particular challenges, in that attorneys often don't recognize such clients who have mild impairments. Thus, a client who has intellectual disabilities may well be able to admit to the facts of the criminal charge but

---

[12] Sell v. United States, 539 U.S. 166 (2003).

[13] CPL 730.60 (4)

may have no comprehension whatsoever of the criminal court processes. The only way for an attorney to know truly whether such clients comprehend their circumstances is for the attorney to ask the client to tell the attorney, in the client's own words without any prompting or assistance from counsel or from the client's family or friends, what the client understands is going on in court. Unless a client can provide such information, including information about the consequences of any plea bargains, the client is not fit to proceed with the case, and a capacity examination should be ordered.

Coercion in civil cases

Attorneys representing clients with impairments that preclude adequate client participation in a civil legal matter can request a guardian ad litem be appointed to assist in the decision making process.[14] The only civil matters where clients are entitled to total autonomy in their legal decisions are proceedings dealing with commitment to psychiatric hospitals or developmental centers. Involuntary commitments of people with intellectual and/or developmental impairments to developmental centers are exceedingly rare. More common are involuntary commitments to psychiatric facilities. In both settings, the attorneys who work for the Mental Hygiene Legal Service (MHLS) represent the patients' interests. Unlike other attorneys, MHLS attorneys are bound to advocate for what their clients want, even if the attorney knows the position of the client is extremely unlikely to prevail. The MHLS also represents people in medication over objection proceedings and in proceedings where an Assisted Outpatient Treatment (AOT) order is being sought.[15]

Even in civil proceedings that do not involve involuntary hospitalization and/or medication over objection, some litigants with mental health concerns may feel coerced in the decision making process.

For example, in some eviction proceedings, tenants with mental health concerns may be facing eviction under a theory of "nuisance" which is directly or indirectly a result of a tenant's mental health. An individual who engages in extreme hoarding behaviors may be subject to eviction. A person with mental health concerns who does not engage in treatment may act in ways that

[14] Part 1200, Rules of Professional Conduct, Rule 1.14 (b).

[15] AOT is a mechanism whereby the Court can order the respondent patient to engage in certain mandated treatment services on an outpatient basis. If the patient violates the terms of the order, the patient can be brought to a psychiatric hospital and evaluated for commitment without a showing that the patient actually appears to meet the need for commitment. In essence, the AOT order permits evaluation for commitment without a need to demonstrate facts showing dangerousness as that concept is set forth in the Mental Hygiene Law. See MHL 9.60.

threaten other tenants in the building and may face potential eviction due to what are, in actuality, mental health symptoms. In most of these cases, Courts will permit the tenant subject to eviction proceedings an opportunity to engage in treatment and abate the nuisance. Most of these cases, if resolved in the tenant's favor, require the tenant to abide by a term of probation, during which term the tenant is required to act in ways that do not create a nuisance condition in the building.

Similarly, clients who are seeking disability benefits may not be able to demonstrate their eligibility for such support without also demonstrating that they sought treatment for the disabling condition but treatment did not provide sufficient recovery that would permit them to engage in work. Obtaining treatment may seem coercive, but the government regulations and court decisions relating to disability benefits can require a showing that treatment has not been effective in restoring a claimant's capacity to work.[16]

Conclusion

Coercion is frequently experienced by people with behavioral health concerns who end up in our courts, whether they be criminal or civil proceedings. Attorneys working with such clients should find creative ways to maximize client choice and minimize the coercive impact of those choices. Coercion is after all a way to view a choice: What one person perceives as coercive, another might see as providing a road to freedom.

[16] See SSR 82-59, retrieved online on April 20, 2016, at https://www.ssa.gov/OP_Home/rulings/di/02/SSR82-59-di-02.html

New York State Attorney and Judicial Ethics: Working or Interacting with People with Mental Health Conditions

Mary Beth Anderson, Esq., L.M.S.W.
Project Director, Urban Justice Center Mental Health Project
Managing Director, Urban Justice Center

People with mental health conditions are present in our civil and criminal courts every day. Some are litigants; some are witnesses; some are lawyers, judges, or other court personnel. Courts are not always accommodating to people with mental health problems. If a person has serious mental illness, and is symptomatic, the person may have difficulty sitting quietly in court, have difficulty understanding the proceedings, or communicating. Some people with mental illness may display emotion in ways that are inappropriate or too intense; others may seem to be flat or emotionless, completely detached from the proceedings. Some people have intellectual and/or developmental disabilities, including Down syndrome and autism spectrum conditions, which preclude them from comprehending even simple aspects of court proceedings. It is essential – for ethical and other legal and practical reasons – that people who work in the courts understand how to work or interact with people who are experiencing mental health challenges more effectively, in order to ensure that people – especially litigants – understand what is happening to them in the legal process.

Common Court Proceedings for Litigants with Mental Health Conditions

People with mental health conditions may be litigants in any sort of court proceeding, but there are some proceedings where a person's mental health condition might be the subject of the court proceeding, or may have led to the litigant's appearance in the particular court.

For example, a person with mental illness or intellectual/developmental challenges may be subjected to civil court proceedings under the New York State Mental Hygiene Law. Such proceedings include those in which medication over a patient's objection is sought, where a hospital seeks to commit a patient involuntarily, assisted outpatient treatment proceedings, and commitment or civil management proceedings for individuals with histories of sexual offending. Sometimes, when a person is so unwell that the person is unable to manage the needs of daily life in any minimal fashion, the person may be subjected to guardianship proceedings.

There are some criminal proceedings that may have a direct relationship to a person's mental health status, including those related to capacity to proceed to trial (governed by Criminal Procedure Law Article 730) or proceedings pursuant to section 330.20 of the Criminal Procedure Law, related to a finding of that the accused is not responsible for the charge criminal act, due to mental disease or defect.

In criminal courts, there is additional focus on mental health in many of the alternative-to-incarceration treatment courts. Legal staff who work in treatment courts need to be familiar with their ethical obligations in this court setting; most of these ethical obligations are similar to those that guide lawyers and judges in other court settings.

This is a guide to some of the ethical concepts that provide guidance to lawyers representing people with mental health conditions, to prosecutors who encounter witnesses or defendants with mental health conditions, and to judges who preside over courtrooms where people with mental health conditions appear. This guide deals generally with ethics and also includes a section relevant to those who practice in problem-solving court settings. The section on problem-solving court settings includes information about the ethical obligations of treatment professionals who appear in these courts.

Ethical Obligations for Legal Professionals Who Interact with People with Mental Health Conditions

Judges

Judges in New York State adhere to the Rules of the Chief Administrator of the Courts Governing Judicial Conduct, which is located in Chapter 22 of the New York Code of Rules and Regulations (NYCRR), part 100. There are no provisions in the code that specifically advise judges on how to relate to people with mental health concerns that appear before the court, other than two provisions that mention that (1) judges "shall not manifest bias or prejudice . . . based upon . . . disability" and shall require staff and others under judicial control "to refrain from such words or conduct" (NYCRR § 100.3 (B) (4)) and (2) judges shall require lawyers appearing before them from manifesting bias or prejudice based upon disability (NYCRR § 100.3 (B) (5)), and one provision that requires judges to weigh the privacy interests of people with mental illness who are involved in proceedings under the mental hygiene law, in order to determine if those proceedings should be open to the public (NYCRR § 109.1).

The only other specific guidance provided for judges is that they be "patient, dignified and courteous to litigants, jurors, witnesses, lawyers and others with whom" they deal "in an official capacity," and that they require similar conduct of their staff and lawyers appearing before them (NYCRR 100.3 (B) (3)), and that they give every party appearing before the bench the opportunity to be heard (NYCRR 100.3 (B) (6)).

It would seem that the federal Americans with Disabilities Act places additional obligations upon judges to fashion accommodations for people with mental health conditions who appear before the court in any capacity (litigant, attorney, or witness), when such accommodation can be done reasonably. An example of a reasonable accommodation would be

to permit a defendant to have additional time to confer with his attorney, or to coordinate ways for parties to notify the court if they do not comprehend what's happening in court. For many years, courts have permitted witnesses to take breaks, if the pressure of the court proceeding seemed to be causing the witness too much anguish; similar accommodations would seem to be proper and, at times, required in order to provide a person with mental health conditions access to the court system.

An example of an accommodation for a person with intellectual disabilities could be appointment of a social worker skilled in communicating with people with intellectual/developmental issues, who could "translate" the language of the court, attorneys, witnesses, and others into language that is understandable to the particular individual with the disabling condition. This may require permitting additional time for the communication to occur. While some judges and attorneys may balk at such a suggestion, it is certainly preferable to take the extra time than to try to correct misunderstandings later in the proceedings, or, even after plea or verdict. I have encountered dozens of cases where defendants literally had no comprehension about past proceedings. Once, in an examination to ascertain capacity to proceed in a criminal proceeding, the doctors wanted to know how the person being examined had ended up in state prison. They asked him, "Why did you go to prison for 4 years?" He answered, "Because my lawyer told me that's what I should do." They then said, "No, we mean *how* did you get there?" He said, "On a bus." I then asked him, "What did they say you did wrong?" He replied, "Oh! I stabbed my fat brother. We had a fight." Given this interaction, it was difficult to ascertain what sort of advice he was given about the previous case. I found out who had represented him on the previous felony matter; the attorney assigned was, in my experience, an excellent attorney. He remembered the case, but had no idea that the client had intellectual disabilities. He never asked the client to relate the client's understanding of the plea bargain. He never investigated whether there was a self-defense, as he said he had asked the client in the initial interview if the client was defending himself and the client said no. However, the client may not have understood the concept of self-defense. In the case in which I represented the client, a misdemeanor, he was found unfit and afterwards was committed to an inpatient developmental center, which is extremely rare. Generally, people found unfit on misdemeanor cases are released to the community with a service plan.

Attorneys

Attorneys, including civil attorneys, criminal defense attorneys, and attorneys who represent the government in any capacity, can find assistance with ethical issues in the New York State Code of Professional Conduct as well as in the ABA Guide to the Defense and Prosecution Functions. The ABA Criminal Justice Mental Health Standards provide additional guidelines, to help safeguard the rights of people with mental health challenges who have become involved in the criminal justice system.

In general, lawyers must advocate for their individual clients. Government attorneys advocate for the particular branch of government or governmental agency which they represent as well as for the needs of the community.

All attorneys are obligated to keep client confidences under most circumstances. Government attorneys sometimes have obligations to reveal information to the opposing party, even if the information came to them in confidential ways. For example, prosecutors must reveal exculpatory and/or mitigating information to the defense in criminal proceedings. All attorneys are officers of the court and cannot hide information from the court (i.e., commit a fraud upon the court by failing to reveal information one has a duty to reveal). All parties have duties to deal fairly with the other parties.

Attorneys have ethical obligations to provide their clients with enough information and advice for their clients to be able to make informed decisions about certain aspects of the proceedings. For example, in a civil tort proceeding, the plaintiff has the right to decide whether to accept a settlement offer. Defendants in criminal proceedings have the rights to decide whether to plead guilty or go to trial, whether to testify at trial, whether to proceed with a jury or bench trial, and whether to speak at sentencing.[1] In general, however, attorneys and not their clients have the right to determine trial strategies (including theories of the case or defense, what witnesses to call, and what questions to ask), although these decisions should be made after consultation with the client whenever possible.

Lawyers are not confined to advising clients solely based on the client's legal circumstances. They can also base advice on social or psychological circumstances. Prosecuting attorneys can advocate for treatment, and make offers to less serious offenses, because they believe such is the just and fair thing to do, even though the evidence in their case may be strong and conviction might otherwise require the defendant to serve a sentence of incarceration.

Lawyers can consider the ethical obligations of other professionals, but cannot allow those ethical considerations to override their own code of ethics unless such is consistent with their obligations to their clients and the attorney code of ethics.

In representing people with mental health or other impairments, attorneys are to follow Rule 1.14. This rule is set forth below.

CLIENT WITH DIMINISHED CAPACITY

(a) When a client's capacity to make adequately considered decisions in connection with a representation is diminished, whether because of minority, mental impairment or for some other reason, the lawyer shall, as far as reasonably possible, maintain a conventional relationship with the client.

[1] See, *supra*, page 3, for an example where a client may not have comprehended his choices.

(b) When the lawyer reasonably believes that the client has diminished capacity, is at risk of substantial physical, financial or other harm unless action is taken and cannot adequately act in the client's own interest, the lawyer may take reasonably necessary protective action, including consulting with individuals or entities that have the ability to take action to protect the client and, in appropriate cases, seeking the appointment of a guardian ad litem, conservator or guardian.

(c) Information relating to the representation of a client with diminished capacity is protected by Rule 1.6. When taking protective action pursuant to paragraph (b), the lawyer is impliedly authorized under Rule 1.6(a) to reveal information about the client, but only to the extent reasonably necessary to protect the client's interests.

The rule makes it clear that attorneys are to treat clients with mental health concerns in the same manner they would treat other clients, to the extent that is possible, but an attorney can take steps to protect the client without the client's consent if this action is necessary to protect the client. In civil cases, guardianship may be an option.

The rule also makes it clear that attorneys have an obligation to protect a client's confidences unless disclosure is permitted under Rule 1.6. Rule 1.6 only permits disclosure under limited circumstances, so attorneys should familiarize themselves with those limits and be prepared to be uncomfortable, at times, with the obligation to maintain a client's confidences.

Attorneys who represent clients in Mental Hygiene Law proceedings may have the most difficult obligations of all attorneys who work with clients with mental illness. These attorneys, who are generally members of the Mental Hygiene Legal Service (MHLS),[2]must advocate for the position chosen by their clients, even when the position seems to be ill advised or even untenable. Respondents in Mental Hygiene Law proceedings are much like defendants in criminal proceedings: They are entitled to make their own decisions. Their attorneys cannot seek to have guardians appointed to make decisions about commitment or medication.

An additional obligation of both criminal defense attorneys and prosecutors, as well as of judges in criminal proceedings, is to ensure that the accused has capacity to comprehend the proceedings and to assist the defense attorney. If there is some question as to this, it becomes incumbent upon the party with the concern to raise the issue. The party with concern is generally the defense attorney, but there are times that the court or the prosecutor is made aware of facts that bear on an accused's fitness to proceed of which the defense attorney is unaware. Once the court is presented with facts that show that the accused *may* lack capacity to proceed, the court *must* order an examination pursuant to Criminal Procedure Law Article 730 (CPL § 730.10(1)). Fitness of the accused is a nonadversarial inquiry within the adversarial process. If an accused

[2] MHLS attorneys are employees of the Appellate Division. Thus, there are four MHLS offices in the state, with individual attorneys sometimes stationed directly in psychiatric facilities, depending on the need of the particular facility.

does not comprehend the proceedings, or cannot assist the defense attorney, the accused is not present, legally, and the court thus has no jurisdiction over the accused's person.

Some of the more common ethical considerations for attorneys are included in Appendix A. Additional information about capacity to proceed is appended as Appendix B.

A core ethical precept relates to an attorney's competence (Rule 1.3). Attorneys must be competent to handle the matters in which they provide representation or seek assistance when they lack such skills. I have witnessed many, many cases – so many I cannot estimate the count – where attorneys had no idea that they were representing a client with mental illness, intellectual disabilities, substance use disorder or a combination of these. While we are not clinicians, we have an obligation to learn how to recognize signs and symptoms of mental health conditions, particularly when ignorance of these can lead to serious miscarriages of justice.

Problem-solving courts

Problem-solving courts include drug treatment courts, mental health courts, domestic violence courts, veterans' courts, sex offender courts, and courts that work with individuals charged with driving while intoxicated. Judges who preside over these courts, attorneys who appear in them, and treatment providers who interface with them follow various codes of ethics, specific to their professions. Sometimes the ethical considerations concur with one another; sometimes they conflict. It's essential for all who practice in problem solving courts to adhere to their roles and their own ethical codes.

Judges

As mentioned earlier in this guide, judges in New York State adhere to the Rules of the Chief Administrator of the Courts Governing Judicial Conduct, which is located in Chapter 22 of the New York Code of Rules and Regulations (NYCRR), part 100. In general, judges who preside over treatment courts are no different than judges who preside over other court parts. Those of us who are treatment professionals hope that treatment court judges have especially keen empathy and ability to connect with the treatment court participants, but this does not impose different ethical guidelines on judges.

One of the most common ethical issues with which judges in treatment courts deal involves ex parte communications. An ex parte communication is one wherein a judge hears from one party to an action without the other party (or parties) present. In that the treatment court forum is often informal, and in that many parties have a need to provide the court with information, ex parte communications happen with some frequency, and thus can pose difficulties for judges. An Office of Court Administration administrative order, 4/08/2003, sets

forth the court rule regarding such communications (in general, ex parte communications are prohibited unless the absent party has consented to such communications).

Other ethical issues involving court attendance at community functions, awards ceremonies, and the like; conflicts of interests with former clients from the judge's prior practice of law; expenditures of excess campaign funds on treatment court awards; and similar issues have generated opinions from the Advisory Committee on Judicial Ethics. These advisory opinions, while not binding, provide guidance to judges. These opinions have been collected and published in a publication: New York State Recommended Practices for Drug Treatment Courts: Ethical Opinions, Administrative Orders, Statutes and Case Law (2009) (available online at http://www1.spa.american.edu/justice/documents/2984.pdf).

Additional resources relating to judicial ethics include:

http://www.nycourts.gov/rules/chiefadmin/100.shtml(Code of Judicial Conduct)

http://www.scjc.state.ny.us/index.html(Website of the NYS Commission on Judicial Conduct)

http://www.law.cornell.edu/wex/judicial_ethics(Cornell University Law School website with focus on judicial ethics)

http://www1.spa.american.edu/justice/project.php?ID=1(United States Department of Justice, Bureau of Justice Assistance Drug Court Clearinghouse Technical Assistance Project Website)

https://www.ncjrs.gov/pdffiles1/nij/grants/197080.pdf (Ethical Considerations for Judges and Attorneys in Drug Courts. National Drug Court Institute. (2002).)

Attorneys

Defense attorneys and prosecutors can find assistance with ethical issues in the New York State Code of Professional Conduct as well as in the ABA Guide to the Defense and Prosecution Functions. The ABA Criminal Justice Mental Health Standards provide additional guidelines, to help safeguard the rights of people with mental health challenges.

In general, defense lawyers appearing in problem-solving courts must advocate for their individual clients, and prosecutors advocate for the needs of the community. While most treatment courts employ a "team model" approach, this model does not relieve the attorneys, judges, and treatment professionals from following their respective codes of ethics.

When defendant-participants have difficulties, the defense lawyer will almost always have the obligation to advocate for the client, even if such advocacy may make the defense lawyer seem not to be a "team player." Similarly, there may be times that the court is willing to

give a defendant-participant another chance in treatment, and the prosecutor may have a genuine need to object and advocate for imposition of the alternative sentence.

Lawyers are not confined to advising clients solely based on the client's legal circumstances. They can also base advice on social or psychological circumstances. Similarly, prosecuting attorneys can advocate for treatment, and make offers to less serious offenses, because they believe such is the just and fair thing to do, even though the evidence in their case may be strong and conviction might otherwise require the defendant to serve a sentence of incarceration.

Lawyers can consider the ethical obligations of other professionals, but cannot allow those ethical considerations to override their own code of ethics unless such is consistent with their obligations to their clients and the attorney code of ethics.

Additional resources that may provide assistance to lawyers who practice in the treatment courts:

Critical Issues for Defense Attorneys in Drug Courts.Monograph. National Drug Court Institute. (2003). Available online at http://www.wvpds.org/Drug%20Court/Critical%20Issues%20Section%202.pdf

Ethical Considerations for Judges and Attorneys in Drug Courts. National Drug Court Institute. (2002). Available online at https://www.ncjrs.gov/pdffiles1/nij/grants/197080.pdf

http://www1.spa.american.edu/justice/project.php?ID=1(United States Department of Justice, Bureau of Justice Assistance Drug Court Clearinghouse Technical Assistance Project Website)

National Association of Drug Court Professionals: Policy Statement on Role of Defense Counsel in Drug Courts. Available online at: http://www.nadcp.org/sites/default/files/nadcp/NADCP%20Board%20Policy%20Statement%20-%20Defense%20Counsel%20in%20Drug%20Courts_0.pdf

Prosecutors and Treatment Diversion: The Brooklyn (NY) Drug Treatment Alternative to Prison Program. Belenko, Sung, Swern, &Donhauser.Contained within: The Changing Role of the American Prosecutor. Worrell & Nugent-Borakove, Eds. SUNY Press. (Albany, NY. 2008).

Treatment Professionals

Various treatment professionals work in treatment courts. Some are employed by the Office of Court Administration; some are employed by various different government and/or nonprofit agencies that provide services to the court. Some of these treatment providers are licensed or certified: social workers (LCSW and LMSW – licensed clinical and master social workers); psychologists (PhD and PsyD), psychiatrists, mental health counselors (LMHC), certified alcohol and substance abuse counselors (CASAC); some of these providers are not

licensed but have education in related fields (e.g., masters' degrees in psychology, criminal justice, public health). The licensed professionals generally must follow certain ethical guidelines, and run the risk of losing their license to, or being suspended from, practice if an ethical breach is significant.

Many of the ethical considerations of treatment professionals are not inconsistent with those considerations of the judiciary and lawyers. Confidentiality may be compromised in the treatment court setting, and thus treatment court participants generally execute waivers of confidentiality in order to permit full communication with the attorneys and court personnel.

There are times that providers have an ethical continue to advocate for their clients to continue to participate in treatment, even if the court has made a determination to revoke the client's right to participate.

Sometimes a provider's role to advocate for treatment can clash with the defense attorney's role to advocate for her client's legal best interests. An individual defendant may desperately need treatment, but an attorney may recommend a different legal course of action.

There are various reasons that attorneys recommend rejection of treatment. For instance, if participation in a treatment court is conditioned upon a guilty plea, and if the defense attorney believes the case is defensible, the defense attorney may recommend that the client reject the treatment offer and litigate the case. In other situations, a treatment offer may be on the table, but the defense attorney may believe the jail alternative in the event of program failure is too high. In such a case, the attorney may recommend rejection of the treatment plea bargain in lieu of one wherein the sentence is more in line with the seriousness of the case.

There are other situations wherein the defense attorney may advocate for a client to be afforded a treatment court disposition although the client and/or treatment providers are not amenable to such a case resolution. This may be due to a client's lack of insight into the need for treatment, a client's refusal to engage in treatment, or a client's nonuse of substances. In both of these situations, the attorney's desire to resolve the case via treatment will not prevail, as the treatment considerations will trump the attorney's wishes.

Finally, there are circumstances wherein the court's treatment court staff may condition participation upon a particular treatment modality, and the client may refuse such treatment conditions. If the treatment staff holds fast to their recommendation, and the client continues to resist the placement, the client may not be allowed to participate in treatment. The usual scenario is one wherein treatment professionals recommend residential treatment when the client is equally insistent on an outpatient program.

Early in the history of problem solving courts, there was a tendency for the courts and prosecutors to want all or most court participants to engage in residential treatment. This could pose problems when residential treatment was either not practical or not available for the given

client. As problem solving courts became more established, judges and prosecutors have been willing to heed the recommendations of treatment professionals.

One of the difficulties for people with intellectual/developmental concerns is that there are few providers willing to engage in the ATI process. It is my opinion we in the legal profession have an obligation to advocate for expansion of alternatives to incarceration for these clients.

Problem solving courts provide a means by which difficult societal issues can be mediated. It does not always serve society well for a person with addiction issues and/or mental health challenges to serve time in jail or prison, or to accrue a criminal record. Treatment professionals that work for, or with, the problem solving courts play an important role in helping the justice system accommodate the societal interests that are served by offering defendants social services in lieu of incarceration.

Some of the resources for treatment providers include:

http://www.socialworkers.org/pubs/code/default.asp (National Association of Social Workers Code of Ethics – links in English and Spanish) (select provisions in the Appendix)

http://www.oasas.ny.gov/sqa/credentialing/casac_canon.cfm (Code of Ethics for Certified Alcohol and Substance Abuse Counselors) (also included in the Appendix)

Defining Drug Courts.1997, reprinted 2004.
http://www.ojp.usdoj.gov/BJA/grant/DrugCourts/DefiningDC.pdf

In addition to these resources, there are hundreds of articles about the effectiveness of problem solving courts in professional journals and other media.

APPENDIX A: *Select Provisions from Various Codes of Ethics/Conduct*

Ethics Provisions from NY Code of Professional Responsibility

RULE 1 .1 :

Competence

(a) A lawyer should provide competent representation to a client. Competent representation requires the legal knowledge, skill, thoroughness and preparation reasonably necessary for the representation.

(b) A lawyer shall not handle a legal matter that the lawyer knows or should know that the lawyer is not competent to handle, without associating with a lawyer who is competent to handle it.

(c) lawyer shall not intentionally:

(1) fail to seek the objectives of the client through reasonably available means permitted by law and these Rules; or

(2) prejudice or damage the client during the course of the representation except as permitted or required by these Rules.

RULE 1 .2:

Scope of Representation and Allocation

of Authority Between Client and Lawyer

(a) Subject to the provisions herein, a lawyer shall abide by a client's decisions concerning the objectives of representation and, as required by Rule 1.4, shall consult with the client as to the means by which they are to be pursued. A lawyer shall abide by a client's decision whether to settle a matter. In a criminal case, the lawyer shall abide by the client's decision, after consultation with the lawyer, as to a plea to be entered, whether to waive jury trial and whether the client will testify.

(b) A lawyer's representation of a client, including representation by appointment, does not constitute an endorsement of the client's political, economic, social or moral views or activities.

(c) A lawyer may limit the scope of the representation if the limitation is reasonable under the circumstances, the client gives informed consent and where necessary notice is provided to the tribunal and/or opposing counsel.

(d) A lawyer shall not counsel a client to engage, or assist a client, in conduct that the lawyer knows is illegal or fraudulent, except that the lawyer may discuss the legal consequences of any proposed course of conduct with a client.

(e) A lawyer may exercise professional judgment to waive or fail to assert a right or position of the client, or accede to reasonable requests of opposing counsel, when doing so does not prejudice the rights of the client.

(f) A lawyer may refuse to aid or participate in conduct that the lawyer believes to be unlawful, even though there is some support for an argument that the conduct is legal.

RULE 1 .4:

Communication

(a) A lawyer shall:

(1) promptly inform the client of:

(i) any decision or circumstance with respect to which the client's informed consent, as defined in Rule 1.0(j), is required by these Rules;

(ii) any information required by court rule or other law to be communicated to a client; and

(iii) material developments in the matter including settlement or plea offers.

(2) reasonably consult with the client about the means by which the client's objectives are to be accomplished;

(3) keep the client reasonably informed about the status of the matter;

(4) promptly comply with a client's reasonable requests for information; and

(5) consult with the client about any relevant limitation on the lawyer's conduct when the lawyer knows that the client expects assistance not permitted by these Rules or other law.

(b) A lawyer shall explain a matter to the extent reasonably necessary to permit the client to make informed

decisions regarding the representation.

RULE 1.6:

Confidentiality of Information

(a) A lawyer shall not knowingly reveal confidential information, as defined in this Rule, or use such information to the disadvantage of a client or for the advantage of the lawyer or a third person, unless:

(1) the client gives informed consent, as defined in Rule 1.0(j);

(2) the disclosure is impliedly authorized to advance the best interests of the client and is either reasonable under the circumstances or customary in the professional community; or

(3) the disclosure is permitted by paragraph (b).

"Confidential information" consists of information gained during or relating to the representation of a client, whatever its source, that is (a) protected by the attorney-client privilege, (b) likely to be embarrassing or detrimental to the client if disclosed, or (c) information that the client has requested be

kept confidential. "Confidential information" does not ordinarily include (i) a lawyer's legal knowledge or legal research or (ii) information that is generally known in the local community or in the trade, field or profession to which the information relates.

(b) A lawyer may reveal or use confidential information to the extent that the lawyer reasonably believes necessary:

(1) to prevent reasonably certain death or substantial bodily harm;

(2) to prevent the client from committing a crime;

(3) to withdraw a written or oral opinion or representation previously given by the lawyer and reasonably believed by the lawyer still to be relied upon by a third person, where the lawyer has discovered that the opinion or representation was based on materially inaccurate information or is being used to further a crime or fraud;

(4) to secure legal advice about compliance with these Rules or other law by the lawyer, another lawyer associated with the lawyer's firm or the law firm;

(5) (i) to defend the lawyer or the lawyer's employees and associates against an accusation of wrongful conduct; or (ii) to establish or collect a fee; or

(6) when permitted or required under these Rules or to comply with other law or court order.

(c) A lawyer shall exercise reasonable care to prevent the lawyer's employees, associates, and others whose services are utilized by the lawyer from disclosing or using confidential information of a client, except that a lawyer may reveal the information permitted to be disclosed by paragraph (b) through an employee.

RULE 1.14:

Client With Diminished Capacity

(a) When a client's capacity to make adequately considered decisions in connection with a representation is diminished, whether because of minority, mental impairment or for some other reason, the lawyer shall, as far as reasonably possible, maintain a conventional relationship with the client.

(b) When the lawyer reasonably believes that the client has diminished capacity, is at risk of substantial physical, financial or other harm unless action is taken and cannot adequately act in the client's own interest, the lawyer may take reasonably necessary protective action, including consulting with individuals or entities that have the ability to take action to protect the client and, in appropriate cases, seeking the appointment of a guardian ad litem, conservator or guardian.

(c) Information relating to the representation of a client with diminished capacity is protected by Rule 1.6. When taking protective action pursuant to paragraph (b), the lawyer is impliedly authorized under Rule 1.6(a) to reveal information about the client, but only to the extent reasonably necessary to protect the client's interests.

RULE 2.1 :
Advisor
In representing a client, a lawyer shall exercise independent professional judgment and render candid advice. In rendering advice, a lawyer may refer not only to law but to other considerations such as moral, economic, social, psychological, and political factors that may be relevant to the client's situation.

RULE 2.3 :
Evaluation for Use by Third Persons
(a) A lawyer may provide an evaluation of a matter affecting a client for the use of someone other than the client if the lawyer reasonably believes that making the evaluation is compatible with other aspects of the lawyer's relationship with the client.

(b) When the lawyer knows or reasonably should know that the evaluation is likely to affect the client's interests materially and adversely, the lawyer shall not provide the evaluation unless the client gives informed consent.

(c) Unless disclosure is authorized in connection with a report of an evaluation, information relating to the evaluation is protected by Rule 1.6.

RULE 3.3 :
Conduct Before a Tribunal
(a) A lawyer shall not knowingly:
(1) make a false statement of fact or law to a tribunal or fail to correct a false statement of material fact or law previously made to the tribunal by the lawyer;
(2) fail to disclose to the tribunal controlling legal authority known to the lawyer to be directly adverse to the position of the client and not disclosed by opposing counsel; or
(3) offer or use evidence that the lawyer knows to be false. If a lawyer, the lawyer's client, or a witness called by the lawyer has offered material evidence and the lawyer comes to know of its falsity, the lawyer shall take reasonable remedial measures, including, if necessary, disclosure to the tribunal. A lawyer may refuse to offer evidence, other than the testimony of a defendant in a criminal matter, that the lawyer reasonably believes is false.\

(b) A lawyer who represents a client before a tribunal and who knows that a person intends to engage, is engaging or has engaged in criminal or fraudulent conduct related to the proceeding shall take reasonable remedial measures, including, if necessary, disclosure to the tribunal.

(c) The duties stated in paragraphs (a) and (b) apply even if compliance requires disclosure of information otherwise protected by Rule 1.6.

(d) In an ex parte proceeding, a lawyer shall inform the tribunal of all material facts known to the lawyer that will enable the tribunal to make an informed decision, whether or not the facts are adverse.

(e) In presenting a matter to a tribunal, a lawyer shall disclose, unless privileged or irrelevant, the identities of the clients the lawyer represents and of the persons who employed the lawyer.

(f) In appearing as a lawyer before a tribunal, a lawyer shall not:
(1) fail to comply with known local customs of courtesy or practice of the bar or a particular tribunal without giving to opposing counsel timely notice of the intent not to comply;
(2) engage in undignified or discourteous conduct;
(3) intentionally or habitually violate any established rule of procedure or of evidence; or
(4) engage in conduct intended to disrupt the tribunal.

RULE 3.4:
Fairness to Opposing Party and Counsel
A lawyer shall not:
(a) (1) suppress any evidence that the lawyer or the client has a legal obligation to reveal or pro duce;
(2) advise or cause a person to hide or leave the jurisdiction of a tribunal for the purpose of making the person unavailable as a witness therein;
(3) conceal or knowingly fail to disclose that which the lawyer is required by law to reveal;
(4) knowingly use perjured testimony or false evidence;
(5) participate in the creation or preservation of evidence when the lawyer knows or it is obvious that the evidence is false; or
(6) knowingly engage in other illegal conduct or conduct contrary to these Rules;

RULE 3.8:
Special Responsibilities of Prosecutors and Other Government Lawyers
(a) A prosecutor or other government lawyer shall not institute, cause to be instituted or maintain a criminal charge when the prosecutor or other government lawyer knows or it is obvious that the charge is not supported by probable cause.

(b) A prosecutor or other government lawyer in criminal litigation shall make timely disclosure to counsel for the defendant or to a defendant who has no counsel of the existence of evidence or information known to the prosecutor or other government lawyer that tends to negate the guilt of the accused, mitigate the degree of the offense, or reduce the sentence, except when relieved of this responsibility by a protective order of a tribunal.

RULE 4.1 :
Truthfulness In Statements To Others
In the course of representing a client, a lawyer shall not knowingly make a false statement of fact or law to a third person.

RULE 5.7:
Responsibilities Regarding Nonlegal Services
(a) With respect to lawyers or law firms providing nonlegal services to clients or other persons:
(1) A lawyer or law firm that provides nonlegal services to a person that are not distinct from

legal services being provided to that person by the lawyer or law firm is subject to these Rules with respect to the provision of both legal and nonlegal services.
(2) A lawyer or law firm that provides nonlegal services to a person that are distinct from legal services being provided to that person by the lawyer or law firm is subject to these Rules with respect to the nonlegal services if the person receiving the services could reasonably believe that the nonlegal services are the subject of a client-lawyer relationship.
(3) A lawyer or law firm that is an owner, controlling party or agent of, or that is otherwise affiliated with, an entity that the lawyer or law firm knows to be providing nonlegal services to a person is subject to these Rules with respect to the nonlegal services if the person receiving the services could reasonably believe that the nonlegal services are the subject of a client-lawyer relationship.
(4) For purposes of paragraphs (a)(2) and (a)(3), it will be presumed that the person receiving nonlegal services believes the services to be the subject of a client-lawyer relationship unless the lawyer or law firm has advised the person receiving the services in writing that the services are not legal services and that the protection of a client-lawyer relationship does not exist with respect to the nonlegal services, or if the interest of the lawyer or law firm in the entity providing nonlegal services is de minimis.

(b) Notwithstanding the provisions of paragraph (a), a lawyer or law firm that is an owner, controlling party, agent, or is otherwise affiliated with an entity that the lawyer or law firm knows is providing nonlegal services to a person shall not permit any nonlawyer providing such services or affiliated with that entity to direct or regulate the professional judgment of the lawyer or law firm in rendering legal services to any person, or to cause the lawyer or law firm to compromise its duty under Rule 1.6(a) and (c) with respect to the confidential information of a client receiving legal services.

(c) For purposes of this Rule, "nonlegal services" shall mean those services that lawyers may lawfully provide and that are not prohibited as an unauthorized practice of law when provided by a nonlawyer.

Code of Ethics Code of Ethics of the National Association of Social Workers

(Select Provisions)

Ethical Principles

The following broad ethical principles are based on social work's core values of service, social justice, dignity and worth of the person, importance of human relationships, integrity, and competence. These principles set forth ideals to which all social workers should aspire.

Value: Service

Ethical Principle: Social workers' primary goal is to help people in need and to address social problems.

Social workers elevate service to others above self-interest. Social workers draw on their knowledge, values, and skills to help people in need and to address social problems. Social workers are encouraged to volunteer some portion of their professional skills with no expectation of significant financial return (pro bono service).

Value: Social Justice

Ethical Principle: Social workers challenge social injustice.

Social workers pursue social change, particularly with and on behalf of vulnerable and oppressed individuals and groups of people. Social workers' social change efforts are focused primarily on issues of poverty, unemployment, discrimination, and other forms of social injustice. These activities seek to promote sensitivity to and knowledge about oppression and cultural and ethnic diversity. Social workers strive to ensure access to needed information, services, and resources; equality of opportunity; and meaningful participation in decision making for all people.

Value: Dignity and Worth of the Person

Ethical Principle: Social workers respect the inherent dignity and worth of the person.

Social workers treat each person in a caring and respectful fashion, mindful of individual differences and cultural and ethnic diversity. Social workers promote clients' socially responsible self-determination. Social workers seek to enhance clients' capacity and opportunity to change and to address their own needs. Social workers are cognizant of their dual responsibility to clients and to the broader society. They seek to resolve conflicts between clients' interests and the broader society's interests in a socially responsible manner consistent with the values, ethical principles, and ethical standards of the profession.

Value: Importance of Human Relationships

Ethical Principle: Social workers recognize the central importance of human relationships.

Social workers understand that relationships between and among people are an important vehicle for change. Social workers engage people as partners in the helping process. Social workers seek to strengthen relationships among people in a purposeful effort to promote, restore, maintain, and enhance the well-being of individuals, families, social groups, organizations, and communities.

Value: Integrity

Ethical Principle: Social workers behave in a trustworthy manner.

Social workers are continually aware of the profession's mission, values, ethical principles, and ethical standards and practice in a manner consistent with them. Social workers act honestly and responsibly and promote ethical practices on the part of the organizations with which they are affiliated.

Value: Competence

Ethical Principle: Social workers practice within their areas of competence and develop and enhance their professional expertise.

Social workers continually strive to increase their professional knowledge and skills and to apply them in practice. Social workers should aspire to contribute to the knowledge base of the profession.

1. SOCIAL WORKERS' ETHICAL RESPONSIBILITIES TO CLIENTS

1.01 Commitment to Clients

Social workers' primary responsibility is to promote the well-being of clients. In general, clients' interests are primary. However, social workers' responsibility to the larger society or specific legal obligations may on limited occasions supersede the loyalty owed clients, and clients should be so advised. (Examples include when a social worker is required by law to report that a client has abused a child or has threatened to harm self or others.)

1.02 Self-Determination

Social workers respect and promote the right of clients to self-determination and assist clients in their efforts to identify and clarify their goals. Social workers may limit clients' right to self-determination when, in the social workers' professional judgment, clients' actions or potential actions pose a serious, foreseeable, and imminent risk to themselves or others.

1.03 Informed Consent

(a) Social workers should provide services to clients only in the context of a professional relationship based, when appropriate, on valid informed consent. Social workers should use clear and understandable language to inform clients of the purpose of the services, risks related to the services, limits to services because of the requirements of a third-party payer, relevant costs, reasonable alternatives, clients' right to refuse or withdraw consent, and the time frame covered by the consent. Social workers should provide clients with an opportunity to ask questions.

(b) In instances when clients are not literate or have difficulty understanding the primary language used in the practice setting, social workers should take steps to ensure clients' comprehension. This may include providing clients with a detailed verbal explanation or arranging for a qualified interpreter or translator whenever possible.

(c) In instances when clients lack the capacity to provide informed consent, social workers should protect clients' interests by seeking permission from an appropriate third party, informing clients consistent with the clients' level of understanding. In such instances social workers should seek to ensure that the third party acts in a manner consistent with clients' wishes and interests. Social workers should take reasonable steps to enhance such clients' ability to give informed consent.

(d) In instances when clients are receiving services involuntarily, social workers should provide information about the nature and extent of services and about the extent of clients' right to refuse service.

(e) Social workers who provide services via electronic media (such as computer, telephone, radio, and television) should inform recipients of the limitations and risks associated with such services.

(f) Social workers should obtain clients' informed consent before audiotaping or videotaping clients or permitting observation of services to clients by a third party.

1.04 Competence

(a) Social workers should provide services and represent themselves as competent only within the boundaries of their education, training, license, certification, consultation received, supervised experience, or other relevant professional experience.

(b) Social workers should provide services in substantive areas or use intervention techniques or approaches that are new to them only after engaging in appropriate study, training, consultation, and supervision from people who are competent in those interventions or techniques.

(c) When generally recognized standards do not exist with respect to an emerging area of practice, social workers should exercise careful judgment and take responsible steps (including appropriate education, research, training, consultation, and supervision) to ensure the competence of their work and to protect clients from harm.

1.05 Cultural Competence and Social Diversity

(a) Social workers should understand culture and its function in human behavior and society, recognizing the strengths that exist in all cultures.

(b) Social workers should have a knowledge base of their clients' cultures and be able to demonstrate competence in the provision of services that are sensitive to clients' cultures and to differences among people and cultural groups.

(c) Social workers should obtain education about and seek to understand the nature of social diversity and oppression with respect to race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, and mental or physical disability.

1.06 Conflicts of Interest

(a) Social workers should be alert to and avoid conflicts of interest that interfere with the exercise of professional discretion and impartial judgment. Social workers should inform clients when a real or potential conflict of interest arises and take reasonable steps to resolve the issue in a manner that makes the clients' interests primary and protects clients' interests to the greatest extent possible. In some cases, protecting clients' interests may require termination of the professional relationship with proper referral of the client.

(b) Social workers should not take unfair advantage of any professional relationship or exploit others to further their personal, religious, political, or business interests.

(c) Social workers should not engage in dual or multiple relationships with clients or former clients in which there is a risk of exploitation or potential harm to the client. In instances when dual or multiple relationships are unavoidable, social workers should take steps to protect clients and are responsible for setting clear, appropriate, and culturally sensitive boundaries. (Dual or multiple relationships occur when social workers relate to clients in more than one relationship, whether professional, social, or business. Dual or multiple relationships can occur simultaneously or consecutively.)

(d) When social workers provide services to two or more people who have a relationship with each other (for example, couples, family members), social workers should clarify with all parties which individuals will be considered clients and the nature of social workers' professional obligations to the various individuals who are receiving services. Social workers who anticipate a conflict of interest among the individuals receiving services or who anticipate having to perform in potentially conflicting roles (for example, when a social worker is asked to testify in a child custody dispute or divorce proceedings involving clients) should clarify their role with the parties involved and take appropriate action to minimize any conflict of interest.

1.07 Privacy and Confidentiality

(a) Social workers should respect clients' right to privacy. Social workers should not solicit private information from clients unless it is essential to providing services or conducting social work evaluation or research. Once private information is shared, standards of confidentiality apply.

(b) Social workers may disclose confidential information when appropriate with valid consent from a client or a person legally authorized to consent on behalf of a client.

(c) Social workers should protect the confidentiality of all information obtained in the course of professional service, except for compelling professional reasons. The general expectation that social workers will keep information confidential does not apply when disclosure is necessary to prevent serious, foreseeable, and imminent harm to a client or other identifiable person. In all instances, social workers should disclose the least amount of confidential information necessary to achieve the desired purpose; only information that is directly relevant to the purpose for which the disclosure is made should be revealed.

(d) Social workers should inform clients, to the extent possible, about the disclosure of confidential information and the potential consequences, when feasible before the disclosure is made. This applies whether social workers disclose confidential information on the basis of a legal requirement or client consent.

(e) Social workers should discuss with clients and other interested parties the nature of confidentiality and limitations of clients' right to confidentiality. Social workers should review with clients circumstances where confidential information may be requested and where disclosure of confidential

information may be legally required. This discussion should occur as soon as possible in the social worker-client relationship and as needed throughout the course of the relationship.

(f) When social workers provide counseling services to families, couples, or groups, social workers should seek agreement among the parties involved concerning each individual's right to confidentiality and obligation to preserve the confidentiality of information shared by others. Social workers should inform participants in family, couples, or group counseling that social workers cannot guarantee that all participants will honor such agreements.

(g) Social workers should inform clients involved in family, couples, marital, or group counseling of the social worker's, employer's, and agency's policy concerning the social worker's disclosure of confidential information among the parties involved in the counseling.

(h) Social workers should not disclose confidential information to third-party payers unless clients have authorized such disclosure.

(i) Social workers should not discuss confidential information in any setting unless privacy can be ensured. Social workers should not discuss confidential information in public or semipublic areas such as hallways, waiting rooms, elevators, and restaurants.

(j) Social workers should protect the confidentiality of clients during legal proceedings to the extent permitted by law. When a court of law or other legally authorized body orders social workers to disclose confidential or privileged information without a client's consent and such disclosure could cause harm to the client, social workers should request that the court withdraw the order or limit the order as narrowly as possible or maintain the records under seal, unavailable for public inspection.

(k) Social workers should protect the confidentiality of clients when responding to requests from members of the media.

(l) Social workers should protect the confidentiality of clients' written and electronic records and other sensitive information. Social workers should take reasonable steps to ensure that clients' records are stored in a secure location and that clients' records are not available to others who are not authorized to have access.

(m) Social workers should take precautions to ensure and maintain the confidentiality of information transmitted to other parties through the use of computers, electronic mail, facsimile machines, telephones and telephone answering machines, and other electronic or computer technology. Disclosure of identifying information should be avoided whenever possible.

(n) Social workers should transfer or dispose of clients' records in a manner that protects clients' confidentiality and is consistent with state statutes governing records and social work licensure.

(o) Social workers should take reasonable precautions to protect client confidentiality in the event of the social worker's termination of practice, incapacitation, or death.

(p) Social workers should not disclose identifying information when discussing clients for teaching or training purposes unless the client has consented to disclosure of confidential information.

(q) Social workers should not disclose identifying information when discussing clients with consultants unless the client has consented to disclosure of confidential information or there is a compelling need for such disclosure.

(r) Social workers should protect the confidentiality of deceased clients consistent with the preceding standards.

1.16 Termination of Services

(a) Social workers should terminate services to clients and professional relationships with them when such services and relationships are no longer required or no longer serve the clients' needs or interests.

(b) Social workers should take reasonable steps to avoid abandoning clients who are still in need of services. Social workers should withdraw services precipitously only under unusual circumstances, giving careful consideration to all factors in the situation and taking care to minimize possible adverse effects. Social workers should assist in making appropriate arrangements for continuation of services when necessary.

(c) Social workers in fee-for-service settings may terminate services to clients who are not paying an overdue balance if the financial contractual arrangements have been made clear to the client, if the client does not pose an imminent danger to self or others, and if the clinical and other consequences of the current nonpayment have been addressed and discussed with the client.

(d) Social workers should not terminate services to pursue a social, financial, or sexual relationship with a client.

(e) Social workers who anticipate the termination or interruption of services to clients should notify clients promptly and seek the transfer, referral, or continuation of services in relation to the clients' needs and preferences.

(f) Social workers who are leaving an employment setting should inform clients of appropriate options for the continuation of services and of the benefits and risks of the options.

2. SOCIAL WORKERS' ETHICAL RESPONSIBILITIES TO COLLEAGUES

2.01 Respect

(a) Social workers should treat colleagues with respect and should represent accurately and fairly the qualifications, views, and obligations of colleagues.

(b) Social workers should avoid unwarranted negative criticism of colleagues in communications with clients or with other professionals. Unwarranted negative criticism may include demeaning comments that refer to colleagues' level of competence or to individuals' attributes such as race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, and mental or physical disability.

(c) Social workers should cooperate with social work colleagues and with colleagues of other professions when such cooperation serves the well-being of clients.

2.02 Confidentiality

Social workers should respect confidential information shared by colleagues in the course of their professional relationships and transactions. Social workers should ensure that such colleagues understand social workers' obligation to respect confidentiality and any exceptions related to it.

2.03 Interdisciplinary Collaboration

(a) Social workers who are members of an interdisciplinary team should participate in and contribute to decisions that affect the well-being of clients by drawing on the perspectives, values, and experiences of the social work profession. Professional and ethical obligations of the interdisciplinary team as a whole and of its individual members should be clearly established.

(b) Social workers for whom a team decision raises ethical concerns should attempt to resolve the disagreement through appropriate channels. If the disagreement cannot be resolved, social workers should pursue other avenues to address their concerns consistent with client well-being.

2.04 Disputes Involving Colleagues

(a) Social workers should not take advantage of a dispute between a colleague and an employer to obtain a position or otherwise advance the social workers' own interests.

(b) Social workers should not exploit clients in disputes with colleagues or engage clients in any inappropriate discussion of conflicts between social workers and their colleagues.

2.05 Consultation

(a) Social workers should seek the advice and counsel of colleagues whenever such consultation is in the best interests of clients.

(b) Social workers should keep themselves informed about colleagues' areas of expertise and competencies. Social workers should seek consultation only from colleagues who have demonstrated knowledge, expertise, and competence related to the subject of the consultation.

(c) When consulting with colleagues about clients, social workers should disclose the least amount of information necessary to achieve the purposes of the consultation.

2.06 Referral for Services

(a) Social workers should refer clients to other professionals when the other professionals' specialized knowledge or expertise is needed to serve clients fully or when social workers believe that they are not being effective or making reasonable progress with clients and that additional service is required.

(b) Social workers who refer clients to other professionals should take appropriate steps to facilitate an orderly transfer of responsibility. Social workers who refer clients to other professionals should disclose, with clients' consent, all pertinent information to the new service providers.

(c) Social workers are prohibited from giving or receiving payment for a referral when no professional service is provided by the referring social worker.

3. SOCIAL WORKERS' ETHICAL RESPONSIBILITIES IN PRACTICE SETTINGS

3.04 Client Records

(a) Social workers should take reasonable steps to ensure that documentation in records is accurate and reflects the services provided.

(b) Social workers should include sufficient and timely documentation in records to facilitate the delivery of services and to ensure continuity of services provided to clients in the future.

(c) Social workers' documentation should protect clients' privacy to the extent that is possible and appropriate and should include only information that is directly relevant to the delivery of services.

(d) Social workers should store records following the termination of services to ensure reasonable future access. Records should be maintained for the number of years required by state statutes or relevant contracts.

3.07 Administration

(a) Social work administrators should advocate within and outside their agencies for adequate resources to meet clients' needs.

(b) Social workers should advocate for resource allocation procedures that are open and fair. When not all clients' needs can be met, an allocation procedure should be developed that is nondiscriminatory and based on appropriate and consistently applied principles.

(c) Social workers who are administrators should take reasonable steps to ensure that adequate agency or organizational resources are available to provide appropriate staff supervision.

(d) Social work administrators should take reasonable steps to ensure that the working environment for which they are responsible is consistent with and encourages compliance with the NASW Code of Ethics. Social work administrators should take reasonable steps to eliminate any conditions in their organizations that violate, interfere with, or discourage compliance with the Code.

3.08 Continuing Education and Staff Development
Social work administrators and supervisors should take reasonable steps to provide or arrange for continuing education and staff development for all staff for whom they are responsible. Continuing education and staff development should address current knowledge and emerging developments related to social work practice and ethics.

3.09 Commitments to Employers
(a) Social workers generally should adhere to commitments made to employers and employing organizations.

(b) Social workers should work to improve employing agencies' policies and procedures and the efficiency and effectiveness of their services.

(c) Social workers should take reasonable steps to ensure that employers are aware of social workers' ethical obligations as set forth in the NASW Code of Ethics and of the implications of those obligations for social work practice.

(d) Social workers should not allow an employing organization's policies, procedures, regulations, or administrative orders to interfere with their ethical practice of social work. Social workers should take reasonable steps to ensure that their employing organizations' practices are consistent with the NASW Code of Ethics.

(e) Social workers should act to prevent and eliminate discrimination in the employing organization's work assignments and in its employment policies and practices.

(f) Social workers should accept employment or arrange student field placements only in organizations that exercise fair personnel practices.

(g) Social workers should be diligent stewards of the resources of their employing organizations, wisely conserving funds where appropriate and never misappropriating funds or using them for unintended purposes.

4. SOCIAL WORKERS' ETHICAL RESPONSIBILITIES AS PROFESSIONALS

4.01 Competence
(a) Social workers should accept responsibility or employment only on the basis of existing competence or the intention to acquire the necessary competence.

(b) Social workers should strive to become and remain proficient in professional practice and the performance of professional functions. Social workers should critically examine and keep current with

emerging knowledge relevant to social work. Social workers should routinely review the professional literature and participate in continuing education relevant to social work practice and social work ethics.

(c) Social workers should base practice on recognized knowledge, including empirically based knowledge, relevant to social work and social work ethics.

Credentialed Alcoholism and Substance Abuse Counselor (CASAC) Canon of Ethical Principles (From New York State Office of Alcoholism and Substance Abuse Services)

The CASAC:

Must practice objectivity and integrity; maintain the highest standards in the services offered; respect the values, attitudes and opinions of others; and provide services only in an appropriate professional relationship.

Must not discriminate in work-related activities based on race, religion, age, gender, disabilities, ethnicity, national origins, sexual orientation, economic condition or any other basis proscribed by law.

Must respect the integrity and protect the welfare of the person or group with whom the counselor is working.

Must embrace, as a primary obligation, the duty of protecting the privacy of patients and must not disclose confidential information or records under his/her control in strict accordance with federal, state and local laws.

Must not engage in relationships with patients, former patients or their significant others in which there is a risk of exploitation or potential harm to the patient.

Must not engage in any sexual activity with current or former patients or their significant others.

Must not knowingly engage in behavior that is harassing or demeaning, including, but not limited to, sexual harassment.

Must not exploit patients or others over whom they have a position of authority.

Must treat colleagues and other professionals with respect, courtesy and fairness and cooperate in order to serve the best interests of their patients.

Must notify appropriate authorities, including employers and OASAS, when they have direct knowledge of a colleague's impairment or misconduct which interferes with treatment effectiveness and potentially places patients and others at risk.

Is expected to recognize the effects of their own impairment on professional performance and must not provide services that create conflict of interest or impair work performance and clinical judgment.

Must cooperate with investigations, proceedings, and requirements of OASAS or other authorities that have jurisdiction over those charged with a violation.

Must not participate in the filing of ethics complaints that are frivolous or have a purpose other than to protect the public.

Must assure that financial practices are in accord with professional standards that safeguard the best interests of the patient, the counselor and the profession.

Must take reasonable steps to ensure that documentation in records is accurate, sufficient and timely thereby ensuring appropriateness and continuity of services provided to patients.

Must uphold the legal and accepted moral codes which pertain to professional conduct.

Must recognize the need for ongoing education to maintain current competence, and to improve expertise and skills.

Must acknowledge the limits of present knowledge in public statements concerning alcoholism and substance abuse. The Credentialed Alcoholism and Substance Abuse Counselor must report fairly and accurately the appropriate information, and must acknowledge and document materials and techniques used.

Must assign credit to all who have contributed to the published material and for the work upon which publication is based.

Must strive to inform the public, of the effects of alcoholism and substance abuse. The Credentialed Alcoholism and Substance Abuse Counselor must adopt a personal and professional stance which promotes the well-being of the recovery community.

(Adapted from the National Association of Alcoholism and Drug Abuse Counselors "Ethical Standards of Alcoholism and Drug Abuse Counselors")

Ethics Principles of Psychologists and Code of Conduct (Select Provisions)

2010 Amendments

General Principles

This section consists of General Principles. General Principles, as opposed to Ethical Standards, are aspirational in nature. Their intent is to guide and inspire psychologists toward the very highest ethical ideals of the profession. General Principles, in contrast to Ethical Standards, do not represent obligations and should not form the basis for imposing sanctions. Relying upon General Principles for either of these reasons distorts both their meaning and purpose.

Principle A: Beneficence and Nonmaleficence

Psychologists strive to benefit those with whom they work and take care to do no harm. In their professional actions, psychologists seek to safeguard the welfare and rights of those with whom

they interact professionally and other affected persons, and the welfare of animal subjects of research. When conflicts occur among psychologists' obligations or concerns, they attempt to resolve these conflicts in a responsible fashion that avoids or minimizes harm. Because psychologists' scientific and professional judgments and actions may affect the lives of others, they are alert to and guard against personal, financial, social, organizational, or political factors that might lead to misuse of their influence. Psychologists strive to be aware of the possible effect of their own physical and mental health on their ability to help those with whom they work.

Principle B: Fidelity and Responsibility
Psychologists establish relationships of trust with those with whom they work. They are aware of their professional and scientific responsibilities to society and to the specific communities in which they work. Psychologists uphold professional standards of conduct, clarify their professional roles and obligations, accept appropriate responsibility for their behavior, and seek to manage conflicts of interest that could lead to exploitation or harm. Psychologists consult with, refer to, or cooperate with other professionals and institutions to the extent needed to serve the best interests of those with whom they work. They are concerned about the ethical compliance of their colleagues' scientific and professional conduct. Psychologists strive to contribute a portion of their professional time for little or no compensation or personal advantage.

Principle C: Integrity
Psychologists seek to promote accuracy, honesty, and truthfulness in the science, teaching, and practice of psychology. In these activities psychologists do not steal, cheat, or engage in fraud, subterfuge, or intentional misrepresentation of fact. Psychologists strive to keep their promises and to avoid unwise or unclear commitments. In situations in which deception may be ethically justifiable to maximize benefits and minimize harm, psychologists have a serious obligation to consider the need for, the possible consequences of, and their responsibility to correct any resulting mistrust or other harmful effects that arise from the use of such techniques.

Principle D: Justice
Psychologists recognize that fairness and justice entitle all persons to access to and benefit from the contributions of psychology and to equal quality in the processes, procedures, and services being conducted by psychologists. Psychologists exercise reasonable judgment and take precautions to ensure that their potential biases, the boundaries of their competence, and the limitations of their expertise do not lead to or condone unjust practices.

Principle E: Respect for People's Rights and Dignity
Psychologists respect the dignity and worth of all people, and the rights of individuals to privacy, confidentiality, and self-determination. Psychologists are aware that special safeguards may be necessary to protect the rights and welfare of persons or communities whose vulnerabilities impair autonomous decision making. Psychologists are aware of and respect cultural, individual, and role differences, including those based on age, gender, gender identity,

race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status and consider these factors when working with members of such groups. Psychologists try to eliminate the effect on their work of biases based on those factors, and they do not knowingly participate in or condone activities of others based upon such prejudices.

Standard 1: Resolving Ethical Issues

1.02 Conflicts Between Ethics and Law, Regulations, or Other Governing Legal Authority
If psychologists' ethical responsibilities conflict with law, regulations, or other governing legal authority, psychologists clarify the nature of the conflict, make known their commitment to the Ethics Code, and take reasonable steps to resolve the conflict consistent with the General Principles and Ethical Standards of the Ethics Code. Under no circumstances may this standard be used to justify or defend violating human rights.

1.03 Conflicts Between Ethics and Organizational Demands
If the demands of an organization with which psychologists are affiliated or for whom they are working are in conflict with this Ethics Code, psychologists clarify the nature of the conflict, make known their commitment to the Ethics Code, and take reasonable steps to resolve the conflict consistent with the General Principles and Ethical Standards of the Ethics Code. Under no circumstances may this standard be used to justify or defend violating human rights.

Standard 3: Human Relations

3.04 Avoiding Harm
Psychologists take reasonable steps to avoid harming their clients/patients, students, supervisees, research participants, organizational clients, and others with whom they work, and to minimize harm where it is foreseeable and unavoidable.

3.05 Multiple Relationships
(a) A multiple relationship occurs when a psychologist is in a professional role with a person and (1) at the same time is in another role with the same person, (2) at the same time is in a relationship with a person closely associated with or related to the person with whom the psychologist has the professional relationship, or (3) promises to enter into another relationship in the future with the person or a person closely associated with or related to the person.

A psychologist refrains from entering into a multiple relationship if the multiple relationship could reasonably be expected to impair the psychologist's objectivity, competence, or effectiveness in performing his or her functions as a psychologist, or otherwise risks exploitation or harm to the person with whom the professional relationship exists.

Multiple relationships that would not reasonably be expected to cause impairment or risk exploitation or harm are not unethical.

(b) If a psychologist finds that, due to unforeseen factors, a potentially harmful multiple relationship has arisen, the psychologist takes reasonable steps to resolve it with due regard for the best interests of the affected person and maximal compliance with the Ethics Code.

(c) When psychologists are required by law, institutional policy, or extraordinary circumstances to serve in more than one role in judicial or administrative proceedings, at the outset they clarify role expectations and the extent of confidentiality and thereafter as changes occur. (See also Standards 3.04, Avoiding Harm, and 3.07, Third-Party Requests for Services.)

3.06 Conflict of Interest
Psychologists refrain from taking on a professional role when personal, scientific, professional, legal, financial, or other interests or relationships could reasonably be expected to (1) impair their objectivity, competence, or effectiveness in performing their functions as psychologists or (2) expose the person or organization with whom the professional relationship exists to harm or exploitation.

3.10 Informed Consent
(a) When psychologists conduct research or provide assessment, therapy, counseling, or consulting services in person or via electronic transmission or other forms of communication, they obtain the informed consent of the individual or individuals using language that is reasonably understandable to that person or persons except when conducting such activities without consent is mandated by law or governmental regulation or as otherwise provided in this Ethics Code. (See also Standards 8.02, Informed Consent to Research; 9.03, Informed Consent in Assessments; and 10.01, Informed Consent to Therapy.)

(b) For persons who are legally incapable of giving informed consent, psychologists nevertheless (1) provide an appropriate explanation, (2) seek the individual's assent, (3) consider such persons' preferences and best interests, and (4) obtain appropriate permission from a legally authorized person, if such substitute consent is permitted or required by law. When consent by a legally authorized person is not permitted or required by law, psychologists take reasonable steps to protect the individual's rights and welfare.

(c) When psychological services are court ordered or otherwise mandated, psychologists inform the individual of the nature of the anticipated services, including whether the services are court ordered or mandated and any limits of confidentiality, before proceeding.

(d) Psychologists appropriately document written or oral consent, permission, and assent. (See also Standards 8.02, Informed Consent to Research; 9.03, Informed Consent in Assessments; and 10.01, Informed Consent to Therapy.)

3.11 Psychological Services Delivered to or Through Organizations

(a) Psychologists delivering services to or through organizations provide information beforehand to clients and when appropriate those directly affected by the services about (1) the nature and objectives of the services, (2) the intended recipients, (3) which of the individuals are clients, (4) the relationship the psychologist will have with each person and the organization, (5) the probable uses of services provided and information obtained, (6) who will have access to the information, and (7) limits of confidentiality. As soon as feasible, they provide information about the results and conclusions of such services to appropriate persons.

(b) If psychologists will be precluded by law or by organizational roles from providing such information to particular individuals or groups, they so inform those individuals or groups at the outset of the service.

Standard 4: Privacy and Confidentiality

4.01 Maintaining Confidentiality
Psychologists have a primary obligation and take reasonable precautions to protect confidential information obtained through or stored in any medium, recognizing that the extent and limits of confidentiality may be regulated by law or established by institutional rules or professional or scientific relationship. (See also Standard 2.05, Delegation of Work to Others.)

4.02 Discussing the Limits of Confidentiality
(a) Psychologists discuss with persons (including, to the extent feasible, persons who are legally incapable of giving informed consent and their legal representatives) and organizations with whom they establish a scientific or professional relationship (1) the relevant limits of confidentiality and (2) the foreseeable uses of the information generated through their psychological activities. (See also Standard 3.10, Informed Consent.)

(b) Unless it is not feasible or is contraindicated, the discussion of confidentiality occurs at the outset of the relationship and thereafter as new circumstances may warrant.

(c) Psychologists who offer services, products, or information via electronic transmission inform clients/patients of the risks to privacy and limits of confidentiality.

4.04 Minimizing Intrusions on Privacy
(a) Psychologists include in written and oral reports and consultations, only information germane to the purpose for which the communication is made.

(b) Psychologists discuss confidential information obtained in their work only for appropriate scientific or professional purposes and only with persons clearly concerned with such matters.

4.05 Disclosures
(a) Psychologists may disclose confidential information with the appropriate consent of the organizational client, the individual client/patient, or another legally authorized person on behalf of the client/patient unless prohibited by law.

(b) Psychologists disclose confidential information without the consent of the individual only as mandated by law, or where permitted by law for a valid purpose such as to (1) provide needed professional services; (2) obtain appropriate professional consultations; (3) protect the client/patient, psychologist, or others from harm; or (4) obtain payment for services from a client/patient, in which instance disclosure is limited to the minimum that is necessary to achieve the purpose. (See also Standard 6.04e, Fees and Financial Arrangements.)

APPENDIX B: Cases dealing with common competency issues . . . and practice tips

by Mary Beth Anderson, Esq. L.M.S.W.
(June 1999; revised January 2005, October 2012)

Competency Standard

The standard for competency is "whether [a defendant] has sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding – and whether he has a rational as well as factual understanding of the proceedings against him." Dusky v. United States, 362 U.S. 402 (1960).

Raising the competency issue

Defense Attorney's obligation

The defense attorney can question client's competency (when it is in the client's interest to do this) even if the client opposes the lawyer's decision. People v. Christopher, 65 N.Y.2d 417 (1985).

Sometimes the attorney has an ethical obligation to raise the issue and failure to do so will constitute ineffective assistance of counsel. See, e.g., People v. Sinatra, 89 A.D.2d 913 (2d Dep't 1982).

Defense counsel is in the best position to assess defendant's capacity. People v. Tortorici, 92 N.Y.2d 757 (1999). (I actually quarrel with this, because my experience has shown time and time again many defense lawyers unable to assess client fitness. I've seen many cases where lawyers believe clients to be fit when they are clearly unfit and an equal number of cases where lawyers believe clients to be unfit when they are clearly fit. And then, of course, there are those cases that are "on the fence." So, in the appropriate case, I would not hesitate to make a record that calls this reasoning of the Court of Appeals into question. One would probably need to present expert testimony on the question. In two appropriate cases, I've advised lawyers to move to vacate pleas on the ground that they did not know their clients were incompetent; both motions were granted - neither lawyer was relieved of their representation. Thanks to my colleague, MM, who talked me into supporting her making of this argument; sometimes the most

effective lawyering CAN happen by acknowledging a mistake that most lawyers would make - if most would make the mistake, the lawyer is NOT ineffective.)

Court's obligation

"If at any time before final judgment in a criminal action it shall appear to the court that there is a reasonable ground for believing that a defendant is in such a state of idiocy, imbecility, or insanity that he is incapable of understanding the charge, indictment or proceedings or making his defense, it is the duty of the court to direct him to be examined in these respects." People v. Smyth, 3 N.Y.2d 184, 187 (1957).

Once the issue of competency has been raised, the court has an obligation to resolve it within the statutory mechanism set forth in C.P.L. Article 730. People v. Armlin, 37 N.Y.2d 167 (1975).

The court can, sua sponte, order a competency evaluation (in spite of protest by prosecutor, defense counsel, and/or defendant). People v. Gonzalez, 20 N.Y.2d 289 (1967).

The competency issue can be raised by the sentencing report. People v. Bangert, 22 N.Y.2d 799 (1968). Capacity is an issue anytime post-arraignment and presentence.

A client cannot waive the competency issue. Pate v. Robinson, 383 U.S. 375, 384 (1966).

Consequently, competency can be raised for the first time on appeal, despite the absence of objection by counsel at any earlier stages. See, e.g., People v. Clancy, 39 A.D.2d 538 (1st Dep't 1972).

Competency can involve physical as well as mental defects. Matter of HRA v. Carey, 107 A.D.2d 625 (1st Dep't 1985) (Competency statute "does not parse the word 'defect' so as to distinguish between the innumerable sources of disability, once found.") (deafness); People v. Jackson, 88 A.D.2d 604 (2d Dep't 1982) (mem.) (hearing problems); Albritton v. Collier, 349 F. Supp. 994 (D. Miss. 1972).

Issues involving the burden of proof

An accused person is presumed to be competent. People v. Silver, 33N.Y.2d 475, 480 (1974).

In any hearing regarding competency, if the defendant has been found unfit and the prosecutor is moving to controvert:

> The initial burden to show unfitness of the accused is on the defense. The defense has the burden to go forward and generally can meet the burden by putting the reports into evidence; sometimes the defense must arrange for the doctors to come to the hearing. The burden then shifts to the prosecution to establish present competence by a preponderance of the evidence. People v. Santos, 43 A.D.2d 73 (2d Dep't 1973).

> Presumably the prosecution should call its own witness(es), but sometimes they will just attempt to impeach the credibility of the doctors who performed the 730 exam. Also, sometimes the prosecutor will call the examining doctors as prosecution witnesses, with the idea of impeaching their credibility during the direct examination. An evidentiary objection should be made, on the ground that the party calling the witness cannot impeach the witness (Richardson on Evidence, § 508, and cases cited therein).

If the defendant has been found fit, and the defense is moving to controvert:

> The prosecution has the burden to go forward with evidence showing competence; the defense has the ultimate burden of persuasion to show unfitness by a preponderance of the evidence. In this case, the prosecutor would have to arrange for the doctors to be present. The defense need not call witnesses, but may need to. The attorney should be able to provide testimony, keeping in mind the restrictions of the attorney-client privilege. See ABA Standards for Criminal Justice, Criminal Justice Mental Health Standard 7-4.8(b)(i). The defense is entitled to retain/call its own expert witness. People v. Christopher, 65 N.Y.2d 417 (1985).

See also People v. Del Rio, 220 A.D.2d 122 (2d Dep't 1996) (explanation of burdens of proof in competency proceeding; prosecutor has right to retain independent expert to contest findings of examiners appointed by Commissioner).

Resolution of fitness questions

Competency to stand trial is a legal, not a medical, question. Whether an accused is fit or unfit is a mixed question of law and fact, "a determination [to be] made by the court after considering the reports of the psychiatric examiners and any additional evidence or testimony." People v. Williams, 204 A.D.2d 77, 81 (1st Dep't 1994), rev'd on other grounds, 85 N.Y.2d 945 (1995). Thus the ultimate obligation to resolve questions regarding an accused's competency lies with the court. See, e.g., People v. Reason, 44 A.D. 2d 533 (1st Dep't 1974), aff'd, 37 N.Y.2d 351 (1975). The court cannot, however, "ignore unassailed professional opinions to favor [its] own psychoanalysis." Id. "[L]awyers (and Judges), in theory at least, should defer to some extent to the expertise of the psychiatrists." Id. at 534 (concurring opinion).

Courts have defined the "ability to make a defense" as meaning more than the mere capacity to discuss the case with the attorney, answer questions, and understand the nature of legal proceedings. While this may be sufficient for some purposes (i.e., to take a plea), if an accused is to go to trial, the accused "should be able to discuss, rationally, the facts relating to his case which are within his recollection. . . should be able, rationally, to consider the evidence offered against him, to advise his attorney concerning it, and to make such decisions as may be necessary for him to make during the course of such a trial." People ex. rel. Bernstein v. McNeill, 48 N.Y.S.2d 764, 766 (S.Ct., Westchester Co. 1944).

The ability to assist in one's defense requires some depth of understanding, not merely surface knowledge of the proceedings. People v. Swallow, 60 Misc.2d 171, 176 (S.C., Richmond Co. 1969).

A defendant does not have an absolute right to be present at a hearing, or other proceedings, involving his/her fitness to proceed. People v. Brown, 184 A.D.2d 856 (1st Dep't 1992). See also People v. Williams, 85 N.Y.2d 945 (1995).

Whether a competency hearing should be ordered is a matter left to the discretion of the trial court. People v. Russell, 74 N.Y.2d 901 (1989).

Statements made by a defendant while testifying at a hearing to determine fitness to stand trial are not admissible at trial on the prosecutor's case but they may be used for purposes of impeachment if the defendant takes the stand. People v. Angelillo, 105 Misc. 2d 338 (Suffolk Co. Ct. 1980).

Defense must serve notice of intent to present psychiatric evidence

People v. Almonor, 93 N.Y.2d 571 (1999). Defense must serve notice of intent to use psychiatric defense. Notice must be served within 30 days of arraignment. Notice can be amended when defense attorney obtains further particulars relating to the defense, but must give the prosecution some idea of the nature of the psychiatric evidence the defense intends to use.

Other cases relevant to unfit clients

Ritter v. Surles, 144 Misc. 2d 945 (S.Ct., Westchester Co. 1988) (persons committed on final orders of observation are entitled to 72-hour review, pursuant to the mental hygiene law)

Jackson v. Indiana, 406 U.S. 715 (1972) (persons who are permanently incapacitated entitled to relief provided via civil commitment statutes)

Rivers v. Katz, 67 NY2d 485 (1986) (specifies rights of hospitalized persons to refuse psychiatric medication and when hospital can medicate over a patient's objections)

People v. Francabandera, 33 NY2d 429 (1971) (sets forth procedures to be used when defendant has retrograde amnesia. Article 730 does not apply to such cases - unless there is a basis of unfitness other than the retrograde amnesia. However, if court finds amnesia is genuine - or prosecutor concedes - this will trigger full disclosure on part of prosecutor. Full disclosure is generally sufficient to assist defense counsel in preparing the case. I have not located any instances where cases have been dismissed after the disclosure, but believe inability to formulate alibi could constitute grounds that might trigger dismissal - perhaps in the interests of justice?)

People v. Schaffer, 86 NY2d 460 (1995) (motion to dismiss in the interest of justice is a remedy not available for a defendant who is committed pursuant to CPL § 730.50 as unfit). However, client's mental illness is a consideration for Clayton dismissal if client has not yet been found unfit. People v. Colon, 86 NY2d 861 (1995).

People v. Lewis, 95 NY2d 539 (2000) (defendant who had been granted Jackson relief not entitled to dismissal of the indictment pursuant to "2/3 dismissal" provision set forth in CPL 730.50(3)) (Note that, in a footnote, court suggests motion to dismiss in the interests of just ice may be appropriate vehicle for dismissal)

People v. Williams, __ A.D.3d __, 2012 NY Slip 04286 (1st Dep't, 2012). Decided June 5, 2012. Court permitted use of information contained in an Article 730 report to satisfy SORA criteria relating to abuse of alcohol/drugs.