Representing a Client with Mental Illness

A South Dakota Defense Attorney's Guide

May 8, 2018

Acknowledgments

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A Note about This Handbook:

This handbook was developed to provide an overview for legal representation for criminal defendants with mental illness. It was drafted and reviewed by both mental health professionals and attorneys experienced in criminal law. It is not a comprehensive guide on mental health law or a definitive guide on how to represent a mentally ill defendant. It is designed to give attorneys a starting point for their work with their clients who have or may have a mental illness, to alert the attorney to some basic legal options they may want to consider, and to give them some ideas about where to go for assistance. It is not a substitute for independent legal research.

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INTRODUCTION

Each year, significant numbers of persons with mental illness come into contact with the criminal justice system nationally and in South Dakota. Following concerns about court processing delays for defendants awaiting competency evaluations and a recognition that there has not been a coordinated effort in the state to improve the evaluation, diversion, and treatment of persons with mental illness coming into the criminal justice system, Chief Justice David Gilbertson, with support from Governor Dennis Daugaard, established the Task Force on Community Justice and Mental Illness Early Intervention in early 2016. The Task Force included representatives of various system stakeholders including the courts, legislators, counties, defense attorneys, prosecutors, treatment providers, state agencies, law enforcement and mental health advocates.

KEY FINDINGS

The examination of how people with mental illness come into contact with and move through the criminal justice system resulted in four key findings:

- Options to divert individuals from the criminal justice system are statutorily authorized, but are not available in all areas of the state;
- The criminal justice system lacks adequate procedures to identify mental illness early once an arrest has been made;
- People with indicators of mental illness are more likely to be detained pretrial and to stay longer in detention, yet jails are not equipped to address their needs; and,
- Court orders regarding competency evaluations tripled in a 3-year period, while the common practice of multi-purpose evaluations and wait times for evaluations drove higher costs.

One of the recommendations from the Task Force to state leaders was to provide training to defense attorneys on signs and symptoms of mental illness, eligibility criteria and availability of mental health services in South Dakota. That recommendation was adopted by the Legislature and codified in SDCL 23A-40-21.

When attorneys recognize clients as mentally ill, they may not be familiar with the specialized mechanisms, procedures, resources and laws that apply to persons with mental illness. This lack of specific training, sometimes coupled with the client's desire to get out of jail quickly or the attorney's desire to help them get out of jail quickly, may result in a client pleading guilty to an alleged offense when he or she

is not competent to do so. A lack of understanding of mental illness and treatment options or the availability of local treatment options may also contribute significantly to delays in court proceedings, longer stays in jail, and frequent revocations of bond or probation for mentally ill defendants.

The Task Force recognized that having procedures in place for screening defendants at the jail and making referrals for further evaluation if necessary, diverting individuals from the criminal justice system, and using the leverage of the criminal justice system to engage in assessment and treatment can all benefit individuals with mental illness that come into contact with the criminal justice system.

HB 1183 (2017) OVERVIEW

AN ACT TO PROVIDE AND REVISE CERTAIN PROVISIONS REGARDING MENTAL HEALTH PROCEDURES IN CRIMINAL JUSTICE, TO MAKE AN APPROPRIATION THEREFORE, AND TO DECLARE AN EMERGENCY.

HB 1183 was intended to respond to the Task Force's findings in the following ways:

Providing tools to law enforcement and communities to address mental health crises early and prevent jail admissions:

- Sets up a one-time grant program to encourage local governments to establish or expand crisis response services as a way to divert individuals with mental health concerns away from jail
- Expands training resources for law enforcement and jails on mental illness and crisis intervention

Expediting the completion of competency exams ensuring speedier court processing and shorter jail stays:

- Transfers existing funds from the Human Services Center forensic evaluation budget to a fund administered by the SD Association of County Commissioners to reimburse counties for competency examinations
- Sets a 21-day timeframe for completion of competency examinations and expands the types of professionals who can perform these examinations

Strengthening opportunities to divert people from the criminal justice system into mental health treatment:

- Encourages state's attorneys to use deferred prosecution for defendants with mental illness by providing training on mental illness and available services
- Revises the conditions of bond to allow the court to add as a condition the requirement that a defendant complete a mental health assessment and follow treatment recommendations
- Allows courts to establish multi-disciplinary teams to help plan and manage cases for people with mental illness

Improving access to treatment of those with mental illness in the criminal justice system through training and studying treatment options:

- Requires training on mental illness for court-appointed criminal defense attorneys, officers in jails and state prisons, judges and court services officers to encourage appropriate response and available services
- Establishes a group to recommend ways to improve communication between jails and mental health providers

Continuing to identify ways to improve criminal justice responses to those with mental illness:

- Creates a 14-person oversight group to monitor implementation and impacts of the Act, and to continue to study related issues and make recommendations to state leaders to improve criminal justice responses

- Pilots the use of a jail mental health screen to establish a procedure for early identification of mental illness, a baseline for how many defendants need further mental health assessment, and a process for statewide rollout

- Requires the Unified Judicial System to track data on probationers assessed and referred for treatment.

Endorsing HB 1183: SD County Commissioners Association, SD Sheriff's Association, SD Association of Criminal Defense Attorneys, SD Council of Mental Health Centers, National Alliance for the Mentally Ill South Dakota, SD Chapter of the National Association of Social Workers, Avera Health, SD Association of Healthcare Organizations, SD Psychological Association, SD Department of Social Services, SD Unified Judicial System.

TOP TEN THINGS TO KNOW ABOUT REPRESENTING A CLIENT WITH MENTAL ILLNESS

1. MENTAL ILLNESS AND INTELLECTUAL AND DEVELOPMENTAL DISABILITIES ARE NOT THE SAME: Intellectual or developmental disabilities are permanent conditions characterized by significantly below average intelligence accompanied by significant limitations in certain skill areas, with onset before age 18. Mental illness, on the other hand, usually involves disturbances in thought processes and emotions and may be temporary, cyclical, or episodic. Most people with mental illness do not have intellectual deficits. However, it is possible for a person with an intellectual or developmental disability to also have a mental illness. *See* SDCL 27B-1-18; SDCL 27B-1-18.1 and SDCL 27A-1-1(24) (defining developmental disability, intellectual disability and severe mental illness).

2. MENTAL ILLNESS AND INCOMPETENCE ARE NOT SYNONYMOUS, AND YOU SHOULD BE CONCERNED ABOUT BOTH: Keep in mind that competence to stand trial is different from mental illness. Some clients who are fit to proceed to trial may still have serious mental illness. Even if your client does not have a competence issue, there may still be significant mental health issues in the case that you should explore. Remember, however, that if your client is competent to stand trial, he or she makes the final decision about how to proceed with the case.

3. YOU OWE YOUR CLIENT ZEALOUS REPRESENTATION: You have the ethical obligation to zealously represent your client, which may include exploring your client's case for mental health issues. It may also include bringing appropriate motions if your client's mental illness has affected his or her case.

4. IF YOU SUSPECT YOUR CLIENT IS NOT COMPETENT, REQUEST AN EVALUATION: If you believe your client may not be competent, he or she may not be able to make informed decisions about fundamental issues, such as whether to enter into a plea bargain agreement or, instead, proceed to trial. Do not allow your client to accept a plea bargain, or make any other decisions regarding the case, when you have reason to believe that he or she is incompetent to stand trial. Instead, immediately request a competency evaluation.

5. AN INSANITY DEFENSE MAY BE APPROPRIATE: Take the time to properly inquire about your client's mental illness and explore various legal and medical options. Your client may share information that will help you decide if you should explore an insanity defense. Keep in mind, however, there may also be

disadvantages to pursuing the insanity defense, and you should discuss all of the pros and cons with your client.

6. MITIGATE, MITIGATE, and MITIGATE: Part of your job as an attorney is to reveal your client's impairments and disabilities that limit his or her reasoning or judgment. Conditions that inspire compassion, without justifying or excusing the crime, can be powerful mitigation evidence. Mitigation evidence can be used to argue for a shorter term of incarceration or for probation instead of incarceration.

7. INEFFECTIVE ASSISTANCE OF COUNSEL AND REVERSIBLE ERROR: An attorney's failure to request the assistance of a qualified mental health professional when indicated can be a violation of a defendant's Sixth Amendment right to effective assistance of counsel. It is important to appreciate that your client's mental illness may impact your obligation to advocate on their behalf.

8. OVERCOME YOUR OWN PREJUDICES BEFORE YOU HURT YOUR CLIENT AND THEIR CASE: A popular misconception is that mental-state defenses are attempts by the defendant to deny responsibility for their behavior. Many people are skeptical that persons with mental illness are in some circumstances unable to fully appreciate the nature of their acts and control them. This denial of psychiatric disability can deeply influence the attitudes of both judges and juries toward expert witnesses and mental health defenses. If you are representing a person with mental illness you must overcome cynicism toward mental health issues in criminal cases. Mental illnesses are neurobiological brain diseases. A mental illness is a medical illness. Mental illness can be diagnosed, treated, and managed. You do your client a disservice by representing it any other way.

9. INCARCERATION CAN BE PARTICULARLY HARMFUL TO PEOPLE WITH MENTAL ILLNESS: Jails can be very damaging to the stability, mental health, and physical health of individuals with mental illness. Numerous studies show that placing mentally ill persons in single cells, isolation, or "lock down" can worsen their schizophrenia, depression, and anxiety. Individuals with mental illnesses are also more likely than others to be victimized by other inmates. They may also be unable to access certain medications in the jail setting. You should visit with your client regularly and communicate about the case while they are incarcerated.

10. DO NOT LET YOUR CLIENT GET CAUGHT IN THE "REVOLVING DOOR": Many adults with mental illness are arrested for minor offenses that directly relate to their illness or poverty. They cycle repeatedly through the courts and jails, charged with the same petty offenses. This "revolving door" is not only a burden to the courts and the criminal justice system, but it is also costly to society, to these individuals, and to their families. By quickly pleading your client to "time served" without exploring your client's mental illness, you may lose the opportunity to help them get better so that he or she does not reoffend. Attorneys should do their best to

link mentally ill defendants to appropriate treatment or services that will help them keep out of trouble. While it is important to get your client out of jail as soon as possible, it is equally important to keep him or her from returning to jail. Releasing persons with mental illness back into the community with no plan for treatment or aftercare is a recipe for revocation and recidivism. Don't set up your client to fail.

WHAT IS MENTAL ILLNESS AND WHY SHOULD YOU CARE?

WHAT IS MENTAL ILLNESS?

South Dakota law defines mental illness in the criminal code as "any substantial psychiatric disorder of thought, mood or behavior which affects a person at the time of the commission of the offense and which impairs a person's judgment, but not to the extent that the person is incapable of knowing the wrongfulness of such act. Mental illness does not include abnormalities manifested only by repeated criminal or otherwise antisocial conduct." SDCL 22-1-2(24).

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

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[1] Ronald Kessler et al., *Prevalence, Severity, and Comorbidity of Twelve-month DSM-IV Disorders in the National Comorbidity Survey Replication*, 62 *ARCHIVES OF GEN. PSYCHIATRY* 617-27 (2005).

[2] Kristen Harris & Mark Edlund, *Use of Mental Health Care and Substance Abuse Treatment Among Adults with Co-occurring Disorders*, 56 PSYCHIATRIC SERVICES 954-59 (2005).

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

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

SERIOUS MENTAL ILLNESS

Severe mental illness is defined as "substantial organic or psychiatric disorder of thought, mood, perception, orientation, or memory which significantly impairs judgment, behavior, or ability to cope with the basic demands of life. Intellectual disability, epilepsy, other developmental disability, alcohol or substance abuse, or brief periods of intoxication, or criminal behavior do not, alone, constitute severe mental illness." SDCL 22-1-2(24).

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

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

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

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

Other common mental disorders or mental illnesses are defined in the Glossary in Appendix. Many of these disorders are also disabling and can profoundly affect the way a person thinks, behaves, and relates to other people. As an attorney, you can help ensure the fair administration of justice by recognizing those defendants who have mental illness.

Serious Mental Illness (SMI) refers to situations when individuals over the age of 18 with diagnosable mental health disorders experience functional impairments that significantly interfere with daily living.

The following services are available to those diagnosed with a SMI:

Comprehensive Assistance with Recovery and Empowerment Services (CARE) includes outpatient counseling, case management, and psychiatric medication management for adults diagnosed with a serious mental illness.

CARE eligibility criteria includes one of the following:

- Undergone psychiatric treatment more intensive than outpatient care more than once
- Single episode of psychiatric hospitalization with a major mental health diagnosis
- Treated with psychotropic medication for at least one year
- Frequent crisis contact with a CMHC or behavioral health provider for more than 6 months

And at least three of the following:

- Unemployed or limited job skills, poor work history
- Exhibits inappropriate social behavior resulting in concern by the community or requests for mental health or legal intervention
- Unable to obtain public services without assistance
- Required public financial assistance for out-of-hospital maintenance or difficulty budgeting public financial assistance or requires ongoing training in budgets skills or needs a payee
- Lacks social support systems in a natural environment or lives alone and is isolated
- Unable to perform basic daily living skills without assistance.

Individualized and Mobile Program of Assertive Community Treatment (IMPACT) provides medically necessary treatment, rehabilitative, and support services for adults who require more intensive services than can be provided through the CARE program. The IMPACT Team is a mobile group of mental health professional who merge clinical, medical, rehabilitation, and staff expertise within one service delivery team under the supervision of a clinical supervisor.

IMPACT eligibility criteria includes:

- Medical necessity as determined by a clinical supervisor
- Meet the Severe Mental Illness Criteria
- Approved by the Division of Behavioral Health
- Voluntary consent from individual to receive IMPACT services
- No other appropriate community-based mental health service is available

And at least 4 of the following:

• Has persistent or recurrent difficulty performing daily living tasks except with significant support or assistance from others such as friends, family, relatives, or community mental health providers;
• Has frequent psychiatric inpatient hospitalizations within the past year;
• Has constant or cyclical turmoil with family, social, or legal systems or inability to integrate successfully into the community;
• Is residing in an inpatient, jail, prison, or residential facility and clinically assessed to be able to live in a more independent living situation if intensive services are provided;
• Has an imminent threat of losing housing or becoming homeless; or
• Is likely to need residential or institutional placement if more intensive community-based services are not provided.

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

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

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

DEFENDANT'S DECISIONS VS. ATTORNEY'S DECISIONS

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

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

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

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

CHECKLIST FOR DEFENSE ATTORNEYS

This checklist is intended to help an attorney recognize a client with mental illness. It is not intended to speculate on a diagnosis.

INITIAL STEPS

1. Ask the client questions to determine if the client has a mental illness diagnosis. See Appendix (Sample Client Interview Form).

    - Interview the client as soon as possible.
    - Ask about the facts of the case.
    - Ask the client whether he or she has been treated for any type of mental illness.
    - Review medical records, if available, or ask for a release to obtain them.
    - Talk to the family.
    - Interview witnesses.
    - Inform the client of his or her right to a jury trial or a trial before the court and the right to be present at hearings, to confront witnesses, to cross-examine witnesses and not to be called as a witness against themselves.

2. Seek to have the client released from jail on bond, if possible. Review SDCL 23A-43-4 (factors to consider in determining conditions of release including "character and mental condition, the results of any mental health assessment") and SDCL 23A-43-5 (conditions of release may include requiring the defendant to "complete a mental health assessment by a specified date and follow any treatment recommendations").

3. Consider whether an evaluation for competency may be appropriate. Failure to do so early on can result in unnecessary delays and longer periods of incarceration for the client.

4. Familiarize yourself with options available in your community. Talk to mental health professionals, mental health advocates, and experienced defense attorneys.

5. Familiarize yourself with the civil commitment procedures as they may be applicable to your client's case.

6. If necessary explain your client's absence to the court at meetings or hearings.

7. Determine if you need an independent mental health evaluation.

THE INITIAL INTERVIEW

HOW CAN YOU TELL IF YOUR CLIENT MAY HAVE A MENTAL ILLNESS?

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

Behavioral or physiological clues. Your client may exhibit certain behaviors or characteristics that may indicate a possibility they have a mental illness. Some of these characteristics include:

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

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

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

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

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

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

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

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

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

Medical symptoms and complaints. You should always be alert for physical symptoms, including hypochondria, self-mutilation, accident-prone, insomnia, hypersomnia, blurred vision, hearing problems, headaches, dizziness, nausea, and loss of control of bodily functions. Some of these problems can develop as a result of incarceration, but may also indicate a serious or long-standing mental health problem. They may also be a side-effect of prescription medications.

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

If you have any indication that your client may not be competent and/or mentally ill, you should explore further. See Appendix (Sample Client Interview Form When Mental Illness is Suspected). Many defendants may go to great lengths to hide any indications that they are mentally ill, especially if they are in a jail setting. They may fear being committed to a mental hospital or being forced to take medication. They may not want to admit that they have not been compliant with their treatment or they just may not want to appear different or dependent in any way for fear of being victimized by others in jail. Other clients, particularly if they have never been formally diagnosed or treated, may not understand that they are mentally ill. The stress of the jail environment has been known to bring on symptoms of a person's mental illness and/or contribute to his or her deterioration.

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

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

Be familiar with the names of community mental health centers and other providers in your area. See Appendix (South Dakota Community Mental Health Providers).

Be delicate, tactful, and resourceful in your questioning when you sense that your client may not be forthcoming with you. Your client may not be willing to discuss a mental illness, especially if this is your first interaction with them. This may require you to gather information from others while you work to build a relationship with the person.

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

- Are you on any medications and, if so, what are they?
- Have you had any previous medical treatment and, if so, what was it?
- Do you have a juvenile record and, if so, for what types of offenses?
- Do you receive disability or Supplemental Security Income (SSI) benefits?
- Have you ever felt depressed?
- Have you ever been a patient at the Veterans' Administration (VA)?
- Have you ever been hospitalized?
- Are there doctors, friends, or family members I can talk with about your case?

Remember to speak simply, and be prepared to repeat some of what you are saying. Ask simple, open-ended questions. Use eye contact to keep control of the dialogue and to keep your client focused. Do not impose on your client's "personal space." Tell

your client when you do not understand and need more information. Paraphrase your client's responses to let him or her know that you understand. Remember that your client's delusions are real to him or her. Do not minimize or try to explain away hallucinations or delusions. You will likely elicit more information with a response such as, "That's interesting—tell me more," than by arguing the logic of statements that may appear bizarre or unusual to you. Speak simply, but remember not to "talk-down" to your client.

Be patient. If your client has a mental illness, he or she may be irritated or belligerent, or see you as a threat. Some of your client's actions, reactions, and mannerisms may be irritating and/or offensive. Do not take this conduct personally; your client's mental illness may be influencing his or her personality.

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

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

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

HELPFUL HINTS TO OBTAIN INFORMATION

If you strongly suspect that your client may be mentally ill and/or not competent after the initial interview with your client, it is important to explore the issue further.

Where Do You Look For More Mental Health Information?

Listed below are some steps you can take to gather relevant information if you suspect your client has a mental illness.

- **Call your client's family.** The family is often the best, most current source of information about your client's mental health treatment and history. Family members can also connect you with treatment professionals. See Appendix (Sample Family Interview Form).

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

- **If a mental health evaluation has been conducted in the past, you should receive a copy of the mental health expert's report.** This information could be invaluable as you determine the appropriate steps in your representation.

- **Look at the police report and review evidence such as videos etc. for any indication of mental illness or unusual behavior** by your client at the time of arrest.

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

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

What Records Would be Helpful?

If it appears that your client has or has had significant mental disorders or received treatment and that his or her mental health history will likely play a role in the proceedings, you may want to obtain the following records. Of course, it is always good to speak to your client first about the matter and to get him or her to sign a medical records release form.

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

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

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

- **Employment records.** Mental illness may have interfered with your client's ability to hold down long-term, stable employment. Look at your client's employment history. Has he or she had trouble keeping jobs? Has your client ever received services from job training programs?

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

- **Military or VA records.** If your client was in the military their military or VA records may be invaluable in substantiating a mental illness. To obtain the records contact the particular branch of service and it will provide the requirements or forms for obtaining this information.

- **Medical records from doctors or clinics.** Check with the client's physician of record and local hospitals. Do not forget to check for emergency room records. Emergency rooms and local jails have often become substitutes for persons in need of treatment for mental illness.

PRETRIAL PROCESS AND OPTIONS

CONFIRM THAT AN ACTUAL CASE HAS BEEN FILED AGAINST YOUR CLIENT

Your client's case may be delayed by the fact that formal charges have not been filed against your client. While this does not happen often, please confirm that a case has been filed to avoid delays.

TALK WITH THE STATE'S ATTORNEY

If you have an indication that your client's mental illness may have played a role in the charged offense, you may want to talk to the state's attorney about the best way to handle your client's case. The prosecutor may be more inclined to consider other avenues besides a formal charge because your client suffers from a mental illness if you clearly document your client's mental illness and then provide that documentation to the prosecutor. Specifically, discuss if there are any diversion options or programs that may benefit your client or that your client could qualify for to assist them.

RELEASE ON BOND

You should speak to your client about whether to seek his or her release on bond. SDCL 23A-43-3 was changed in 2017 to allow a court to impose conditions of bond that include the completion of a mental health assessment and to follow any treatment recommendations. If this condition is imposed, the treatment provider ordered to conduct the assessment will report any noncompliance to the court.

INVOLUNTARY COMMITMENT

For information related to involuntary commitments please review the following resources. *See* SDCL chapter 27A-1; 27A-10; 27A-11; and also the following link: https://dss.sd.gov/docs/behavioralhealth/community/aroadmapofsouthdakota2000.pdf.

COMPETENCY EXAMINATIONS

THE BASICS

Competency evaluations are intended to determine whether the defendant in a criminal case currently has a condition that makes that person incapable of understanding the nature and consequences of the criminal court proceeding or to assist in their defense as a matter of law. These examinations are important because an individual that cannot assist in their defense or understand the nature and consequences of that criminal proceeding cannot be tried for the offense alleged unless or until they regain competency.

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

A person cannot be tried, sentenced, or punished for any public offense while mentally incompetent to proceed. SDCL 23A-10A-1. Your client is "mentally incompetent to proceed," if they are suffering from a mental disease, developmental disability, as defined in § 27B-1-18, or psychological, physiological, or etiological condition rendering the person mentally incompetent to the extent that they are unable to understand the nature and consequences of the proceedings against them or to assist properly in their defense. SDCL 23A-10A-1.

A case is suspended until the question of mental competency is determined by the court. The State always has the burden of proof to establish a defendant is mentally competent to proceed by the preponderance of the evidence. SDCL 23A-10A-6.

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

- Does your client understand his or her legal situation?
- Does your client understand the charges against him or her?
- Does your client understand the legal issues/procedures in his or her case?
- Does your client understand the available legal defenses?
- Does your client understand the dispositions, pleas, and possible penalties?

- Can your client appraise the likely outcomes of his or her case?
- Can your client appraise his or her role and the roles of defense counsel, prosecutor, judge, jury, and witnesses in his or her case?
- Can your client identify and locate witnesses?
- Does your client trust you and communicate relevant information to you, including pertinent facts, events, and states of mind?
- Does your client comprehend instructions and advice?
- Can your client make decisions after receiving advice?
- Is your client able to collaborate with you on developing legal strategy?
- Can your client follow his or her own testimony and the testimony of others for contradictions or errors?
- Can your client testify about relevant information and be cross-examined if necessary?
- Can your client help you challenge prosecution witnesses?
- Can your client tolerate the stress of the trial process?
- Can your client refrain from irrational and unmanageable behavior in court?
- Can your client disclose pertinent facts about the alleged offense?

COMPETENCE TO STAND TRIAL EXAMINATIONS

WHEN IS IT APPROPRIATE TO FILE A MOTION SEEKING A COMPETENCY EVALUATION?

Generally, issues relating to your client's competence to stand trial should be resolved before the trial on the merits. However, you can request a competency examination at any point during the proceedings at which you believe your client is not competent to stand trial. You should note that the American Bar Association (ABA) has resolved that it is improper to use competence procedures for purposes unrelated to the determination of competence, such as obtaining mitigation information, obtaining favorable plea negotiations, or delaying proceedings. STANDARDS RELATING TO COMPETENCE TO STAND TRIAL § 7-4.3(e) (2016).

Many attorneys find themselves in an ethical bind when their client objects to having the competence issue raised. Some clients facing misdemeanor charges just want to plea to the charges, spend a short time in jail, and then get out. Oftentimes, getting an examination means that the client will spend more time in jail pending the examination, plus a lengthy time at the state hospital if he or she is found incompetent. However, the ABA stresses a lawyer's professional responsibility toward the court and the fair administration of justice as the paramount obligations

in such an instance, and an attorney may advance the issue even over a client's objection whenever a good faith doubt arises about a defendant's competence to stand trial. RESPONSIBILITY FOR RAISING THE ISSUE OF COMPETENCE TO PROCEED § 7-4.3(c) (2016). Of course, if your client is competent to stand trial, he or she makes the final decision about how to dispose of his or her case regardless of whether you agree with this decision. If you believe your client is incompetent to stand trial, you should file a motion to that effect.

REQUSTING THE COMPETENCY EVALUATION

If you believe your client is not competent to stand trial, whether your client is in jail or out on bond, you should file a motion seeking a competency evaluation.

Even though defense counsel usually files such a motion, the court itself or the prosecutor may raise the issue of competency to stand trial.

See Appendix for Evaluation Motion, Order and Completion Forms.

CONSIDERATIONS REGARDING THE COMPETENCY EVALUATION

Prior to the date of the hearing on the issue of competency, the court will enter an order that a psychiatric or psychological examination of the defendant be conducted and that a report be filed with the court, pursuant to the provisions of §§ 23A-46-1 and 23A-46-2. The examination should be completed within twenty-one days of the court order unless the court grants a continuance for good cause.

The competency evaluation must be conducted by a:

- licensed or certified psychiatrist;
- licensed clinical psychologist;
- certified social worker licensed for private independent practice with two years of supervised clinical experience in a mental health setting and with training on how to conduct and score competency evaluations;
- certified nurse practitioner or clinical nurse specialist with current psychiatric certification and with training on how to conduct and score competency evaluations; or
- licensed professional counselor-mental health with training on how to conduct and score competency evaluations.

The licensing board of each professional listed in § 23A-46-1 maintains a list of each professional qualified to conduct competency evaluations. The Department of Social Services also maintains a list of those evaluators for use by the courts.

That list can be found here:

http://dss.sd.gov/licensed_professionals_comp_eval.pdf.

YOUR RESPONSIBILITIES REGARDING THE EXAMINATION

• You should obtain and submit to the examiner any record or information that the examiner regards as necessary for conducting a thorough evaluation on the matters referred.

• You should do everything you can to ensure that needed information is obtained and that the examination is conducted promptly.

PREPARING THE CLIENT FOR THE EXAMINATION

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

- The purpose and nature of the examination;
- The potential uses of any disclosures made during the examination; and
- The conditions under which the prosecutor will have access to reports and other information obtained for the examination and the reports prepared by the evaluator.

WHAT TO EXPECT IN COMPETENCY REPORTS

A competency evaluation report should include:

- The person's history, if applicable, and present symptoms;
- A description of the psychiatric, psychological, and medical tests that were employed and their results;
- The examiner's findings;
- The examiner's opinions as to diagnosis and prognosis; and
- Whether the person is suffering from a mental disease or defect rendering the person mentally incompetent to the extent that the person is unable to understand the nature and consequences of the proceedings against the person or to assist properly in the person's defense. *See* SDCL 23A-46-2.

CAN YOUR CLIENT "REGAIN" COMPETENCE?

Whatever the particular diagnosis or disorder, your client may be restored to competency, through hospitalization, other treatment, and/or psychotropic medication. If, however, the examining expert has determined that your client is incompetent but unlikely to be restored to competency in the foreseeable future, the court shall commit the defendant to the custody of an approved facility having residential capability. The facility shall have custody and treat the defendant for such a reasonable period of time as is necessary, not to exceed four months, to determine whether there is a substantial probability that in the foreseeable future he or she will attain the capacity to permit the trial to proceed. A commitment may not be made to an approved facility which is not owned by the state without first obtaining the consent of the administrator of the privately-owned facility.

When the director of the facility in which the person is being treated determines that the person has recovered to such an extent that they are able to understand the nature and consequences of the proceedings against them and to assist properly in their defense, the director will promptly file a certificate to that effect with the clerk of the court that ordered the commitment. The court will then send a copy of the certificate to the person's counsel and to the prosecuting attorney.

The court will hold a hearing to determine the competency of the defendant. If, after the hearing, the court finds by a preponderance of the evidence that the person has recovered to such an extent that the individual is capable of understanding the nature and consequences of the proceedings against them and to assist properly in their defense, the court shall order their immediate discharge from the facility in which they are hospitalized and will set the matter for trial.

If, after the hearing, the court does not find by a preponderance of the evidence that the defendant has recovered to such an extent that they are capable of understanding the nature and consequences of the proceedings and to assist properly in their defense, the court will order the individual to again be placed in an approved facility. *See* SDCL 23A-10A-14; 15 (detailing the potential length of placement).

After regaining competence, if your client decides to go to trial, you should be ready to try the case quickly so that your client does not deteriorate and become incompetent again before you get to trial.

SHOULD A COMPETENCY EVALUATION BE COMBINED WITH A GUILTY BUT MENTALLY ILL OR INSANITY EXAMINATION?

See later section discussing the desirability of seeking a competency evaluation in combination with these other examinations.

MENTAL IMPAIRMENT AS A DEFENSE

GUILTY BUT MENTALLY ILL

A defendant may plead "guilty but mentally ill" to a charged offense. A guilty but mentally ill examination is intended to provide evidence from a medical professional to assist a court in determining whether a person's plea of guilty for the reason that the they were mentally ill at the time of the offense is factually supported. The court can only accept such a plea if it finds a factual basis supported by medical testimony that the defendant was mentally ill at the time of the offense. SDCL 23A-7-16.

Those professionals that are qualified to perform guilty but mentally ill examinations include:

- Psychiatrists
- Psychologists

AFFIRMATIVE DEFENSE OF INSANITY

A defendant may also raise a defense of insanity at the time of the alleged offense. Insanity is defined as "the condition of a person temporarily or partially deprived of reason, upon proof that at the time of committing the act, the person was incapable of knowing its wrongfulness, but not including an abnormality manifested only by repeated unlawful or antisocial behavior." SDCL 22-1-2(20). This is different than guilty but mentally ill because it is an affirmative defense to the alleged offense. The person cannot be found guilty of the offense if they were insane at the time it was committed. The defendant must prove they were insane at the time of the offense by clear and convincing evidence.

Those professionals that are qualified to perform insanity evaluations include:

- Psychiatrists

WHAT HAPPENS IF YOUR CLIENT IS FOUND GUILTY BUT MENTALLY ILL OR IS ACQUITTED BY REASON OF INSANITY?

Guilty but Mentally Ill

If a defendant is found "guilty but mentally ill" or enters that plea and the plea is accepted by the court, the court shall impose any sentence which could be imposed

upon a defendant pleading or found guilty of the same charge. If the defendant is sentenced to the state penitentiary, he or she will undergo further examination and may be given the treatment that is psychiatrically indicated for their mental illness. If treatment is available, it may be provided through facilities under the jurisdiction of the Department of Social Services. The Secretary of Corrections may transfer the defendant from the penitentiary to other facilities under the jurisdiction of the Department of Social Services, with the consent of the Secretary of Social Services, and return the defendant to the penitentiary after completion of treatment for the balance of their sentence.

If a defendant is found "guilty but mentally ill" and is placed on probation, the sentencing court, upon recommendation of a licensed psychiatrist, will make treatment a condition of probation. Treatment reports will be filed with the court services department and the sentencing court. The defendant's failure to continue treatment, except by agreement with the treating agency and the sentencing court, is a basis for probation revocation.

Insanity

If the defendant is found not guilty by reason of insanity, the defendant will be committed to the care of the Human Services Center (HSC). When the administrator of HSC determines that the person has recovered from his mental disease or defect to such an extent that their release, or a conditional release under a prescribed regimen of medical, psychiatric, or psychological care or treatment, would no longer create a substantial risk of bodily injury to another person or serious damage to property of another, the administrator will file a certificate to that effect with the clerk of the court that ordered the commitment. The clerk will send a copy of the certificate to the person's counsel and to the prosecuting attorney.

The court will subsequently order the discharge of the acquitted person, or, on the motion of the prosecuting attorney or on its own motion, hold a hearing to determine whether the individual should be released. After the hearing, the court may find by the standards specified in SDCL 23A-26-12.3 that the person has recovered from his mental disease or defect to such an extent that:

(1) Release would no longer create a substantial risk of bodily injury to another person or serious damage to property of another, the court shall order that the person be immediately discharged; or

(2) Conditional release under a prescribed regimen of medical, psychiatric, or psychological care or treatment would not create a substantial risk of bodily injury to another person or serious damage to property of another.

If that occurs, the court will:

(a) Order that the individual be conditionally discharged under a prescribed regimen of medical, psychiatric, or psychological care or treatment that has been

prepared for them that has been certified to the court as appropriate by the administrator of HSC and that has been found by the court to be appropriate; and

(b) Order, as an explicit condition of release, that the defendant comply with the prescribed regimen of medical, psychiatric, or psychological care or treatment.

The court may modify or eliminate the regimen of medical, psychiatric, or psychological care or treatment at any time. If the individual fails to comply with the regimen of treatment, the court retains jurisdiction to remand the person to a suitable facility based on a failure to comply. *See* SDCL 23A-26-12.6.

SHOULD A COMPETENCY EXAMINATION AND A GUILTY BUT MENTALLY ILL OR INSANITY EVALUATION BE COMBINED?

A defense attorney will need to determine if multiple mental health examinations should be sought together. This includes the competency examination, guilty but mentally ill examination, or an examination to support an insanity defense. There are times where a defense attorney may find it necessary, and in their client's best interests to request a competency examination simultaneously with a guilty but mentally ill and insanity examination. If there appears to be a potential guilty but mentally ill or insanity issue in the client's case, it might be important for the expert to examine and see your client in the state they were in at the time of the offense. The competency and guilty but mentally ill / insanity evaluations can be conducted simultaneously but separately. A defense attorney should be cautious because during a guilty but mentally ill or insanity evaluation, the client may make admissions or statements harmful to their case. By combining these evaluations into one, the defense attorney may be providing harmful information to the State and Court that they might not otherwise be entitled to receive.

The Task Force on Community Justice and Mental Illness Early Intervention recognized that delays associated with the competency examination could harm both the client and the defense attorney's ability to proceed with the case. Remember, competency only relates to your client's current mental state, not their mental state at the time of the offense. As a practical matter, if the issue of competency remains unresolved, it may be difficult for an attorney to discuss all aspects of the case with their client including possible defenses.

The Task Force and HB 1183 addressed this in a number of ways:

- Creating a larger pool of individuals qualified to perform competency evaluations.
- Requiring that competency evaluations be completed within 21 days unless good cause is shown.

By expanding the pool of evaluators and creating a 21-day time requirement, South Dakota law is intended to enable defense attorneys to obtain information about their client's competency so they may then proceed with a tactical decision about

their case with more information about a client's competence, including whether to perform a guilty but mentally ill or insanity examination. This is important because the decision on what plea to enter in a case remains the client's decision. Addressing all three issues at once may eliminate the client's active and informed decision-making on this issue if the attorney also has a good faith belief the defendant may not be competent to stand trial. For further discussion of this issue please refer to "The Bifurcation of Competency and Sanity Evaluations." 33-OCT Wyo. Law. 20 (October 2010) (Appendix*).*[5]

[5] *See also ABA Standard 7-3.5 PRETRIAL EVALUATIONS AND EXPERT TESTIMONY and Standard 7-4.4 COMPETENCE TO STAND TRIAL 7-4.4 (https://www.americanbar.org/publications/criminal_justice_section_archive/crimjust_standards_mentalhealth_blk.html#7-4.1.).*

EXPERT MENTAL HEALTH WITNESSES, MITIGATION AND SENTENCING CONSIDERATIONS

EXPERT MENTAL HEALTH WITNESSES

HOW CAN THEY HELP YOU?

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

- The manner in which you relate to your client;
- Your client's competence to proceed;
- Your client's mental state at the time of the offense;
- Plea negotiations;
- Jury selection;
- Whether your client should testify;
- Medical treatment or other services for your client while the case is pending;
- What types of assessments or evaluations are needed; and
- The selection of witnesses for the trial, including the penalty phase.

MALINGERING

Malingering is the act of intentionally feigning or exaggerating psychological symptoms or disability to avoid legal consequences. A defense attorney should never try to determine if their client is malingering.

According to the DSM-IV TR, when any of the following are observed, malingering is suspected:

- Medicolegal context of presentation;
- Marked discrepancy between the person's claimed stress of disability and the objective findings;
- Lack of cooperation during the diagnostic evaluation and in complying with prescribed treatment regimen; or

- The presence of Antisocial Personality Disorder.

Some tests commonly used to determine malingering are:

  - Structured Interview of Reported Symptoms (SIRS);
  - The Test of Memory Malingering (TOMM);
  - Recognition Memory Test; and
  - Minnesota Multiphasic Personality Inventory (MMPI).

If an expert mentions malingering concerns about your client, question the expert on the tests administered and basis for the determination. A malingering diagnosis can be extremely harmful to your client.

MITIGATION

Why is mitigation important?

Mitigation is not a defense to prosecution. Mitigation is the explanation of what influences converged in the years, days, hours, minutes, and seconds leading up to the crime, how information was processed by a person with a mental disability, and the behavior that resulted. Mitigation evidence can provide information to help the judge or jury understand who your client is, how he or she experiences the world, and why your client behaves as he or she does.

Your Client's Mental Illness Should Be Factored into Decisions about Probation.

If your client receives probation, you should work to assure that your client has probation conditions that he or she can successfully complete. If your client is facing revocation of his or her probation, you should educate the court about your client's mental illness and the treatment options that could be made part of the conditions of probation. You may want to ask for your client to be placed on a specialized probation caseload or program if available. Bring your client's needs to the attention of both the judge and court services.

Your Client May Not Want Treatment.

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

a probation sentence. However, you have an obligation to set out all the pros and cons of any plea bargain agreement for your client.

APPENDIX

GLOSSARY OF COMMON MENTAL HEALTH TERMS

ADD – *see attention-deficit hyperactivity disorder*.

ADHD – *see attention-deficit hyperactivity disorder*.

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

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

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

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

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

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

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

Attention-deficit hyperactivity disorder- a disorder characterized by a persistent pattern of inattention and/or hyperactivity and impulsivity that is more frequent

and severe than is typically found in individuals of a comparable level of development. Symptoms might include impatience, fidgetiness, excessive talking, inability to focus or pay attention, and distractibility. Most children with ADHD receive a diagnosis during the elementary school years. For an adolescent or adult to receive a diagnosis of ADHD, the symptoms need to be present prior to age 12.

Atypical antipsychotics – *see second generation antipsychotics.*

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

Autism spectrum disorder – then name for a group of developmental disorders that begins in early childhood and lasts throughout a person's life. It affects how a person acts and interacts with other, communicates, and learns. It is called a "spectrum" disorder because people with ASD can have a wide range of symptoms such as significant deficits in communication, social interaction, and bonding and play activities. Children with ASD may engage in repetitive behaviors and self-damaging acts. Established in DSM-V, autism spectrum disorder incorporates the former DSM-IV diagnoses of autistic disorder, Asperger's disorder, childhood disintegrative disorder, or the catch-all diagnosis of pervasive developmental disorder not otherwise specified.

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

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

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

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

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

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

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

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

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

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

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

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

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

Dementia – a decline and/or loss of memory, reasoning, judgment, behavior, language and other mental abilities that are not a part of normal aging; usually progressively worsens over time.

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

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

Dissociative identity disorder – *see multiple personality disorder*.

Electroconvulsive therapy – a treatment for severe depression in which a mild electric current is applied to the brain, producing a seizure similar to an epileptic

convulsion. Also known as electroshock therapy. It is most often used to treat severe, persistent depression.

Electroshock therapy – *see electroconvulsive therapy above*.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Nervous breakdown – a non-technical term used by the lay public, usually referring to an episode of psychosis.

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

New generation antipsychotics – *see second generation antipsychotics.*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Psychosis (pl. psychoses) – a severe mental disorder in which thinking and emotion are so impaired that the person is seriously out of contact with reality.

Psychosomatic disorder – physical illness that has psychological causes.

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

Psychotic behavior – behavior indicating gross impairment in reality contact as evidenced by delusions and/or hallucinations. It may result from damage to the

brain or from a mental disorder, such as schizophrenia or a bipolar disorder, or a metabolic disorder.

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

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

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

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

Shock therapy – *see electroconvulsive therapy*.

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

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

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

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

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

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

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

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

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

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

SOME COMMON PSYCHIATRIC MEDICATIONS

- **Typical Antipsychotics (Old):** Haldol (most potent), Thorazine, Mellaril, Navane, Prolixin

- **Atypical Antipsychotics (Newer):** Geodon (Ziprasidone), Abilify (Aripiprazile), Seroquel (Quetiapine), Risperdol (Risperidone), Zyprexa (Olanzapine), Clozaril (Clozapine), Saphris (Asenapine), Fanapt (Ilperidone)

- **Antidepressants** (sometimes used to treat anxiety and eating disorders as well). **SSRIs**: Prozac, Zoloft, Celexa, Lexapro, Luvox, Paxil, Effexor, Cymbalta **Others:** Elavil (also used for sleep or nerve pain), Buproprion (Wellbutrin), Trazadone (also used for sleep), Remeron (also used for sleep), Phenelzine, Pranylcypromine, Isocarboxazid

- **Mood Stabilizers** (For Bipolar disorder, also used to augment medications in depression and psychosis): Lithium, Valproic Acid (Depakote), Carbamazepine (Tegratol), Oxbarbazapine (Trileptal), Gabapntin (Neurontin), Lamotrigine (Lamictal), Topiramate (Topomax)

- **Anti-anxiety:** Benzodiazapenes: Xanax, Librium, Nlonipin, Ativan Non-Benzo: Buspar

- **Dementia:** Namenda, Aricept

SAMPLE CLIENT INTERVIEW FORM WHEN MENTAL ILLNESS IS SUSPECTED

Client: _____

Facility: _____

Date: _____

Interviewer: _____

Interviewee: _____

1. When and where were you born?

2. Do you know anything about your mother's pregnancy or about your birth?

3. What kind of kid were you? Did you get in trouble a lot or did you stay out of trouble?

4. Who did you live with when you were growing up?

5. Who do you live with now?

6. Tell me about your parents and your siblings. What do they do?

7. How about the rest of your family – grandparents, cousins, aunts? Are they in good health? Do they have any history of mental illness?

8. Where did you go to school?

9. Did you repeat a grade?

10. What is the highest grade you finished?

11. How was your behavior while you were in school?

12. Do you remember learning to read and write? Was it hard or easy?

13. How is your health? Do you take any medicine? Have you ever? Do you hear and see well?

14. Have you ever been in the hospital? Have you ever been in an accident or had a head injury?

15. Have you ever seen a psychiatrist or a psychologist? What did they tell you?

16. Have you ever had a job? What kind of job would you like to do?

17. Do you have a group of friends? What do they like to do for fun?

18. How is your mood? Are you usually happy or sad? Do you get angry easily or does it take a lot to get you upset?

19. Have you ever been treated for a mental or emotional issue? Where? With whom? Timeframe?

20. Have you ever been treated for substance abuse?

21. Are you currently receiving treatment? If so, from whom? Do you know your diagnosis?

22. What types of medication are you taking? Have you taken medications in the past? What were those medications?

23. Have you ever been hospitalized for a mental health issue? If so, when and where? Did a court or judge order that you be hospitalized?

24. Are there doctors, friends, or family members I can talk to who are familiar with your treatment?

25. Do you have or have you had a case manager?

26. Have you ever been a patient at the Veterans' Administration (VA)?

27. Tell me three things about yourself that you are proud of.

28. Tell me three things about yourself that you wish you could change.

29. I am going to list some things and I want you to tell me if they are easy or hard for you to do:

- Looking up a phone number
- Writing a check
- Shopping for groceries
- Making change
- Telling time on a clock with hands

- Naming the days of the week
- Paying attention to what people are saying
- Reading a bus schedule
- Following a recipe
- Understanding what people are saying
- Reading
- Washing clothes
- Learning new phone numbers

SAMPLE FAMILY INTERVIEW FORM WHEN CLIENT'S MENTAL ILLNESS SUSPECTED

Client: _____

Facility: _____

Date: _____

Interviewer: _____

Interviewee: _____

1. How are you related to my client?

2. What can you tell me about the pregnancy? Was there prenatal care? Did his/her mother use drugs, alcohol or cigarettes? Was there any illness or accident?

3. Was s/he a term birth? How much did he weigh? How long was s/he in the hospital?

4. Are there any family members with a history of mental illness? Did his/her parents and siblings graduate from high school? What do they do now?

5. Did s/he meet his/her developmental milestones on time?
   Walking? _____ 8-16 months
   Talking? _____ 12-24 months
   Toilet Training? _____ 24-36 months

6. How was his/her school experience? Has s/he ever repeated a grade?

7. Was s/he in special education? What kind of class?

8. What kinds of grades did s/he make? What did his/her teachers say about him/her?

9. Did s/he have trouble learning to read or write?

10. Did s/he graduate?

11. Has s/he ever had a job?

12. I am going to list some things, and I want you to tell me if they are easy or hard for him/her to do:

- Looking up a phone number
- Writing a check
- Shopping for groceries
- Making change
- Telling time on a clock with hands
- Naming the days of the week
- Paying attention to what people are saying
- Reading a bus schedule
- Following a recipe
- Understanding what people are saying
- Reading
- Washing clothes
- Learning new phone numbers

BIFURCATION OF COMPETENCY AND SANITY EVALUATIONS

33-OCT Wyo. Law. 20

Wyoming Lawyer
October, 2010

Feature
Ronna J. Dillinger, Ph.D.[a1] Stephen L. Golding, Ph.D.[aa1]

THE BIFURCATION OF COMPETENCY AND SANITY EVALUATIONS

Significant revisions to Wyoming's statutes regarding psycholegal evaluations of fitness to proceed and mental state at the time of the alleged offense were implemented in 2009. It is important for attorneys, judges, and forensic examiners to be aware of the rationale for, and the consequences of, these changes.

Previously, courts routinely ordered both evaluations simultaneously and received a single report on both issues. Numerous pragmatic, ethical, and constitutional problems accompanied so-called "two-fers." Staff and consultants associated with both the Wyoming State Hospital and the Attorney General's office addressed these problems in a revision of Wyoming's statute that now specifically states, "If an examination of the defendant's fitness to proceed has been ordered pursuant to W.S. § 7-11-303, an examination following a plea of 'not guilty by reason of mental illness or deficiency' *shall not occur, or be ordered, until the court has found the defendant is competent to proceed* under W.S. § 7-11-303" (W.S. § 7-11-304 (e), emphasis added). Additionally, the American Bar Association's Criminal Justice Standards (hereinafter "CJS") recognize the fundamental need for separate evaluations: "An evaluation of defendant's present mental competency should not be combined with an evaluation of defendant's mental condition at the time of the alleged crime, or with an evaluation for any other purpose, unless defendant so requests or, for good cause shown, the court so orders." (Standard 7-3.5).

While continually confused, these two types of evaluations refer to two distinct mental states (Gutheil, 1999; Perlin, Champine, Dlugacz, & Connell, 2008). An evaluation regarding fitness to proceed is focused on a defendant's present mental state while an assessment of mental state at time of the alleged offense is, by definition, historic in nature. W.S. § 7-11-303 delineates the required elements for competency; specifically, it requires an opinion from the designated examiner regarding, "... as to whether the accused, as result of mental illness or deficiency, lacks [the present] capacity to comprehend his position, to understand the nature and object of the proceedings against him, to conduct his defense in a rational manner, and to cooperate with his counsel to the end that any available defense may be interposed" (W.S. § 7-11-303(c)(iii)). Competency to proceed is an issue that can arise at anytime during adjudication but is most commonly raised before trial by an officer of the court. Indeed, constitutionally it must be raised anytime a bona fide doubt as to the defendant's competency exists. In contrast, a mental state at time of the alleged offense (MSO) evaluation is concerned with whether the defendant had the required culpable mental state at the time of the alleged crime; further, raising the issue is a matter of discretionary trial strategy. W.S. 7-11-304 reads, "A person is not responsible for criminal conduct if at the time of the ***21** criminal conduct, as a result of mental illness or deficiency, he lacked substantial capacity either to appreciate the wrongfulness of his conduct or to conform his conduct to the requirements of the law" (W.S. § 7-11-304(a)). Essentially both issues address the linkage between mental disorder and capacity, but differ as to the time frame and the nature of the capacities involved (capacity to proceed; capacity to

form the required *mens rea*) (W.S. § 7-11-303(a)). Given these important differences, we now turn to why it is critical that the evaluations be separated.

Speedy Trial Issues

Some attorneys have argued that separating the evaluations violates a defendant's speedy trial rights, but the Wyoming Rules of Criminal Procedure expressly state that proceedings relating to mental disorder are excluded from speedy trial considerations (Wyo R. Crim. P. 48, see also *Potter v. State*, 2007 WY 83, 158 P.3d 656).

Discovery Issues

The discovery problems associated with "two-fers" are also addressed by the CJS: "When the court has ordered a pretrial evaluation on any present mental competency issue, the evaluator should prepare a separate report on that issue even if other issues have also been referred for evaluation. The report should not contain information or opinions concerning either defendant's mental condition at the time of the alleged crime or any statements made by defendant regarding the alleged crime or any other crime" (Standard 7-3.8). Additionally, an evaluation on present mental state does not automatically call for evaluation mental state at time of the alleged offense. Importantly, Wyoming statute clearly states that any information gathered during either type of evaluation cannot be introduced into evidence, other than to determine mental state (§ 7-11-303(h) and § 7-11-304(h)).

Clinical and Ethical Difficulties with Simultaneous Evaluations

Court-ordered evaluations in Wyoming are usually prompted by concern regarding a defendant's fitness to proceed; previously, however, courts routinely also requested a MSO evaluation, even if a Not Guilty By Reason of Mental Illness (NGMI) plea had not been entered. Performing these two very different evaluations simultaneously placed the designated examiner in a legal and ethical bind. An MSO evaluation requires a detailed inquiry into a defendant's cognitions, feelings, symptoms, and behavior immediately preceding, during, and following the alleged offense. Individuals who are actively psychotic often cannot provide that information reliably and, if not competent, would be unable to rationally make the decision whether or not they even desire an NGMI defense. Including such details in a ***23** report that also assesses competency reveals this information to the prosecution, even if technically it cannot be used on the issue of the defendant's guilt. Pragmatically, gathering detailed interviews of third parties, reviewing investigative reports, and obtaining and reviewing prior mental health and medical records, are usually required for an MSO evaluation but often difficult to accomplish within a competency evaluation timeframe.

Responses to these changes in statute have been mixed, as some have pointed out that the process is now lengthened due to this bifurcation and have simply continued to request both evaluations simultaneously. The longer length of time is necessary since, if a competency evaluation is ordered, an evaluation of MSO may not occur until the competency issue has been determined by the court. Such an extension may be true for those that truly seek an NGMI plea, but it is also noted that this is based on the assumption that every defendant that needs a competency evaluation should also have an NGMI evaluation and vice versa, which is erroneous. Additionally, given the protection of the rights of the defendant and the ethical and clinical responsibilities of the evaluator, lengthening the process by the bifurcation of these evaluations seems like a small price to pay.

Footnotes

a1 ***Ronna J. Dillinger, Ph.D.*** *graduated from the University of Utah in 2007 with a doctorate in clinical psychology. She completed her internship at the Federal Correctional Institution in Fort Worth, Texas, and a forensic post-doctoral residency at the Wyoming State Hospital. She is currently employed as a psychologist performing court-ordered competency and mental state at time of the offense evaluations at WSH. She is co-chair of the Ethics Committee at WSH. Dr. Dillinger is licensed in Utah and Wyoming, maintains a forensic private practice in each state, and also performs general psychological evaluations for a local mental health center in Wyoming.*

aa1 ***Stephen Golding, Ph.D.*** *is Professor Emeritus of Psychology at the University of Utah and a Diplomate of the American Board of Forensic Psychology. He was Clinical Training Director at the University of Utah, 1985-1993; Adjunct Professor of Law and Adjunct Professor of Psychiatry at the University of Utah, 1985-2005; President of the Division of Psychology and Law (APA), 1991-1992;*

and recipient of the Distinguished Contributions to Forensic Psychology Award by the American Academy of Forensic Psychology in 1994. His teaching, research and clinical supervision concentrates on critical professional, scientific and ethical issues at the interface of psychology and the legal system, including forensic expertise, professional standards of practice, reforms in expert evidence, criminal competencies and responsibility, and child abuse. Professor Golding maintains a private and public forensic practice in these areas, and is licensed in Utah and Wyoming.

33-OCT WYLAW 20

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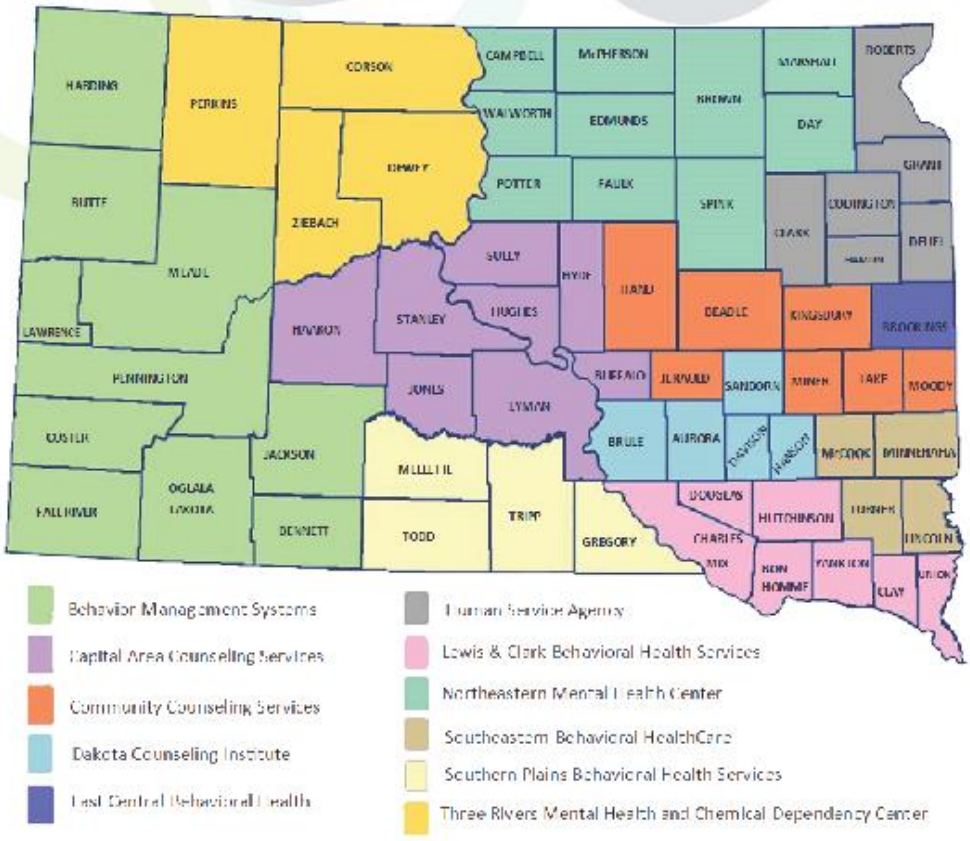
RESOURCES FOR HELP

1. Community Health Centers
2. Mental Health Services
3. Substance Abuse Disorder Services

South Dakota
Community Mental Health Centers



Further information for each Community Mental Health Center can be found on the reverse side.

Individuals who meet programmatic and financial eligibility guidelines or who have considerable personal circumstances, may qualify for state funded services.

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Frequently Asked Questions

What is a mental illness?
A mental illness is a disease causing mild to severe disturbances in thought and/or behavior resulting in an inability to cope with life's demands and routines.

What is a serious mental illness?
A serious mental illness includes both diagnosable mental health disorders and functional impairments significantly interfering with daily living.

What is a serious emotional disturbance?
A serious emotional disturbance is diagnosed in individuals under 18 who are experiencing mental health disorders and functional impairments significantly interfering with functioning in the community, school and family.

What is an assessment?
An assessment includes an interview with a trained clinician to review a person's mental health and its impact on his or her daily life.

How are services determined?
A trained clinician recommends treatment services based on an assessment with the individual to best meet his or her needs.

How are services funded?
A variety of funding options are available for an individual who is assessed as needing services. Funding options include:

- Insurance
- Private pay
- Other 3rd party payers
- Combination of state and federal funding
- Medicaid

How do I qualify for state and federal funding?
Individuals who meet programmatic and financial eligibility may qualify for state funded services. The community mental health provider will assist the individual in completing the eligibility process.

Is there a program to help pay for medications?
The Indigent Medication Program provides temporary funding for medications to treat behavioral health disorders for individuals whose income is at or below 185 percent of the federal poverty level. For additional questions regarding the Indigent Medication Program, email dssbhindmed@state.sd.us or call 605.773.3123.

Contact Us

For more information or to ask questions, please contact the Division of Behavioral Health at dss.sd.gov/behavioralhealth/ or 1.855.878.6057.

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South Dakota Mental Health Services

How do I find help?

1. Contact local mental health provider
2. A trained clinician completes an assessment to determine services
3. The individual is recommended and referred to services

Resources for Local Treatment Providers

- SAMHSA Treatment Locator - findtreatment.samhsa.gov/
- DSS - dss.sd.gov/behavioralhealth/agencycounty.aspx

Mental Health Services

Community mental health centers in South Dakota provide quality services to both adults and youth. Services provided include screenings and assessments, case management, individual therapy, group therapy and crisis intervention. Individuals who meet programmatic and financial eligibility guidelines or who have considerable personal circumstances, may qualify for state funded services.

Outpatient Services
Outpatient mental health counseling services are provided to individuals of all ages.

Children, Youth and Family (CYF) Services
CYF services are specialized outpatient services provided to youth with serious emotional disturbance (SED). Services may include case management, individual, group and/or family counseling. Family counseling may include Functional Family Therapy, which is a strength-based model for building skills to help improve family relationships, reduce behavioral issues and improve school performance.

Comprehensive Assistance with Recovery and Empowerment (CARE) Services
CARE services may include outpatient counseling, case management services and psychiatric medication management for adults with serious mental illness (SMI).

Individualized and Mobile Program of Assertive Community Treatment (IMPACT)
IMPACT services provide intensive outpatient counseling, case management services and psychiatric medication management for adults living with SMI.

Frequently Asked Questions

What is a substance use disorder?

A substance use disorder is a disease which occurs when the recurrent use of alcohol and/or drugs causes significant impairments. Impairments may include health problems, disability and failure to meet major responsibilities at work, school or home.

What is an assessment?

An assessment includes an interview with a trained clinician to review a person's substance use and its impact on his or her daily life.

How are services determined?

A trained clinician recommends treatment services based on an assessment with the individual to best meet his or her needs.

How are services funded?

A variety of funding options are available for an individual who is assessed as needing services. Funding options include:

- Insurance
- Private pay
- Other 3rd party payers
- Combination of state and federal funding
- Medicaid (children and pregnant women).

How do I qualify for state and federal funding?

Individuals who meet programmatic and financial eligibility may qualify for state funded services. The treatment provider will assist the individual in completing the eligibility process.

Is there a program to help pay for medications for behavioral health disorders?

The Indigent Medication Program provides temporary funding for medications to treat behavioral health disorders for individuals whose income is at or below 185 percent of the federal poverty level. For additional questions regarding the Indigent Medication Program, email dssbhindmed@state.sd.us or call 605.773.3123.

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South Dakota Substance Use Disorder Services

Substance Use Disorder Services

The Division of Behavioral health accredits and contracts with addiction treatment agencies across the state to provide quality services to both adults and youth. Services include screenings and assessments, early interventions, detoxification, outpatient and inpatient treatment services. Individuals who meet programmatic and financial eligibility guidelines, or who have considerable personal circumstances, may qualify for state funded services.

Early Intervention Services
Early intervention services offer outpatient services to individuals who may have substance use related problems, but are not diagnosed with a substance use disorder.

Outpatient Treatment Services
Outpatient treatment services provide counseling services to individuals diagnosed with substance use disorders.

Low Intensity Residential Treatment Services
Low intensity residential treatment services include residential, peer-oriented treatment programs for individuals with substance use disorders whose living situation or recovery environment is incompatible with recovery goals. To prepare the client to live successfully in the community, the program provides substance use disorder counseling along with case management services.

Inpatient Treatment Services
Inpatient treatment services provide residential treatment with medically monitored intensive treatment for individuals with severe substance use disorders.

Detoxification Treatment Services
Detoxification treatment services are residential treatment services delivered by trained staff who provide 24-hour supervision, observation and support for individuals who are intoxicated or experiencing withdrawal symptoms. The goal is to motivate the individual to seek further treatment services.

Resources for Local Treatment Providers

- SAMHSA Treatment Locator - findtreatment.samhsa.gov/
- DSS - dss.sd.gov/behavioralhealth/agencycounty.aspx

MENTAL HEALTH EVALUATION FORMS

1. Notice of Evaluation Completion
2. Order for Evaluation
3. Motion Evaluation

Notice of Evaluation Completion

STATE OF SOUTH DAKOTA IN CIRCUIT/ MAGISTRATE COURT

COUNTY OF JUDICIAL CIRCUIT

* *

STATE OF SOUTH DAKOTA,

Plaintiff, CR.

- ☐ NOTICE OF COMPLETION OF EVAL FOR MENTAL HEALTH COMPETENCY **(NCEC)**
- ☐ NOTICE OF COMPLETION OF EVAL FOR GUILTY BUT MENTALLY ILL PLEA **(NCEMI)**
- ☐ NOTICE OF COMPLETION OF EVAL FOR NOT GUILTY BY REASON OF INSANITY PLEA **NCERI)**
- ☐ NOTICE OF COMPLETION OF EVAL FOR MENTAL HEALTH COMPETENCY; GUILTY BUT MENTALLY ILL PLEA; AND NOT GUILTY BY REASON OF INSANITY PLEA **(NCECMIRI)**
- ☐ NOTICE OF COMPLETION OF EVAL FOR MENTAL HEALTH COMPETENCY AND GUILTY BUT MENTALLY ILL PLEA **(NCECMI)**
- ☐ NOTICE OF COMPLETION OF EVAL FOR MENTAL HEALTH COMPETENCY AND NOT GUILTY BY REASON OF INSANITY PLEA **(NCECRI)**
- ☐ NOTICE OF COMPLETION OF EVAL FOR GUILTY BUT MENTALLY ILL AND NOT GUILTY BY REASON OF INSANITY PLEA **(NCEMIRI)**

(Check appropriate box)

,

Defendant.

* *

, through his/her attorney, [insert name], having been evaluated by (insert provider and address), hereby gives notice of receipt of the completed evaluation(s) on _____, 20_____.

Respectfully submitted this _____ day of _____, 20_____.

/s/
Attorney for Defendant

Order for Evaluation

STATE OF SOUTH DAKOTA IN CIRCUIT/ MAGISTRATE COURT

COUNTY OF JUDICIAL CIRCUIT

* *

STATE OF SOUTH DAKOTA,

Plaintiff, CR.

- ☐ ORDER FOR EVAL FOR MENTAL HEALTH COMPETENCY **(OFEC)**
- ☐ ORDER FOR EVAL FOR GUILTY BUT MENTALLY ILL PLEA **(OFEMI)**
- ☐ ORDER FOR EVAL FOR NOT GUILTY BY REASON OF INSANITY PLEA **(OFERI)**
- ☐ ORDER FOR EVAL FOR MENTAL HEALTH COMPETENCY; GUILTY BUT MENTALLY ILL PLEA; AND NOT GUILTY BY REASON OF INSANITY PLEA **(OFECMIRI)**
- ☐ ORDER FOR EVAL FOR MENTAL HEALTH COMPETENCY AND GUILTY BUT MENTALLY ILL PLEA **(OFECMI)**
- ☐ ORDER FOR EVAL FOR MENTAL HEALTH COMPETENCY AND NOT GUILTY BY REASON OF INSANITY PLEA **(OFECRI)**
- ☐ ORDER FOR EVAL FOR GUILTY BUT MENTALLY ILL AND NOT GUILTY BY REASON OF INSANITY PLEA **(OFEMIRI)**

(Check appropriate box)

,

Defendant.

* *

The defendant , through his/her attorney, , having motioned the Court for an evaluation for the purposes of determining MENTAL HEALTH COMPETENCY, and the Court being familiar with the file, and believing that such an evaluation is necessary, now, therefore, it is hereby:

ORDERED that (provider name and address) be and hereby is appointed to perform the required evaluation of the defendant, and it is further

ORDERED that the required evaluation be paid by .

Dated this _____ day of _____ 20_____.

BY THE COURT:

_____

ATTEST:

_____

Clerk of Courts

Motion for Evaluation

STATE OF SOUTH DAKOTA IN CIRCUIT/ MAGISTRATE COURT

COUNTY OF JUDICIAL CIRCUIT

* *

STATE OF SOUTH DAKOTA,

Plaintiff,

CR.

- ☐ MOTION FOR EVAL FOR MENTAL HEALTH COMPETENCY (**MFEC**)
- ☐ MOTION FOR EVAL FOR GUILTY BUT MENTALLY ILL PLEA (**MFEMI**)
- ☐ MOTION FOR EVAL FOR NOT GUILTY BY REASON OF INSANITY PLEA (**MFERI**)
- ☐ MOTION FOR EVAL FOR MENTAL HEALTH COMPETENCY; GUILTY BUT MENTALLY ILL PLEA; AND NOT GUILTY BY REASON OF INSANITY PLEA (**MFECMIRI**)
- ☐ MOTION FOR EVAL FOR MENTAL HEALTH COMPETENCY AND GUILTY BUT MENTALLY ILL PLEA (**MFECMI**)
- ☐ MOTION FOR EVAL FOR MENTAL HEALTH COMPETENCY AND NOT GUILTY BY REASON OF INSANITY PLEA (**MFECRI**)
- ☐ MOTION FOR EVAL FOR GUILTY BUT MENTALLY ILL AND NOT GUILTY BY REASON OF INSANITY PLEA (**MFEMIRI**)

(Check appropriate box)

,

Defendant.

* *

COMES NOW, the above-named defendant , acting through his/her attorney, , and hereby moves the Court for an evaluation for the purposes of determining MENTAL HEALTH COMPETENCY,for the reason and upon the grounds that there is reasonable cause to believe such evaluation is appropriate as it relates to the defense in the above-entitled matter.

[Insert any additional information as deemed appropriate here:]

Respectfully submitted this _____ day of _____ 20_____.

_____

Attorney for the Defendant