MDO and 1026.5 Recommitments from a Defense Perspective

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Can't you see he is ill?

Why are you fighting us when we are just trying to help him?

Because civil commitment proceedings involve the deprivation of liberty, they involve the most elemental of liberty interests.

People v. Litmon (2008) 162 Cal.App.4th 383, 399

FUNDAMENTAL DEFINITIONS FOR MDO AND 1026.5

Respondent?

The person the government is trying to recommit.

MDO Standard

CALCRIM 3427

The People must prove beyond a reasonable doubt that:

- The respondent has a severe mental disorder;
- The severe mental disorder is not in remission or cannot be kept in remission without continued treatment; and
- Because of the severe mental disorder, respondent presently represents a substantial danger of physical harm to others.

What is a severe disorder?

CALCRIM 3457

an illness or disease or condition that substantially impairs the person's thought, perception of reality, emotional process, or judgment; or that grossly impairs his or her behavior; or that demonstrates evidence of an acute brain syndrome for which prompt remission, in the absence of treatment, is unlikely.

What is not a severe disorder?

CALCRIM 3457

a personality or adjustment disorder,

epilepsy,

mental retardation or other developmental disabilities, or

addiction to or abuse of intoxicating substances.

Remission?

The external signs and symptoms of the severe mental disorder are controlled by either psychotropic medication or psychosocial support.

Cannot be kept in remission

A severe mental disorder cannot be kept in remission without treatment if, during the period of the year prior to trial, respondent:

- Was physically violent except in self-defense;
- Made a serious threat of substantial physical harm upon the person of another so as to cause the target of the threat to reasonably fear for his or her safety or the safety of his or her immediate family;
- Intentionally caused property damage; or
- Did not voluntarily follow the treatment plan.

No switching disorders

"The mental disorder for which extended involuntary treatment is sought must be the same mental disorder for which defendant was treated as a condition of his parole."

People v. Garcia (2005) 127 Cal.App.4th 558, 567

Court can decide outpatient

the court has authority to release the MDO for outpatient treatment so long as it finds "there is reasonable cause to believe that the committed person can be safely and effectively treated on an outpatient basis." (§ 2972, subd. (d).)

People v. May (2007) 155 Cal.App.4th 350, 359

But respondent has to ask

People v. Gregerson (2011) 202 Cal.App.4th 306, 315

But if asks, only a reasonable cause showing

the patient must raise a strong suspicion in a person of ordinary prudence that outpatient treatment would be safe and effective. The patient need not meet "the higher burden" set by the preponderance standard of showing it is more likely than not that outpatient treatment would be safe and effective.

People v. Gregerson (2011) 202 Cal.App.4th 306, 315

1026.5 Standard

CALCRIM 3453

The People must prove respondent:

- suffers from a mental disease, defect, or disorder; and
- As a result of the mental disease, defect, or disorder, respondent now:
  - Poses a substantial danger of physical harm to others; and
  - Has serious difficulty in controlling dangerous behavior.

1026.5 Affirmative Defense
CALCRIM 3453

Control of a mental condition through medication. Respondent must prove that:

- no longer poses a substantial danger of physical harm to others because is now taking medicine that controls the mental condition; and
- will continue to take that medicine in an unsupervised environment.

DIFFERENCES BETWEEN MDO & 1026.5

Differences in illness

MDO	1026.5
severe mental disorder	mental disease, defect, or disorder
Exclusions	No exclusions

Differences in defenses

MDO	1026.5
Prosecution must prove won't take medication	Likely to take meds is affirmative defense
People v. Noble (2002) 100 Cal.App.4th 184, 190	

Differences in recommitments

MDO	1026.5
1 year recommitment	2 year recommitment

Differences in eligible crimes

MDO	1026.5
Felony Offenses listed in Penal Code, section 2962, subd. (e)(2)	Any offense that someone has been found not guilty by reason of insanity

Differences in self-incrimination

MDO	1026.5
No right to refuse to testify if called by government	Right to refuse to testify if called by government
People v. Merfeld (1997) 57 Cal.App.4th 1440, 1446	*People v. Haynie* (2004) 116 Cal.App.4th 1224, 1230

Differences in self-representation

MDO	1026.5
No constitutional right to self-representation	Constitutional right to self-representation
People v. Williams (2003) 110 Cal.App.4th 1577, 1591	*People v. Williams* (2003) 110 Cal.App.4th 1577, 1591

Differences in outpatient treatment

MDO	1026.5
Court can order after trial	No authorization to order
Pen. Code, § 2972, subd. (d)	

RESPONDENTS' RIGHTS

Right to an Attorney

"If the person is indigent, the county public defender shall be appointed."

Pen Code § 2972, subd. (a)

Jury Trial

"The trial shall be by jury unless waived by both the person and the district attorney."

Pen Code, § 2972, subd. (a)

Unanimous Verdict

Also from Penal Code, § 2972, subd. (a)

No directed verdict

"In this case, defendant did not waive his right to a jury trial. Hence, the trial court improperly granted the People's motion for a directed verdict--which essentially converted defendant's jury trial into a bench trial without defendant's waiver."

People v. Cosgrove (2002) 100 Cal.App.4th 1266, 1275

Defense Attorney can waive jury trial

Attorney can waive even over respondent's objection.

People v. Montoya (2001) 86 Cal.App.4th 825, 831

Reasonable time to prepare

"the defendant in a continued treatment proceeding has a due process right to a reasonable amount of time to prepare for trial."

People v. Fernandez (1999) 70 Cal.App.4th 117, 132

General 5th Amendment

Every witness has right not to testify if answers could possibly incriminate them.

US Const. V Amend.; Cal. Const., art. I, § 15; Evid. Code, § 930; *People v. Merfeld* (1997) 57 Cal.App.4th 1440, 1443

To actually get treated

Any commitment under this article places an affirmative obligation on the treatment facility to provide treatment for the underlying causes of the person's mental disorder.

Pen. Code, § 2972, subd. (f)

ATTORNEY DUTIES

Same duties as to any other client

Competence

Loyalty

Confidentiality

"As advocate, a lawyer zealously asserts the client's position under the rules of the adversary system."

ABA Model Rules, Preamble, (2)

Loyalty

And when his client is on the ropes, the lawyer, standing alone if need be, is that one person who, in the interest of his client, skillfully defies the state, the opposing litigant, or whoever threatens. The lawyer is prepared to stand against the forces of hell though others see that as his client's just desert. He assures all adversaries, in the vernacular of the streets, 'You may get my client but you're got to come through me first.'

Thornton v. Breland (Miss. 1983) 441 So.2d 1348, 1350

But the passenger tells the captain where to go

Waiving jury and ethics

Because the client controls the objective of the representation . . .

Attorneys can only waive jury over the client's objection if it helps get to the objective

EVALUATOR'S DUTIES

APA Ethical Standard 9.01(a)

Psychologists base the opinions contained in their recommendations, reports and diagnostic or evaluative statements, including forensic testimony, on information and techniques sufficient to substantiate their findings.

APA Ethical Standard 9.02(a)

Psychologists administer, adapt, score, interpret or use assessment techniques, interviews, tests or instruments in a manner and for purposes that are appropriate in light of the research on or evidence of the usefulness and proper application of the techniques.

APA Ethical Standard 9.02(b)

Psychologists use assessment instruments whose validity and reliability have been established for use with members of the population tested. When such validity or reliability has not been established, psychologists describe the strengths and limitations of test results and interpretation.

APA Ethical Standard 9.02(c)

Psychologists use assessment methods that are appropriate to an individual's language preference and competence, unless the use of an alternative language is relevant to the assessment issues.

APA Ethical Standard 2.04(a)

Psychologists who perform interventions, or administer, score, interpret, or use assessment techniques are familiar with the reliability, validation, and related standardization, or outcome studies of, and proper applications and uses of, the techniques they use.

APA Ethical Standard 9.06

When interpreting assessment results, including automated interpretations, psychologists take into account the purpose of the assessment as well as the various test factors, test-taking abilities and other characteristics of the person being assessed, such as situational, personal, linguistic and cultural differences, that might affect psychologists' judgments or reduce the accuracy of their interpretations. They indicate any significant limitations of their interpretations.

APA Ethical Standard 9.08

(a) Psychologists do not base their assessment or intervention decisions or recommendations on data or test results that are outdated for the current purpose.

(b) Psychologists do not base such decisions or recommendations on tests and measures that are obsolete and not useful for the current purpose.

APA Ethical Standard 9.09

a) Psychologists who offer assessment or scoring services to other professionals accurately describe the purpose, norms, validity, reliability and applications of the procedures and any special qualifications applicable to their use.

(b) Psychologists select scoring and interpretation services (including automated services) on the basis of evidence of the validity of the program and procedures as well as on other appropriate considerations. (See also Standard 2.01b and c, Boundaries of Competence.)

(c) Psychologists retain responsibility for the appropriate application, interpretation and use of assessment instruments, whether they score and interpret such tests themselves or use automated or other services.

APA Ethical Standard 3.09

When indicated and professionally appropriate, psychologists cooperate with other professionals in order to serve their clients/patients effectively and appropriately.

APA Ethical Principle D: Justice

Psychologists recognize that fairness and justice entitle all persons to access to and benefit from the contributions of psychology and to equal quality in the processes, procedures and services being conducted by psychologists. Psychologists exercise reasonable judgment and take precautions to ensure that their potential biases, the boundaries of their competence and the limitations of their expertise do not lead to or condone unjust practices.

APA Ethical Principle E:

Psychologists respect the dignity and worth of all people, and the rights of individuals to privacy, confidentiality, and self-determination. Psychologists are aware that special safeguards may be necessary to protect the rights and welfare of persons or communities whose vulnerabilities impair autonomous decision making. Psychologists are aware of and respect cultural, individual and role differences, including those based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language and socioeconomic status and consider these factors when working with members of such groups. Psychologists try to eliminate the effect on their work of biases based on those factors, and they do not knowingly participate in or condone activities of others based upon such prejudices.

Testing Standard 1.1

A rationale should be presented for each recommended interpretation and use of test scores, together with a comprehensive summary of the evidence and theory bearing on the intended use or interpretation.

Testing Standard 2.10

When subjective judgment enters into test scoring, evidence should be provided on both inter-rater consistency in scoring and within-examinee consistency over repeated measurements.

Testing Standard 7.9

When tests or assessments are proposed for use as instruments of social, education, or public policy, the test developers or users proposing the test should fully and accurately inform policy makers of the characteristics of the tests as well as any relevant and credible information that may be available concerning the likely consequences of test use.

PREPARATION

Client relationship

Need to build trust

Mentally ill ≠ stupid

Written communication helps

Discovery

Hospital records
Underlying case
Previous Recommitments
Civil Discovery rules apply
Doctors' malpractice coverage

Investigation

Talk to respondent's family

Talk with staff at hospital

Research situation around committing offense

Narrative/Case Theme

Dangerousness not Weirdness

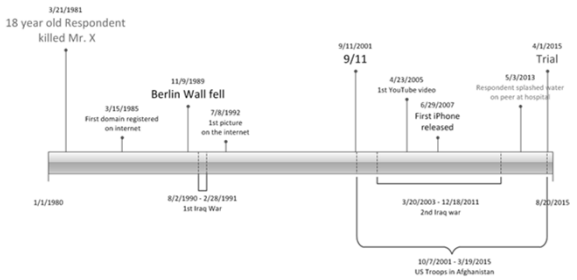
Current risk of physical harm

In remission and will stay that way

Length of time since last injury

What world events and major changes have occurred since the last time respondent caused an injury

Timeline with major events



PRE-TRIAL MOTIONS

Due Process Confrontation

The United States Supreme Court has determined that because of the significance of the interest that "[d]ue process, in other words, requires that he be present with counsel, have an opportunity to be heard, be confronted with witnesses against him, have the right to cross-examine, and to offer evidence of his own." (*Specht v. Patterson* (1967) 386 U.S. 605, 610 [87 S.Ct. 1209, 1212, 18 L.Ed.2d 326].)

Victim Hearsay

For incidents at the hospital, victim hearsay statements require special indicia of reliability. (*People v. Otto* (2001) 26 Cal.4th 200, 210 [a sexually violent predator commitment proceeding].)

"Unreliable evidence lacks trustworthiness and is speculative; therefore it is irrelevant." (*People v. Parrison* (1982) 137 Cal.App.3d 529, 539; citing *People v. Allen* (1976) 65 Cal.App.3d 426, 434.)

Object to Hearsay that is basis of opinion

"while an expert may give reasons on direct examination for his opinions, including the matters he considered in forming them, he may not under the guise of reasons bring before the jury incompetent hearsay evidence."

People v. Coleman (1985) 38 Cal.3d 69, 92 citing *People v. LaMacchia* (1953) 41 Cal.2d 738

Objecting to admission as business records

Many mental health records are not business records because they do not record events or acts, but are instead reasoning and thought processes. And they rely on statements of unknown reliability

- *People v. O'Tremba* (1970) 4 Cal.App.3d 524, 528-529
- *People v. Reyes* (1974) 12 Cal.3d 486, 503
- *People v. Young* (1987) 189 Cal.App.3d 891, 912

No testimony re other experts' reports

"[I]t generally is not appropriate for the testifying expert to recount the details of the other physician's report or expression of opinion."

People v. Catlin (2001) 26 Cal.4th 81, 137

Object to psychiatric conclusion of dangerousness

In the light of recent studies it is no longer heresy to question the reliability of psychiatric predictions. Psychiatrists themselves would be the first to admit that however desirable an infallible crystal ball might be, it is not among the tools of their profession.

People v. Burnick (1975) 14 Cal.3d 306, 325-27

It must be conceded that psychiatrists still experience considerable difficulty in confidently and accurately *diagnosing* mental illness. Yet those difficulties are multiplied manyfold when psychiatrists venture from diagnosis to prognosis and undertake to predict the consequences of such illness:

People v. Burnick (1975) 14 Cal.3d 306, 325-27

Perhaps the psychiatrist is an expert at deciding whether a person is mentally ill, but is he an expert at predicting which of the persons so diagnosed are dangerous? Sane people, too, are dangerous, and it may legitimately be inquired whether there is anything in the education, training or experience of psychiatrists which renders them particularly adept at predicting dangerous behavior.

People v. Burnick (1975) 14 Cal.3d 306, 325-27

"Predictions of dangerous behavior, no matter who makes them, are incredibly inaccurate, and there is a growing consensus that psychiatrists are not uniquely qualified to predict dangerous behavior and are, in fact, less accurate in their predictions than other professionals."

People v. Burnick (1975) 14 Cal.3d 306, 325-27

Object to relevance of incidents more than a year old for remission

A person "cannot be kept in remission without treatment" if during the year prior to the question being before the Board of Parole Hearings or a trial court, he or she has been in remission and he or she has been physically violent, except in self-defense, or he or she has made a serious threat of substantial physical harm upon the person of another so as to cause the target of the threat to reasonably fear for his or her safety or the safety of his or her immediate family, or he or she has intentionally caused property damage, or he or she has not voluntarily followed the treatment plan.

Pen. Code, § 2962

What doors do the doctors open?

Does the expert give an opinion that would allow us to cross-examine on a subject we might not ordinarily get to?

- For example, doctors mention respondent's statements that he should have just plead guilty in analyzing his mental health. The maximum sentence assists jury in assessing whether respondent's comments are a function of rational 20/20 hindsight or mental illness.

Jury Selection

Front load the bad stuff – if the client killed someone, tell the prospective jurors that

Seek those distrustful of mental health professionals if not putting own expert on

Government's Case

Limit with motions

Don't be afraid to take an expert on voir dire

Defense Case

Own expert

Hospital staff with day to day contact

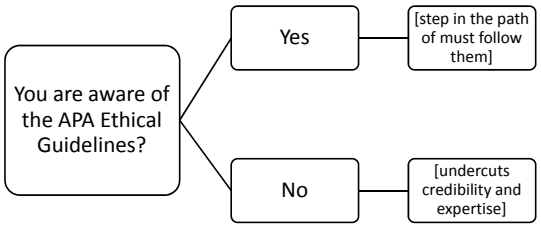
Client?

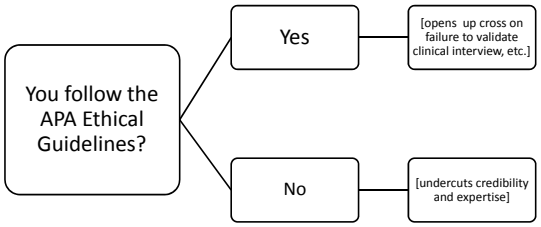
CROSS-EXAMINATION OF EXPERTS

Expert opinion requirements

Opinion must assist factfinder

Must be based on principles generally accepted in the field





Unaided Clinical Judgment

". . . Clinicians have difficulty distinguishing between actual violence risk variables and those they intuitively believe to be predictive but which are not. They have difficulty incorporating all of the available data and thus emphasize variables that are most memorable or most consistent with personal bias, resulting in faulty weighting."

Cunningham & Reidy (1999). Don't Confuse me with the facts: Common errors in violence risk assessment at capital sentencing. Criminal Justice and Behavior, 26, 20-43.

Unaided clinical judgment

Professionals are ". . . accurate in no more than one out of three predictions of violent behavior over a several year period among institutionalized populations that both have committed violence in the past (and thus had high base rates for it) and who were diagnosed as mentally ill."

Monahan, J. (1981). The clinical prediction of violent behavior. A monograph series. U.S. Department of Health and Human Services, Rockville: MD: National. Institute of Mental Health.

Unaided clinical judgment

no better than base rate

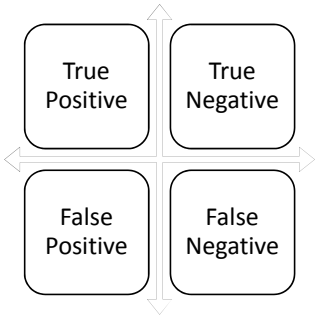
Werner, P.D., Rose, T.L., & Yesavage, J.A. (1983). Reliability, accuracy, and decision-making strategy in clinical predictions of imminent dangerousness. Journal of Consulting and Clinical Psychology, 51, 815-825.

Unaided clinical judgment

Unacceptable levels of accuracy

Bonta, J., Law, M., & Hanson, K. (1998). The prediction of criminal and violent recidivism among mentally disordered offenders: a meta-analysis. Psychological Bulletin, 122, 123-142.

False Positives



Outcome vividness & low probability events

If it is easy to imagine, but low probability, it will be given greater weight than warranted.

Koehler, J.J. & Macchi, L. (2004). Thinking about low-probability events. Psychological Science, 15, 54-546.

Overlooking Normalcy

Is the behavior truly a factor of mental illness?

Preconceived expectations

Same information, but different label, creates different level of pathology: students interested in psych courses v. candidates for hospitalization.

Sattin, D.B. (1980). Possible sources of error in the evaluation of psycho-pathology. Journal of Clinical Psychology, 36, 99-105.

Ruling in v. Ruling Out

Scientific method is ruling out, not ruling in

Questioning tends to be ruling

Subjective Recall

Even experienced interviewers do not accurately recall their behavior during interviews.

- Truax, C.B. (1966). Reinforcement and non-reinforcement in Rogerian psychotherapy. Journal of Abnormal Psychology, 71, 1-9.

Diagnostic impressions lead to selective recall.

- Arkes, H.R. & Harkness, A.R. (1980). Effect of making a diagnosis on subsequent recognition of symptoms. Journal of Experimental Psychology, 6, 99-105.

Anchoring Bias

Mental health professionals affected by anchoring bias – heard it early so colors expectations

Friedlander, M.L. & Stockman, S.J. (1983). Anchoring and publicity effect in clinical judgment. Journal of Clinical Psychology, 39, 637-643.

Mental Health professionals worse about anchoring than random college students.

Friedlander, M.L. & Phillips, S.D. (1984). Preventing anchoring errors in clinical judgment. Journal of Consulting and Clinical Psychology, 52, 366-371

Attribution Bias

Clinicians often overestimate personality factors and underestimate situational factors.

Plous, S. & Zimbardo, P.G. (1986). Attributional biases among clinicians: A comparison of psychoanalysts and behavior therapists. Journal of Consulting and Clinical Psychology, 45, 101-103.

Low inter-rater reliability in clinical interview

Doctoral-level psychologists had a 39% agreement on there conclusions from the interview of the same subjects.

Wilson, F.E. & Evans, I.M. (1983). The reliability of target-behavior selection in behavioral assessment. Behavioral Assessment, 5, 15-32.

Actuarial procedures fare better

Meta-analysis of 136 studies found in 64 actuarial more accurate, in 64 equal accuracy, only 8 found clinical judgment more accurate.

Grove, W.M., Zald, D.H., Lebow, B.S., Snits, B.E., & Nelson, C.E. (1996). Clinical vs. Mechanical prediction: A meta-analysis. Psychology, Public Policy, and Law, 2, 293-323.

Bias Blind Spot

The tendency to see oneself as less biased than other people, or to be able to identify more cognitive biases in others than in oneself

Negativity Bias

The bad sticks out more than the good.

Bizarreness Effect

Bizarre material is better remembered than common material.

Von Restorff effect

That an item that sticks out is more likely to be remembered than other items

Brain Development

If the committing offense occurred before 22, has the evaluator factored in brain development.

Consistency

If you attack the opposing experts for not using objective testing, your expert should have used objective testing

GAF scores

Yes, the DSM 5 did away with them. But the hospital records will still contain them. And not everyone is happy with the DSM 5.

GAF 1-10

Persistent danger of severely hurting self or others (e.g., recurrent violence) OR persistent inability to maintain minimal personal hygiene OR serious suicidal act with clear expectation of death.

GAF 11-20

Some danger of hurting self or others (e.g., suicide attempts without clear expectation of death; frequently violent; manic excitement) OR occasionally fails to maintain minimal personal hygiene (e.g., smears feces) OR gross impairment in communication (e.g., largely incoherent or mute).

GAF 21-30

Behavior is considerably influenced by delusions or hallucinations OR serious impairment in communication or judgment (e.g., sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) OR inability to function in almost all areas (e.g., stays in bed all day; no job, home, or friends)

GAF 31-40

Some impairment in reality testing or communication (e.g., speech is at times illogical, obscure, or irrelevant) OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood (e.g., depressed man avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant at home, and is failing at school).

GAF 41-50

Serious symptoms (e.g.. suicidal ideation, severe obsessional rituals, frequent shoplifting) OR any serious impairment in social, occupational, or school functioning (e.g., no friends, unable to keep a job).

GAF 51-100

Unlikely to be talking about.

How to use

If it is not 1-20,

then the evaluator had an option of choosing something reflecting current risk of physical harm and did not choose that option

Co-occurring disorders

Especially critical in MDO cases

Past Behavior as predictor

In last 180 days, he hasn't injured anyone

In last 365 days, he hasn't injured anyone

In last 3650 days, he hasn't injured anyone

In the last 11,000 days, he hasn't injured anyone

Client with diagnosis of schizophrenia keeps talking about monsters eating client alive from stomach.

Client also has delays with a developmental level between 8-11 years

Client also diagnosed with metastasized stage III stomach cancer with poor treatment prognosis