

# DISABILITY LAW: It's Not Just for NGI's Anymore

by Robert "Rock" Pledl  
and Raymond Dall'Osto

## I. Effective and Creative Representation of Disabled Persons in Criminal Cases.

- A. Identifying disabilities and developing options for your client.
  - (i) Don't stop your search so soon.
  - (ii) Get *all* the background information, research the medical condition and consult with experts.
  - (iii) Research the caselaw, not just criminal cases, and the medical conditions too. Google it!
  - (iv) If you don't do it, who will? *Rompilla v. Beard*, \_\_\_ U.S. \_\_\_, 125 S.Ct. 2456 (2005).
- B. Enough for an NGI?
  - (i) Mental disease.
  - (ii) Mental defect.
  - (iii) Regardless, be creative and pry open the *Steele* door; see, e.g., *State v. Gardner*, 230 Wis. 2d 32, 601 N.W.2d 670 (Ct. App. 1999).
- C. If not enough for an NGI finding, how can the condition be utilized to improve your client's situation:
  - (i) Use in plea negotiations.
  - (ii) Use as basis for alternative to revocation.

- (iii) Use as mitigation at sentencing.
- (iv) Use in guardianship proceedings.
- (v) Use to obtain funding, treatment, vocational and other rehab and placement.

D. Two Case Examples.

- (i) NGI client who wants case over.
- (ii) Brain-injured disabled client, who the system wants to send back to prison

(See materials at Appendix 1).

## **II. Legal Challenges Based Upon Your Client's Disabilities.**

A. Introduction to disability services that can serve as alternatives to criminal prosecution:

- (i) Legal proceedings involving individuals with mental disabilities:
  - (a) Chapter 51 - civil commitment for treatment.
  - (b) Chapter 54 - guardianship.
  - (c) Chapter 55 - protective placement.
- (ii) Disability services in general:
  - (a) Special education services in public schools (legal eligibility through age 21) may include significant counseling and treatment services if specified in the individual's plan. Detailed transition process

to link graduating student to services in the adult disability system.

- (b) Case management and community support programs -- assertive community treatment for individuals with mental illness.
- (c) Diversion programs for individuals with developmental disabilities -- designed to deal with behavior problems in the community to prevent unnecessary admissions to psychiatric hospitals and nursing homes.

B. Dealing with and suppression of statements allegedly made by defendants with disabilities.

(i) Disabilities affecting the communication process:

- (a) Deafness and other hearing impairments.
- (b) Developmental disabilities including autism spectrum disorders.
- (c) Brain injuries.
- (d) Mental Illness.
- (e) Alcohol and drug use.

(ii) The United States Department of Justice (USDOJ) has recently issued new guidelines pertaining to police procedures and people with disabilities. These three **resources are attached at Appendix 2** and are also available at [www.usdoj.gov/crt/ada/publicat.htm](http://www.usdoj.gov/crt/ada/publicat.htm).

C. Communicating with people who are deaf or hard of hearing. The following are excerpts from the USDOJ brochure:

- (i) When you are interviewing a witness or a suspect or engaging in any complex conversation with a person

whose primary language is sign language, a qualified interpreter is usually needed to ensure effective communication.

- (ii) If a sign language interpreter is requested, be sure to ask *which* language the person uses. American Sign Language (ASL) and Signed English are the most common. [Emphasis in original].
  - (iii) It is inappropriate to ask a family member or companion to interpret in a situation like this [referring to case example] because emotional ties may interfere with the ability to interpret impartially.
- D. Model policy for law enforcement on communicating with people who are deaf or hard of hearing.
- E. Commonly asked questions about the Americans With Disabilities Act (ADA) and law enforcement.
- (i) There is also an informational video designed for law enforcement roll call training available from USDOJ.
  - (ii) USDOJ has extensive rule-making authority under Title II, 42 U.S.C. §12134, so its interpretations of the ADA in these guidelines and materials are either controlling or entitled to significant deference. *Bragdon v. Abbott*, 524 U.S. 624, 646 (1998).
  - (iii) Use the USDOJ materials to determine whether officers utilized appropriate procedures to obtain information and make the decision to arrest.
    - (a) Has the law enforcement agency provided the DOJ materials to its officers?
    - (b) Has the law enforcement agency adopted the model policy?

- (c) Did the investigating officers follow the DOJ guidelines?
  - (d) Were the Miranda warnings communicated effectively?
  - (e) Was the waiver decision intelligent and voluntary?
  - (f) Did the defendant understand the questions?
  - (g) Did the investigating officers understand the answers?
- (iv) Provision of interpreter service or other "standard" aids and services may not be sufficient based on individual's needs. *Gregory v. Administrative Office of the Courts of New Jersey*, 168 F.Supp.2d 319 (D.N.J. 2001) (failure to provide computer aided realtime translation (CART) violated civil litigant's right to effective participation in court proceedings).
  - (v) Get expert testimony about effectiveness of various communication modalities for the specific defendant. Some developmental disabilities including autism spectrum disorders involve communication issues in connection with cognitive limitations. Some brain injuries and other disabilities also affect the process of communication.
- F. Seeking to dismiss the criminal case entirely based on the defendant's disability.
- (i) Cases that have addressed the dismissal of criminal prosecutions based on the defendant's disability status:
    - (a) *Robinson v. California*, 370 U.S. 660 (1962), involved a state statute that criminalized being "addicted to the use of narcotics." The defendant was found guilty solely based on the extensive

needle marks on his arms although he was not under the influence or possessing drugs at the time of the arrest. The United States Supreme Court held:

It is unlikely that any state at this moment in history would attempt to make it a criminal offense for a person to be mentally ill, or a leper, or be afflicted with a venereal disease. A state might determine that the general health and welfare require that the victims of these and other human afflictions be dealt with by compulsory treatment, involving quarantine, confinement, or sequestration. But, in the light of contemporary human knowledge, a law which made a criminal offense of such a disease would doubtless be universally thought to be an infliction of cruel and unusual punishment in violation of the Eighth and Fourteenth Amendments . . .

Even one day in prison would be a cruel and unusual punishment for the "crime" of having a common cold. 370 U.S. at 666-7.

- (b) *Powell v. Texas*, 392 U.S. 514 (1968), involved a conviction for public intoxication. The defendant sought to apply *Robinson* based on the involuntary nature of alcoholism. The Court issued a confusing 4-1-4 decision in which the concurrence seemed to agree with the dissent on most points but agreed with the plurality that the Texas statute prohibited the conduct of drinking in public rather than the clinical condition of alcoholism which the defendant was free to continue as long as it was in private.
- (c) *State v. Cummins*, 168 N.J. Super. 429, 403 A.2d 67 (Law Div. 1979), was an appeal from a conviction for municipal disorderly conduct while the

defendant was involuntarily committed to a New Jersey State Hospital with a diagnosis of manic-depressive illness. The record showed that he had a history of making racial accusations, being "over-talkative" and belligerent while in the acute phases of his illness. On the date in question, he was arrested for "being unruly and calling the attendant 'nasty names.'" The Superior Court reversed the conviction, saying:

The state had decided that defendant required compulsory treatment for his illness and he was accordingly involuntarily committed to the Marlboro Psychiatric Hospital. To convict the involuntary committee of a Quasi-criminal offense for displaying the symptoms of his illness while in a place intended to treat that illness, and upon the complaint of one whose duty it is to have the care and custody of such a patient, imposes punishment where none can either constitutionally or morally be justified. The application of the statute to this defendant under the facts presented not only constitutes a misapplication of the statute but constitutes an unconstitutional infliction of cruel and unusual punishment in violation of the Eighth and Fourteenth Amendments. See *Robinson v. California*, . . . 403 A.2d at 69.

- (d) *Jones v. City of Los Angeles*, 444 F.3d 1118 (9th Cir. 2006), was a §1983 civil rights case challenging the enforcement of a city ordinance that provided: "No person shall sit, lie or sleep in or upon any street, sidewalk or other public way." Six homeless individuals sought an injunction to prohibit enforcement of the ordinance during nighttime hours and at any time against

individuals with disabilities. The record showed that there are 1,000 more homeless people than there are beds in shelters and other similar housing resources in the City. There are 50,000 more homeless individuals than available beds in Los Angeles County. The District Court granted summary judgment based on its reading of *Robinson, Powell and Joyce v. City and County of San Francisco*, 846 F.Supp. 843 (N.D. Cal. 1994). The Ninth Circuit reversed in a 2-1 decision. It first held that the plaintiffs had standing to challenge the application of the ordinance under the Eighth Amendment prior to prosecution and sentencing:

The Cruel and Unusual Punishment Clause's third protection differs from the first two in that it limits what the state can criminalize, not how it can punish. See *Ingraham*, 430 U.S. at 667. This protection governs the criminal law process as a whole, not only the imposition of punishment postconviction. See, e.g., *Robinson v. California*, 370 U.S. 660 (1962) . . . . If the state transgresses this limit, a person suffers constitutionally cognizable harm as soon as he is subjected to the criminal process. (Citations omitted.) 444 F.3d at 1128-9.

The Court held that the availability of the general necessity defense at trial did not save the statute since by that point the individuals would already have been exposed to jail and the loss of their possessions. 444 F.3d at 1131. The Ninth Circuit considered the City's arguments based on *Powell v. Texas* that many people were voluntarily homeless, but decided that "an individual may become homeless based on factors both within and beyond his immediate control, especially in consideration of the composition of the homeless as a group: the mentally ill, addicts, victims of

domestic violence, the unemployed and the unemployable. 444 F.3d at 1137.

The Court ultimately held that the ordinance would violate the Eighth Amendment unless its enforcement was limited and remanded to the District Court to issue an appropriate injunction. (The defendants requested *en banc* review. That petition is undecided at the time this outline was prepared.)

- (e) *U.S. v. Sarver*, 2006 WL 1390421 (N.D. Cal. 2006), was a prosecution for bank robbery. The defendant sought to apply the *Jones v. City of Los Angeles* theory to challenge the Federal insanity standard and dismiss the case on the ground that he was being prosecuted for the “status of being mentally ill.” This was denied because the defense had not shown . . . “that the conduct that is being criminalized, bank robbery, “is integral to and an unavoidable result of” being mentally ill. Simply stated, there is no nexus between the charged conduct and the defendant’s status.” 2006 WL 1390421, \*2.
- (ii) Challenging the prosecution of individuals with disabilities who are in government care or custody.
- (iii) If the government has a duty to provide care and treatment, the legal basis for dismissal may be the outrageous government conduct defense. *State v. Gibas*, 184 Wis. 2d 355, 360-1, 516 N.W.2d 785 (Ct. App. 1994). This requires “that the government’s conduct must be enmeshed in criminal activity in order for the defense to apply.” *Id.*
- (iv) Sections 51.42 and 51.437, *Stats.*, make the county of residence responsible for care and treatment of individuals with disabilities who are not under criminal commitments. Those are a state responsibility.

- (v) Sections 51.61 and 51.35, *Stats.*, contain substantive rights to care and treatment.
- (vi) The United States Supreme Court has found a substantive due process right to care and treatment for people with disabilities who are in state custody or in a "special relationship." *Youngberg v. Romeo*, 457 U.S. 307 (1982); *DeShaney v. Winnebago County*, 489 U.S. 189, 199 (1989), ("In *Youngberg* . . . [we held] that the substantive component of the Fourteenth Amendment's Due Process Clause requires the state to provide involuntarily committed mental patients with such services as are necessary to ensure their "reasonable safety" from themselves and others."); *Collignon v. Milwaukee County*, 163 F.3d 982 (7th Cir. 1998), (discussion of *Youngberg* and *DeShaney* in the mental health context).
- (vii) It is important to investigate whether a defendant was under an inpatient or outpatient commitment, commitment settlement, protective placement, protective services or guardianship order at the time of the alleged crime. Also investigate whether he or she was released from any inpatient facility under circumstances that would arguably violate the transfer and discharge provisions in section 51.35, *Stats.*, or the more general right to treatment in section §51.61, *Stats.*
  - (a) Case Example -- *State v. Hartman*, Case No. F-933164 (Milw. Cnty. Cir. Ct. 1995).
  - (b) Background -- Milwaukee SPD Attorney Peter Goldberg and Attorney Pledl represented the defendant. She injured a nurse on the grounds at the Milwaukee County Mental Health Complex and was charged with aggravated battery. She had been protectively placed under a Chapter 55 order for many years and had a legal guardian. Investigation revealed internal memoranda

stating that her behavioral problems exceeded the ability of MHC to care for her safely. Before the incident, MHC staff had requested that she be transferred to a more secure unit at Winnebago but this was denied for financial reasons. Her treatment plan specifically provided that she was not to be alone with any staff person without nearby backup. A single female nurse took her for a walk in the grove of trees behind the MHC and the assault occurred.

- (c) Motion to Dismiss -- the defense moved to dismiss citing the outrageous government conduct defense and the constitutional impediments to prosecuting the defendant for the status of being mentally disabled. The Circuit Court held:

Given the facts in the instant case, the case involving Ms. Hartman, this court finds persuasive the reasoning of the New Jersey Superior Court in *State v. Cummins*, 403 A.2d 67, a 1979 decision that the prosecution of an institutionalized patient for acting out as might be expected is neither "constitutionally nor morally justified."

In the instant case, the state is in essence seeking to prosecute the defendant for her status, that is as an individual permanently committed for her mental health disabilities and acting in conformity with them; acting in an institutionalized context in which the state itself had placed her, thus assuming responsibility for custodial care and rehabilitative treatment and the risk that such conduct might occur.

\* \* \*

Therefore, the decision to dismiss this action is consistent with the Court's authority to dismiss a prosecution where dismissal would be in the public interest. Given the few benefits that would attach to successful prosecution, the extraordinary expenditure of resources to monitor defendant's competency and the mitigating circumstances concerning her status, the Court finds that dismissal of this case is in the public interest. [Decision, June 15, 1995].

- (d) The civil case -- A §1983 action on Ms. Hartman's behalf was filed in federal court seeking damages and an injunction since it was likely that she would face the threat of prosecution in the future. *Jennifer H. v. Milwaukee County*, Case No. 94-C-1004 (E.D. Wis.). That case resulted in a financial settlement. MHC also agreed to adopt a specific policy covering the prosecution of patients based largely on Applebaum & Applebaum, *A Model Hospital Policy on Prosecuting Patients for Presumptively Criminal Acts*, 42 *Hospital and Community Psychiatry* 12, 1233 (Dec. 1991). Other Wisconsin mental health facilities have adopted similar policies.

G. Applying the ADA to challenge the prosecution of individuals with disabilities who are in and out of government custody.

- (i) Title II of the ADA and §504 of the Rehabilitation Act apply to all activities of public entities. 42 U.S.C. §12131; 42 U.S.C. §12132. There is no exception for "core" functions such as operating prisons. *Pennsylvania Dept. of Corrections v. Yeskey*, 524 U.S. 206 (1998). The United States Department of Justice tells police departments that they must follow the ADA.

- (ii) The United States Supreme Court has found substantial overlap between Title II of the ADA and the Fourteenth Amendment along with other Constitutional provisions. *United States v. Georgia*, \_\_\_ U.S. \_\_\_, 126 S.Ct. 877 (2006); *Tennessee v. Lane*, 541 U.S. 509 (2004).
- (iii) Disparate treatment -- the ADA prohibits classic discrimination against individuals with disabilities in comparison to those without disabilities and also in comparison to other groups of people with disabilities. *Washington v. Indiana High School Athletic Association*, 181 F.3d 840, 847 (7th Cir.), cert. denied, 528 U.S. 1046 (1999), *Olmstead v. L.C.*, 527 U.S. 581, 598 (1999).
- (iv) Reasonable accommodation -- the ADA also requires public entities to make changes and/or modifications in public services in order provide effective access for people with disabilities. 28 C.F.R. §35.130; *Washington*, 181 F.3d at 848; *Wisconsin Community Services v. City of Milwaukee*, 309 F.Supp.2d 1096 (E.D. Wis. 2004) (the trial court's decision in favor of the plaintiffs is currently pending before the Seventh Circuit Court of Appeals *en banc*.)
- (v) The United States Department of Justice, which promulgated the Title II regulations also issued the *Americans with Disabilities Act: Title II Technical Assistance Manual* (1993) (found on the internet at [www.ada.gov/taman2.html](http://www.ada.gov/taman2.html)) which uses a municipal ordinance violation as an example of a law enforcement situation that could call for a reasonable modification. The case example is as follows:

A county ordinance prohibits the use of golf carts on public highways. An individual with a mobility impairment uses a golf cart as a mobility device. Allowing use of the golf cart as a mobility device on the shoulders of public highways where pedestrians are permitted, in limited circumstances that do not involve a significant

risk to the health or safety of others, is a reasonable modification of the county policy. [TA Manual, §II-3.6100, Illus. 3 at 15].

It is very significant that USDOJ takes the position that the reasonable modification right extends into the realm of enforcing public safety provisions. That is also the approach taken by the recent DOJ guidelines.

- (vi) Various *civil* cases have applied the ADA to criminal proceedings. *Lewis v. Truitt*, 960 F.Supp. 175 (S.D. Ind. 1997) (person with hearing impairment who was arrested for failure to respond appropriately to officers' questions stated an ADA claim); *Schorr v. Borough of Lemoyne*, 243 F.Supp.2d 232 (M.D. Pa. 2003) (plaintiffs stated a claim for failure to train based on police shooting of individual with mental illness).
- (vii) The ADA has also been applied in the parole context. *Thompson v. Davis*, 295 F.3d 890 (9th Cir. 2002) (unwritten policy of denying parole to prisoners with substance abuse histories would violate Title II of the ADA); *Webber v. Pa. Bd. of Probation & Parole*, 2006 WL 581197 (M.D. Pa. 2006) (ADA applies but judgment for defendants).
- (viii) The ADA clearly trumps contrary state laws. *Wisconsin Correctional Service v. City of Milwaukee*, 173 F.Supp.2d 842 (E.D. Wis. 2001). The question is whether violating an ADA right in the course of a criminal investigation or prosecution can be a basis for dismissal in addition to stating a civil claim. This may depend on whether the ADA violation is also within the overlapping coverage of the Fourteenth Amendment or other constitutional provisions.
- (ix) In a termination of parental rights case decided shortly after the ADA went into effect, the Wisconsin Court of Appeals held that the ADA did not increase the

county's responsibility to provide court-ordered services "or dictate how these responsibilities must be discharged." *In the Interest of Torrance P.*, 187 Wis. 2d 10, 522 N.W.2d 243 (Ct. App. 1994). This holding is questionable in light of the evolution of the reasonable accommodation right and the general scope of the ADA. Also, the Wisconsin Supreme Court held in a recent TPR case involving an incarcerated mother that it was improper to terminate "based on an impossible condition of return, without consideration of any other relevant facts and circumstances particular to the parent." *In re the Termination of Parental Rights to Max G.W.*, 2006 WL 1889969, ¶56 (Wis. 2006). That is reasonable accommodation language and *Max G.W.* provides some support for making the due process argument for dismissal in criminal cases involving defendants with disabilities.

- (x) The case law provides a basis for applying the jurisprudence developed in the constitutional "status" cases and ADA civil cases to the criminal realm in order to challenge criminal prosecutions where the alleged illegal acts are intertwined with behaviors characteristic of the individual's disability.

### III. Inclusion Of Individuals With Disabilities On Juries.

- A. Categorical exclusion of people with visual impairments from jury service violated ADA. *Galloway v. Superior Court of District of Columbia*, 816 F.Supp. 12 (D.D.C. 1993). The "American concept of the jury trial contemplates a jury drawn from a fair cross-section of the community." *Taylor v. Louisiana*, 419 U.S. 522, 527 (1975); see also *Duren v. Missouri*, 439 U.S. 357, 364 (1979). The defense lawyer is on the front line of guaranteeing this fundamental right to a fair and representative jury for his or her clients.
- B. Specialized technology or services may be necessary to permit effective participation on juries by individuals with visual,

hearing and other impairments. See *Gregory v. Administrative Office of the Courts of New Jersey*, 168 F.Supp.2d 319 (D.N.J. 2001) (failure to provide computer aided realtime translation (CART) violated civil litigant's right to effective participation in court proceedings-this presumably would apply to jurors).

- C. Wisconsin recognizes partial incompetence for purposes of guardianship in current Chapter 880 and the new Chapter 54. More and more people under guardianship orders retain the right to vote, testify, etc. This makes it important to identify local policies or procedures that could automatically exclude people with mental disabilities rather than conduct an individualized determination as to whether they can serve as jurors with or without reasonable modifications.
- D. Investigate what clerk of court is doing to enforce provisions of Chapter 756, *Stats.*, and what affirmative efforts are being done by the clerk and local judges to include the disabled. GET THE ACTUAL NUMBERS, not just lip service.
- E. Research, prepare and bring motions to include disabled jurors and/or to strike unrepresentative panels. §756.07, *Stats.* Don't accept the *status quo*!
- F. Network with state and national disabled rights groups, NLADA, NACDL, the Federal Defender, Legal Services Corporation and other lawyers and groups who have researched and brought such challenges to find out how to do it and the arguments to make.

# **APPENDIX 1**

## **Two Case Examples –**

- (i) NGI Client who wants case over**
- (ii) Brain-injured disabled client**

# **APPENDIX 1**

## **Case Example**

- (i) NGI Client who wants case over**

STATE OF WISCONSIN

CIRCUIT COURT

ANY COUNTY

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STATE OF WISCONSIN,

Plaintiff,

Case No. 03-CF-111

NGI CLIENT,

Defendant.

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**PETITION FOR TERMINATION OF COMMITMENT  
AND CONDITIONAL RELEASE ORDER**

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Defendant NGI Client (Client), by his attorneys Raymond M. Dall'Osto and Gimbel, Reilly, Guerin & Brown, respectfully petitions this court, the Honorable Circuit Judge presiding, for an order terminating his commitment and conditional supervision, which arose out of the not guilty by reason of mental disease (NGI) finding made by the court after hearing the trial of this case. This petition is brought pursuant to section 971.17(5), *Stats.*, and it has been more than six (6) months since the Client was placed on conditional supervision by the court in December 2003.

Section 971.17(5), *Stats.*, states that "the court shall terminate the order of commitment unless it finds that by clear and convincing evidence further supervision is necessary to prevent a significant risk of bodily harm to the person or to others or to private property." To make such a determination, the court should consider not only the "nature and circumstances of the crime," but also the "person's mental history and current mental condition, the person's behavior

while on conditional release, and plans for the living arrangements, support, treatment and other required services after termination of the commitment order." *Id.*

As grounds for the court granting the relief requested, Client submits the attached brief of counsel and affidavits of Attorney Raymond M. Dall'Osto and Psychiatrist, which establish that all of the statutorily required conditions and factors have been fulfilled and that the petitioner poses no significant risk or danger to himself, others, or of causing serious property damage. Therefore, the commitment and conditional release order should be terminated forthwith.

Dated this \_\_\_\_ day of September, 2006.

Respectfully submitted,

GIMBEL, REILLY, GUERIN & BROWN

By:

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STATE OF WISCONSIN

CIRCUIT COURT

ANY COUNTY

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STATE OF WISCONSIN,

Plaintiff,

Case No. 03-CF-111

NGI CLIENT,

Defendant.

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**BRIEF IN SUPPORT OF PETITION FOR TERMINATION  
OF ORDER OF COMMITMENT**

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**FACTS**

The Client was charged with attempting to kill a person in 2003. The Client began to suffer from major depression prior to the incident and was in a psychotic state at the time of the shooting. As a result of Client's actions while suffering from this psychotic condition, the person was injured. Fortunately for all concerned, both the person and the Client have fully recovered. The Client therefore brings this petition to the court to terminate the commitment and conditional release order entered in December 2003 following a court trial, in which Client was found not guilty by reason of mental disease (NGI).

## I. STATUTORY REQUIREMENTS.

A criminal defendant who has been found NGI and is placed on conditional release may petition the court for termination of his conditional release no sooner than six (6) months after the original NGI finding. The statute that governs the termination petition process is section 971.17(5), *Stats.*, which states --

**Petition for termination.** A person on conditional release, or the department of health and family services on his or her behalf, may petition the committing court to terminate the order of commitment. If the person files a timely petition without counsel, the court shall serve a copy of the petition on the district attorney and, subject to sub. (7) (b), refer the matter to the state public defender for determination of indigency and appointment of counsel under s. 977.05 (4) (j). If the person petitions through counsel, his or her attorney shall serve the district attorney. The petition shall be determined as promptly as practicable by the court without a jury. The court shall terminate the order of commitment unless it finds by clear and convincing evidence that further supervision is necessary to prevent a significant risk of bodily harm to the person or to others or of serious property damage. In making this determination, the court may consider, without limitation because of enumeration, the nature and circumstances of the crime, the person's mental history and current mental condition, the person's behavior while on conditional release, and plans for the person's living arrangements, support, treatment and other required services after termination of the commitment order. A petition under this subsection may not be filed unless at least 6 months have elapsed since the person was last placed on conditional release or since the most recent petition under this subsection was denied.

**II. PETITIONER HAS SATISFIED ALL OF THE REQUIRED STATUTORY ELEMENTS FOR A TERMINATION OF HIS CONDITIONAL RELEASE.**

A defendant may petition the committing court after he has been on NGI conditional release starting six (6) months after the commitment order, and must provide the district attorney with notice of his petition. § 971.17(5), *Stats.* The court "shall" grant termination of the commitment order unless the state meets its burden of proof. § 971.17(5), *Stats.* If the state opposes the petition for termination, the state has the burden of proof to demonstrate "by clear and convincing evidence" that the petitioner remains a significant risk and danger to himself, others, or to cause serious property damage. *Id.*

Under section 971.17(5), *Stats.*, an NGI defendant's conditional release status is not analogous to parole or discretionary release under an indeterminate sentencing scheme. Instead, an NGI acquittee is entitled under section 971.17(5), *Stats.*, to termination of the order of commitment *unless* the court finds by clear and convincing evidence that further supervision is necessary in order to prevent a significant risk of bodily harm to the person or to others or of serious property damage.

In making a determination on dangerousness, courts should take full advantage of expert testimony presented at trial and expert opinions provided afterwards as to an NGI acquittee's progress and mental condition. *See State v.*

*Randall*, 192 Wis. 2d 800, 838, 532 N.W.2d 94 (1995). A circuit court should not base a finding of dangerousness only or largely upon just the defendant's past conduct, which led to the original criminal charge and NGI finding. *Randall*, 192 Wis. 2d at 838. Absent an actual showing of evidence by the state indicative of continued dangerousness at the time of the petition for termination, a court should not legally adopt any negative inference. See e.g., *Stewart v. State*, 83 Wis. 2d 185, 265 N.W.2d 489 (1978).

After Client's trial, the court ordered his release on such conditions as it determined to be necessary, including supervision by Department of Corrections probation and contracted mental health agents. See § 971.17(8), *Stats.*, and *State v. Randall*, 222 Wis. 2d 53, 57, 586 N.W.2d 318 (Ct. App. 1998). The standard for continuing a commitment and/or not terminating a conditional release early, is dangerousness. That is, the burden is upon the state to prove by clear and convincing evidence that the defendant is presently a danger to himself or others. § 971.17(5), *Stats.*, and *State v. Randall*, 192 Wis. 2d at 822-824.

In determining whether a person on an NGI conditional release poses such a significant risk and danger, the court must consider the following statutory factors under section 971.17(5): (a) the nature and circumstances of the crime; (b) the defendant's mental history; (c) the defendant's behavior while on conditional release; (d) where the defendant will live; (e) how the defendant will

support himself; and (f) what treatment needs may still exist and what arrangements are available for possible treatment and other required services after the termination of the conditional supervision. *Id.*

The Affidavits of Psychiatrist and Attorney Raymond M. Dall'Osto submitted herewith provide ample evidence the Client's compliance with all of the statutory requirements necessary for the court to order a termination of his conditional release. The Client has partaken in the conditional release program for many years, has been exemplary in his cooperation and has fully overcome the mental illness and psychoses that he suffered from in 2003. Notice of this petition and intent to terminate conditional release, along with the supporting documents, have been duly served upon the district attorney who originally prosecuted this case.

The Client has demonstrated that he has met all of the statutory factors that a court may consider "without limitation." § 971.17(5), *Stats.* The nature and circumstances of the crime do not prohibit the court from terminating the Client's conditional release at this time, because the Client does not pose a danger to the safety of himself or others. The psychosis is no longer an issue. *See* Psychiatrist's Affidavit. The Client has demonstrated no signs of psychosis or serious mental illness since 2003 and his current medical condition is

asymptomatic, thus posing no risk if the court terminates his conditional release. See affidavit and opinions of Psychiatrist submitted herewith.

The Client's behavior while on conditional release has been exemplary and his recovery complete. Therefore, he is entitled to a termination of the December 2003 commitment and conditional release order. Because the Client meets all of the statutory requirements and factors of section 971.17(5), *Stats.*, the circuit court should terminate the commitment and conditional release order forthwith.

**III. PETITIONER DOES NOT POSE A DANGER TO HIMSELF OR OTHERS OR TO PERSONAL PROPERTY AND IS THEREFORE ENTITLED TO TERMINATION OF CONDITIONAL RELEASE.**

The United States Supreme Court has ruled that it is violative of a criminal defendant's due process rights to continue commitment following an NGI finding when the person is no longer mentally ill and dangerous. *Foucha v. Louisiana*, 504 U.S. 71 (1992). In *Foucha*, the defendant was found not guilty by reason of insanity of aggravated burglary and illegal discharge of a firearm while in the midst a drug-induced psychosis. *Id.* at 74. The Louisiana statute at issue in *Foucha* was similar to the Wisconsin statutory scheme in many respects.

The defendant in *Foucha* challenged the Louisiana statute as denying him "due process and equal protection because it allowed a person acquitted by reason of insanity to be committed to a mental institution until he was able to demonstrate that he was not dangerous to himself and others, even though he

did not suffer from any mental illness.” *Id.* In *Foucha*, a panel of doctors reported that the defendant was no longer mentally ill, but the physician panel was unable to say that the defendant was no longer a “menace to himself or others if released” because of his antisocial personality and his having committed numerous violations and altercations during the course of his commitment period. *Id.* at 74. The defendant was ordered to return to the mental institution. *Id.* at 75. The United States Supreme Court found that this statutory scheme violated both due process and equal protection principles, and the law was struck down. *Id.* at 83-84.

The Supreme Court found that absent certain exceptions, a finding of “dangerousness” without a continued mental illness was insufficient to continue commitment. *Foucha, id.*, at 80-81. In the instant case, Psychiatrist opines that the Client is neither dangerous nor is he suffering from a mental illness any longer. His 2003 psychosis was an aberration and is not likely to recur, especially given the procedures, therapy and medications provided since.

The *Foucha* court held that a finding that a defendant is *both* dangerous and mentally ill is required to continue his commitment. This is consistent with the applicable Wisconsin statute. The Supreme Court has definitively held that “[T]he committed acquittee is entitled to release when he has recovered his sanity or is no longer dangerous, i.e., the acquittee may be held as long as he is

both mentally ill and dangerous, but no longer." *Foucha* at 77, citing both *Addington v. Texas*, 441 U.S. 418 (1979); and *Jones v. United States*, 463 U.S. 354, 363 (1983). The logic and rationale of *Foucha* applies to both custodial and noncustodial commitment orders, as well as to continuation of supervised release, which the Client has been on since December 2003.

While *Foucha* addressed continued NGI confinement in a mental institution, its rationale and principles likewise apply to an NGI termination of conditional release. The same criteria, if not a lesser standard, should be applied to requests for early termination of conditional release for NGI acquittees like the Client, whom the trial court has already determined did not have to be institutionalized and were safe enough to be released into the community on conditional release.

In the Client's case, the state cannot meet its burden of proof by clear and convincing evidence that the Client continues to suffer from a significant mental illness and/or continues to be a danger to himself, to others or to personal property. See affidavits of Psychiatrist and Attorney Dall'Osto and statements of DOC agent and DHFS contract caseworkers cited therein.

**CONCLUSION**

For all the foregoing reasons, petitioner Client respectfully requests that the court grant his petition and terminate the December 2003 commitment order and conditional release.

Dated this \_\_\_\_ day of September, 2006.

Respectfully submitted,

GIMBEL, REILLY, GUERIN & BROWN

By:

---

RAYMOND M. DALL'OSTO  
State Bar No. 1017569  
Attorneys for Defendant

**POST OFFICE ADDRESS:**

Two Plaza East, Suite 1170  
330 East Kilbourn Avenue  
Milwaukee, Wisconsin 53202  
Telephone: 414/271-1440  
*outlines/2006SPDconf/brief*

# **APPENDIX 1**

## **Case Example**

### **(ii) Brain-injured disabled client**


**State of Wisconsin DIVISION OF HEARINGS AND APPEALS**

David H. Schwarz, Administrator  
 819 North 6th Street  
 Room 92  
 Milwaukee, WI 53203-1685

Telephone: (414) 227-4781  
 FAX: (414) 227-3818  
 E-mail: dha.mail@dha.state.wi.us  
 Internet: http://dha.state.wi.us

**FINAL REVOCATION HEARING NOTICE**

May 7, 2002

Hearing Date: **June 17, 2002**

**DISABLED CLIENT**

Hearing Time: **1:00 PM**

Waukesha County Jail  
 515 West Moreland Blvd  
 Waukesha, WI 53186-2428

Hearing Type: **Parole**

Hearing Location: **Waukesha County Jail**

A final revocation hearing has been scheduled to determine whether you have violated the rules or conditions of probation and/or parole and whether the violation warrants revocation of supervision. The hearing will be held before an Administrative Law Judge in accordance with sec. HA 2.05, Wis. Admin. Code, under sec. 973.155, Stats., and the period of reincarceration/good time forfeiture under sec. 302.11, Stats.

The alleged violations of your probation and/or parole are shown on the attached "Notice of Violation and Receipt" (DOC-414a). A list of the evidence and witnesses to be presented at the hearing is shown on the attached "Revocation Hearing Request" (DOC-429). If you are on parole, the request also contains information about the period of reincarceration or good time forfeiture.

Information or evidence in the possession of the Department of Corrections, including information from the "Chronological History" prepared by your agent, may be entered into the hearing record and is available for inspection from the Department of Corrections unless the information or evidence is otherwise confidential. If you are in custody, your attorney may inspect the information.

Your rights at the hearing include: to be present; to deny the allegation; to be heard and to present witnesses; to present documentary evidence; to question witnesses; to the assistance of counsel; to waive the hearing, to receive a written decision stating the reasons for it based upon the evidence presented; and, to appeal the decision in accordance with sec. HA 2.05(8), Wis. Admin. Code.

The division will make a record of all testimony at the hearing and will prepare a written transcript only at the request of a judge who has granted a petition for certiorari review of the decision or upon prepayment of the transcription cost billed at \$3.25 for each page of transcribed material. A duplicate audio tape of the hearing may be obtained at a cost of \$7.50 per cassette. If a request is made for audio copies of hearings which have been recorded in digital format, a copy of that recording will be provided on a compact disk at a cost of \$10.00 per compact disk. You may record the hearing at your own expense.

Inquiries should be directed to (414) 227-4781, or FAX: (414) 227-3818.

cc: Attorney:  
 Agent:  
 Supervisor:  
 Waukesha

**RECEIVED**

MAY 20 2002

STATE PUBLIC DEFENDER  
 Waukesha, Wisconsin

DEPARTMENT OF CORRECTIONS  
Division of Community Corrections  
DOC-260 (Rev. 9/97)

SEP 07 2001

WISCONSIN  
Federal Law  
Federal Regulation  
42 U.S.C. §§ 2000D-3, 2000e-3  
42 C.F.R. Part 2

### ALTERNATIVE TO REVOCATION AGREEMENT

I understand that the Alternative to Revocation Program is a privilege and that I may voluntarily request admission to the Program in lieu of revocation of my probation or parole supervision. Understanding this, I petition the Department of Corrections, Division of Community Corrections, to consider me for placement in the Alternative to Revocation Program, in lieu of revocation.

I admit that I violated the rules and/or conditions of my probation or parole supervision as stated below:

On or about 1/22/01 Disabled Client did grab both arms of Terry Fiala. I also admit to grabbing Dan Shears on 1/25/01. Further, I admit that, between 2/14/01 and 3/5/01, while at the DCJ, I violated the rules of the DCJ by acting disrespectful, displaying unacceptable conduct and was disorderly on at least three occasions, and did threaten to hit Deputy Pickar with my cane

#### ALTERNATIVE TO REVOCATION - Probation and Parole



I agree to the following if I am accepted into the Alternative to Revocation Program:

1. I will stay in the facility designated by the Department for until discharge days.
2. I will obey all of the rules of that facility as acknowledged by my signature on the attached copy of the Acknowledgment of Receipt of Disciplinary Rules for the rules of that facility.
3. A violation of any of the above-mentioned rules, including the Department of Corrections rules governing behavior of a probation or parolee which I previously signed, may lead to a termination of my stay at the facility. If my stay is terminated by the facility, a recommendation for revocation of my probation or parole may be made by the Division of Community Corrections, based on my above-acknowledged violation and/or my conduct in the facility.
4. I will participate in full-time programming (treatment, employment, education or community service).
5. I permit the Department of Corrections to disclose my location in a program/facility to parties having a need to know, as deemed appropriate by the Department.

#### ALTERNATIVE TO REVOCATION - Intensive Supervision



I agree to participate in intensive supervision as an alternative to revocation. I understand that I will be required to participate until successful completion of the case plan objectives set forth by the intensive supervision agent or until discharge, whichever is less. If I am unable to successfully complete intensive supervision, the revocation of my probation/parole will be recommended. I also agree to the following:

1. If required, I will participate in the Electronic Monitoring Program (EMP), following the schedule set forth by my agent.
2. I will continue to be responsible for the payment of any court ordered obligations and supervision fees.
3. I will participate in full-time programming (employment, treatment, education and / or community service).
4. I will abide by the intensive supervision rules.
5. I permit the Department of Corrections to disclose my location in a program / facility to parties having a need to know, as deemed appropriate by the Department.

SIGNATURE OF OFFEN <i>x</i> Disabled Client	DATE SIGNED 9-4-01	SIGNATURE OF WITNESS <i>[Signature]</i>	DATE SIGNED 9-4-01
SIGNATURE OF APPROVING AGENT <i>[Signature]</i>	DATE SIGNED 9-4-01	SIGNATURE OF APPROVING SUPERVISOR <i>[Signature]</i>	DATE SIGNED 9/20/01
SIGNATURE OF APPROVING SUPERINTENDENT OR SOCIAL WORKER			DATE SIGNED

WISCONSIN  
Department of Corrections  
Community Corrections  
(Rev. 2/01)

WISCONSIN  
Administrative Code  
Chapter DOC 328 & 329  
Federal Law  
42 U.S.C. §§ 20000-9, 20000-3  
Federal Regulation  
42 C.F.R. Part 2

# PROBATION / PAROLE RULES

OFFENDER NAME

Disabled Client

DOC NUMBER

256

Notice: If you are on parole and sentenced for crimes committed on or after June 1, 1984, or have chosen to have the new Good Time Law apply to your case and you violate these rules, the highest possible parole violator sentence will be the total sentence less time already served in prison or jail in connection with the offense.

As established by Administrative Rule DOC 328.11, you have an opportunity for administrative review of certain types of decision through the offender complaint process.

The following rules are in addition to any court-ordered conditions. Your probation or parole may be revoked if you do not comply with any of your court-ordered conditions or if you violate any of the following rules.

1. You shall avoid all conduct which is in violation of federal or state statute, municipal or county ordinances, tribal law or which is not in the best interest of the public welfare or your rehabilitation. Some rules listed below are covered under this rule as conduct contrary to law and are listed for particular attention.
2. You shall report all arrests or police contact to your agent within 72 hours.
3. You shall make every effort to accept the opportunities and counseling offered by supervision.

The confidentiality of drug and alcohol treatment records is protected by Federal laws and regulations. Generally programs you are involved in may not say to a person outside the Department of Corrections that an offender is attending the program, or disclose any information identifying him/her as a drug/alcohol abuser unless: 1) You consent in writing; or 2) The disclosure is allowed by a court order; or 3) The disclosure is made to medical personnel in a medical emergency or to a qualified personnel for research, audit, or program evaluation; or 4) You commit or threaten to commit a crime either at the program or against any person who works for the program. Programs that contract with the Wisconsin Department of Corrections can release information to Wisconsin Department of Corrections staff.

Violation of the Federal law and regulations by a program is a crime. These regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate authorities.

Refusal to sign the consent for releasing information, including placement for treatment, shall be considered a refusal of the program.

4. You shall inform your agent of your whereabouts and activities as he/she directs.
5. You shall submit a written report monthly and any other such relevant information as directed by your agent.
6. You shall make yourself available for searches or tests ordered by your agent including but not limited to urinalysis, breathalyzer, DNA collection and blood samples or search of residence or any property under your control.
7. You shall not change residence or employment unless you get approval in advance from your agent, or in the case of emergency, notify your agent of the change within 72 hours.
8. You shall not leave the State of Wisconsin unless you get approval and a travel permit in advance from your agent.
9. You shall not purchase, trade, sell or operate a motor vehicle unless you get approval in advance from your agent.
10. You shall not borrow money or purchase on credit unless you get approval in advance from your agent.
11. You shall pay monthly supervision fees as directed by your agent in accordance with Wis. Stats. s.304.073 or s.304.074, DOC Administrative Rule Chapter 328.043 to 328.046 and shall comply with any department and/or vendor procedures regarding payment of fees.
12. You shall not purchase, possess, own or carry any firearm or any weapon unless you get approval in advance from your agent. Your agent may not grant permission to carry a firearm if you are prohibited from possessing a firearm under Wis. Stat. s. 941.29, Wisconsin Act 71, the Federal Gun Control Act (GCA), or any other state or federal law.
13. You shall not, as a convicted felon, and until you have successfully completed the terms and conditions of your sentence, vote in any federal, state or local election as outlined in Wisconsin Statutes s.6.03(1)(b).
14. You shall abide by all rules of any detention or correctional facility in which you may be confined.
15. You shall provide true and correct information verbally and in writing, in response to inquiries by the agent.
16. You shall report to your agent as directed for scheduled and unscheduled appointments.

I have reviewed and explained these rules to the offender.		I have received a copy of these rules.	
AGENT SIGNATURE	AREA NUMBER	OFFENDER SIGNATURE	DATE SIGNED
	40205	X Disabled Client	9-9-01

WISCONSIN  
COMMUNITY CORRECTIONS  
3/Rev 2/01

WISCONSIN  
Administrative Code  
Chapter DCC 328 & 332  
Federal Law  
42 U.S.C. et 28000-3, 28000-3  
Federal Regulation  
42 C.F.R. Part 2

### PROBATION / PAROLE RULES

OFFENDER NAME

Disabled Client

DOC NUMBER

256

- 17. You shall submit to the polygraph (lie detector) examination process as directed by your agent in accordance with Wisconsin Administrative Code 332.15.
- 18. You shall pay fees for the polygraph (lie detector) examination process as directed by your agent in accordance with Wisconsin Administrative Code 332.17(5) and 332.18 and shall comply with any required Wisconsin Department of Corrections procedures regarding payment of fees.
- 19. You shall follow any specific rules that may be issued by an agent to achieve the goals and objectives of your supervision. The rules may be modified at any time, as appropriate. The specific rules imposed at this time are stated below. You shall place your initial at the end of each specific rule to show you have read the rule.
- 20. You shall not use or possess any illegal drugs, drug paraphernalia or medications not prescribed to you by a medical doctor X OK
- 21. You shall attend, participate in, and complete programming in anger management treatment as directed by Brotoloc staff or your supervising agent X OK
- 22. You shall not be involved in any type of violent or aggressive behavior. Any behavior on your part considered threatening or violent will result in your being jailed until an investigation is completed by your agent X OK
- 23. You shall not consume or possess any beer, wine, liquor, or any alcoholic beverage X OK
- 24. You shall attend, participate in, and complete alcohol and/or drug treatment as directed by Brotoloc staff or your supervising agent X OK
- 25. You shall comply with all of the rules of Brotoloc Health Care Systems, Inc X OK

I have reviewed and explained these rules to the offender.		I have received a copy of these rules.	
AGENT SIGNATURE	AREA NUMBER	OFFENDER SIGNATURE	DATE SIGNED
<u>MAH</u>	40205	X Disabled Client	9-9-0

Scott McCallum  
Governor

Jon E. Litscher  
Secretary



State of Wisconsin  
Department of Corrections

---

Mailing Address  
Division of Community Corrections  
2902 N. Mason Street  
Appleton, WI 54914  
Phone: (920) 832-2700  
Fax: (920) 832-2716

Honorable Circuit Judge  
Dane County Courthouse  
210 Martin Luther King, Jr. Blvd.  
Madison, Wisconsin 53709

RE: *Disabled Client*

Dear Judge DeChambeau:

On or about January 24, 2001, Disabled Client was taken into custody for violations of parole. It was the Department of Corrections' recommendation that Disabled Client's parole be revoked. That decision was made as an appropriate alternative to revocation agreement could not be reached based on Disabled Client's need for anger management courses while addressing the fact that he had suffered a brain injury and was in need of treatment for that injury.

During the course of the revocation process, it was determined that Disabled Client would be referred to Mendota Mental Health Center for a competency evaluation prior to the Department of Corrections final revocation hearing. Since that time, it is the agent's understanding that Disabled Client was found competent, when not in an agitated state, and the Department of Corrections was to move forward with the final revocation hearing. However, thanks to the efforts of Disabled Client's representing attorney, an appropriate alternative to revocation placement has been found for Disabled Client at Brotoloc in Muskego, Wisconsin. Disabled Client has agreed to abide by the rules and conditions of Brotoloc as an alternative to revocation and has signed all needed paperwork agreeing to follow all rules of his parole supervision.

Disabled Client was released from custody and began his alternative to revocation placement.

Sincerely,

Probation and Parole Agent  
Division of Community Corrections  
DEPARTMENT OF CORRECTIONS

STATE OF WISCONSIN : CRIMINAL-TRAFFIC DIVISION : WAUKESHA COUNTY  
CIRCUIT COURT

---

STATE OF WISCONSIN,

Plaintiff,

vs.

CRIMINAL COMPLAINT

DISABLED CLIENT,

Defendant.

---

Captain David Beguhn, Waukesha County Sheriff's Department, being first duly sworn on oath, upon information and belief, says that:

On June 20, 2002, at the Waukesha County Jail, 515 West Moreland Boulevard, in the City of Waukesha, Waukesha County, Wisconsin, the defendant, did: in a private place, engage in abusive and violent conduct under circumstances tending to cause or provoke a disturbance contrary to Section 947.01, Wisconsin Statutes.

And further advising the Court that the above-alleged offense is defined as a Class B misdemeanor; upon conviction of the above-alleged offense, the above-named defendant is subject to a fine of not more than \$1,000 or imprisonment of not more than ninety (90) days, or both.

And further advising the Court that the said has been previously convicted within the past five (5) years of the following crime: party to a crime of delivery/manufacturing of coke on June 7, 1995, contrary to Sections 939.05 and 161.41 (1)(cm), Wisconsin Statutes, and was in prison until October 27, 1997; which conviction remains of record and unreversed; therefore, the said defendant constitutes a habitual criminal pursuant to Section 939.62 (2), Wisconsin Statutes, and pursuant to Section 939.62 (1)(a), Wisconsin Statutes, the defendant is subject to not more than three (3) years imprisonment as a result of his previous felony conviction above stated.

And prays that the defendant be dealt with according to law; that the basis for complainant's charge of such offense is: based upon complainant's review of the investigative report of Detective Bryan Guhr, Correctional Lieutenant Kelly and Correctional Lieutenant Healy, all of whom are employed by the Waukesha County Sheriff's Department.

Lieutenant Kelly's report indicates that on June 20, 2002, he was working as a Correctional Lieutenant in the Waukesha County Jail at the above-stated location. Lieutenant Kelly stated that the above-named defendant, an inmate at the jail, was being transported to another room. The defendant was angry because he wanted to shower, but he agreed to move to a

new place in the jail. Lieutenant Kelly stated that the defendant was walking down the hallway toward him, the defendant made eye contact with Lieutenant Kelly, and made a statement, "I've got your attention now, motherfucker." Lieutenant Kelly stated that the defendant then charged in his direction, intended to either grab his throat or strike him in the face. Lieutenant Kelly is not sure which was the defendant's intent. He stated that the defendant grabbed a hold of the collar and sleeve of his shirt. Lieutenant Kelly stated that he immediately raised his hands to defend himself from the defendant's attack. Lieutenant Kelly stated he struck the defendant with his left forearm in the area of his upper chest, pushing backwards. The defendant continued to hold onto Lieutenant Kelly's shirt. Other correctional officers, namely Correctional Officer Toy, Ertl, Pankow, Marshall, and Lieutenant Healy, assisted in restraining the defendant and placing him onto the floor. Once stabilized on the floor, wrist and ankle restraints were applied on the defendant. The defendant was then placed onto a restraint chair and given medical attention for a small abrasion on his left eye.

Detective Guhr interviewed the above-named defendant about the incident. The defendant was advised of his constitutional rights. The defendant stated that he could not remember anything and that he wanted to speak to his attorney. Detective Guhr then stated that, for the next ten (10) minutes he listened to the defendant profanely ranting about his pre-existing medical problems.

Based on the foregoing, the complainant believes this complaint to be true and correct.

  
Complainant

Subscribed and sworn to before me  
this 21 day of October, 2002.

  
Assistant District Attorney

APPROVED FOR FILING:

  
Assistant District Attorney  
State Bar # 1040212

SC/ks

STATE OF WISCONSIN

CIRCUIT COURT

OUTAGAMIE COUNTY

In the matter of

**ORDER**

Disabled Client

Case No. 99 GN

adjudged incompetent.

WHEREAS, there has been an annual review of the protective placement of the above named individual, said review being as directed by the Supreme Court of the State of Wisconsin pursuant to the provisions of State Ex Rel WATTS v. Combined Community Services Board, 122 Wis. 2d 65; and

WHEREAS, as a result of said review it was determined that a full hearing should be held; and

WHEREAS, the following parties have submitted the attached Stipulation to the Court, Court Commissioner Brian G. Figy, on April 3, 2003: Attorney Karen L. Marone, Assistant Corporation Counsel, attorney for Outagamie County Department of Health and Human Services; Attorney Raymond M. Dall'Osto, Attorney for Client + Attorney Gerard F. Kuchler, guardian ad litem; and Attorney Robert Theine Pledl, Attorney for ? guardian; and

WHEREAS, the Court makes the attached Stipulation a part of these findings and Order; and

NOW, THEREFORE, the Court Commissioner finds as follows:

1. That Client continues to be substantially incapable of caring for himself and managing his property. That guardian, continues to be a competent person to serve as guardian of the person and estate of Client.
2. That Client continues to have a primary need for residential care and custody as a result of infirmities of aging, developmental disabilities and other like incapacities.

3. That Client poses a substantial risk of serious harm to himself or others as a result of his disabilities, if he is not protectively placed.

4. Such need appears likely to be permanent.

5. The least restrictive setting appropriate for such care and treatment is: Winnebago Mental Health Institute.

**WHEREFORE**, the Court does hereby enter the following Order:

1. That the Court does adopt the Stipulation of the parties hereto as part of its Order.

2. That shall continue as guardian of person and estate of Jon Pfeiffer.

3. That protective placement of Client is hereby ordered to continue, through the Outagamie County Department of Health and Human Services, to the Winnebago Mental Health Institute.

4. That this Order is granted without further hearing or appearance by any of the parties. That the WATTs review hearing, now scheduled for April 4, 2003, shall be removed from the Court calendar.

5. Let the Register in Probate enter this Order accordingly.

Dated at Appleton, Wisconsin, this 3rd day of April, 2003.

By the Court:



Brian G. Figy  
Court Commissioner

STATE OF WISCONSIN

CIRCUIT COURT  
PROBATE JURISDICTION

OUTAGAMIE COUNTY

In the Matter of the Protective Placement of:

Disabled Client

Case No. 99-GN-

---

**STIPULATION**

---

The parties to the above matter by their undersigned counsel hereby stipulate and agree to the following, subject to the approval of the Court:

(1) All objections by any party to *Client* current placement at the Winnebago Mental Health Institute are hereby withdrawn.

(2) *Client* current placement at Winnebago is the least restrictive placement appropriate to his needs pursuant to *State ex rel Watts v. Combined Community Services Board*, 122 Wis.2d 65 (1985).

(3) Outagamie County will facilitate an assessment by Lakeview Rehabilitation Center for the purpose of possible placement at that facility. No party to this matter shall be bound by the outcome of that assessment process, but all parties agree to participate in good faith. *Client* may also be assessed for potential placement at other facilities that may be identified at a later time.

(4) The next *Watts* proceeding will begin at the customary time pursuant to Outagamie County policy based on the anniversary date of the original finding.

(5) Each party reserves any and all rights to initiate a change of placement or to request a hearing pursuant to Wis.Stats., §55.06(9)(b) & (c) and (10)(b) and/or *Watts*.

  
 \_\_\_\_\_  
 Atty. Karen L. Marone  
 Outagamie County Corporation Counsel's Office  
 --Attorneys for Outagamie County

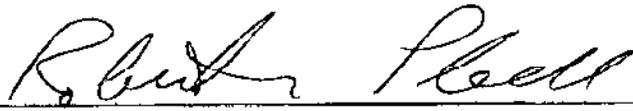
4-2-03  
 Date

\_\_\_\_\_  
 Atty. Raymond M. Dall'Osto  
 Gimbel, Reilly, Guerin & Brown  
 --Attorneys for Client

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Atty. Gerard F. Kuchler  
 --Guardian *ad Litem*

\_\_\_\_\_  
 Date

  
 \_\_\_\_\_  
 Atty. Robert Theine Pledl  
 Schott, Bublitz & Engel, s.c.  
 --Attorneys for \_\_\_\_\_ legal guardian.

04/02/03  
 Date

This document was drafted by:  
 Robert Theine Pledl  
 State Bar No. 1007710



State of Wisconsin DIVISION OF HEARINGS AND APPEALS

David H. Schwarz, Administrator  
5005 University Avenue, Suite 201  
Madison, WI 53705-5400

Deputy Clerk – Circuit Court  
Dane County Circuit Court  
210 Martin Luther King, Jr. Blvd.  
Madison, WI 53703-3342

RE: *State of Wisconsin v. Disabled Client*  
Case No. 95CF222

Dear Clerk:

This letter is to confirm that the probation revocation hearing for Disabled Client, which had been adjourned for a competency determination, has been cancelled as an Alternative to Revocation has been approved and commenced. This was done at the request of his agent, James Neitzel, and his attorney, Raymond M. Dall'Osto.

Sincerely yours,

Administrative Law Judge

Comprehensive  
Neuropsychiatric  
Services, Inc.

5325 W. Burleigh Street  
Suite 200  
Milwaukee, WI 53210  
414-445-4267

---

Jeffrey R. Zigun, M.D., Medical Director

Raymond M. Dall'Osto  
Gimbel, Reilly, Guerin and Brown Law Offices  
Two Plaza East, Suite 1170  
330 East Kilbourn Avenue  
Milwaukee, Wisconsin 53202

Dear Mr. Dall'Osto

11/19/2002

In your letter of 11/11/2002 you posed the questions below. I offer opinions to a reasonable degree of medical/psychiatric certainty based on the materials described in Appendix 1. As I indicated to you, I feel comfortable providing responses to your questions without an examination, because the documentation of *Client's* deficits is quite adequate and is consistent with the literature for those who have suffered the injury described in his brain CT and MRI scans. I reserve the right to modify my opinions were new information to come to light. I have provided Appendix 2 to provide the scientific clinical basis for my opinions.

Questions and responses:

1. Whether *Client* is suffering from a mental disease or defect and, if so, what is the nature of such and your and other physicians' previous diagnoses of same?

My diagnostic formulation is:

- Axis I Dementia Due to Head Trauma 294.1  
Personality change due to a general medical condition (traumatic brain injury) 310.1  
disinhibited type  
Alcohol and Substance abuse in remission
- Axis II Rule out antisocial personality disorder antedating his brain injury
- Axis III Head Trauma with Brain Injury to Frontal Lobes and Corpus Callosum  
Status post tracheostomy and gastrostomy  
Neurogenic Bladder  
Spasticity to right upper and lower extremities  
History of altered consciousness after brain injury – rule out Seizure Disorder
- Axis IV Medical condition  
Legal status
- Axis V Global assesment of functioning: 40

This formulation is substantively the same as the authors of reports sited below.

2. If he is suffering from a mental disease or defect, did this cause or affect him so that he was unable to conform his conduct to the requirements of the law when he acted out at the residential treatment center and in the jail, which has led to the proposed revocation of his parole?

It is my opinion that this man was not able to conform his conduct to the requirements of the law. When this man is irritated by an "injustice" he is prone to "see red". His ability to weigh various information in "real-time" is significantly limited by his brain injury. As Drs. Smith and Diedrich wrote (see Appendix 1) "...an individual with a head injury such as *Client*: essentially loses the ability to effectively control the changes in mood state, has a tendency towards aggression, and has a diminished ability to heed internal or external inhibitions"

Please refer in Appendix 2 to the descriptions by Lishman pp. 188-189 and Saver et. al p531-532, table 245.3 and page 540. *Client* left frontal brain injury involves the same "real estate" from the classical case of Phineas Gage (i.e. a predominantly left sided frontal [likely orbitofrontal] lesion). Note on page 532 that they refer to the relative impact of left versus right sided deficits.

His frontal lobe injury causes him to have difficulty in processing information – and prevents response inhibition. Therefore, thinking leads to action without consideration of consequence. While his preinjury life suggests that he has not valued other's interests too highly, he rarely acted in a violent manner. Even when he acted out physically, he did he did not do so in the face of so obvious adverse consequences. In effect, he wasn't "dumb enough" to take on law enforcement or others who controlled his situation. This being "dumb" is not a lack of intelligence, but rather the inability to wait long enough to weigh consequences. His perseverating or "holding a grudge" is also related to his brain injury – but not the basis of the reasoning of my opinion. It is the inability to hold thoughts on line long enough to decide whether to act (whether this is related to moral values or a less mature goal of avoiding getting in trouble).

While it is possible that behavioral disruption is related to temporal lobe epilepsy, the descriptions of the history of disruptive/aggressive behaviors and the lack of EEG findings argues against that particular neuropsychiatric syndrome to be the cause of the behaviors at issue. Table 24.3 from Saver et. al. demonstrates a differential diagnostic approach.

3. What is your recommendation for a treatment protocol, including specific drug therapy, for Mr. **Client** which would begin to address and ameliorate his current condition, which has led him into legal difficulty?

Please refer to Appendix 2 including Saver et. al table 24.6; Yudofsky, Silver and Hales; Silver Hales, and Yudofsky; and Citrome and Volakva.

Medication classes for considerations include in rank order of recommendation:

<u>Buspiron</u>	Increasing this medication to 60mg or even higher might be considered since it has been documented to be of some benefit for this man and has been generally tolerated
<u>Propanolol</u>	brand name Inderal - an antihypertensive
<u>Valproic acid</u>	brand name Depakote an anticonvulsant different from Carbamazepine (Tegretol, Carbatrol) but apparently rejected by mother/guardian (see Theda Clark records)
Risperidone or Ziprasadone or Quetiapine	Risperdal, Geodon, Seroquel atypical antipsychotics (i.e. that do not cause the same side effects as the classical Haldol, Thorazine, Prolixin etc.).

It is possible to "mix and match these medications". For example, I would suggest getting the buspiron to a maximal tolerable dose close to 60mg/day divided dose. I would wait 2 weeks and see if there was adequate response (i.e. when it seemed that frustrations did not have the same aggressive response).

Propanolol could be instituted as Dr. Pappenheim was about to do before the ultimate disruption that caused **Client** to leave the Brotoloc system. Pulse and blood pressure monitoring would be required. Yudofsky has published algorithms for propanolol administration (see Silver, Hales and Yudofsky Table 19-14 p 546). Review by other treating physicians might identify the relative indication for other beta blockers instead of propanolol.

Risperdal or other "atypical antipsychotics" could be added (e.g. Risperdal .25 mg 1-2 two to three times a day). There is risk for movement disorder (especially in a brain injured man) but I have used these medications in similar patients without development of these side effects.

I agree with Dr. Pappenheim's comment to reserve Lithium, a classical mood stabilizer, given this man's medical condition.

4. What would you recommend for treatment and placement of **Client** i.e., in-patient treatment with new drug therapy, phasing into a residential treatment, then halfway house and ultimately community placement with follow-up out-patient care?

This man's history of violent acting out during conflict precludes medication trials in any but a psychiatric facility that can both institute and monitor his response to medications – and that is locked and has the staff to manage his potential violent outbursts. It is my expectation that upon

establishing a more effective medication regimen that this man could return to a group home setting. In my opinion this treatment protocol would provide a more clinically appropriate alternative to revocation of parole.

I do not anticipate his return to fully independent living even with the institution of more effective medications. I expect the medications to allow him the time to reason that he should not act (i.e. not to go from zero to sixty in seconds) and also to help him avoid the fight or flight response (i.e. "seeing red"). However, I suspect this man will require monitoring to avoid alcohol and street drug use as well as to assist him in avoiding conflict with the general public. I suspect he will still be prone to verbal insults or threats which will still be off putting even when medications have assisted him in avoiding physical outbursts.

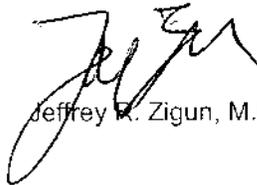
5. Where would you recommend *Client* go for the in-patient component of treatment and what options exist for follow-up residential treatment, which you would recommend.

Medications trials should likely be conducted at Mendota or Winnebago. An appropriate location would likely be the "Secure Assessment and Treatment" unit at MMHI where he was assessed/treated before.

This man might well be able to return to a setting like Brotoloc (see their discharge note) once the medication regimen was instituted and if their plan could be effected.

If further response is required to these or other questions, please feel free to contact me.

Sincerely,



Jeffrey R. Zigun, M.D.

**APPENDIX 1**

**MATERIALS REVIEWED**

<u>Date</u>	<u>Documents</u>	
<u>Various</u>	Time line and various letters	
<u>5/5/99-6/1/99</u>	Theda Clark Hospital Records	
<u>6/1/99-8/9/99</u>	Theda Clark Rehabilitation Records	
<u>10/24/00</u>	HIRC Discharge Summary	Louanne Lisk, Ph.D.
<u>11/15/00</u>	Residential Performance Review	Vocational Consulting Services
<u>8/29/01</u>	Neuropsychological Evaluation	Donald Mickey Ph.D.
<u>9/18/2002</u>	Mental Competency to Stand Trial	Robert Barahal Ph.D.
<u>3/26/01</u>	Letter to the Court	Louanne Lisk, Ph.D.
<u>4/26-5/29/01</u>	Court Ordered Competency Evaluation 5/7/01 and treatment records from Mendota Mental Health Institute	Brad ER Smith, MD Dana Diedrich, MD
<u>5/14/01</u>	Neuropsychological Evaluation	Louanne Lisk, Ph.D.
<u>5/7/2002</u>	Final Revocation Hearing Notice	
<u>6/21/02</u>	Discharge plan for <del>Client</del> Progress Notes and Physician Orders from Brotoloc Stay	Marsha Snyder Brotoloc Regional Director

**Disruptive Behavior**

<u>1/23/01</u>	Pushed VSC staffer Fiala out of his apartment.
<u>4/26/01</u>	Kicking out windows of squad car while en route to Mendota
<u>4/26-5/29/01</u>	At Mendota reported to grab and swing around another patient.
<u>4/24/02</u>	Bit a Brotoloc staffer. Threatening posture, gestures and comments.

**Some Aspects of Preinjury History**

Father had a history of Huntington's disease (Client - tested negative), alcohol abuse, and a diagnosis of ADD. He graduated high school with honors with advanced course in math and science. He had 1 year at technical university for mechanical engineering.

history of alcohol and polysubstance abuse :

**Legal History**

- 1990 Conviction for drug crime in Arizona
- 1992 Battery/resisting an officer
- 1993 Domestic Battery
- 1995 Conviction for delivering a controlled substance (cocaine).  
2 ½ years in prison with work release

**Living Arrangements**

**May-June 1999**

Theda Clark Medical Center, Neenah Wisconsin

**June – August 1999**

Theda Clark Hospital Rehabilitation Unit

**8/1999- 10/ 2000**

Clearview HIRC Brain Injury Rehabilitation Unit

**10/2000-1/2001**

Private Apartment with VSC.

**1/2001-9/2001**

Jail Green Bay → Dane County

**September 2001 (2 Days)**

Home

**9/6/2001-4/24/2002**

Brotoloc Group Home

**4/24/2002**

Waukesha County Jail

**Medical Problems and Assessments/Care (Underlining by JRZ)**

**May 5 1999: MVA with over two weeks of coma**

**5/5/99 LAWRENCE L. BAUER, M.D. CT HEAD SCAN**

Axial scanning of the head was performed without intravenous contrast administration. There was a hemorrhagic contusion which appeared to be located in the mid body of the corpus callosum in the midline just above the level of the bodies of the lateral ventricles on image #17. A second hemorrhagic contusion was seen in the deep white matter of the posterior frontal lobe on the left just lateral to the inferior frontal horn of the left lateral ventricle. No other intracranial blood is visualized. No focal low attenuation lesions or midline shift are seen. There are no intracranial calcifications. Gray/white matter distinction is somewhat diminished but this may be due to motion artifact. ...

**CONCLUSIONS:**

1. Hemorrhagic contusions within the body of the corpus callosum and the deep white matter of the posterior frontal lobe on the left.
2. Mild blurring of the gray/white matter distinction which may be more apparent than real.
3. Soft tissue swelling of the scalp particularly in the right temporal region and about the left orbit.
4. Chronic sinus inflammatory change in the left maxillary sinus.
5. Otherwise negative CT scan of the head

**05/09/1999 THOMAS L. TOLLY, M.D. CT OF BRAIN WITHOUT CONTRAST**

Axial computed tomograms were obtained through the brain without contrast. The comparison study is from 05/06/99.

**FINDINGS:** There has been a further decrease in size and density of the small hemorrhagic contusion in the deep left frontal lobe. The hemorrhagic lesion in the corpus callosum is grossly stable. There are no new hemorrhagic lesions identified. The ventricles and basilar cisterns are stable in size. There are no extra-axial fluid collections. There is no shift of the midline structures...

**IMPRESSIONS:**

1. Continued evolution of the hemorrhagic contusion in the deep left frontal lobe. Grossly stable appearance to the hemorrhagic contusion in the corpus callosum.
2. Worsening soft tissue opacification of the paranasal sinuses.

**05/10/1999 Forrest Bates, MD MAGNETIC RESONANCE IMAGING OF THE HEAD WITHOUT GADOLINIUM**

**CLINICAL HISTORY:** 32 year-old man involved in a motor vehicle accident on 5/5/99. The patient remains on a ventilator and is not waking up as he should. CT examinations have suggested possible injury to the corpus callosum.

**TECHNIQUE:** The brain was scanned in the sagittal plane using a T1 weighted pulse sequence. Fast spin echo T2 weighted axial images and FLAIR axial images were then performed. FLAIR sagittal images completed the study.

FINDINGS: The ventricles, cortical sulci, and cisternal spaces are normal. No shift in midline structures is identified. There is abnormal increased signal seen within the corpus callosum on the T2 weighted and FLAIR images consistent with contusion and shear injury of the posterior half of the corpus callosum. On the T1 weighted images a tiny punctate area of high signal intensity is seen at the upper margin of the posterior aspect of the body of the corpus callosum suggesting a small subacute hemorrhage. In addition, a contusion containing a small amount of subacute hemorrhage is seen in the inferior aspect of the left frontal lobe. This frontal lobe hemorrhagic contusion and the findings in the corpus callosum were identified on the previous CT study of 5/6/99. MR reveals that there is one or two other small white matter shear type injuries in the left frontal lobe as well as a white matter shear injury seen in the left temporal lobe. An additional white matter injury is suggested near the left temporal lobe. An additional white matter injury is suggested near the junction of the left frontal and parietal lobes near the vertex of the skull. No abnormal signal is seen within the brainstem or cerebellum. Normal flow voids are present at the vessels of the base of the brain. ...

IMPRESSION:

1. Magnetic resonance imaging confirms the small hemorrhagic contusion of the inferior left frontal lobe and the injury to the corpus callosum suspected on 5/6/99 CT exam. The corpus callosum injury is quite extensive with the posterior half of the corpus callosum showing abnormal increased signal and enlargement.
2. Additional white matter sheer injuries are seen in the left frontal lobe, left temporal lobe, and high near the junction-of-the left frontal and parietal lobes which were not identifiable on the CT study.
3. Extensive inflammatory disease of the paranasal sinuses and fluid opacifying numerous mastoid air cells.
4. Extensive soft tissue swelling of the scalp.

**APPENDIX 2**

Lishman, WA: "Head Injury" in Lishman, WA Organic Psychiatry Third Ed 1998  
Blackwell Science

Saver JL, Salloway SP, Devinsky O, Bear DM: "Neuropsychiatry of Aggression"  
in  
Fogel BS, Schiffer RB and Rao SM Neuropsychiatry Williams and Wilkins 1996

Silver JM and Hales RE, and Yudofsky SC: "Neuropsychiatric Aspects of  
Traumatic Brain Injury" in The American Psychiatric Press Textbook of  
Neuropsychiatry 1997

Yudofsky SC, Silver JM and Hales, RE: "Treatment of Aggressive Disorders" in  
The American Psychiatric Press Textbook of Psychopharmacology 1995

Citrome L and Volavka J: "Psychopharmacology of Violence: Part II Beyond the  
Acute Episode" Psychiatric Annals 27: 10 October 1997 ppp 696-701.

Selected pages were copied from the textbook chapters, underlining by JRZ

# ORGANIC PSYCHIATRY

## *The Psychological Consequences of Cerebral Disorder*

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THIRD EDITION

1998

*b*

Blackwell  
Science

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# NEUROPSYCHIATRY

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1996

# NEUROPSYCHIATRY OF AGGRESSION

*Jeffrey L. Saver, Stephen P. Salloway, Orrin Devinsky, and David M. Bear*

Human aggression is an urgent social and clinical problem. In the United States, homicide is the 12th leading cause of death and the second most common cause of mortality among young, healthy individuals (1, 2).

Aggression is an inescapable clinical challenge in diverse neuropsychiatric patient populations. Relatives of individuals with traumatic brain injury identify temper and irritability as major behavioral difficulties in 70% of patients (3). Ten to twenty percent of psychiatric inpatients commit acts of violence or assault during the 2 weeks prior to their admission (4-7), and 3-37% assault staff or patients during their hospitalization (8-11). Costs of inpatient care for assaultive patients are over 40% greater than for their nonassaultive counterparts (12).

Past attempts to understand and treat violent behavior have been thwarted by the outmoded dichotomy of nature versus nurture. Undoubtedly, sociocultural factors are critically important in the genesis of many aggressive behaviors. Epidemiological studies demonstrate that key environmental variables contributing to the development of repeatedly violent individuals include rearing in disordered households, physical and/or sexual abuse in childhood, and social deprivation (13-16).

However, every violent behavior, whether motivated by disturbed rearing or the highest political and religious ideals, requires a neurobiological substrate to orchestrate the complex array of perceptual, motor, and autonomic components of acts that constitute aggressive conduct. In humans, acquired brain lesions may disrupt the neural systems that ordinarily regulate hostile behavior. In some instances, individuals with focal brain injury may exhibit aggressive behavior that has no relevant developmental or environmental precipitant, or only minimal social provocation. More often, damage to neural circuits controlling aggression leads not to random acts of overt aggression, but to alterations in temperament and inappropriate choices of targets and settings for aggressive behavior. The recognition, diagnostic evaluation, and treatment of such patients are challenges facing the neuropsychiatrist and behavioral neurologist.

Neuropsychiatric investigations of aggression have been hampered by an overly simplified concept of "organicity."

Explicitly or implicitly, some authors have suggested that neurological impairment produces a unitary "organic aggression syndrome," possessing stable, invariant behavioral features independent of lesion type or location. The stereotypic organic aggression syndrome is often postulated to lower a general threshold for aggression or to result in episodic dyscontrol. This formulation is both simplistic and imprecise, obscuring fundamental evolutionary, neurochemical, neurophysiological, and clinical distinctions among discrete aggression-related neural circuits in the brainstem, diencephalon, limbic system, and neocortex.

As an alternative, this chapter outlines a multiregional, hierarchical model of the neural regulation of aggression that draws upon converging sources of evidence from evolutionary studies, ethology, neurophysiology, pharmacology, and clinical neuroscience. Recognizing multiple, hierarchical controls over hostile behavior affords the neuropsychiatrist a framework for identifying distinctive clinical syndromes of aggression due to brain injury, considering the differential diagnosis and diagnostic workup of patients, and implementing rational, pathophysiologically-directed treatment.

## NEUROSCIENCE OF AGGRESSION

### Biological Origins of Human Aggression

Clinicians confronted with aggressive patients tend to regard hostile behavior as a problem needing to be suppressed. However, aggression has important sociobiological functions. Like fear, hunger, sexual desire, and social cohesion, adaptive aggression is present throughout the order Mammalia, triggered by environmentally appropriate and highly specific stimuli (17-19). Agonistic behavior to obtain food, defend a territory, protect offspring, or win a mate is essential for the survival of the individual and for propagation of its genetic material.

Recent formulations of evolutionary theory suggest that competitive selection favors the development of closely regulated and intertwined aggressive and peacemaking behaviors (18, 20, 21). Within the primate and other lines of evolution, unregulated, wanton aggression would rapidly reduce support among an organism's conspecifics and impair

# **The American Psychiatric Press Textbook of Neuropsychiatry**

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*Third Edition*

Edited by

Stuart C. Yudofsky, M.D.

Robert E. Hales, M.D.

1997



Washington, DC  
London, England

## Neuropsychiatric Aspects of Traumatic Brain Injury

*Jonathan M. Silver, M.D.  
Robert E. Hales, M.D.  
Stuart C. Yudofsky, M.D.*

**E**ach year in the United States, more than 2 million people sustain a traumatic brain injury (TBI); 300,000 of these persons require hospitalization, and over 80,000 of the survivors are afflicted with the chronic sequelae of such injuries (Kraus and Sorenson 1994). In this population, psychosocial and psychological deficits are commonly the major source of disability to the victims and of stress to their families. The psychiatrist, neurologist, and neuropsychologist are often called on by other medical specialists or the families to treat these patients. In this chapter, we review the role these professionals play in the prevention, diagnosis, and treatment of the cognitive, behavioral, and emotional aspects of TBI.

### **I Epidemiology**

It is commonly taught in introductory courses in psychiatry that suicide is the second most common cause of

death among persons under the age of 35. What is often not stated is that the most common cause is from injuries incurred during motor vehicle accidents. TBI accounts for 2% of all deaths and 26% of all injury deaths (Sosin et al. 1989). A conservative estimate of the annual incidence of TBI (including brain trauma and transient and persistent postconcussion syndromes) is 200 per 100,000 per year (Kraus and Sorenson 1994). Disorders arising from traumatic injuries to the brain are more common than any other neurological disease, with the exception of headaches (Kurtzke 1984).

Those at the highest risk for brain injury are men from 15 to 24 years old. Alcohol use is common in brain injury; a positive blood alcohol concentration was demonstrated in 56% of one sample of victims (Kraus et al. 1989). Motor vehicle accidents account for approximately one-half of traumatic injuries; other common causes are falls (21%), assaults and violence (12%), and accidents associated with sports and recreation (10%)

# The American Psychiatric Press Textbook of Psychopharmacology

*Edited by*

**Alan F. Schatzberg, M.D., and  
Charles B. Nemeroff, M.D., Ph.D.**

1995

American  
Psychiatric  
Press, Inc.

Washington, DC  
London, England

# Treatment of Aggressive Disorders

*Stuart C. Yudofsky, M.D., Jonathan M. Silver, M.D., and  
Robert E. Hales, M.D.*

## ■ PREVALENCE AND RELEVANCE OF AGGRESSION IN PSYCHIATRIC AND OTHER MEDICAL PATIENTS

### ■ Prevalence

Psychiatrists are frequently called upon to assess and treat patients with aggressive disorders. Approximately 10% of patients with chronic psychiatric disorders admitted to psychiatric services in both the private and not-for-profit sectors exhibited violence toward others just prior to their admissions (Tardiff and Sweillam 1982). Among patients with neuropsychiatric disease—such as patients with posttraumatic brain injury, delirium, and Alzheimer's disease or other dementias—the incidence is much higher. For example, among a sample of outpatients with Alzheimer's disease, Reisberg and colleagues (1987) reported that 48% exhibited agitation, 30% violent behavior, and 24% verbal outbursts, which taken together accounted for the most common of all behavioral symptomatology in this population. Chandler and Chandler (1988) reported that the most common behavioral problems in a sample of 65 nursing home residents were agitation and aggression, which affected 48% ( $n = 32$ ) of their sample.

Aggression is highly prevalent in both the acute and chronic recovery stages of traumatic brain injury. Rao and colleagues (1985) reported that 96% of 26 patients ( $n = 25$ ) were acutely agitated following traumatic brain injury. But in a prospective study of 100 patients after acute brain injury, Brooke and col-

leagues (1992) documented that 11% were aggressive and agitated and 35% were restless. As with posttraumatic seizure disorders, aggression may occur in patients months or even many years following head injury. Oddy and colleagues (1985) followed 44 patients for 7 years after severe traumatic brain injury, and the researchers determined that agitation occurred in 31% ( $n = 14$ ) of this population. An additional 43% ( $n = 19$ ) had severe irritability, temper outbursts, and aggression.

### ■ Relevance

The high prevalence of aggression and violence among psychiatric patients is reflected in reports of assaults by patients against psychiatrists and other physicians. Approximately 40% of psychiatrists report being attacked at least once during their careers, and 48% of psychiatric residents acknowledge that they were assaulted at least once during their residency training programs (New York State Senate Select Committee on Mental and Physical Handicaps 1977; Pardith 1987). In Veterans Administration hospitals nationwide, 12,000 assaultive incidents were reported over a 5-year period (Reid et al. 1985).

Aggression in psychiatric patients exacts an even greater toll on their family members and other primary caregivers than it does on mental health professionals. Rabins and colleagues (1982) studied families and primary caregivers of 55 patients who met DSM-III (American Psychiatric Association 1980) criteria for dementia. Sixty percent ( $n = 33$ ) of the patients had clinical diagnoses of Alzheimer's disease,

# Psychopharmacology of Violence

## Part II: Beyond the Acute Episode

by LESLIE CITROME, MD, MPH, and  
JAN VOLAVKA, MD, PhD

**P**harmacotherapy for the long-term management of violent behavior depends on the individual patient's underlying clinical problem. Theoretical rationales for treatment strategies have included the serotonin hypothesis, atypical antipsychotics (such as clozapine and risperidone), beta-adrenergic blockers, mood stabilizers (lithium, carbamazepine, and valproic acid), antidepressants, buspirone, serotonin precursor treatment, and a new class of drugs dubbed the "serenics" have been used with varying success.

### AFTER THE ACUTE AGGRESSIVE EPISODE, WHAT NEXT?

Treatment of the underlying disorder is key. Often, when the primary psychiatric problem is treated successfully, the associated aggressive behavior is reduced. Unfortunately, perhaps one-third of patients with schizophrenia do not respond to antipsychotic treatment or respond only partially. Chronically violent patients with schizophrenia may receive higher doses of neuroleptics without clear evidence that this treatment reduces the incidence of violent behavior.<sup>1,2</sup> Neuroleptics may actually worsen akathisia, further increasing the risk of

aggressive behavior, as discussed in Part I (pp 691-695). Another complicating factor is the presence of comorbid conditions such as substance abuse or antisocial personality disorder. Because of the previous considerations, several pharmacologic agents have been studied with regard to specific antiaggressive activity, the goal being to use them to specifically target aggressive behavior.

A common theme among many agents proposed as antiaggressive drugs has been their effect on the serotonin neurotransmitter system. The serotonergic system is involved in the modulation of aggressive behavior in many species, and a disturbance of this system has been implicated in impulsive violence in humans. Impulsive violent behavior may be directed against others or against one's self.<sup>3,4</sup> These issues have been extensively reviewed elsewhere.<sup>1,5</sup> In humans, disturbance of the serotonergic system as a factor in violent behavior has been inferred from low levels of the 5-hydroxyindoleacetic acid (5-HIAA) in the cerebrospinal fluid (CSF) of violent patients,<sup>5,8</sup> or from a blunted response to neuroendocrine challenges.<sup>9</sup> This work was done largely in aggressive patients with personality disorders and substance use disorders. Drugs that affect the serotonin neurotransmitter system include antipsychotics such as clozapine and risperidone, antidepressants such as fluoxetine and citalopram, anxiolytics such as buspirone, and novel agents such as eltoprazine. These and other medications are described in more detail in the following sections.

### Antipsychotics: Clozapine and Risperidone

**Clozapine:** The atypical antipsychotic clozapine, in addition to being an effective treatment in patients refractory to typical neuroleptics, may have specific antiaggressive effects. This may be due to its effects on the serotonin system and its selective affinity for the limbic system.<sup>1</sup> One retrospective study in a state hospital found that the number of vio-

*Drs. Citrome and Volavka are from New York University and Nathan S. Kline Institute for Psychiatric Research, Orangeburg, New York.*

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*Authors' Note: Portions of this article draw on Dr. Volavka's book Neurobiology of Violence (American Psychiatric Press, Inc; 1995), on Drs. Citrome and Volavka's chapter entitled "Causes of Violence: Psychiatric Disorders," in Medical Management of the Violent Patient: Clinical Assessment and Therapy, edited by K. Tardiff (Marcel Dekker, Inc; in preparation), and on Drs. Citrome and Volavka's chapter entitled "Violence in Schizophrenia" in Management of Schizophrenia with Comorbid Conditions, edited by P. Bermanzohn and M. Y. Hwang (American Psychiatric Press, Inc; in preparation).*

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DIAGNOSTIC AND STATISTICAL  
MANUAL OF  
MENTAL DISORDERS

FOURTH EDITION

DSM-IV<sup>TM</sup>



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PUBLISHED BY THE  
AMERICAN PSYCHIATRIC ASSOCIATION  
WASHINGTON, DC

### 294.9 Dementia Due to HIV Disease

The essential feature of Dementia Due to HIV Disease is the presence of a dementia that is judged to be the direct pathophysiological consequence of human immunodeficiency virus (HIV) disease. Neuropathological findings most commonly involve diffuse, multifocal destruction of the white matter and subcortical structures. The spinal fluid may show normal or slightly elevated protein and a mild lymphocytosis, and HIV can usually be isolated directly from cerebrospinal fluid. Dementia that is associated with direct HIV infection of the central nervous system is typically characterized by forgetfulness, slowness, poor concentration, and difficulties with problem solving. Behavioral manifestations most commonly include apathy and social withdrawal, and occasionally these may be accompanied by delirium, delusions, or hallucinations. Tremor, impaired rapid repetitive movements, imbalance, ataxia, hypertonia, generalized hyperreflexia, positive frontal release signs, and impaired pursuit and saccadic eye movements may be present on physical examination. Children may also develop Dementia Due to HIV Disease, typically manifested by developmental delay, hypertonia, microcephaly, and basal ganglia calcification. Dementia in association with HIV infection may also result from accompanying central nervous system tumors (e.g., primary central nervous system lymphoma) and from opportunistic infections (e.g., toxoplasmosis, cytomegalovirus infection, cryptococcosis, tuberculosis, and syphilis), in which case the appropriate type of dementia should be diagnosed (e.g., 294.1 Dementia Due to Toxoplasmosis). Unusual systemic infections (e.g., *Pneumocystis carinii* pneumonia) or neoplasms (e.g., Kaposi's sarcoma) may also be present.



### 294.1 Dementia Due to Head Trauma

The essential feature of Dementia Due to Head Trauma is the presence of a dementia that is judged to be the direct pathophysiological consequence of head trauma. The degree and type of cognitive impairments or behavioral disturbances depend on the location and extent of the brain injury. Posttraumatic amnesia is frequently present, along with persisting memory impairment. A variety of other behavioral symptoms may be evident, with or without the presence of motor or sensory deficits. These symptoms include aphasia, attentional problems, irritability, anxiety, depression or affective lability, apathy, increased aggression, or other changes in personality. Alcohol or other Substance Intoxication is often present in individuals with acute head injuries, and concurrent Substance Abuse or Dependence may be present. Head injury occurs most often in young males and has been associated with risk-taking behaviors. When it occurs in the context of a single injury, Dementia Due to Head Trauma is usually nonprogressive, but repeated head injury (e.g., from boxing) may lead to a progressive dementia (so called dementia pugilistica). A single head trauma that is followed by a progressive decline in cognitive function should raise the possibility of another superimposed process such as hydrocephalus or a Major Depressive Episode.

### 294.1 Dementia Due to Parkinson's Disease

The essential feature of Dementia Due to Parkinson's Disease is the presence of a dementia that is judged to be the direct pathophysiological consequence of Parkinson's disease. Parkinson's disease is a slowly progressive neurological condition, characterized

**Diagnostic criteria for 293.89 Catatonic Disorder Due to . . . [Indicate the General Medical Condition] (continued)**

- C. The disturbance is not better accounted for by another mental disorder (e.g., a Manic Episode).
- D. The disturbance does not occur exclusively during the course of a delirium.

**Coding note:** Include the name of the general medical condition on Axis I, e.g., 293.89 Catatonic Disorder Due to Hepatic Encephalopathy; also code the general medical condition on Axis III (see Appendix G for codes).

→ **310.1 Personality Change  
Due to a General Medical Condition**

**Diagnostic Features**

The essential feature of a Personality Change Due to a General Medical Condition is a persistent personality disturbance that is judged to be due to the direct physiological effects of a general medical condition. The personality disturbance represents a change from the individual's previous characteristic personality pattern. In children, this condition may be manifested as a marked deviation from normal development rather than as a change in a stable personality pattern (Criterion A). There must be evidence from the history, physical examination, or laboratory findings that the personality change is the direct physiological consequence of a general medical condition (Criterion B). The diagnosis is not given if the disturbance is better accounted for by another mental disorder (Criterion C). The diagnosis is not given if the disturbance occurs exclusively during the course of a delirium or if symptoms meet the criteria for a dementia (Criterion D). The disturbance must also cause clinically significant distress or impairment in social, occupational, or other important areas of functioning (Criterion E).

Common manifestations of the personality change include affective instability, poor impulse control, outbursts of aggression or rage grossly out of proportion to any precipitating psychosocial stressor, marked apathy, suspiciousness, or paranoid ideation. The phenomenology of the change is indicated using the subtypes listed below. An individual with the disorder is often characterized by others as "not himself [or herself]." Although it shares the term "personality" with the Axis II Personality Disorders, this diagnosis is coded on Axis I and is distinct by virtue of its specific etiology, different phenomenology, and more variable onset and course.

The clinical presentation in a given individual may depend on the nature and localization of the pathological process. For example, injury to the frontal lobes may yield such symptoms as lack of judgment or foresight, facetiousness, disinhibition, and euphoria. Right hemisphere strokes have often been shown to evoke personality changes in association with unilateral spatial neglect, anosognosia (inability of the individual to recognize a bodily or functional deficit such as the existence of hemiparesis), motor impersistence, and other neurological deficits.

### **Subtypes**

The particular personality change can be specified by indicating the symptom presentation that predominates in the clinical presentation:

**Labile Type.** This subtype is used if the predominant feature is affective lability.

**Disinhibited Type.** This subtype is used if the predominant feature is poor impulse control (e.g., as evidenced by sexual indiscretions).

**Aggressive Type.** This subtype is used if the predominant feature is aggressive behavior.

**Apathetic Type.** This subtype is used if the predominant feature is marked apathy and indifference.

**Paranoid Type.** This subtype is used if the predominant feature is suspiciousness or paranoid ideation.

**Other Type.** This subtype would be used, for example, for a personality change associated with a seizure disorder.

**Combined Type.** This subtype is used if more than one feature predominates in the clinical picture.

**Unspecified Type.**

### **Recording Procedures**

In recording Personality Change Due to a General Medical Condition, the clinician should note both the specific phenomenology of the disturbance, including appropriate subtype, and the general medical condition judged to be causing the disturbance on Axis I (e.g., 310.1 Personality Change Due to Systemic Lupus Erythematosus, Paranoid Type). The ICD-9-CM code for the general medical condition (e.g., 710.0 systemic lupus erythematosus) should also be noted on Axis III. (See Appendix G for a list of selected ICD-9-CM diagnostic codes for general medical conditions.)

### **Associated General Medical Conditions**

A variety of neurological and other general medical conditions may cause personality changes, including central nervous system neoplasms, head trauma, cerebrovascular disease, Huntington's disease, epilepsy, infectious conditions with central nervous system involvement (e.g., human immunodeficiency virus), endocrine conditions (e.g., hypothyroidism, hypo- and hyperadrenocorticism), and autoimmune conditions with central nervous system involvement (e.g., systemic lupus erythematosus). The associated physical examination findings, laboratory findings, and patterns of prevalence and onset reflect those of the neurological or other general medical condition involved.

### **Differential Diagnosis**

**Chronic general medical conditions** associated with pain and disability can also be associated with changes in personality. The diagnosis of Personality Change Due to a General Medical Condition is given only if a direct pathophysiological mechanism can be established. Personality change is a frequent associated feature of a **dementia** (e.g., Dementia of the Alzheimer's Type). A separate diagnosis of Personality Change Due to a General Medical Condition is not given if criteria are also met for a dementia or if the

change occurs exclusively during the course of a **delirium**. Furthermore, the diagnosis of Personality Change Due to a General Medical Condition is not given if the disturbance is better accounted for by **another Mental Disorder Due to a General Medical Condition** (e.g., Mood Disorder Due to Brain Tumor, With Depressive Features).

Personality changes may also occur in the context of **Substance Dependence**, especially if the dependence is long-standing. The clinician should inquire carefully about the nature and extent of substance use. If the clinician wishes to indicate an etiological relationship between the personality change and substance use, the Not Otherwise Specified category for the specific substance (e.g., Cocaine-Related Disorder Not Otherwise Specified) can be used.

Marked personality changes may also be an **associated feature of other mental disorders** (e.g., Schizophrenia, Delusional Disorder, Mood Disorders, Impulse-Control Disorders Not Elsewhere Classified, Panic Disorder). However, in these disorders, no specific physiological factor is judged to be etiologically related to the personality change. Personality Change Due to a General Medical Condition can be distinguished from a **Personality Disorder** by the requirement for a clinically significant change from baseline personality functioning and the presence of a specific etiological general medical condition.

■ **Diagnostic criteria for 310.1 Personality Change Due to . . . [Indicate the General Medical Condition]**

- A. A persistent personality disturbance that represents a change from the individual's previous characteristic personality pattern. (In children, the disturbance involves a marked deviation from normal development or a significant change in the child's usual behavior patterns lasting at least 1 year).
- B. There is evidence from the history, physical examination, or laboratory findings that the disturbance is the direct physiological consequence of a general medical condition.
- C. The disturbance is not better accounted for by another mental disorder (including other Mental Disorders Due to a General Medical Condition).
- D. The disturbance does not occur exclusively during the course of a delirium and does not meet criteria for a dementia.
- E. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify type:

**Labile Type:** if the predominant feature is affective lability

**Disinhibited Type:** if the predominant feature is poor impulse control as evidenced by sexual indiscretions, etc.

**Aggressive Type:** if the predominant feature is aggressive behavior

(continued)

**Diagnostic criteria for 310.1 Personality Change Due to . . .**  
**[Indicate the General Medical Condition] (continued)**

**Apathetic Type:** if the predominant feature is marked apathy and indifference

**Paranoid Type:** if the predominant feature is suspiciousness or paranoid ideation

**Other Type:** if the predominant feature is not one of the above, e.g., personality change associated with a seizure disorder

**Combined Type:** if more than one feature predominates in the clinical picture

**Unspecified Type**

**Coding note:** Include the name of the general medical condition on Axis I, e.g., 310.1 Personality Change Due to Temporal Lobe Epilepsy; also code the general medical condition on Axis III (see Appendix G for codes).

**293.9 Mental Disorder Not Otherwise Specified  
Due to a General Medical Condition**

This residual category should be used for situations in which it has been established that the disturbance is caused by the direct physiological effects of a general medical condition, but the criteria are not met for a specific Mental Disorder Due to a General Medical Condition (e.g., dissociative symptoms due to complex partial seizures).

**Coding note:** Include the name of the general medical condition on Axis I, e.g., 293.9 Mental Disorder Not Otherwise Specified Due to HIV Disease; also code the general medical condition on Axis III (see Appendix G for codes).

**PDR MEDICAL DICTIONARY**  
SECOND EDITION

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**PDR<sup>®</sup>**  
*Medical  
Dictionary*

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MEDICAL  
ECONOMICS  
COMPANY

at typically used with

a membrane or other which can so pass. [L.]

s of spreading through ant neoplasm by pro- the blood vessels or ss through]

Rarely used term condition or disease

harmful; denoting a il without appropriate 'mices, destruction] .. *pernio*, chilblain, +

vidual with a congen- forearm. [per- + G.

vidual with congeni- *thalē*, head] with a congenital mal- *cheir*, hand]

ak'ti-lē, -dak-til'ē-ā), *perio-* + G. *daktylos*,

dium perborate that, er, liberates 10% of

ē-rom'ē-lē). Severe including absence of

z, brooch, the small o pierce]

*oneus*, fr. G. *peronē*,

ibiofibular.

genital malformation

noting a method of + *os* (*or-*), mouth]

noting a method of

genital malformation ]

. *per.* through, + *os*,

s 1.1]. Hydrogen in animal and plant idation) of various ide, which acts as n the process.

ish that is used in ibody complex.

series that contains ) most correctly to hydrogen peroxide

2. The  $O_2^{2-}$  ion. 3. contain the perox-

ound organelle oc-; an electron-dense oxidase, and other and degradation of various molecules to acetyl-CoA; an

ence of p.'s is found in individuals with Zellweger syndrome. [per- + G. *sōma*, body]

**PER-OXY-**, Prefix denoting the presence of an extra O atom, as in peroxides, peroxy acids (e.g., hydrogen peroxide, peroxyformic acid). Often shortened to *per-*.

**PER-OXY-*a*-CE-TYL NI-TRATE** (per-ok-sē-ā-sē'til). The major pollutant responsible for eye and nose irritation in smog.

**PER-OXY-AC-*id*** (per-ok'sē). SYN peracid.

**PER-OXY-FOR-MIC AC-*id*** (per-ok'sē-fōr'mik). SYN performic acid.

**PER-OXYL** (per-ok'sil). H-O-O; one of the free radicals presumed formed as a result of the bombardment of tissue by high-energy radiation.

**PER-PHE-NA-ZINE** (per-fen'ā-zēn). An antipsychotic of the phenothiazine type.

**PER-PRIMAM** (per prī'mam in-ten-shē-ō'nem). By first intention, *per-* healing by first intention. [L.]

**PER-REC-TUM** (per rek'tūm). By or through the rectum, denoting a method of medication. [L.]

**PER-SALT** (per'sawlt). In chemistry, any salt that contains the greatest possible amount of the acid radical.

**PER-SAL-TUM** (per sal'tūm). At a leap; at one bound; not gradually or through different stages. [L.]

**PER-SEV-ER-A-TION** (per-sev-er-ā'shān). 1. The constant repetition of a meaningless word or phrase. 2. The duration of a mental impression, measured by the rapidity with which one impression follows another as determined by the revolving of a two-colored disk. 3. In clinical psychology, the uncontrollable repetition of a previously appropriate or correct response, even though the repeated response has since become inappropriate or incorrect. [L. *persevero*, to persist]

**PER-SIC OIL** (per'sik). The fixed oil expressed from the kernels of varieties of *Prunus armeniaca* (apricot kernel oil) or *Prunus persica* (peach kernel oil); used as a vehicle.

**PER-SIS-TENCE** (per-sis'tens). Obstinate continuation of characteristic behavior, or of existence in spite of treatment or adverse environmental conditions. [L. *persisto*, to abide, stand firm]

**LACTASE P.**, an inherited trait (autosomal dominant) in which the levels of lactase do not decline after weaning. Cf. *lactase restriction*.

**MICROBIAL P.**, the phenomenon of survival, in high concentration of an antimicrobial substance, of microbes that seem not to be resistant variants (mutants) since their progeny are fully susceptible.

**PER-SIS-TER** (per-sis'ter). That which, or one who, is capable of persistence; especially a bacterium that exhibits microbial persistence.

**PER-SO-NA** (per-sō'nā). A term that embodies the totality of the individual, the total constellation of the physical, psychological, and behavioral attributes of each unique individual; in jungian psychology, the outer aspect of character, as opposed to anima (2); the assumed personality used to mask the true one. [L. *per*, through, + *sonare*, to sound; from the small megaphone in ancient dramatic masks, to aid in projecting the actor's voice]

**PER-SON-AL-I-TY** (per-sōn-al'i-tē). 1. The unique self; the organized system of attitudes and behavioral predispositions by which one feels, thinks, acts, and impresses and establishes relationships with others. 2. An individual with a particular p. pattern.

**AFFECTIVE P.**, a chronic behavioral pattern in an enduring disturbance of feelings or mood expressed as a form of depression and related emotional features that color the whole of the psychic life.

**ANTISOCIAL P.**, SEE psychopath, sociopath, antisocial personality disorder. SYN psychopathic p.

**ASTHENIC P.**, an older term for a p. type characterized by low energy level, easy fatigability, incapacity for enjoyment, lack of enthusiasm, and oversensitivity to physical and emotional stress. SYN asthenic personality disorder.

**AUTHORITARIAN P.**, a cluster of p. traits reflecting a desire for security and order, e.g., rigidity, highly conventional outlook, unquestioning obedience, scapegoating, desire for structured lines of authority.

**AVOIDANT P.**, SYN avoidant personality disorder.

**BASIC P.**, SEE basic personality type.

**BORDERLINE P.**, SEE borderline personality disorder.

**COMPULSIVE P.**, SYN obsessive-compulsive personality disorder.

**CYCLOTHYMIC P.**, a p. disorder in which a person experiences regularly alternating periods of elation and depression, less severe than seen in bipolar disorder, usually not related to external circumstances. SYN cyclothymic personality disorder.

**DEPENDENT P.**, SYN dependent personality disorder.

**DUAL P.**, an older term for a mental disturbance in which a person assumes alternately two different identities without either p. being consciously aware of the other. SEE ALSO multiple p.

**HYSTERICAL P.**, SYN histrionic personality disorder.

**INADEQUATE P.**, a p. disorder, characterized by personal and social ineptness plus emotional and physical instability, that renders the individual unable to cope with the normal vicissitudes of life.

**MASOCHISTIC P.**, a p. disorder in which the individual accepts exploitation and sacrifices self-interest while at the same time feeling morally superior or feigning moral superiority, attempting to elicit sympathy, and inducing guilt in others.

**MULTIPLE P.**, SYN dissociative identity disorder.

**NEURASTHENIC P.**, an obsolete term for a condition characterized by some of the following features: poor appetite or overeating, insomnia or hypersomnia, low energy or fatigue, low self esteem, poor concentration or difficulty making decisions, and feelings of hopelessness. In its most severe form it may become a chronic disturbance of mood called dysthymia (depressive neurosis) in which a depressive mood accompanies the features listed above.

**OBSSIVE P.**, SYN obsessive-compulsive personality disorder; SEE obsessive-compulsive p., obsessive-compulsive disorder.

**OBSSIVE-COMPULSIVE P.**, SYN obsessive-compulsive personality disorder.

**PARANOID P.**, SYN paranoid personality disorder.

**PASSIVE-AGGRESSIVE P.**, a p. disorder characterized by a pervasive and enduring pattern of behavior in which aggressive feelings are manifested in passive ways, especially through mild obstructionism and stubbornness.

**PERFECTIONISTIC P.**, a p. characterized by rigidity, extreme inhibition, and excessive concern with conformity and adherence to often unique standards.

**PSYCHOPATHIC P.**, SYN antisocial p.

**SCHIZOID P.**, SYN schizoid personality disorder.

**SCHIZOTYPAL P.**, SYN schizotypal personality disorder.

**SHUT-IN P.**, a rarely used term for a person who responds inadequately to contacts with other people.

**SYNTONIC P.**, a rarely used term for a stable p., one characterized by even temperament.

**TYPE A P., TYPE B P.**, SEE type A behavior, type B behavior.

**PER-SON-YEARS.** The product of the number of years times the number of members of a population who have been affected by a certain condition; e.g., years of treatment with a certain drug.

**PERS-PI-RATION** (pers-pi-rā'shūn). 1. The excretion of fluid by the sweat glands of the skin. SYN diaphoresis, sudation, sweating. SEE ALSO sweat. 2. All fluid loss through normal skin, whether by sweat gland secretion or by diffusion through other skin structures. 3. The hypotonic fluid excreted by the sweat glands; it consists of water containing sodium chloride and phosphate, urea, ammonia, ethereal sulfates, creatinine, fats, and other waste products; the average daily quantity is estimated at about 1500 g. SYN sudor. SEE ALSO sweat (1). [L. *per-spīro*, pp. -atus, to breathe everywhere]

**INSENSIBLE P.**, p. that evaporates before it is perceived as moisture on the skin; the term sometimes includes evaporation from the lungs.

**SENSIBLE P.**, the p. excreted in large quantity, or when there is much humidity in the atmosphere, so that it appears as moisture (sweat) on the skin.

**PER-STIL-LATION** (per-sti-lā'shūn). SEE pervaporation. [L. *per*, through, + *stillo*, to trickle, distil]

**PER-SUA-SION** (per-swā'zhūn). The act of influencing the mind of another, by authority, argument, reason, or personal insight; an

# **APPENDIX 2**

## **Department of Justice Guidelines On Police Procedures with Disabled People**



## COMMONLY ASKED QUESTIONS ABOUT THE AMERICANS WITH DISABILITIES ACT AND LAW ENFORCEMENT

### I. Introduction

Police officers, sheriff's deputies, and other law enforcement personnel have always interacted with persons with disabilities and, for many officers and deputies, the Americans with Disabilities Act (ADA) may mean few changes in the way they respond to the public. To respond to questions that may arise, this document offers common sense suggestions to assist law enforcement agencies in complying with the ADA. The examples presented are drawn from real-life situations as described by police officers or encountered by the Department of Justice in its enforcement of the ADA.

#### 1. *Q: What is the ADA?*

**A:** The Americans with Disabilities Act (ADA) is a Federal civil rights law. It gives Federal civil rights protections to individuals with disabilities similar to those provided to individuals on the basis of race, color, sex, national origin, age, and religion. It guarantees equal opportunity for individuals with disabilities in State and local government services, public accommodations, employment, transportation, and telecommunications.

#### 2. *Q: How does the ADA affect my law enforcement duties?*

**A:** Title II of the ADA prohibits discrimination against people with disabilities in State and local governments services, programs, and employment. Law enforcement agencies are covered because they are programs of State or local governments, regardless of whether they receive Federal grants or other Federal funds. The ADA affects virtually everything that officers and deputies do, for example:

- receiving citizen complaints;
- interrogating witnesses;
- arresting, booking, and holding suspects;
- operating telephone (911) emergency centers;
- providing emergency medical services;
- enforcing laws;
- and other duties.

#### 3. *Q: Who does the ADA protect?*

**A:** The ADA covers a wide range of individuals with disabilities. An individual is considered to have a "disability" if he or she has a physical or mental impairment that substantially limits one or more major life activities, has a record of such an impairment, or is regarded as having such an impairment.

Major life activities include such things as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working. To be substantially limited means that such activities are restricted in the manner, condition, or duration in which they are performed in comparison with most people.

- The ADA also protects people who are discriminated against because of their association with a person with a disability.

**Example:** Police receive a call from a woman who complains that someone has broken into her residence. The police department keeps a list of dwellings where people with AIDS are known to reside. The woman's residence is on the list because her son has AIDS. Police fail to respond to her call, because they fear catching the HIV virus. The officers have discriminated against the woman on the basis of her association with an individual who has AIDS.

**4. Q: What about someone who uses illegal drugs?**

**A:** Nothing in the ADA prevents officers and deputies from enforcing criminal laws relating to an individual's current use or possession of illegal drugs.

## **II. Interacting with People with Disabilities**

**5. Q: What are some common problems that people with disabilities have with law enforcement?**

**A:** Unexpected actions taken by some individuals with disabilities may be misconstrued by officers or deputies as suspicious or illegal activity or uncooperative behavior.

**Example:** An officer approaches a vehicle and asks the driver to step out of the car. The driver, who has a mobility disability, reaches behind the seat to retrieve her assistive device for walking. This appears suspicious to the officer.

- Individuals who are deaf or hard of hearing, or who have speech disabilities or mental retardation, or who are blind or visually impaired may not recognize or be able to respond to police directions. These individuals may erroneously be perceived as uncooperative.

**Example:** An officer yells "freeze" to an individual who is running from an area in which a crime has been reported. The individual, who is deaf, cannot hear the officer and continues to run. The officer mistakenly believes that the individual is fleeing from the scene. Similarly, ordering a suspect who is visually impaired to get over "there" is likely to lead to confusion and misunderstanding, because the suspect may have no idea where the officer is pointing.

Some people with disabilities may have a staggering gait or slurred speech related to their disabilities or the medications they take. These characteristics, which can be associated with neurological disabilities, mental/emotional disturbance, or hypoglycemia, may be misperceived as intoxication.

**Example:** An officer observes a vehicle with one working headlight and pulls the vehicle over. When the driver hands the registration to the officer, the officer notices that the driver's hand is trembling and her speech is slurred. The officer concludes that the individual is under the influence of alcohol, when in fact the symptoms are caused by a neurological disability.

**Example:** A call comes in from a local restaurant that a customer is causing a disturbance. When the responding officer arrives at the scene, she discovers a 25-year-old man swaying on his feet and grimacing. He has pulled the table cloth from the table. The officer believes that the man has had too much to drink and is behaving aggressively, when in fact he is having a seizure.

### **What can be done to avoid these situations?**

Training, sensitivity, and awareness will help to ensure equitable treatment of individuals with disabilities as well as effective law enforcement. For example:

- When approaching a car with visible signs that a person with a disability may be driving (such as a designated license plate or a hand control) , the police officer should be aware that the driver may reach for a mobility device.
- Using hand signals, or calling to people in a crowd to signal for a person to stop, may be effective ways for an officer to get the attention of a deaf individual.
- When speaking, enunciate clearly and slowly to ensure that the individual understands what is being said.
- Finally, typical tests for intoxication, such as walking a straight line, will be ineffective for individuals whose disabilities cause unsteady gait. Other tests, like breathalyzers, will provide more accurate results and reduce the possibility of false arrest.

### **6. Q: *What if someone is demonstrating threatening behavior because of his or her disability?***

**A:** Police officers may, of course, respond appropriately to real threats to health or safety, even if an individual's actions are a result of her or his disability. But it is important that police officers are trained to distinguish behaviors that pose a real risk from behaviors that do not, and to recognize when an individual, such as someone who is having a seizure or exhibiting signs of psychotic crisis, needs medical attention. It is also important that behaviors resulting from a disability not be criminalized where no crime has been committed. Avoid these scenarios:

- A store owner calls to report that an apparently homeless person has been in front of the store for an hour, and customers are complaining that he appears to be talking to himself. The individual, who has mental illness, is violating no loitering or panhandling laws. Officers arriving on the scene arrest him even though he is violating no laws.
- Police receive a call in the middle of the night about a teenager with mental illness who is beyond the control of her parents. All attempts to get services for the teenager at that hour fail, so the responding officer arrests her until he can get her into treatment. She ends up with a record, even though she committed no offense.

### **7. Q: *What procedures should law enforcement officers follow to arrest and transport a person who uses a wheelchair?***

**A:** Standard transport practices may be dangerous for many people with mobility disabilities. Officers should use caution not to harm an individual or damage his or her wheelchair. The best approach is to ask the person what type of transportation he or she can use, and how to lift or assist him or her in transferring into and out of the vehicle.

**Example:** An individual with a disability is removed from his wheelchair and placed on a bench in a paddy wagon. He is precariously strapped to the bench with his own belt. When the vehicle begins to move, he falls off of the bench and is thrown to the floor of the vehicle where he remains until arriving at the station.

- Some individuals who use assistive devices like crutches, braces, or even manual wheelchairs might be safely transported in patrol cars.
- Safe transport of other individuals who use manual or power wheelchairs might require departments to make minor modifications to existing cars or vans, or to use lift-equipped vans or buses. Police departments may consider other community resources, e.g., accessible taxi services.

**8. Q:** *What steps should officers follow to communicate effectively with an individual who is blind or visually impaired?*

**A:** It is important for officers to identify themselves and to state clearly and completely any directions or instructions -- including any information that is posted visually. Officers must read out loud in full any documents that a person who is blind or visually impaired needs to sign. Before taking photos or fingerprints, it is a good idea to describe the procedures in advance so that the individual will know what to expect.

**9. Q:** *Do police personnel need to take special precautions when providing emergency medical services to someone who has HIV or AIDS?*

**A:** Persons with HIV or AIDS should be treated just like any other person requiring medical attention. In fact, emergency medical service providers are required routinely to treat all persons as if they are infectious for HIV, Hepatitis B, or other blood borne pathogens, by practicing universal precautions. Many people do not know that they are infected with a blood borne pathogen, and there are special privacy considerations that may cause those who know they are infected not to disclose their infectious status.

- Universal precautions for emergency service providers include the wearing of gloves, a mask, and protective eye wear, and, where appropriate, the proper disinfection or disposal of contaminated medical equipment. Protective barriers like gloves should be used whenever service providers are exposed to blood.

**Example:** Police are called to a shopping mall to assist a teenager who has cut his hand and is bleeding profusely. As long as the attending officers wear protective gloves, they will not be at risk of acquiring HIV, Hepatitis B, or any other blood borne pathogen, while treating the teenager.

- Refusing to provide medical assistance to a person because he or she has, or is suspected of having, HIV or AIDS is discrimination.

**Example:** Police are called to a shopping mall, where an individual is lying on the ground with chest pains. The responding officer asks the individual whether she is currently taking any medications. She responds that she is taking AZT, a medication commonly prescribed for individuals who are HIV-positive or have AIDS. The officer announces to his colleagues that the individual has AIDS and refuses to provide care. This refusal violates the ADA.

### III. Effective Communication

**10. Q:** *Do police departments have to arrange for a sign language interpreter every time an officer interacts with a person who is deaf?*

**A:** No. Police officers are required by the ADA to ensure effective communication with individuals who are deaf or hard of hearing. Whether a qualified sign language interpreter or other communication aid is required will depend on the nature of the communication and the needs of the requesting individual. For example, some people who are deaf do not use sign language for communication and may need to use a different communication aid or rely on lipreading. In one-on-one communication with an individual who lipreads, an officer should face the individual directly, and should ensure that the communication takes place in a well-lighted area.

- Examples of other communication aids, called “auxiliary aids and services” in the ADA, that assist people who are deaf or hard of hearing include the exchange of written notes, telecommunications devices for the deaf (TDD’s) (also called text telephones (TT’s) or teletypewriters (TTY’s)), telephone handset amplifiers, assistive listening systems, and videotext displays.
- The ADA requires that the expressed choice of the individual with the disability, who is in the best position to know her or his needs, should be given primary consideration in determining which communication aid to provide. The ultimate decision is made by the police department. The department should honor the individual’s choice unless it can demonstrate that another effective method of communication exists.
- Police officers should generally not rely on family members, who are frequently emotionally involved, to provide sign language interpreting.

**Example:** A deaf mother calls police to report a crime in which her hearing child was abused by the child’s father. Because it is not in the best interests of the mother or the child for the child to hear all of the details of a very sensitive, emotional situation, the mother specifically requests that the police officers procure a qualified sign language interpreter to facilitate taking the report. Officers ignore her request and do not secure the services of an interpreter. They instead communicate with the hearing child, who then signs to the mother. The police department in this example has violated the ADA because it ignored the mother’s request and inappropriately relied on a family member to interpret.

- In some limited circumstances a family member may be relied upon to interpret.

**Example:** A family member may interpret in an emergency, when the safety or welfare of the public or the person with the disability is of paramount importance. For example, emergency personnel responding to a car accident may need to rely on a family member to interpret in order to evaluate the physical condition of an individual who is deaf. Likewise, it may be appropriate to rely on a family member to interpret when a deaf individual has been robbed and an officer in hot pursuit needs information about the suspect.

**Example:** A family member may interpret for the sake of convenience in circumstances where an interpreter is not required by the ADA, such as in situations where exchanging written notes would be effective. For example, it would be appropriate to rely on a passenger who is a family member to interpret when an individual who is deaf is asking an officer for traffic directions, or is stopped for a traffic violation.

11. **Q:** If the person uses sign language, what kinds of communication will require an interpreter?

**A:** The length, importance, or complexity of the communication will help determine whether an interpreter is necessary for effective communication

- In a simple encounter, such as checking a driver's license or giving street directions, a notepad and pencil normally will be sufficient.
- During interrogations and arrests, a sign language interpreter will often be necessary to effectively communicate with an individual who uses sign language.
- If the legality of a conversation will be questioned in court, such as where Miranda warnings are issued, a sign language interpreter may be necessary. Police officers should be careful about miscommunication in the absence of a qualified interpreter -- a nod of the head may be an attempt to appear cooperative in the midst of misunderstanding, rather than consent or a confession of wrongdoing.
- In general, if an individual who does not have a hearing disability would be subject to police action without interrogation, then an interpreter will not be required, unless one is necessary to explain the action being taken.

**Example:** An officer clocks a car on the highway driving 15 miles above the speed limit. The driver, who is deaf, is pulled over and issued a noncriminal citation. The individual is able to understand the reasons for the citation, because the officer exchanges written notes with the individual and points to information on the citation. In this case, a sign language interpreter is not needed.

**Example:** An officer responds to an aggravated battery call and upon arriving at the scene observes a bleeding victim and an individual holding a weapon. Eyewitnesses observed the individual strike the victim. The individual with the weapon is deaf, but the officer has probable cause to make a felony arrest without an interrogation. In this case, an interpreter is not necessary to carry out the arrest.

12. **Q:** *Do I have to take a sign language interpreter to a call about a violent crime in progress or a similar urgent situation involving a person who is deaf?*

**A:** No. An officer's immediate priority is to stabilize the situation. If the person being arrested is deaf, the officer can make an arrest and call for an interpreter to be available later at the booking station.

13. **Q:** *When a sign language interpreter is needed, where do I find one?*

**A:** Your department should have one or more interpreters available on call. This is generally accomplished through a contract with a sign language interpreter service. Communicating through sign language will not be effective unless the interpreter is familiar with the vocabulary and terminology of law enforcement, so your department should ensure that the interpreters it uses are familiar with law enforcement terms.

**14. Q: Is there any legal limit to how much my department must spend on communication aids like interpreters?**

**A:** Yes. Your department is not required to take any step that would impose undue financial and administrative burdens. The "undue burden" standard is a high one. For example, whether an action would be an undue financial burden is determined by considering all of the resources available to the department. If providing a particular auxiliary aid or service would impose an undue burden, the department must seek alternatives that ensure effective communication to the maximum extent feasible.

**15. Q: When would an officer use an assistive listening device as a communication aid?**

**A:** Assistive listening systems and devices receive and amplify sound and are used for communicating in a group setting with individuals who are hard of hearing.

- At headquarters or a precinct building, if two or more officers are interrogating a witness who is hard of hearing, or in meetings that include an individual who is hard of hearing, an assistive listening device may be needed.

**16. Q: What is a TDD and does every police station have to have one?**

**A:** A telecommunications device for the deaf (TDD) is a device used by individuals with hearing or speech disabilities to communicate on the telephone. A TDD is a keyboard with a display for receiving typed text that can be attached to a telephone. The TDD user types a message that is received by another TDD at the other end of the line.

- Arrestees who are deaf or hard of hearing, or who have speech disabilities, may require a TDD for making outgoing calls. TDD's must be available to inmates with disabilities under the same terms and conditions as telephone privileges are offered to all inmates, and information indicating the availability of the TDD should be provided.
- TDDs typically cost \$200-300 each and can be used with a standard telephone. It is unlikely that the cost of purchasing a TDD will be prohibitive. Still, a small department with limited resources could arrange to share a TDD with a local courthouse or other entity, so long as the TDD is immediately available as needed.

**17. Q: What about "911" calls? How are those made accessible to people with speech or hearing disabilities?**

**A:** Individuals with hearing and speech disabilities must have direct access to "911" or similar emergency telephone services, meaning that emergency response centers must be equipped to receive calls from TDD and computer modem users without relying on third parties or state relay services. It is important that operators are trained to use the TDD when the caller is silent, and not only when the operator recognizes the tones of a TDD at the other end of the line. For additional information, please refer to the Department of Justice's publication, *Commonly Asked Questions Regarding Telephone Emergency Services*. For information about how to obtain this and other publications, see the resources section at the end of this document.

**18. Q: Procedures at my office require citizens to fill out forms when reporting crimes. What if the person has a vision disability, a learning disability, mental retardation or some other disability that may prevent the person from filling out a form?**

**A:** The simplest solution is to have an officer or clerk assist the person in reading and filling out the form. Police officers have probably been doing this for years. The form itself could also be provided in an alternative format. Providing a copy of the form in large print (which is usually as simple as using a copy machine or computer to increase type size) will make the form accessible to many individuals with moderate vision disabilities.

#### **IV. Architectural Access**

**19. Q: Does the ADA require all police stations to be accessible to people with disabilities?**

**A:** No. Individuals with disabilities must have equal access to law enforcement services, but the ADA is flexible in how to achieve that goal. The ADA requires programs to be accessible to individuals with disabilities, not necessarily each and every facility. Often, structural alterations to an existing police station or sheriff's office will be necessary to create effective access. In some situations, however, it may be as effective to use alternative methods, such as relocating a service to an accessible building, or providing an officer who goes directly to the individual with the disability. Whatever approach to achieving "program access" is taken, training of officers and deputies, well-developed policies, and clear public notice of the approach will be critical to ensuring successful ADA compliance.

**Example:** A police station in a small town is inaccessible to individuals with mobility disabilities. The department decides that it cannot alter all areas of the station because of insufficient funds. It decides to alter the lobby and restrooms so that the areas the public uses -- for filling out crime reports, obtaining copies of investigative reports for insurance purposes, or seeking referrals to shelter care -- are accessible. Arrangements are made to conduct victim and witness interviews with individuals with disabilities in a private conference room in the local library or other government building, and to use a neighboring department's accessible lock-up for detaining suspects with disabilities. These measures are consistent with the ADA's program accessibility requirements.

**Example:** An individual who uses a wheelchair calls to report a crime, and is told that the police station is inaccessible, but that the police department has a policy whereby a police officer will meet individuals with disabilities in the parking lot. The individual arrives at the parking lot, waits there for three hours, becomes frustrated, and leaves. By neglecting to adequately train officers about its policy, the police department has failed in its obligation to provide equal access to police services, and has lost valuable information necessary for effective law enforcement.

**20. Q: What about holding cells and jails that are not accessible?**

**A:** An arrestee with a mobility disability must have access to the toilet facilities and other amenities provided at the lock-up or jail. A law enforcement agency must make structural changes, if necessary, or arrange to use a nearby accessible facility.

- Structural changes can be undertaken in a manner that ensures officer safety and general security. For example, grab bars in accessible restrooms can be secured so that they are not removable.

- If meeting and/or interrogation rooms are provided, those areas should also be accessible for use by arrestees, family members, or legal counsel who have mobility disabilities.

**21. Q: *Is there a limit to the amount of money my agency must spend to alter an existing police facility?***

**A:** Yes. It is the same legal standard of "undue burden" discussed earlier with regard to the provision of communication aids. Your agency is not required to undertake alterations that would impose undue financial and administrative burdens. If an alteration would impose an "undue burden", the agency must choose an alternative that ensures access to its programs and services.

**22. Q. *We are building a new prison. Do we need to make it accessible?***

**A:** Yes. All new buildings must be made fully accessible to, and usable by, individuals with disabilities. The ADA provides architectural standards that specify what must be done to create access.

- Either the Uniform Federal Accessibility Standards (UFAS) or the ADA Standards for Accessible Design (without the elevator exemption) (ADA Standards) may be used. UFAS has specific scoping requirements for prisons that require, among other things, that 5% of all cells be made accessible to individuals with mobility disabilities.
- Unlike modifications of existing facilities, there is no undue burden limitation for new construction.
- In addition, if an agency alters an existing facility for any reason -- including reasons unrelated to accessibility -- the altered areas must be made accessible to individuals with disabilities.

## **V. Modifications of Policies, Practices, and Procedures**

**23. Q: *What types of modifications in law enforcement policies, practices, and procedures does the ADA require?***

**A:** The ADA requires law enforcement agencies to make reasonable modifications in their policies, practices, and procedures that are necessary to ensure accessibility for individuals with disabilities, unless making such modifications would fundamentally alter the program or service involved. There are many ways in which a police or sheriff's department might need to modify its normal practices to accommodate a person with a disability.

**Example:** A department modifies a rule that prisoners or detainees are not permitted to have food in their cells except at scheduled intervals, in order to accommodate an individual with diabetes who uses medication and needs access to carbohydrates or sugar to keep blood sugar at an appropriate level.

**Example:** A department modifies its enforcement of a law requiring a license to use motorized vehicles on the streets, in order to accommodate individuals who use scooters or motorized wheelchairs. Such individuals are pedestrians, but may need to use streets where curb cuts are unavailable.

**Example:** A department modifies its regular practice of handcuffing arrestees behind their backs, and instead handcuffs deaf individuals in front in order for the person to sign or write notes.

**Example:** A department modifies its practice of confiscating medications for the period of confinement, in order to permit inmates who have disabilities that require self-medication, such as cardiac conditions or epilepsy, to self-administer medications that do not have abuse potential.

**Example:** A department modifies the procedures for giving Miranda warnings when arresting an individual who has mental retardation. Law enforcement personnel use simple words and ask the individual to repeat each phrase of the warnings in her or his own words. The personnel also check for understanding, by asking the individual such questions as what a lawyer is and how a lawyer might help the individual, or asking the individual for an example of what a right is. Using simple language or pictures and symbols, speaking slowly and clearly, and asking concrete questions, are all ways to communicate with individuals who have mental retardation.

- Informal practices may also need to be modified. Sometimes, because of the demand for police services, third party calls are treated less seriously. Police officers should keep in mind that calling through a third party may be the only option for individuals with certain types of disabilities.

## **VI. Resources**

**24. Q:** *It sounds like awareness and training are critical for effective interaction with individuals with disabilities. How can I find out more about the needs of my local disability community?*

**A:** State and local government entities were required, by January 26, 1993, to conduct a "self-evaluation" reviewing their current services, policies, and practices for compliance with the ADA. Entities employing 50 or more persons were also to develop a "transition plan" identifying structural changes that needed to be made. As part of that process, the ADA encouraged entities to involve individuals with disabilities from their local communities. Continuing this process will promote access solutions that are reasonable and effective. Even though the deadlines for the self-evaluation, transition plan, and completion of structural changes have passed, compliance with the ADA is an ongoing obligation.

**25. Q:** *Where can I turn for answers to other questions about the ADA?*

**A:** The Department of Justice's toll-free ADA Information Line answers questions and offers free publications about the ADA. The telephone numbers are: 800-514-0301 (voice) or 800-514-0383 (TTY). Publications are also available from the ADA Website [www.ada.gov](http://www.ada.gov).

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## What Situations Require an Interpreter?

Generally, interpreter services are not required for simple transactions – such as checking a license or giving directions to a location – or for urgent situations – such as responding to a violent crime in progress.

**Example:** An officer clocks a car on the highway going 15 miles per hour above the speed limit. The driver, who is deaf, is pulled over and is issued a noncriminal citation. The individual is able to understand the reason for the citation because the officer points out relevant information printed on the citation or written by the officer.

**Example:** An officer responds to an aggravated battery call and upon arriving at the scene observes a bleeding victim and an individual holding a weapon. Eyewitnesses observed the individual strike the victim. The individual with the weapon is deaf. Because the officer has probable cause to make a felony arrest without an interrogation, an interpreter is not necessary to carry out the arrest.

However, an interpreter may be needed in lengthy or complex transactions – such as interviewing a victim, witness, suspect, or arrestee – if the person being interviewed normally relies on sign language or speech reading to understand what others are saying.

**Example:** An officer responds to the scene of a domestic disturbance. The husband says the wife has been

beating their children and he has been trying to restrain her. The wife is deaf. The officer begins questioning her by writing notes, but her response indicates a lack of comprehension. She requests a sign language interpreter. In this situation an interpreter should be called. If the woman's behavior is threatening, the officer can make an arrest and call for an interpreter to be available later at the booking station.

It is inappropriate to ask a family member or companion to interpret in a situation like this because emotional ties may interfere with the ability to interpret impartially.

**Example:** An officer responds to the scene of a car accident where a man has been seriously injured. The man is conscious, but is unable to comprehend the officer's questions because he is deaf. A family member who is present begins interpreting what the officer is saying.

A family member or companion may be used to interpret in a case like this, where the parties are willing, the need for information is urgent, and the questions are basic and uncomplicated. However, in general, do not expect or demand that a deaf person provide his or her own interpreter. As a rule, when interpreter service is needed, it must be provided by the agency.

List your agency's contact information for obtaining an interpreter, an assistive listening device, or other communication aid or service here.

For further information on the Americans with Disabilities Act contact:

**ADA Website**  
[www.ada.gov](http://www.ada.gov)

**ADA Information Line**  
800-514-0301 (voice)  
800-514-0383 (TTY)

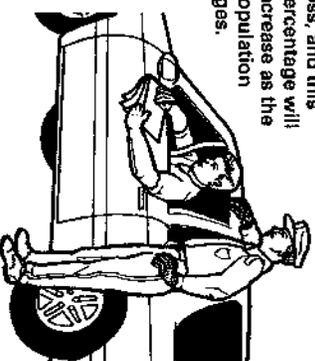
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## Communicating with People Who Are Deaf or Hard of Hearing

### ADA Guide for Law Enforcement Officers

As a law enforcement officer, you can expect to come into contact with people who are deaf or hard of hearing. It is estimated that up to nine percent of the population has some degree of hearing loss, and this percentage will increase as the population ages.



A driver who is deaf writes on a pad of paper to communicate with an officer.

Under the Americans with Disabilities Act (ADA), people who are deaf or hard of hearing are entitled to the same services law enforcement provides to anyone else. They may not be excluded or segregated from services, be denied services, or otherwise be treated differently than other people. Law enforcement agencies must make efforts to ensure that their personnel communicate effectively with people whose disability affects hearing. This applies to both sworn and civilian personnel.

Your agency has adopted a specific policy regarding communicating with people who are deaf or hard of hearing. It is important to become familiar with this policy.

### Requirements for Effective Communication

The ADA requires that . . .

- Law enforcement agencies must provide the communication aids and services needed to communicate effectively with people who are deaf or hard of hearing, except when a particular aid or service would result in an undue burden or a fundamental change in the nature of the law enforcement services being provided.
- Agencies must give primary consideration to providing the aid or service requested by the person with the hearing disability.
- Agencies cannot charge the person for the communication aids or services provided.
- Agencies do not have to provide personally prescribed devices such as hearing aids.
- When interpreters are needed, agencies must provide interpreters who can interpret effectively, accurately, and impartially.
- Only the head of the agency or his or her designee can make the determination that a particular aid or service would cause an undue burden or a fundamental change in the nature of the law enforcement services being provided.

Your agency's policy explains how to obtain interpreters or other communication aids and services when needed.

### Communicating with People Who are Deaf or Hard of Hearing

Officers may find a variety of communication aids and services useful in different situations.

- Speech supplemented by gestures and visual aids can be used in some cases.
  - A pad and pencil, a word processor, or a typewriter can be used to exchange written notes.
  - A telly/pewriter (TTY, also known as a TDD) can be used to exchange written messages over the telephone.
  - An assistive listening system or device to amplify sound can be used when speaking with a person who is hard of hearing.
  - A sign language interpreter can be used when speaking with a person who knows sign language.
  - An oral interpreter can be used when speaking with a person who has been trained to speech read (read lips). **Note:** Do not assume that speech reading will be effective in most situations. On average, only about one third of spoken words can be understood by speech reading.
- The type of situation, as well as the individual's abilities, will determine which aid or service is needed to communicate effectively.

### Practical Suggestions for Communicating Effectively

- Before speaking, get the person's attention with a wave of the hand or a gentle tap on the shoulder.
- Face the person and do not turn away while speaking.
- Try to converse in a well-lit area.
- Do not cover your mouth or chew gum.
- If a person is wearing a hearing aid, do not assume the individual can hear you.
- Minimize background noise and other distractions whenever possible.
- When you are communicating orally, speak slowly and distinctly. Use gestures and facial expressions to reinforce what you are saying.
- Use visual aids when possible, such as pointing to printed information on a citation or other document.
- Remember that only about one third of spoken words can be understood by speech reading.
- When communicating by writing notes, keep in mind that some individuals who use sign language may lack good English reading and writing skills.
- If someone with a hearing disability cannot understand you, write a note to ask him or her what communication aid or service is needed.
- If a sign language interpreter is requested, be sure to ask which language the person uses. American Sign Language (ASL) and Signed English are the most common.
- When you are interviewing a witness or a suspect or engaging in any complex conversation with a person whose primary language is sign language, a qualified interpreter is usually needed to ensure effective communication.
- When using an interpreter, look at and speak directly to the deaf person, not to the interpreter.
- Talk at your normal rate, or slightly slower if you normally speak very fast.
- Only one person should speak at a time.
- Use short sentences and simple words.
- Do not use family members or children as interpreters. They may lack the vocabulary or the impartiality needed to interpret effectively.

# **MODEL POLICY FOR LAW ENFORCEMENT ON COMMUNICATING WITH PEOPLE WHO ARE DEAF OR HARD OF HEARING**

## **OVERVIEW**

It is the policy of this law enforcement agency (Agency) to ensure that a consistently high level of service is provided to all community members, including those who are deaf or hard of hearing. This Agency has specific legal obligations under the Americans with Disabilities Act [*insert the following text if your agency receives financial assistance from the Federal government:* and the Rehabilitation Act] to communicate effectively with people who are deaf or hard of hearing. To carry out these policies and legal obligations, the Agency instructs its officers and employees as follows:

- People who are deaf or hard of hearing are entitled to a level of service equivalent to that provided to other persons.
- The Agency will make every effort to ensure that its officers and employees communicate effectively with people who are deaf or hard of hearing.
- Effective communication with a person who is deaf or hard of hearing involved in an incident -- whether as a victim, witness, suspect, or arrestee -- is essential in ascertaining what actually occurred, the urgency of the matter, and type of situation.
- Various types of communication aids -- known as "auxiliary aids and services" -- are used to communicate with people who are deaf or hard of hearing. These include use of gestures or visual aids to supplement oral communication; use of a notepad and pen or pencil to exchange written notes; use of an assistive listening system or device to amplify sound for persons who are hard of hearing; or use of a qualified oral or sign language interpreter.
- The type of aid that will be required for effective communication will depend on the individual's usual method of communication, and the nature, importance, and duration of the communication at issue.
- In many circumstances, oral communication supplemented by gestures and visual aids or an exchange of written notes will be an effective means of communicating with people who are deaf or hard of hearing. In other circumstances, a qualified

sign language or oral interpreter may be needed to communicate effectively with persons who are deaf or hard of hearing. The more lengthy, complex, and important the communication, the more likely it is that a qualified interpreter will be required for effective communication. For example:

- If there has been an incident and the officer is conducting witness interviews, a qualified sign language interpreter may be required to communicate effectively with someone whose primary means of communication is sign language. A qualified oral interpreter may be required to communicate effectively with someone who has been trained to speech read (read lips).
  - If a person is asking an officer for directions to a location, gestures or an exchange of written notes will likely be sufficient to communicate effectively.
- To serve each individual effectively, primary consideration should be given to providing the type of communication aid or service requested by the individual. Officers should find out from the person who is deaf or hard of hearing what type of auxiliary aid or service he or she needs. Officers should defer to those expressed choices, unless:
  - there is another equally effective way of communicating, given the circumstances, length, complexity, and importance of the communication, as well as the communication skills of the person who is deaf or hard of hearing; or
  - doing so would fundamentally alter the nature of the law enforcement activity in question or would cause an undue administrative or financial burden; only the Agency head or his or her designee may make this determination.
- The input of people who are deaf or hard of hearing who are involved in incidents is just as important to the law enforcement process as the input of others. Officers must not draw conclusions about incidents unless they fully understand -- and are understood by -- all those involved, including people who are deaf or hard of hearing.
- People who are deaf or hard of hearing must not be charged for the cost of an auxiliary aid or service needed for effective communication.

## **ON-CALL INTERPRETIVE SERVICES**

- The Agency will maintain a list of sign language and oral interpreting services that are available (on-call 24 hours per day) and willing to provide qualified interpreters as needed. Each of these services will be chosen after having been screened for the quality and skill of its interpreters, its reliability, and other factors such as cost. The Agency will update this list annually.
- A qualified sign language or oral interpreter is one who is able to interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary. Accordingly, an interpreter must be able to sign to the deaf individual (or interpret orally to the person who speech reads) what is being said by the officer and be able to voice to the officer what is being signed or said by the deaf individual. The interpreter must be able to interpret in the language the deaf person uses (e.g., American Sign Language or Signed English) and must be familiar with law enforcement terms and phrases. Because a qualified interpreter must be able to interpret impartially, a family member, child, or friend of the individual who is deaf may not be qualified to render the necessary interpretation because of factors such as professional, emotional, or personal involvement, or considerations of confidentiality. Additionally, although a "qualified" interpreter may be certified, a certified interpreter is not necessarily "qualified," if he or she is not a good communications match for the deaf person (e.g., where the deaf person uses Signed English and the interpreter uses American Sign Language) or for the situation (e.g., where the interpreter is unfamiliar with law enforcement vocabulary).

## **TTY AND RELAY SERVICES**

- In situations when a nondisabled person would have access to a telephone, officers must provide persons who are deaf or hard of hearing the opportunity to place calls using a teletypewriter (TTY, also known as a telecommunications device for deaf people, or TDD). Officers must also accept telephone calls placed by persons who are deaf or hard of hearing through the Telecommunications Relay Service.

## **TECHNIQUES FOR OFFICERS TO COMMUNICATE EFFECTIVELY**

- Officers may utilize the following auxiliary aids, when available, to communicate effectively:
  - Use of gestures;
  - Use of visual aids;
  - Use of a notepad and pen or pencil;

- Use of a computer or typewriter;
  - Use of an assistive listening system or device;
  - Use of a teletypewriter (TTY);
  - Use of a qualified oral or sign language interpreter.
- Officers must review and have a working knowledge of the publication *Communicating with People Who Are Deaf or Hard of Hearing: ADA Guide for Law Enforcement Officers*. This document reviews how officers should communicate effectively in the types of situations officers will encounter.

## **PROCEDURES FOR OBTAINING AUXILIARY AIDS AND SERVICES**

*[Insert an explanation of the department's procedures for obtaining auxiliary aids and services.]*