Legal Advocacy

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Introduction

Judge Learned Hand once remarked that "as a litigant I should dread a law suit beyond almost anything else short of sickness and death" (Frank 1957). What if you were in the tragic position of having chronic legal issues *and* mental health problems? Persons who are mentally ill are often burdened with both. The mentally ill are 10 times more likely to be imprisoned than receive inpatient mental health care (Murphy 2015). Approximately 20 % of state prisoners and 21 % of local jail inmates have a recent history of a mental health condition (Glaze and James 2006). Almost every patient within the walls of state forensic psychiatric hospitals is also a litigant in a criminal or civil court case involving public defenders or human rights groups. In order for these individuals to truly begin the recovery process, they must work toward *both* legal independence and mental wellness.

Each person directs his or her process of recovery uniquely. Mental health professionals utilize a myriad of tools to develop wellness for their patients, including psychotherapy and medications. Similarly, legal advocates counsel each individual client about their civil rights and develop case-specific strategies to accomplish an end goal. The legal advocate's role goes well beyond that of a guardian ad litem (who gives the client a "best interests" voice), because lawyers must attend to all legal needs of their clients even when they are not immediately aligned with their medical needs as patients. This imbues the legal process with dignity, and people flourish when they know their choices are considered and respected. Thus, the ideal of individual rights is not at all different from the ideal of recovery.

Even so, the practices of law and medicine have not always shared the same perspective. Fundamental disagreements exist between those treating illness and those protecting civil liberties (Bennion 2013). The "medical model" promotes treatment as the path to recovery, even if it is by way of involuntary hospitalizations and forced medication. The "civil rights model" advocates for the liberty of the individual to choose his or her own path to recovery, even if it includes rejecting medical treatment. Proponents of both models believe that they are improving society and the ultimate autonomy of the individual. Cannot both be correct?

Attorneys ensure the civil liberties of all individuals remain intact. In the civil and forensic mental health settings, effective legal advocacy efforts enable an individual's path to recovery by ensuring that all stakeholders meet his or her unique needs across multiple systems. Simply put, attorneys can knock down barriers to meaningful medical treatment. When the role of

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the attorney is balanced with that of the mental health professional, patients achieve the support they need for recovery because they have agency. In this context, agency is achieved through individual empowerment and intact civil rights, fostering a healthy emotional intelligence essential for the recovery process.

Using this paradigm, one can argue in a broad sense that both the "medical model" and "civil rights model" can actually work hand in hand to promote individual wellness in a free society. This chapter will focus on the particularities of the legal practice as it intersects with the practice of mental health professionals. In some cases, the treatment needs of the individual will take a backseat to the civil liberties at stake, and the necessity of these laws is explored. As is appropriate considering modern state hospital populations, the bulk of the material addresses the forensic subjects of criminal competency, restoration, and dangerousness, followed by a review of the lawyer's role in civil commitments. Attention is given to questions of recovery through the eyes of defense counsel and individuals facing chronic legal issues while saddled with mental health problems.

Criminal Competency

Overview of the Competency Process

In criminal competency cases, judges and (almost always) lawyers are involved. Courts are only authorized to order criminal competency evaluations when a criminal case has been filed. Hence the starting point of any competency evaluation must be the Court Order directing that it be done; it should indicate what is being sought, whether treatment or restoration is also anticipated, if additional evaluations (like insanity, restorability to competency, or dangerousness) are ordered, what the time frame to comply is, maybe whether certain testing is required, and often what form the report should take.

The primary purpose behind criminal competency placement is *expert evaluation* and not *treatment*. That is not to say that treatment is undesirable for the court system, but that treatment may be part of a secondary competency restoration process instead. In some jurisdictions (such as the federal courts), the two processes are clearly separate (18 U.S.C. § 4241(a–d)). In fact, federal defendants are often sent to different facilities for the competency evaluation and the restoration treatment. However, most states immediately initiate treatment during any evaluation placement. Practitioners involved in competency forensics should familiarize themselves with whether their jurisdiction separates treatment from evaluation.

It is important to note from the start that in competency and restoration processes, unlike most treatment protocols, recovery of good mental health is not necessarily the goal for all involved. For instance, should a defendant be found incompetent and unable to be restored, then the criminal charges will eventually be dismissed. The defense lawyer and/or the defendant may desire that outcome over a conviction, its collateral consequences, and any potential incarceration. Thus, a defendant who would otherwise normally want to gain better mental health may want to remain actively psychotic during the pendency of criminal charges.

Criminal defense attorneys have a different responsibility than treating psychiatric personnel. The lawyers' duty is to maximize their clients' *liberty*, not maximize their *health* (Uphoff 1988).[1] In other words, attorneys represent the defendants' liberty interests, not what is in their best medical interests. That is, remaining mentally ill may in fact be the best path for overall "recovery" for this defendant at this time. Hence, the goals of criminal defense may be at odds with

[1]Because liberty is the primary goal for criminal defense, the reality of the practice is that it sometimes may trump concerns that a client may be incompetent. For example, if a defendant who is obviously psychotic is offered a "time served" misdemeanor plea bargain, rather than raise incompetency (which could take 6 months in custody to resolve), the lawyer may advise the client and allow him or her to go forward with the guilty plea. As Uphoff (1988) noted, for defendants "charged with minor offenses, raising competency subjects [them] to far greater deprivation of liberty than if [they] were convicted of the crime."

the goals of the forensic treatment providers as well as the prosecution and court. This issue will be taken up again below when discussing forced medication to restore competency. That is not to say that the defense will usually try to thwart recovery; in fact, many lawyers and defendants will embrace restoration to competency so that they can return to litigation or negotiation.

The strategy decision whether to try to be found incompetent or competent is a complex one that should have been discussed between the defense lawyer and client. Treating personnel should take care not to try to advise or persuade the defendant whether to fight or go along with competency—as that is a matter of legal advice, and they would be interfering with the attorney's legal guidance as well as the defendant's Sixth Amendment right to counsel. This decision is not simple because there can be collateral consequences to being found incompetent and unrestorable as well. In some jurisdictions, there is mandatory commitment of a person found to be incompetent in a criminal case (18 U.S.C. § 4241 (d)); additionally, persons adjudicated incompetent may lose some future rights, such as the right to bear arms (18 U.S.C. § 922(d); Fla. Stat. § 790.25(1)). Moreover, some defendants have actively resisted findings of incompetence because they want to return to responsible positions once their criminal cases are behind them. Some are concerned that it will have an adverse impact on regaining custody or visitation with their children. Others simply reject it because they do not want to be considered defective or disabled by such a finding. So deciding whether to remain mentally ill (untreated), fight restoration, or try to challenge any finding of competency is a legal decision that cannot be lightly undertaken.

Certain history will lead to a decision to refer a defendant for a competency evaluation. Most commonly, a request for a competency evaluation occurs after the defense attorney or arresting law enforcement officers report that the defendant exhibits bizarre behavior. Sometimes when the defendant displays patently florid symptoms in court, the judge will order a competency examination, even absent any request by the lawyers. Competency evaluations may also arise based solely on a history of prior civil commitments and criminal incompetency or insanity findings; in an abundance of caution, referral is sometimes made simply to "rule out" incompetency at the present time.

However, a defendant's incompetency is not always immediately apparent. Highly functional individuals (especially true for those suffering from Delusional Disorders which appear reasonable because they are reality-based, or those with intellectual disabilities who have learned to try to behave normally) may not reveal underlying paranoias, delusions, or cognitive disorders for some time; alternatively, defense counsel may not be able to detect chronic psychoses until interacting with the client or investigating the client's claims for some time as well. Further, incompetency can wax and wane; the Supreme Court noted that "Mental illness … can vary over time. It interferes with an individual's functioning at different times in different ways" (*Indiana v. Edwards*, 2008). Thus, incompetency sometimes only arises well after the case is advancing, especially as the defendant's stress mounts with an imminent trial or sentencing, generating competency evaluations well into the progress of a criminal case.

Legal Standards of Competency

The legal basis for the proposition that an incompetent defendant should not be prosecuted is the Due Process clause of the Fifth Amendment to the U.S. Constitution (*Ryan v. Gonzales*, 2013; *Cooper v. Oklahoma*, 1996). It is "fundamentally unfair" to prosecute a person whose mental illness interferes with his or her ability to understand and assist counsel in the proceedings. Evaluating doctors need to know the precise legal standard for competency in their jurisdiction before starting an evaluation. The lawyers can provide the applicable law that defines it. Note that it may differ from the common conception of competency provided below.

Virtually every jurisdiction also has statutes, rules, or regulations that govern criminal

competency. Typically, state competency laws derive from the Supreme Court's federal standard from the *Dusky* case: "whether he has sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding—and whether he has a rational as well as factual understanding of the proceedings against him" (*Dusky v. United States*, 1960). These are seen as two independent means of establishing competency: an individual is incompetent if he or she is either (a) unable to understand the proceedings, or (b) unable to assist counsel in his or her defense (Conn. Gen. Stat. §§ 54-56d (2012)), or of course both.

Given those options, persons may be incompetent even if they do not have a DSM-5 diagnosis. A defendant who cannot communicate due to stroke or paralysis can be incompetent, even if not suffering from any mental illness (*United States v. Calkins,* 1990; *State v. Connor*, 2014). A defendant who is developmentally disabled may be incompetent, even if he or she falls outside a neurodevelopmental diagnosis (Cal. Penal Code § 1367(d)). A person who speaks a language that cannot be translated could be incompetent.[2] Occasionally, defendants with severe or terminal medical conditions requiring considerable attention (such as advanced HIV or terminal pancreatic cancer) have been determined incompetent to assist in their defense (*United States v. Pollock*, 2014). Some jurisdictions have declared persons suffering from complete amnesia of critical events to be incompetent to assist their lawyers in defending them as well (but usually only when that is combined with other conditions to create incompetency) (*Altoonian v. Warren*, 2015; *United States v. Minter*, 2014; Tysse and Hafemeister 2006).

Insanity has different standards, but the legally significant difference between it and incompetency is that there is no constitutional right to an insanity defense, while there is a Due Process (constitutional) right to be competent.[3] This explains some of the seemingly incongruous exceptions that have been carved out of insanity defenses: what constitutes "insanity" is set by legislature or courts, whereas what constitutes "incompetency" cannot be readily cut back due to broad constitutional protections. Hence, a number of jurisdictions reject an insanity defense—no matter how psychotic the defendant was—when the mental state arose from or during substance abuse (Ariz. Rev. Stat. § 13-502(a)); similarly, some reject it when the psychosis occurred during a transitory state (*i.e.*, "temporary insanity") (Ariz. Rev. Stat. § 13-502(a); Colo. Rev. Stat. § 16-8-101.5(1)); additionally, some refuse the defense when the mental abnormality constitutes "repeated criminal or otherwise antisocial conduct" (*Bethea v. United States*, 1976). Exceptions like those cannot generally be imposed on competency assessments.

Most jurisdictions take the position that competency is an objective status, not dependent on the nature of the circumstances the defendant is facing. However, others recognize that there can be differing standards of competency depending on the situation. It makes good sense that competency may be higher or more specific to waive a myriad of trial rights when pleading guilty under a plea agreement than, for instance, to be aware of being executed (Poythress et al. 2002). While evaluating professionals should verify if their jurisdiction has differing standards for incompetency depending on what the defendant is facing, following are some common competency tests where the legal undertakings make a difference:

- Competency to testify as a witness: capacity to receive accurate impressions of the facts and relate them truthfully (*State v. Kinney*, 1987).

[2]The writer represented a man who was deaf from birth. Erroneously diagnosed as profoundly mentally retarded, he was institutionalized as a very young child and never taught any language, including sign language, whatsoever. Although he was neither mentally ill nor intellectually disabled, he could not assist counsel and was found incompetent.

[3]Most present insanity standards are derived from the *M'Naghten* Rule stating that a defendant is insane when "laboring from such a defect of reason, from disease of the mind, as to not know the nature and quality of the act he was doing, or, if he did know it, that he did not know what he was doing was wrong" (*Daniel M'Naghten's* Case 1843). However, because an insanity defense is not a constitutionally protected entitlement, Idaho, Montana, Utah, and Kansas do not allow it (Applebaum 2013).

- Competency of defendant to waive *Miranda* rights and answer questions without counsel: the defendant must knowingly, intelligently, and voluntarily decide to waive *Miranda* rights (*State v. Camacho*, 1997).
- Competency to stand trial: the *Dusky* standard, "whether he has sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding —and whether he has a rational as well as factual understanding of the proceedings against him" (*Dusky v. United States*, 1960).
- Competency to waive trial rights and plead guilty: in addition to the *Dusky* standard, the defendant must knowingly, intelligently, and voluntarily waive his *Miranda* and trial rights (*Jones v. Knipp*, 2013).
- Competency of a "gray area incompetent" defendant to waive the right to counsel and represent oneself at trial: a heightened standard of *Dusky* plus accounting for the borderline incompetent defendant's mental capabilities to conduct trial (*Indiana v. Edwards*, 2008).
- Competency to be sentenced: the *Dusky* standard is commonly used (*United States v. Wolfson*, 2008; N.C. Gen. Stat. § 15A-1001 (a)).
- Competency to be executed: "when, as a result of mental disease or defect, he lacks the mental capacity to understand the nature and effect of the death penalty and why it is to be carried out (*Ford v. Wainwright*, 1986; N.Y. Corr. Law § 656; Ariz. Rev. Stat. § 13-4021; Fla. Stat. § 922.07; Ga. Code § 17-10-60; Ohio Rev. Code § 2949.28; Wyo. Stat. § 7-13-901).

Lawyers' Involvement with Competency Evaluations

Lawyers often are—and should be—involved in competency evaluations. Some forensic practitioners perceive attorneys from either side as interfering with their work, and would prefer to not deal with them. This is fair enough, as most of the population would prefer not to deal with lawyers! But generally, information from attorneys can be helpful, and sometimes the lawyer can persuade his or her client to cooperate with the evaluation or treatment.

Because one prong of the competency standard is the ability to assist counsel in legal proceedings, the competency determination must address problems the lawyer has interacting with the client. Generally, a forensic evaluator should try to discuss this relationship with the defense attorney. Admittedly, the lawyer may decline to engage, or may consider his or her interaction with the client to be "privileged" so non-disclosable. But, to the extent that lawyers are willing to discuss this with doctors, it contributes to an informed opinion.

Lawyers generally are not willing to allow the doctor to watch actual interactions between them and their clients. First, those interactions are confidential under the attorney/client privilege, and attorneys as well as their clients will seldom waive that. Second, lawyers may decline to interact with clients at all during the pendency of the evaluation, for fear of allegations that they "coached" their clients to fake symptoms (*People v. Brown*, 2014; *Matter of Foley*, 2003). Third, it is critical that lawyers not put themselves into a position where they become the evidence against their clients' liberty interests; when the strategy is to try to establish incompetency, they do not want favorable interactions with their clients to establish that the clients are competent and thereby create a conflict of interest with their client. For the same reason, defense attorneys will not want their letters, emails, or phone calls with clients to be disclosed to the evaluating physicians; it is not "hiding the ball," but rather legitimate protection of the attorney–client relationship.

Incompetency as a Litigation Strategy

As mentioned, incompetency may in fact be the litigation strategy of choice. Having the client found incompetent and unrestorable may be the

best outcome for the case, leading to dismissal of charges.[4]

Some profoundly ill individuals both were insane at the time of the offense and remain incompetent without hope of restoration, and so either option is available. But, frequently persons determined to be incompetent will have greater liberty options available to them than those determined to be insane. Hence a defendant who is committed upon a finding that he or she is incompetent, unrestorable, and dangerous is favored over one who is found not guilty by reason of insanity, placing the burden of proof on the prosecution for the former but on the defendant for the latter, and allowing greater conditions for early release to the former than the latter (18 U.S.C. § 4246(a); 18 U.S.C. § 4243(d); 18 U.S.C. § 4246 (e); 18 U.S.C. § 4243(d)). Under those circumstances, a finding of incompetency will produce a better liberty result than a finding of insanity.

On the other hand, insanity may be the goal of litigation. If the mental illness is ongoing, then a finding of incompetency could contribute substantially toward an eventual verdict of insanity. It is also not unusual to try an insanity defense "to the bench," meaning to ask the judge (rather than a jury) to decide the case; a judge who has reviewed extensive psychological records and reports from competency proceedings may already be well informed as to the defendant's mental state by the time of trial.

Competency litigation also educates the judge as to mental illness that constitutes profound mitigation for sentencing. Thus, even if the defendant will ultimately be found competent, he may want the evaluation and report to familiarize the judge familiar with these issues so that they can be weighed in when formulating the appropriate sentence.

In some states, a person who had been found incompetent in a criminal case may have a "leg up" on others when seeking to secure social services. To help the client avoid future entanglements with the authorities, a thoughtful lawyer may seek an incompetency finding so as to increase the likelihood of greater social services, which in turn will help the client remain law abiding. Moreover, a person who is found incompetent now will have a "track record" of serious mental illness for the future that precludes criminal prosecution, should that person face the proverbial "revolving door" of arrests.

Defendants do not, however, always agree with this litigation strategy. Generally, defense counsel wants to pursue the same case goals that his or her client wants (Uphoff 1988). But there are times when a lawyer is required to raise and fight for a finding of incompetency despite the client's adamant resistance. "Because the trial of an incompetent defendant necessarily is invalid as a violation of Due Process, a defense lawyer's duty to maintain the integrity of judicial proceedings requires that a trial court be advised of the defendant's possible incompetence" (*Moye v. Warden*, 2014; ABA Criminal Justice Mental Health Standards 7-4.2). This impasse arises most clearly with clients suffering from delusions, including delusions that there is nothing wrong with them (*United States v. Gillenwater*, 2013). Therefore, defense counsel may be in the untenable position of disclosing a limited amount of information conveyed by the client supposedly in confidence, so as to try to get a competency finding that the client is adamantly opposed to. The justice system prefers ruination of the attorney–client relationship, despite odds against success in competency litigation, to prosecution of an incompetent defendant.

Prosecutors likewise have a duty not to prosecute persons who are incompetent. In practice, nonetheless, they are as suspicious of claims of incompetency as they are of pleas of insanity. Unless it is facially apparent that the defendant is incompetent, they typically vigorously oppose having the defendant declared incompetent.

Determining Competency

Although this is not a forensic how to text, a few words of caution with important implications for

[4]Competency restoration staff should also consider their own ethical conflicts raised in "regarding how, and in what ways, information could be obtained from a defendant that might not be in the defendant's best interests" (Samuel and Michaels 2011).

legal advocacy should be sounded. First, as mentioned above, because one prong of incompetency has to do with the defendant's ability to assist counsel, serious attention should be paid to examining and investigating the lawyer's interactions with his or her client. While the defense attorney may decline to discuss these matters with treatment staff, information may be available in a motion filed in court for a competency hearing and/or a transcript of what the lawyer stated in court during preliminary competency proceedings. Note that evaluating professionals should not seek to surreptitiously examine interactions between the defendant and his or her lawyer (for instance, by listening to their "legal calls" or reviewing correspondence/email between them). When seeking advice of counsel is used against a defendant, the attorney–client relationship is fractured, and the Sixth Amendment right to counsel has been poisoned.

Records of prior criminal competency matters and reports may be found in the courts rather than in traditional institutions of psychiatric medicine. Often, the lawyers can assist physicians in securing copies of those records.

Even when formal time periods are not set for the evaluation of competency and restorability, the Supreme Court held that defendants are entitled to a prompt determination of this (*Jackson v. Indiana*, 1973).

A sizeable number of criminal defendants are non-citizens. Although interpreters may assist medical staff in communicating with their patient, language translation alone may not help evaluators understand the defendant's world view and culture. It can be very beneficial, consequently, to have a network of psychological practitioners and allied professionals who hail from different countries and cultures to consult with when determining an immigrant's competency.

Often, evaluating professionals will be asked to offer multiple opinions. It is not uncommon to seek opinions on competency as well as insanity, or on restorability to competency as well as dangerousness.

Finally, much of forensic psychology focuses on trying to uncover whether the defendant is faking symptoms (Feuerstein et al. 2005). Determination if a defendant is malingering can be an important aspect of reaching a competency opinion, but it is not dispositive. The emphasis some forensic practitioners place on malingering is out of step with the rest of the mental health practice (which generally does not look for malingering to disprove a diagnosis, but instead looks for symptoms to support a diagnosis); and certainly, motives to fake mental illness outside the criminal justice system are myriad as well (Feuerstein et al. 2005).[5] A tendency to turn first to malingering would suggest a professional prejudice concerning an offender population.

Furthermore, evaluators must consider that thoroughly incompetent individuals are capable of trying to fake symptoms (*United States v. Frazier*, 2001). So just because a defendant malingers does not mean he or she must be competent (*United States v. Gigante*, 1999).

Additionally, malingering is usually defined as intentional production of false or grossly exaggerated physical or psychological symptoms (i.e., malady) for a secondary gain (Rogers 2008). Nonetheless, faking being well, when the patient is mentally ill, can be equally problematic. Professionals exploring malingering should consequently consider that it can embrace both "fake-bad" as well as "fake-good," and should attend to defendants trying to appear competent when they are not, just as they watch for the converse. There can be as many reasons to fake competency as is seen outside an offender population, especially from intellectually impaired patients (who have learned to adapt and function) as well as persons suffering from a serious Delusional Disorder.

[5]These authors claim that forensic psychology is "unique" due to motivation arising from pending criminal prosecutions. That premise has been rightfully criticized, as seasoned nonforensic practitioners well know that there are always motivations of some kind that impact the reliability of their patients' claims and symptoms. Indeed, such motivations can arise from avoiding military duty, obtaining financial compensation, and obtaining drugs—in addition to evading criminal prosecution.

Post-incompetency Detention Process

After a competency report has been issued, the court will generally return the defendant from the therapeutic setting to the previous detention setting. If the defendant had been released to the community before the evaluation placement, then he or she would usually be released back to that same status. Departure from the hospital setting has implications for maintaining any competency that has been achieved. A defendant who is stable on a medication regimen may have to contend with irregular (or no) dosing during transportation. Furthermore, medical units in jails do not typically stock the variety of psychotropic medications that are available in psychiatric medical centers; consequently, doctors in jails may substitute other medications that may not be as efficacious. Furthermore, defendants may elect to decline treatment when in the jail setting. In addition, often the jail environment is more stressful than a therapeutic setting, so patients who are stable in psychiatric treatment facilities may decompensate under the stressors they face in detention facilities. Competency can be a fleeting state, even in the best of medical centers, and achieving competency there does not necessarily mean that it will be maintained after leaving.

One of the inherent difficulties of competency work is that psychological professionals are tasked with offering opinions on whether the defendant will be competent to proceed with trial, when all they can do is assess or render the defendant competent in a more stability-conducive medical setting. In one case, the defendant was determined to be competent 4 months before the competency hearing took place; one judge pointed out that the *Dusky* standard of competency includes "sufficient *present* ability to consult with his lawyer," and that the dated report would not necessarily reflect the defendant's *present* mental state (*United States v. Lindley*, 1985). Consequently, opinions of competency that extend beyond the psychiatric placement may not be very valid or reliable. Certainly evaluating professionals should offer a caveat that continued competency after leaving is dependent upon certain treatment/circumstances. In addition, they would best serve their patients by specifying in their reports their recommendations for continued treatment to try to maintain competency after leaving the therapeutic milieu.

Before a competency hearing is done, the lawyers may seek to explore the facts underlying and bases of the opinion. There is great utility in gathering wide-ranging information that contributes to a competency opinion (Philipsborn 2015; *United States v. Merriweather*, 2013). Bear in mind that the competency process takes place in a litigation setting, and it is not unusual for parties to contest the opinions. Hence, lawyers may want to see copies of complete medical records (including notes from support staff and security personnel), tests (including actual answers and raw test data), security camera tapes, videotaped treatment or "educational" footage (*United States v. Merriweather*, 2013), normal administrative records (such as admission, housing, movement, discipline, commissary, activities, meetings, religious practice, visitation, sick call, and personal property management), and any recorded visitation or phone calls. In rare cases, depositions will be ordered. Doctors may be asked for their CV's, medical school transcripts, and any training programs and authorities they relied upon in reaching their opinions. Treating professions should not take offense at being challenged this way, as it is part and parcel of an investigation step in the normal adversary process.

A medical opinion regarding competency is only part of what a court must consider in coming to a legal opinion regarding competency. While judges are informed by competency opinions, they may not agree with them. Moreover, there often are multiple experts offering conflicting opinions—so ultimately in those circumstances, the judge will reject someone's professional opinion regarding competency.

The judge may decide competency without a formal hearing or any testimony, but alternatively may want to hear from the doctors on the stand. Witnesses should always seek to discuss their testimony with the lawyers in advance. In the end, if the defendant is found incompetent, he

or she may proceed to restoration to competency treatment, discussed further below.

Offender Population Characteristics Relevant to Competency

Culture: There are some characteristics of the offender population that should be borne in mind when assessing competency. For instance, irrational ideas are not necessarily part of a psychotic process, but may instead be learned. Many persons who run afoul of the laws are not fully immersed in the predominant American culture, and may have grown up with ideas and values quite apart from the norm. The evaluator is well advised to investigate the cultural, family, and educational background of the defendant who has bizarre ideas but otherwise appears intact.

Age: The offender population is skewed in terms of age, with a far greater representation of younger defendants than normal. There is a clear decline of criminal conduct that tracks with age (United States Department of Justice 2003). The disproportionate number of youthful offenders is likely due to maturity lagging behind the age of majority: the full development of the human brain does not occur until approximately age 25 (Giedd 2004; Giedd and Blumenthal 1999), whereas the full legal responsibility for one's actions occurs generally at age 18. Consequently, in competency assessments of youthful adults, evaluators should consider developmental maturity issues.

Compartmentalized Incompetency: Some defendants may be rational about many aspects of their lives, but harbor segmented delusions, paranoias, or phobias about certain things. One of us represented a client who had delusions of being heir to the Ford Motor Company, and since these thoughts did not affect his drug case, competency was not initially raised. However, those delusions eventually intruded into the case when the defendant began to believe that the prosecution colluded with Ford to deprive him of his inheritance by falsely charging him with this crime. At that point, his paranoia impacted his competency to proceed to trial, and a competency hearing ensued. This type of fragmentation is not news to psychiatric professionals, but it has important implications for competency. Defendants who may appear rational or high functioning may harbor irrational but persistent fears about their lawyers, the prosecution, the government, or the police; deeper inquiries concerning compartmentalized delusions should be made when an intact-appearing defendant is evaluated.

Intellectual Disability: Although courts have held that having intellectual disabilities does not per se mean those defendants are incompetent (*Pruitt v. State*, 2005), it can clearly impact their ability to comprehend the justice system, to keep up with and grasp what is happening (often at lightning speed) in trial, and to assist counsel. Professionals should consequently delve into how these individuals function when assessing their competency. Most persons with intellectual challenges have learned to cope well and cover it up so as to secure employment or social relationships; "mentally retarded individuals use a 'cloak of competence' in an attempt to present themselves as 'normal' (or at least more capable than they actually are) as a means of avoiding the stigma of being identified as mentally retarded" (*Gumm v. Mitchell*, 2014). Extra care must therefore be taken to sort out "fake-good" attempts to portray a false sense of competency.

Amnesia: Due to heavy substance abuse, brain trauma, or severe psychosis, a number of defendants may genuinely experience amnesia concerning the crime (distinguished from a short-term memory disorder with chronic recall problems). Recognizing that defendants' ability to assist counsel in their defense may be truncated by retrospective amnesia, some jurisdictions allow amnesia as a basis for incompetency, concluding that "amnesia could render a defendant incompetent to stand trial under some circumstances;" on the other hand, the majority of jurisdictions have distrusted amnesia alone as a basis for incompetency (*People v. Amador*, 1988; *Morrow v. State*, 1982; *United States v. Robertson*, 2015; *Wilson v. United States*, 1968). This may be motivated by the fact that amnesia can be easily faked and all but impossible to disprove,

allowing defendants an easy means of malingering incompetency (*Simon v. McCarty*, 2015). Nonetheless for those who in fact suffer from retrospective amnesia, courts may create a "legal fiction" that their lawyers can compensate for that by educating their clients as to what occurred during the crime (based on the police and witness reports). That is hardly a satisfactory corrective, as the defendant may be the only one who could give information that can generate a defense or undermine the charges.

Multiple Personalities: Although Dissociative Identity Disorder (DID) involving multiple personalities occurs rarely, it is not unusual for persons who have this condition to act out and attract the attention of the authorities. Those suffering from this disorder, even when highly functional, are commonly referred for competency evaluations due to their bizarre personality changes. Simple dissociation, and its attendant amnesia, does not necessarily create incompetency; in one case, the court concluded that "a splitting of defendant's mind into different directions" was not likely to interfere with trial given that he was not likely to dissociate during trial (*People v. Girk*, 2014; *United States v. Brown*, 2015). However, deciding competency when there are multiple personalities with different mental states (such as child personas or alters who are psychotic) is a far more complex undertaking. Evaluating professionals must explore which personalities are competent, which are not, and predict which of those may appear during trial. This is complicated by the speed at which these patients can switch personas (Putnam et al. 1986). Consequently, monitoring which one is present during trial, when pleading guilty, or at sentencing (if realistically possible at all) may be necessary to ensure competency during those critical stages of the criminal case; note that "sustained period of identity disruption may occur when psychosocial pressures are severe" (American Psychiatric Association 2013). Given the stressors that entering a guilty plea or trial can generate, the possibility that a substitute persona may emerge at those proceedings is not insignificant.

One fascinating case of a psychopathic killer who suffered from multiple personalities illustrates the complexities of forensic determinations with this illness. After finding the DID defendant who had committed a brutal homicide not guilty by reason of insanity, the judge committed him to the state hospital. The hospital eventually asked the judge to release him. Psychiatric staff acknowledged that he genuinely suffered from multiple personalities, but had concluded that he had been faking incompetency and insanity. Analyzing his different "alters," the state's expert concluded that several had psychotic disorders (treatable), but only one of them was psychopathic (not treatable). Because the dominant personality at that time was the psychopathic one, and it could remain dominant for years, the defendant would pose a danger if released. Consequently, he was not released from the hospital (*Ex parte Alabama Dept. of Mental Health*, 2013). Similar depths might have to be plumbed when evaluating competency of a defendant who suffers from DID involving multiple alters, including which personas are competent, which are potentially restorable to competency, and the likelihood that certain personas may take over at given junctures in the court proceedings.

Restoration to Competency

Restoration Process

The court order placing the defendant in a competency restoration program should spell out what the medical center is asked to try to accomplish, what reporting is needed, and what time frame is allowed for this process.

Restorative treatment can be relegated to a secondary placement, or it can be authorized during a competency evaluation. Those jurisdictions that handle it sequentially will usually conduct a hearing to determine competency before initiating restorative therapy. Although no court will fault a medical institution for offering voluntary treatment to defendants in need, whether it is expected of the evaluating facility should be spelled out in the court's order asking for the competency evaluation.

Patients returning to medical settings for competency restoration may be more psychotic than when they left. Because they have the right to be present at court proceedings, they will typically be transported to court for such purposes; they may be gone for weeks or occasionally months before returned for competency restoration. It may take that long for further expert evaluations, reports, discovery, and litigation; alternatively, the defendant's bed space in the medical center could have been assigned to the next person awaiting inpatient services, and the defendant may have to wait until bed space becomes available to return (Pemberton 2014). In any event, there can be a clinically significant time period before a defendant is returned to the medical facility for restoration to competency. Consequently, any therapeutic treatment may have been interrupted in the interim, and the restoration program could have a patient who is more psychotic than he or she was when evaluated for competency.

On the other hand, some creative institutions have allowed the defendant to stay there while appearing for the hearing by videoconference (*United States v. Baker*, 1995). This has avoided or minimized any disruption in treatment. Furthermore, some fortunate defendants will have good medical attention while incarcerated in detention centers pending the competency hearings; despite being deemed incompetent when they left, they may return fully restored due to efficacious treatment provided in the detention center.

There are cases that are effectively "doomed" for restoration, where no amount of treatment or education can correct the problem. Typically those with severe intellectual disabilities may not be restored to competency, and quite a few mental illnesses will not be sufficiently resolved within the time constraints laws allow for restoration. Similarly, those who have had no beneficial impact from previous regimens of antipsychotics will likely fare no better with yet another round of like treatment. Further, deeply disturbed individuals (such as those with developed Delusional Disorders or Dissociative Identity Disorders) may need years of therapy to restore them—time that is simply not available for these efforts. Some jurisdictions nonetheless require commitment for restoration regardless of its likelihood (18 U.S.C. § 4241(d)).

Constitutional rights impose a reasonable time frame on restoration. For example, federal courts allow 4 months whereas Washington allows only 90 days for those charged with felonies and 45 days for misdemeanors (18 U.S.C. § 4241(d)(1); Rev. Code Wash. 10.77.086(1)). Courts also place a high premium on avoiding delay in resolving criminal cases, for defendants as well as victims have rights to speedy outcomes. Hence indefinite commitment based solely on the defendant's incompetence violates the Equal Protection and Due Process clauses of the U.S. Constitution (*Jackson v. Indiana*, 1972). Nonetheless, only about half the jurisdictions set maximum periods of time for restoration (*State v. Davis*, 2008), so judges may impose their own temporal restrictions.

Restoration Treatment

There are many paths to recovery, and many means of restoring an incompetent defendant. Historically it seems, the preferred path has been pharmacological, despite the abundance of other sound therapeutic options. Admittedly, time limitations on restoration to competency may call for a "quick fix" solution; but, practitioners involved in restoration programs should consider more creative options, especially when those do not involve serious side-effects such as sedation, slurred speech, distracting bodily movements, or a declination to assert rights and make critical decisions. In other words, because many of the drugs being favored in restoration presently may also impair competency, alternatives should be considered.

Medical centers offer a therapeutic milieu. A stable and less stressful environment in a psychological unit can have beneficial impact on a patient's recovery. Providing a safe haven, counseling, and supportive staff alone can improve any patient's condition. Its drawback is that defendants who are restored by being in a

therapeutic setting may not be able to maintain competency once returned to a jail setting. On the other hand, many defendants are not detained pretrial; if they are to be returned to a home environment, then the treatment staff can work on a discharge plan with the defendant's family and outpatient providers that could provide an environment that is therapeutic in the home upon discharge.

Work and purposeful activity is beneficial to recovery as well. For that reason, many hospital settings incorporate occupational therapy and related art therapies into their treatment regimens. Aside from keeping idle hands busy and the distraction/focus that these offer, they also provide motivation for the patient to get better as patients start to want to accomplish occupational goals they are undertaking.

Educational programs can have the same productive impact of occupational and arts therapies. However, a word of caution must be sounded about some "competency restoration education" modalities. These programs started to spread in the 1990s, ostensibly as an adjunct to traditional restoration, seeking to better educate defendants as to the criminal system, its procedures, and their rights (Samuel and Michaels 2011). Based on the premise that a competent defendant must intelligently appreciate what he is facing and what will happen in his case, they seek to educate the defendant on those matters. Though this can be a helpful component of restoration, in some restoration programs "competency classes" have unfortunately become the norm and main focus of restoration rather than an adjunct to it. These programs can be criticized for merely teaching defendants to "parrot" answers to questions commonly asked by judges who are deciding whether the defendant is competent. There is little research establishing that such training programs in fact restore the ability to assist counsel and appreciate and apply judgment to critical legal decisions concerning trial; a movement may be in the offing to take into account more than the intellectual component of competency, to instead consider "the client's *appreciation* of competency-related issues as well as his *reasoning processes*—the defendant's *functional* ability" (McCoy 2011). Highly delusional defendants, individuals with paralyzing depression, floridly psychotic patients, and those with intellectual disabilities can be taught by rote learning and simple conditioning to state correct answers to a judge's inquiries such as:

Q "Do you know who your lawyer is?"
A "Yes, she is right here next to me."
Q "Do you know what a jury does?"
A "Yes, they decide if am guilty or not."
Q "Do you know what I do?"
A "Yes, you decide how much time I will get."

Yet their ability to appreciate and process what they are encountering in the justice system may remain impaired. Dr. Kathleen Ronan has posed the thoughtful question: "How do you know the defendant is not simply parroting back what you have told him rather than truly understands the legal issues and can apply them?" (McCoy 2011). Therefore, the fact that they can state correct answers to these questions should not be confused with whether they can process, understand, and use this information in making intelligent and rational decisions.

Traditional counseling or "talk therapy" may have a role to play in restoration as well. Patients in the debilitating grip of anxiety, PTSD, or depression may improve even under short-term counseling sessions with a qualified therapist (*In re N.J.M.*, 2010).

Treatment may need to escalate to harsher modalities such as antipsychotic medication—and theoretically ECT and neurosurgery (though these options have almost never been used in competency cases since the 1970s). Defendants commonly start to balk at treatment when harsher options are prescribed.

Conflicting Goals

The goal of competency restoration as far as the court and prosecution are concerned is to restore the defendant sufficiently so that the case can

proceed to trial or a plea agreement. The goal of restoration as far as the defense is concerned may align with that. However, in some cases, the best outcome of the case for the defendant may be a finding of incompetency. The defense attorney will actively fight for and protect such a finding. That is not to say that the lawyer is trying to do something underhanded—no ethical professional would advise or encourage a defendant to fake incompetency; no lawyer serious about maintaining a bar license would raise the issue of incompetence when he or she does not see any indications of incompetency. But, when there is evidence suggesting that the defendant is incompetent, the defense could reasonably conclude that the goal is a judicial finding of incompetency coupled with a finding of unrestorability.

In short, recovery (for criminal competency purposes) may involve not recovering (for best medical outcome purposes). The defense may pursue this strategy in earnest from the start of restoration. This is understandable given that the prosecution very often distrusts psychological defenses, and opposes them vigorously. Anticipating a pitched courtroom battle, the defense must plan in advance to fight for an incompetence finding.

Treatment Decision-Making

Defendants maintain the right to decide their medical treatment unless and until a court orders otherwise. They are not utterly stripped of the right to refuse medical treatment simply because they have been arrested for a crime or found incompetent. The need to make a decision nevertheless calls into question who will render that decision; when a defendant has been deemed incompetent, his or her ability to make intelligent decisions is obviously questionable.

As a matter of law, however, a defendant is allowed to decide to reject treatment meant to restore competency (*Riggins v. Nevada*, 1992). Whether mildly incompetent or floridly psychotic, a restoration defendant's refusal of treatment must be scrupulously honored. Thus, when a defendant declines recommended treatment, the restoration program has to try alternatives acceptable to the defendant, or seek a court order (via a *Sell* hearing) to involuntarily medicate.

The more difficult problem arises when a defendant appears willing to accept treatment, but the lawyer feels that the defendant should refuse it. Unlike the above scenario, the defendant's express wishes may not decide the matter. This seeming incongruity arises because the decision to refuse treatment is a matter of preserving the legal rights guaranteed to the criminally accused, and is not based on how competent the defendant is factually to make medical decisions. Where the defense attorney has concerns that undergoing restoration treatment would harm the defendant, hurt the defendant's ability to assist in his defense, or make the defendant even less competent, the attorney can assert a refusal of treatment on behalf of the client. When that occurs, restoration staff should not go forward with the defendant's apparent voluntary acceptance of treatment until a court decides the matter. The lawyer's assertion of the right to refuse treatment suffices to trigger the *Sell* litigation needed for a judge to decide this issue.

In rare and unfortunate instances, courts have appointed a guardian ad litem to make medical decisions for an incompetent defendant (*State v. Curry*, 2009; *State v. Veale*, 2009). Defense attorneys may resist that, as guardians ad litem are not trained in criminal defense and consequently may not sufficiently understand the subtle criminal legal rights and issues that are at stake—subject matter that criminal defense specialists are experts on. Guardians ad litem may not appreciate, for instance, that although administering antipsychotic medication to an agitated psychotic individual may help him or her think more clearly, remain calmer, and enjoy a better sense of well-being, the sedative effect of these drugs could be detrimental to his or her competency to proceed with trial.

Involuntary Treatment

We open with the proposition that involuntary treatment can be antithetical to the concept of

recovery advanced in this text. Under the premises that an individual may best determine how to achieve highest functioning in his or her environment, and that self-determination is an essential factor in psychological wellness, doctors may decline to recommend forced treatment. Note that that does not mean that a judge will agree, and the court may disregard doctors' recommendations and order the defendant to comply, including involuntary administration of medication if the defendant does not.

There is no "bright line" test to determine involuntary treatment in a criminal restoration setting. Involuntary medication decisions within a non-offender population are normally decided by balancing the patients' rights to refuse treatment against health and safety (of self and others) concerns (405 I.L.C.S. 5/2-107.1). A similar balancing is done when deciding forced medication within a criminal competency setting, but there are more factors than those two to consider.

Generally, treatment can be forced onto a criminal defendant involuntarily only under two circumstances. First, if a defendant needs medication because he or she is gravely disabled or poses an imminent risk of danger to self or others, forced medication can be authorized through an administrative (hospital administration, as opposed to a criminal court) process. Some jurisdictions set forth procedures for administrative hearings in statutes or regulations, others establish it in case law. In federal courts, this is referred to as a *Harper* hearing (*Washington v. Harper*, 1990; 28 C.F.R. § 549.43). The federal courts recognize a Due Process liberty interest to not be medicated against a person's will, but that is balanced against the defendant presenting a danger to self or others, and that the medication is medically appropriate. These administrative hearings typically offer only short-term intervention. They do not authorize long-term involuntary treatment, which usually must be justified by a court order even in a noncriminal inpatient population. Because of that, these administrative hearings will not support the long-term restoration needed to return a client to get through trial. *Harper* hearings are consequently not a viable restoration strategy.

Second, if there are no such imminent dangers, defendants committed for competency or restoration have additional rights that judges must weigh before involuntary treatment is given. In addition to Due Process, their Sixth Amendment (trial) rights may be implicated by psychotropic medication (*Riggins v. Nevada*, 1992). Judges must conduct a *Sell* hearing before hospital staff can involuntarily medicate an incompetent defendant (*Sell v. United States*, 2003). According to the Supreme Court's *Sell* decision, a judge may authorize a medical center to administer involuntary treatment within the competency restoration arena, but only when a number of rights are considered. The Supreme Court in *Sell* (2003) balanced these rights in a four factor test that the government must meet: (1) there must be "important governmental interests" at stake; (2) involuntary medication must "significantly further" those important governmental interests; (3) involuntary medication must be "necessary" to further those interests; and (4) involuntary medication must be "medically appropriate." When refusal of recommended treatment occurs, medical staff must inform the judge and lawyers of this impasse, and wait for the judge to analyze these factors to determine whether treatment can be forcefully administered to the unwilling defendant.

One of the more important issues that a judge must consider in a *Sell* hearing is whether the side-effects of the anticipated medication may in fact interfere with the defendant's interaction with counsel and assistance in his defense. While physicians must be concerned with potential medical side-effects of psychoactive medications, judges must additionally be concerned with the legal impact of those side-effects. Treatment can interfere with court hearings as much as assist with them. For instance, the so-called "antipsychotic" drugs have some degree of sedative effect on the patient. A defendant whose psychosis can be controlled on Haldol may nonetheless be slow to respond, may not grasp critical testimony, may be sluggish while testifying (hesitation in answering questions could be interpreted by a jury as evidence of lying), or may sleep through part of a trial. So even though the drug corrected

the underlying psychosis, it ultimately interferes with the defendant's right to defend him- or herself, and assist counsel at trial.

Additionally, the second *Sell* factor (whether the recommended treatment is in fact likely to restore the defendant to competency) is not easily established for some drugs given some diagnoses. Medications with reliable efficacious impact on certain diseases will best meet this criterion. This depends upon how well the psychoactive ingredients correct the condition causing the illness. Some drugs are well tailored to certain diseases, and may pass this *Sell* factor easily: for instance, Ritalin works reliably and dramatically well—if for short time periods—with persons having ADHD; Lithium improves many persons suffering from Bipolar disorder; and the antipsychotic drugs are effective on approximately 75 % of Schizophrenics. Other less well understood or well tailored medications, or ones being applied off-label, may be rejected during *Sell* litigation (*United States v. Holden*, 2014; Elm and Passon 2008).

Furthermore, physically forcing medication on a resistant defendant may have seriously adverse impact when he or she has certain critical symptoms. For instance, persons suffering from persecutory delusions that the government or medical institution is "out to get them" will have their "delusions" confirmed as "reality" in this process! It will be far harder to disabuse them of their paranoias after a squad in protective (identity-concealing and depersonalizing) gear physically tie them to a bed and forcefully inject a drug.[6] The experience similarly may trigger flashbacks in persons who had suffered previous trauma, contributing to the inception or worsening of PTSD. Furthermore, phobic individuals may be so terrified by this procedure that they would prefer to take their own lives rather than face it a second time (*Ferch v. Jett*, 2015). Forcefully administering treatment can thus have grave impact on both recovery and restoration in a sizeable portion of the criminal restoration population.

Because so many factors are at play in a *Sell* analysis, it is not uncommon for courts to impose restrictions on a forced medication regimen. For instance, the judge may allow it: only for a short period of time; only if the defendant willfully complies with court-ordered treatment; may specify what medication (or class of drugs) may be used; and/or may require a trial run of second generation antipsychotics (such as Geodon) first, and only progress to first generation (such as Haldol) if that is unsuccessful. The Court may also impose restrictions on what could be considered "punitive" measures. In the *Sell* case, it was apparent that Dr. Sell's noncompliance with recommended medication was being "punished" by solitary confinement, lack of freedom and normal programming within the facility, and alleged mistreatment; judges have thereafter sometimes included in their orders limitations on the type of "motivational" techniques that the facility can use to try to secure the defendant's compliance with treatment. Restoration physicians should expect judges to exercise much greater "hands on" involvement in the treatment plan after *Sell* litigation.

Defendants may also resist medication (or competency) at trial so as to demonstrate to the jury their mental state when not under treatment. This occurs rarely, but may arise when an insanity or diminished capacity defense is raised. The defense attorney may want the jury to see for themselves how insane or compromised the defendant is when not adequately medicated, so would want the defendant to remain untreated during trial. This generates a conflict between the constitutional right to an effective defense and the Due Process right to be competent when prosecuted (*Commonwealth v. Louraine*, 1983; *State v. Maryott*, 1971; *State v. Hayes*, 1978). The *Louraine* court held that the right to present an insanity defense means more than the ability to verbalize or offer an expert's testimony about it: "the jury are likely to assess the weight of the various pieces of evidence before them with reference to defendant's demeanor. Further, if the defendant appears calm and controlled at trial,

[6]No professional practicing in forensic competency or restoration should start their work without having first watched a video of the aggressive physical confrontation that occurs in forced treatment.

the jury may well discount any testimony" regarding his insanity (*Commonwealth v. Louraine*, 1983).

Post-*Sell* Hearing

If the hospital or prosecution succeeds in securing court-ordered involuntary treatment, then the medical staff must comply whether they recommended it or not. If the treatment works, then the defendant can be returned to court for legal proceedings to resume. However, because of the numerous legal rights and concerns implicated, if treatment interventions are not showing promise, doctors should discontinue their efforts as soon as lack of improvement is apparent.

If restoration fails to render a defendant competent, then charges can eventually be dismissed. In some states, the court must dismiss some charges when the defendant is determined to likely remain incompetent; others give courts discretion whether to immediately dismiss charges. Montana and Missouri call for immediate dismissal (Mont. Code § 46-14-221(3)(b); Mo. Stat. § 522.020.11(6)); Minnesota applies that principle to misdemeanors (Minn. R. Crim. P. § 20.01(6)(b)); and Arkansas and Hawaii allow dismissal when the judge believes that so much time has elapsed that it would be "unjust" to resume a prosecution (Ark. Code § 5-2-310(C); Haw. Rev. Stat. § 704-406(3)). However, a number of jurisdictions would interpose one additional procedure before releasing an incompetent defendant: determining whether he or she would pose a danger to society.

Dangerousness

Dangerousness Determination Process

In some jurisdictions, the judge will seek a forensic opinion whether the defendant poses a danger if released, and may accordingly commit him or her (18 U.S.C. § 4243(b); 18 U.S.C. § 4246(b)). In anticipation of this process, some evaluating facilities offer, and some judges seek, opinions of dangerousness during competency or restorability evaluations.

Assessing risk of danger is notoriously difficult—just due to the unpredictability of human behavior alone. It becomes increasing more complex, hence less accurate, given variations in most patients' psychological conditions over time, impact of changing hospital environments and a mobile staff, vagaries of funding for treatment regimens and placement centers, and unreliability of stable placements and support upon release (*State v. Germane*, 2009; *Atchison v. Cruz*, 2011). Nevertheless, evaluating professionals may be tasked with offering their best educated judgment of a defendant's future dangerousness if released from the hospital.

These are quasi-civil/quasi-criminal commitment proceedings, and criminal commitments may have different procedures or standards than their civil counterparts (*Matter of L.W.*, 2015). Like civil commitment processes, defendants retain Due Process rights and entitlement to counsel for these proceedings. However, this process may be overseen by criminal courts, rather than civil or mental health courts.

Once an opinion of dangerousness is issued, the judge will generally hold a hearing to determine dangerousness and the need for commitment. As in competency and restoration litigation, the lawyers could seek discovery of evidence concerning dangerousness, and professional staff may be called as witnesses or experts in this litigation.

Post-commitment Review

There have to be options to release defendants from these commitments. Analyzing them under Equal Protection, the Supreme Court concluded that committed criminal defendants should get no worse treatment than committed civil patients (*Jackson v. Indiana*, 1972). Indiana, for example, had a statutory provision for civil commitments that allowed for release when the patient was no longer gravely disabled or no longer posed a danger to self or others. The criminal statute providing for commitment of defendants found

incompetent and unrestorable was, however, silent as to any potential future release. In the *Davis* case, for instance, the committed criminal defendant contended he was deprived of constitutional protections by this scheme (*State v. Davis*, 2008). The Indiana Supreme Court agreed. Accordingly, Indiana's protocol was changed to allow for release from commitment when the defendant no longer poses any danger or is no longer gravely disabled.

The United States Supreme Court has only approved involuntary commitment statutes (both civil and criminal) under the Due Process clause when they satisfy these three requirements: (1) "the confinement takes place pursuant to proper procedures and evidentiary standards;" (2) there is a finding of "dangerousness either to one's self or to others;" and (3) proof of dangerousness is "coupled … with the proof of some additional factor," such as a "mental illness" or "mental abnormality" (*Kansas v. Hendricks*, 1997). Thus, although different jurisdictions have their particularized wording and laws, they include at the least these three conditions. Some states require more of course. California, for instance, decided that in order to commit a defendant who is mentally retarded, the state must prove mental retardation, danger to self or others, and that "mental retardation was a substantial cause of serious difficulty in controlling dangerous behavior" (*People v. Cuevas*, 2013). Mental health professionals should ask the lawyers for the particular standards that apply to their opinions.

Although the focus of release hearings is often on dangerousness, defendants are entitled to release—despite posing a serious threat of danger—if their mental illness is resolved. After all, release can also be premised upon remission of the triggering mental condition (*State v. Beaver*, 2014). At that point it is the responsibility of the law enforcement system, rather than the mental health system, to control a defendant's conduct.

Each jurisdiction has its own process, allowing for review hearings periodically for the defendant to seek release, and often allowing for the hospital to ask for release (usually whenever it opines it is appropriate). Practitioners should familiarize themselves with the standards applicable in their state. Defendants are also entitled to counsel at these hearings.

Recovery Implications

Criminal defense lawyers have an obligation to preserve their clients' liberty interests (*Humphrey v. Cady*, 1972). Recall that these lawyers may attempt to secure their clients' release even when it is clearly not in their best medical or personal interests. Defendants' release is usually conditioned upon their no longer suffering from the mental illness or defect that led to their commitment, and/or their no longer posing any danger to the community. Ironically then, the same attorneys who had been advocating that their clients were mentally ill (hence incompetent or insane), and could not be restored (so charges should be dismissed), would of necessity reverse their tactics at this juncture.

Although they try to secure their clients' release, they may also stay involved with the clients post release. After all, most defendants initially secure only conditional releases that impose a number of terms that the defendant must comply with (such as taking prescribed medication, refraining from substance abuse, remaining in a productive residence or program, and reporting to supervising social work staff). Often continued support and assistance from the lawyer helps a defendant stay on track with his or her release terms so that the defendant will not violate those conditions. The long-range goal of defense counsel at times is to free the defendant from court-ordered commitment and supervision; that is best realized by ensuring success while the client is on a conditional release plan.

Civil Commitment

The Roots of Modern Civil Commitment Laws

Theoretically, the modern practice of civil commitment balances individual liberty interests with

the need for involuntary psychiatric treatment. In this ideal world, the courts and mental health providers practice in a Goldilocks zone providing just the right amount of Due Process and treatment toward the goal of healthy independence for all. The reality is that shifting financial and legislative priorities constantly challenge America's mental health safety net. Many state hospitals struggle daily to provide meaningful treatment and legal services to clients seeking recovery. Despite these flawed systems, it is vital for all stakeholders to contribute to the success of each patient by understanding and strategically applying involuntary treatment laws, which exist to protect citizens and promote personal and societal wellness.

The common law concept of *parens patriae*, which originally existed as a doctrine granting English royalty the inherent power and authority to "parent" the people, has survived in American jurisprudence permitting the government to protect the interests of those who cannot speak for themselves. The most common application of *parens patriae* occurs in the court's treatment of children, the elderly, the mentally ill, or others deemed incompetent to manage their own affairs (Ratliff 2000; Testa and West 2010; *Alfred L. Sapp & Son, Inc. v. Puerto Rico*, 1982; *Hawaii v. Standard Oil Co. of California*, 1972; Curtis 1976). In the context of involuntary treatment laws, *parens patriae* operates in tandem with the police powers granted to the states via the Tenth Amendment to the United States Constitution, which leaves to them expansive regulatory discretion to legislate and enforce order for the health and welfare of the masses (Arrigo 2002; Testa and West 2010). Together, these legal principles provide the underpinning for modern involuntary civil commitments. In practice, the inherent dilemma has been reaching a balance between the government's obligations to ensure the safety of the masses while preserving the civil liberties of the individual.

Faced with the perpetual question of how best to care for individuals with significant mental health issues, the United States has gradually modified its involuntary treatment laws. During the 1700s and 1800s, oversimplified statutes governed indefinite hospitalizations, which were common due to a prevailing belief system that stigmatized mental illness and presumed that the asylum benefitted every patient (Gordon 2015). Instead of offering shelter and support, the asylum eventually became known for its abuses of civil liberties (Gordon 2015; Testa and West 2010). Beginning in the 1950s, a shift toward deinstitutionalization began to occur, based in part on the efforts of mental health professionals and civil rights lawyers working in tandem for reform (Appelbaum 1997). Concurrently, pharmaceutical science gave doctors an option to manage patient care in an outpatient setting. Further, the enactment of nationwide programs like Medicare and Medicaid, which provided federal funds to support community-based treatment, prompted widespread closures of state hospitals (Gordon 2015; Testa and West 2010).

Hand in hand with this deinstitutionalization shift came the development of the "dangerousness paradigm." In the civil commitment setting, this new legal standard was prescribed by the Supreme Court in *O'Connor v. Donaldson* (1975): "a State cannot constitutionally confine without more a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends." The Supreme Court made clear that the state must show at least one of the following three justifications for civil commitment: danger to self or others, inability to care for oneself, or the necessity of treatment to cure a mental illness (*O'Connor v. Donaldson*, 1975). These parameters remain the underpinning of almost every involuntary treatment commitment law today.

Since this major shift in American mental health policy, problems have continued to plague the nation's mentally ill. The positive growth of community-based treatment providers seen in the early days of deinstitutionalization faltered as state and federal spending shifted to a decentralized model in the 1980s, which impaired the development of comprehensive modern mental health services (Gordon 2015; McGuan 2009). Scores of mentally ill Americans have since been funneled into the prison system (Gordon 2015;

McGuan 2009; Testa and West 2010). For others caught in the revolving door of involuntary commitments, meaningful mental health treatment with individualized recovery in the least restrictive setting remains an elusive goal.

Recently, perceived problems with the "dangerousness" legal framework have led to an uptick in the demand for further reform of the civil commitment system. The change is toward a focus on a "need for treatment" standard and increased use of outpatient treatment (Gordon 2015; McGuan 2009; Stettin et al. 2014). Some of these proposals are promising, and many have been spearheaded by mental health professionals and lawyers alike. Even so, the current state of the law in almost every state continues to use "dangerousness" language, and therefore all practitioners must remain educated in these standards and work within them to promote health and wellness for their patients.

Inpatient Civil Commitment: Elements, Definitions, and Due Process

Since the *Donaldson* case, the Supreme Court has been quite laissez-faire in the arena of civil commitments. Even so, certain important precedent has been set by the highest court, which continues to dictate state legislation and civil commitment procedure. Four years after the groundbreaking *Donaldson* decision, in *Addington v. Texas* (1979), the Supreme Court raised the standard of proof for all involuntary treatment commitments from "preponderance of the evidence," to "clear and convincing evidence." Thus, the Court required greater proof (of dangerousness or grave disability) before allowing a judge to deprive an individual of his or her liberty interests by commitment. In 1982, the Supreme Court made clear in *Youngblood v. Romero* (1982) that every person has a protected interest in freedom from confinement and personal restraint, requiring Due Process before that civil liberty is restrained by involuntary commitment.

Every state allows for involuntary commitments of individuals who suffer from a diagnosable mental health disorder and are a danger to themselves or others. Not all statutes read similarly, nor are they used uniformly across the nation (Brooks 2007; Treatment Advocacy Center 2011). Commonly, involuntary treatment laws include the following legal elements: the individual is currently suffering from a diagnosable mental health disorder (DSM-5) *and as a result of this disorder*; the individual is a danger to herself or others, *or* the individual is gravely disabled, *and* the individual is unwilling or unable to be voluntarily treated, *and* Assisted Outpatient Treatment ("AOT") is inadequate to address the immediate risk. These statutory elements are legal and not medical in nature. State laws or court opinions define, for example, "dangerousness" or "grave disability;" these terms are not intended to be flexible, nor are they subject to interpretation by mental health professionals on a case-by-case basis. These standards exist to promote uniformity, fairness, and integrity to the process due each patient every time he or she is facing commitment proceedings.

To understand these legal elements, definitions, and commitment practices, it is useful to focus on one particular state's Involuntary Treatment Act. The state of Washington has a well-developed system for handling civil commitments that is typical of others found across the country. Washington prefers that an individual receive the least restrictive means of treatment possible, and allows for AOT orders when appropriate (Rev. Code Wash. 71.05.012; Rev. Code Wash. 71.05.145). Where inpatient commitment is sought, the state must prove that the individual (a) has a mental disorder and, as a result of that mental disorder, (b) is gravely disabled, or (c) presents a likelihood of serious harm to themselves, others, or property (Rev. Code Wash. 71.05.153; Rev. Code Wash. 71.05.240). Washington's definition of "mental disorder" encompasses "any organic, mental, or emotional impairment which has substantial adverse effects on a person's cognitive or volitional functions" (Rev. Code Wash. 71.05.020(26)). Therefore, it includes, but is not limited to, the following: depression, schizophrenia, bipolar disorder,

dementia, developmental disabilities, and traumatic brain injury (Rev. Code Wash. 71.05.040).

The presence of a “mental disorder” alone cannot result in an involuntary commitment (*In re LaBelle*, 1986). It must be sufficiently serious to impair cognitive or volitional functioning, resulting in presenting as gravely disabled or dangerous. Washington’s “gravely disabled” standard is met when the state can prove by clear and convincing evidence that, as a result of the person’s mental disorder, the person is: (a) in danger of serious physical harm resulting from a failure to provide for his or her essential human needs or health or safety; or (b) manifesting severe deterioration in routine functioning evidenced by repeated and escalating loss of cognitive or volitional control over his or her actions and not receiving such care as is essential for his or her health or safety (Rev. Code Wash. 71.05.020(17)). Gravely disabled persons may display the following examples of behavior occurring as a result of a diagnosable mental condition and its symptoms: individuals who are starving themselves; individuals who are allowing medical conditions to become unmanageable; individuals who are on reckless spending sprees or losing their homes; individuals who are not perceiving reality or orienting themselves to time, place, and person; or individuals who have lost cognitive functioning or cannot remember or retain information. These persons may suffer from dementia and Alzheimer’s, have been inflicted with traumatic brain injury, or are catatonic. They can be gravely disabled under other medical conditions as well, so long as those fit within the parameters of the DSM-5, and the problematic behavior is a result of those symptoms.

Even though these gravely disabled cases can include some factually very disturbing situations, civil commitment remains a significant deprivation of liberty that is not to be taken lightly. Even when the patient is nonresponsive, if a civil commitment lawyer believes that the alleged grave disability does not meet the above elements, or that the individual can be cared for by family and friends in a less restrictive setting, the lawyer will actively contest commitment. In most states, the simple fact that a person may need treatment is not grounds for involuntary commitment (Brooks 2007). Additionally, just because a person may make questionable choices should not result in loss of liberty. The concerning behavior must not be a lifestyle choice, but rather a result of such deteriorated thinking based on the underlying mental condition so as to render the person incapable of making rational decisions (*In re LaBelle*, 1986). This standard may seem cruel as it results in the release of people whose condition may be improved by treatment, but the *Donaldson* (1975) opinion made clear that no one should be confined against their will if they can live free in adequate safety.

The presence of a mental disorder alone also does not establish dangerousness. Unlike the gravely disabled standard, which relies on a danger of harm due to *passive* behavior, this provision relies on that danger from *active* conduct by the patient (*In re LaBelle*, 1986). The individual must present with a likelihood of serious harm. Washington’s dangerousness standard is met when the state can prove by clear and convincing evidence that as a result of the person’s mental disorder, there is a substantial risk that: (a) physical harm will be inflicted by an individual upon his or her own person, as evidenced by threats or attempts to commit suicide or inflict physical harm on oneself; (b) physical harm will be inflicted by an individual upon another person, as evidenced by behavior which has caused such harm or which places another person or persons in reasonable fear of sustaining such harm; (c) physical harm will be inflicted by an individual upon the property of others, as evidenced by behavior which has caused substantial loss or damage to the property of others; or (d) the individual has threatened the physical safety of another and has a history of one or more violent acts (Rev. Code Wash. 71.05.020(25)).

Recent and tangible factual evidence of these elements must be present, which often includes suicidal or homicidal threats, or criminal acting out (where law enforcement benevolently decided the better course would be commitment rather than arrest). This may mean that the

evidence of the problematic behavior used to determine commitment is often established by some non-medical assessment by a lay person or police; these lay witnesses are not trained mental health professionals, and their evidence consequently may not be the most useful information for proving dangerousness or grave disability. Hence, many states allow courts to also consider the individual's recent history when determining dangerousness, including information from recent civil commitments or treating physicians (Rev. Code Wash. 71.05.012).

If the person is likely to be arrested if released from the involuntary treatment hold, lawyers will often attempt to convince the patient to agree to the civil commitment in lieu of facing criminal charges. However, if the individual is likely to face freedom should they be released from the hold, these dangerousness commitments can often result in contested hearings with testimony not unlike criminal trials.

It should be noted that even in the civil, nonforensic arena, people face significant social stigma and collateral consequences if involuntarily civilly committed. Even a short 14-day commitment can cost people their jobs or housing, or displace them from a comforting schedule of activities or interaction with friends and family, which may be invaluable to that person. Involuntary commitment also carries potential future criminal consequences, for example, in some jurisdictions those who were committed can be arrested if they later possess a firearm (18 U.S.C. §922(g)(4)). Therefore, although the individual could benefit from treatment, he or she may vigorously contest commitment for reasons far beyond those contemplated by mental health professionals. Again, it is the lawyer's job to advocate for liberty, which may or may not always be in line with an individual's path to recovery.

Once a mental health professional has identified an individual who meets commitment criteria, the involuntary treatment process begins with an initial detention. In Washington, this is a 72-hour hold period that cannot last longer without patient consent or a court order (Rev. Code Wash. 71.05.180; Rev. Code Wash. 71.05.240). Though some individuals never need more than the three-day hospitalization, so do not see legal advocates, most persons in initial detention are moving into the commitment process, so end up with counsel. The court appoints a lawyer to represent any individual facing a 14-day (or longer) civil commitment (Rev. Code Wash. 71.05.150(2)(c)). The attorney visits the client and advises him or her of Due Process rights and what to expect in this process. Often, the lawyer will seek information about the circumstances surrounding the current detention, as well as the individual's background and life circumstances. It should be noted that attorneys are often referred to by the apt title of "counselors at law," and the civil commitment legal practice involves a lot of active listening and redirection, professional interactions commonly associated with therapeutic "counseling." If the client is able to communicate a decision regarding commitment, he or she will either consent to it or request a contested hearing (Rev. Code Wash. 71.05.240). When the client is unable to speak for him- or herself, the attorney must request the appointment of a guardian ad litem to speak for the client. This should be minimized, as even the most disabled patients should guide their own legal representation if they can communicate at all (*In re Detention of J.S.*, 2007).

The legal representation of persons facing civil commitment is both necessary and important. Because Due Process is a constitutional mandate, it behooves mental health professionals to assist lawyers, even when they are on opposite sides of commitment litigation. To that end, hospital and treatment center staff should consider the following: (1) providing confidential areas for attorney–client visits that are also safe and accessible by security; (2) accommodating lawyers when they request access to medical records and copy machines; and (3) engaging in candid conversations with legal advocates about relevant recovery topics, including social services, and community resources, and other long-term plans for the client beyond the narrow four corners of the commitment petition. In the end, even when medical staff "loses" a commitment hearing, the patient's rights were protected, and the doctors will have contributed to devising

the best outpatient treatment plan for their patient.

All is not adversarial in the civil commitment setting. When the client chooses to comply with treatment, the legal advocate may be more willing to work hand in hand with the mental health professional. But, before this can occur, attorneys need to be able to safely and timely assess the client's legal situation. Staff efforts to hamper this process would only create more litigation; cooperation with discovery for the lawyer may thus avoid a pitched court battle. Additionally, because civil commitment cases move quickly, lawyers do not have time to mediate any conflict with staff before they are expected to competently advise the client and appear in court. Consequently, when lawyers have easy access to clients and records in a safe and confidential environment, they have more time to work with treating doctors, family, and community support systems to further the recovery needs of the patient.

When the client wants to fight commitment, or when conciliatory efforts fail, the court holds an evidentiary hearing and makes findings of fact and law determining whether the person is released or hospitalized. In Washington, a 90-day petition for inpatient treatment is available for individuals who continue to meet commitment standards even after the initial period of detention, and still cannot be served by less restrictive conditions in the community (Rev. Code Wash. 71.05.300). At this stage, Due Process is heightened, and so a jury trial may be requested. For these trials, legal advocates can also hire their own experts (Rev. Code Wash. 71.05.300). Further 180-day proceedings are rare and have somewhat different procedures, such as excluding commitments for individuals who are a harm to self (Rev. Code Wash. 71.05.320(2)).

Patient Rights

Once committed, patients continue to have rights, which are codified in state law and the federal mental health patient's Bill of Rights (42 U.S.C. § 9501; Rev. Code Wash. 71.05.220). Relevant to this topic is the patients' continuing rights to the following:

- appropriate treatment and services in a setting most supportive of their personal liberty, which should only be restricted to the extent necessary consistent with all relevant laws and court orders;
- regular review of their individualized treatment plan to include reassessment of whether inpatient treatment is necessary;
- patient participation with that treatment plan with accessible explanations thereof;
- protection from certain treatment modalities, including experimentation, unless permitted by law;
- freedom from restraints and seclusion unless in an emergent well-documented situation;
- humane conditions of confinement, including privacy and confidentiality with access to records and visitors with limited exceptions;
- grievance procedures for patients to self-advocate without fear of retaliation; and
- referrals to case-appropriate community professionals upon discharge.

While these standards are all exercised in slightly different ways throughout the nation's hospitals, they must be posted in the wards where patients can access and review them (42 U.S.C. § 9501(3)(D)). The monumental *Donaldson* (1975) case arose not only in response to the lack of Due Process at the commitment stage, but also due to Donaldson's subsequent 15-year restraint with virtually no liberties within the facility itself. The Court was shocked by the continual denial (without explanation) of Donaldson's repeated requests for ground privileges, occupational training, and opportunities to discuss his treatment plan. Patient rights are an integral piece of the commitment process, without which the fundamental ideals of treatment toward recovery crumble.

Involuntary medication in civil commitments continues to present challenges. While the law regulating involuntary medication of a criminal defendant is well defined in the forensic context, it is less well developed in the civil context. "Forced meds" in the civil commitment setting is

not governed by any Supreme Court case, and so there is a great variation in how different states handle it. Nonetheless, all must at least overcome the "compelling state interest" standard (Hinton and Forrest 2007). Generally in Washington, patients have a right to refuse antipsychotic medicine unless the failure to medicate is determined to result in a likelihood of serious harm or substantial deterioration and there is no less intrusive course of treatment (Rev. Code Wash. 71.05.210; Rev. Code Wash. 71.05.215; Rev. Code Wash. 71.05.217). ECT may only be administered upon a court order after full Due Process and proof shown by clear and convincing evidence that it is necessary (Rev. Code Wash. 71.05.217; *In re Schuoler*, 1986).

Beyond the "Dangerousness" Standard

After *Donaldson* (1975), many states constructed narrow statutes including specific language tracking the Supreme Court opinion. However, exceptions exist, such as in Arizona, which has a "need-for-treatment" standard as opposed to the typical "danger to self or others" requirement (Ariz. Rev. Stat. § 36-540(A)). Commitment will be ordered in Arizona even when a person can still meet basic survival needs and exhibits no violent or suicidal tendencies if they are found to be "persistently or acutely disabled" (Ariz. Rev. Stat. § 36-501(31)). This is defined as a severe mental disorder meeting the following criteria:

- If not treated has a substantial probability of causing the person to suffer or continue to suffer severe and abnormal mental, emotional, or physical harm that significantly impairs judgment, reason, behavior, or capacity to recognize reality.
- Substantially impairs the person's capacity to make an informed decision regarding treatment and this impairment causes the person to be incapable of understanding and expressing an understanding of the advantages and disadvantages of accepting treatment and understanding and expressing an understanding of the alternatives to the particular treatment offered after the advantages, disadvantages, and alternatives are explained to that person.
- Has a reasonable prospect of being treatable.

Thus, immanency and dangerousness are not required in Arizona, which casts a broader net and impacts the liberty interests of more individuals. This type of statutory language has been widely advocated for by mental health professionals—and for good reason from their perspective—as it may serve to protect more people and treat patients before actual harm or an arrest occurs. However, if history is any indication, the shift back to an over-reliance on *parens patriae* and the police powers of the states to involuntarily commit people only because they need treatment can result in a myriad of civil liberties abuses that the Supreme Court has specifically precluded. A measured approach is needed to ensure that Due Process and patient rights remain intact, while the abuses of the past are not repeated and relitigated in an infinite loop.

The emerging push to better utilize "assisted outpatient treatment" laws or "AOT" is perhaps less polarizing to civil libertarians and mental health providers. New York's "Kendra's Law" is an AOT statute backed by a state mandate for counties to "operate, direct and supervise an AOT program" (N.Y. Mental Hyg. Law § 9.60). Thus, involuntary treatment courts in New York have far more less restrictive options when fashioning commitment orders because AOT is funded and available. This assists new patients as well as individuals reintegrating into society after a lengthier inpatient commitment. While AOT impacts civil liberties (because discharged patients are still under court orders mandating treatment, and violation may result in returning to hospital placement), the restraints on freedom of movement, privacy, and other constitutional concerns are mitigated in this setting. In Washington, individuals facing violation of their AOT have the same right to notice, hearing, and counsel as a person facing initial commitment (Rev. Code. Wash. 71.05.230; Rev. Code. Wash. 71.05.240). Thus, AOT provides an opportunity for greater liberty while ensuring that Due

Process remains intact should the individual's mental state worsen.

Whether or not a state has a "dangerousness" or "need-for-treatment" statute, or is utilizing their AOT laws to their fullest extent, the mental health community faces challenging populations who need treatment, but do not fully meet the definitions for the "severe mental disease or defect" requirement. These individuals include persons suffering from personality disorders, eating disorders, and disorders involving addiction (Testa and West 2010). The DSM-5 may resolve some of these concerns by removing the "Axis II" label and relying more heavily on the impact of symptoms. Mental health professionals should expect to see litigation regarding those DSM-5 changes over the coming years, if not already in some localities.

The Goals of Civil Commitment

Despite the frequent adversarial relationship of lawyers and mental health professionals in civil commitment courts, these two groups also have a history of working together on systemic change. In fact, the ultimate goals of mental health professionals and lawyers in the involuntary treatment setting are not so different (Rev. Code. Wash. 71.05.010). Mental health advocates have always looked to put an end to the inappropriate, indefinite commitment of the mentally ill; legal advocates have worked to try to find the best treatment options for clients as well. Mental health providers aim to provide prompt evaluation and short-term treatment of patients; lawyers want to provide effective advocacy quickly so as to avoid continuances and unnecessary involuntary detentions. Mental health advocates often hope to safeguard individual rights of patients just as much as lawyers, and extend those sensitivities into the realm of forced medications and controversial treatment modalities. Hospitals want to provide continuity of care and attorneys want to maintain communication with clients, mental health professionals, and family to accomplish their client's unique end goal. Mental health advocates are actively promoting and encouraging community-based care, just as lawyers advocate for the recovery path of the client's choosing. Mental health professionals are interested in protecting the public safety; civil commitment lawyers are always educating the client on both short-and long-term impacts of legal decisions while enabling choices leading the client away from future involuntary detention in hospitals or jails. In all of these ways, these two groups have more in common than it may seem at first glance.

Conclusion

Despite efforts in the latter half of the twentieth century to shift mental health treatment into the community, more than 200 state hospitals remain open and serve a diverse patient population (Fisher et al. 2009). All of these patients have a constitutionally protected interest in their liberty and specific Due Process rights associated with their detention. Doubtless they also have medical needs that must be addressed before reaching a state of wellness. Doctors and lawyers may have different roles to play in the lives of these patients, but everyone is working toward an overarching goal of recovery in a free society.

The modern Hippocratic Oath (Miles 2004) champions the circumvention of "those twin traps of overtreatment and therapeutic nihilism," and urges "that warmth, sympathy, and understanding may outweigh the surgeon's knife or the chemist's drug." The Oath encourages seeking assistance "when the skills of another are needed for a patient's recovery," reminds that illness "may affect the person's family and economic stability," and inspires a sense of social responsibility "with special obligations to all my fellow human beings." Similarly, the Preamble to the American Bar Association's Model Rules of Professional Conduct (ABA Model Rules of Professional Conduct, Preamble (1), (6)) states that "[a] lawyer, as a member of the legal profession, is a representative of clients, an officer of the legal system and a public citizen having special responsibility for the quality of justice." It continues:

> As a public citizen, a lawyer should seek improvement of the law, access to the legal system, the administration of justice and the quality of service rendered by the legal profession. In addition, a lawyer should further the public's understanding of and confidence in the rule of law and the justice system because legal institutions in a constitutional democracy depend on popular participation and support to maintain their authority. A lawyer should be mindful of deficiencies in the administration of justice and of the fact that the poor, and sometimes persons who are not poor, cannot afford adequate legal assistance. Therefore, all lawyers should devote professional time and resources and use civic influence to ensure equal access to our system of justice for all those who because of economic or social barriers cannot afford or secure adequate legal counsel.

Collectively, these professional vows and guidelines are inspiring and complimentary. Together, mental health providers and legal advocates can mold a genuine yet practical vision of a mental health system providing justice and a path to recovery for all.

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Statutes

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18 U.S.C. § 4241
18 U.S.C. § 4243
18 U.S.C. § 4246
28 C.F.R. § 549.43
42 U.S.C. § 9501
405 I.L.C.S. 5/2-107
ABA Criminal Justice Mental Health Standards
ABA Model Rules of Professional Responsibility
Ariz. Rev. Stat. § 13-502
Ariz. Rev. Stat. § 13-4021
Ariz. Rev. Stat. § 36-501
Ariz. Rev. Stat. § 36-540
Ark. Code § 5-2-310
Cal. Penal Code § 1367
Colo. Rev. Stat. § 16-8-101.5
Conn. Gen. Stat. §§ 54-56d
Fla. Stat. § 790.25
Fla. Stat. § 922.07
Ga. Code § 17-10-60
Haw. Rev. Stat. § 704-406
Minn. R. Crim. P. § 20.01
Mo. Stat. § 522.020.11
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N.C. Gen. Stat. § 15A-1001
N.Y. Corr. Law § 656
N.Y. Mental Hygiene Law § 9.60
Ohio Rev. Code § 2949.28
Rev. Code Wash. 10.77.086
Rev. Code Wash. 71.05.010
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Rev. Code Wash. 71.05.150
Rev. Code Wash. 71.05.153
Rev. Code Wash. 71.05.180
Rev. Code Wash. 71.05.210
Rev. Code Wash. 71.05.215
Rev. Code Wash. 71.05.217
Rev. Code Wash. 71.05.220
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