The American Bar Association's Criminal Justice Mental Health Standards: Revisions for the Twenty-First Century

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Introduction

In 1981, the American Bar Association ("ABA"), bolstered by a grant from the John D. and Catherine T. MacArthur Foundation, decided to develop standards for governing the involvement of persons with mental disabilities in the criminal justice system.[1] To accomplish this task the

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1. CRIMINAL JUSTICE MENTAL HEALTH STANDARDS xvi–xvii (AM. BAR ASS'N 1989) (hereinafter "Standards").

ABA established six task forces, each focused on a different topic, and each composed of judges, prosecutors, defense attorneys, law professors, and mental health professionals well-known for their expertise about criminal mental health law.[2] The result, promulgated in 1984 by the ABA's House of Delegates, was more than eighty black letter Criminal Justice Mental Health Standards, accompanied by commentary that spanned more than 400 pages in the first edition and over 500 pages in the second edition.[3] Among other issues, the Mental Health Standards dealt with: (1) the role of mental health professionals in the criminal justice system; (2) the interaction between the police and people with mental disorders; (3) general issues concerning evaluations and testimony by mental health professionals; (4) competence to participate in the legal process; (5) the insanity defense and related defenses; (6) commitment of insanity acquittees; and (7) special commitment, sentencing, and prison issues that affect offenders with mental disorders.[4]

Since the Standards were adopted, there have been vast changes in mental health law, knowledge about mental disability, and the constitutional and evidentiary rules governing mental health evaluations. Recognizing the significance of these changes, in August 2012 the Standards Committee of the ABA's Criminal Justice Section established an interdisciplinary group force tasked with examining the Standards in their entirety and drafting proposed revisions to reflect current law and best practices.[5] The new Task Force was composed of twelve members: three law professors, one judge, two prosecutors, two defense attorneys, two psychiatrists, and two psychologists.[6] Liaisons from the National Alliance

2. *Id.*

3. *See id.* The second edition included new material on competency to confess and competency to be executed.

4. *See id*. at vii–xi (Table of Contents).

5. *See* Memorandum from the Criminal Justice Section Standards Comm. and the Task Force on Criminal Justice Mental Health Standards to Criminal Justice Council 1 (Sept. 10, 2015) (on file with author).

6. The members of the Task Force were: Christopher Slobogin, Vanderbilt University Law School (Chair); W. Lawrence Fitch, Professor, University of Maryland School of Law (Reporter); Richard Bonnie, Professor, University of Virginia School of Law; Steven Leifman, Judge, 11th Judicial Circuit, Fla.; Richard Burr, Defense Attorney, Houston, Texas; Virginia Murphrey, Chief Public Defender, 10th Judicial Circuit, Anoka, Minn.; Guy Arcidiacono, Deputy Chief, Appeals Bureau, Forensic Litigation Unit, Suffolk County, N.Y.; William F. Klumpp, Jr., Office of Attorney General, St. Paul, Minn.; Alex Buchanan, Ph.D., M.D., FRCPsych, Associate Professor of Law & Psychiatry, Yale University, New Haven, Conn.; Steven K. Hoge, M.D., Director, Columbia-Cornell Forensic Psychiatry Fellowship Program, Clinical Professor, Columbia University College of Physicians and Surgeons, New York State Psychiatric Inst., N.Y.; Kirk Heilbrun, Ph.D., Professor, Drexel University, Phil., Pa.; Randy Otto, Ph.D., Florida Mental Health Institute, Tampa, Fla.

on Mental Illness, the Department of Justice, and the National Association of Criminal Defense Lawyers were also heavily involved.[7]

The Task Force deliberated for over three years. Ultimately, it recommended significant revisions to virtually every aspect of the Standards, including in each of the seven areas noted above. After vetting by other groups within the ABA,[8] the revised Standards were adopted by the ABA's House of Delegates in August 2016.[9]

This article discusses the Standards in more detail, using as an organizational template three goals that I think explain much of the Standards.[10] The first goal that permeates the Standards is ensuring that people with mental disabilities who encounter the criminal justice system are treated humanely and fairly. Achieving this goal requires a delicate balance between providing the treatment necessary to ensure the safety and health of these individuals and avoiding interventions that are not legally necessary. A second goal of the Standards is to promote reliable case outcomes. This goal requires substantive doctrines that recognize the mitigating impact of mental disabilities and an adequate evaluation system that permits clinicians to gather the information they need to address legal questions; treatment is an important element of this goal as well when necessary to enable a defendant's meaningful participation in the legal proceedings. The third goal is to honor the autonomy of people with mental disabilities by ensuring their desires and decisions are accorded appropriate respect by their own lawyers and the rest of the criminal justice system. The Standards adopt the position that competent defendants should have the power not only to participate but also to control the most important aspects of their case.

7. *See* Memorandum to Criminal Justice Council, *supra* note 5, at 1–2.

8. In particular, as is the case with all ABA Criminal Justice Standards, the Mental Health Standards were reviewed by the Standards Committee and by the Criminal Justice Section Council. *See* Criminal Justice Standards Committee, AM. BAR ASSOC., http://apps.americanbar.org/dch/committee.cfm?com=CR105000; Criminal Justice Section Council Leadership Roster, AM. BAR ASSOC., http://www.americanbar.org/groups/criminal_justice/about_us.html.

9. House of Delegates Resolution 107, AM. BAR ASSOC., http://www.americanbar.org/news/reporter_resources/annual-meeting-2016/house-of-delegates-resolutions/107.html/. The official version of the Standards can be found at CRIMINAL JUSTICE MENTAL HEALTH STANDARDS (AM. BAR ASS'N 2016), http://www.americanbar.org/content/dam/aba/publications/criminal_justice_standards/mental_health_standards_2016.authcheckdam.pdf.

10. The views expressed in this article are those of the author and are not necessarily shared by the members of the Task Force, the Standards Committee, the Council, or the ABA at large.

I. Goal #1: Humane and Dignified Treatment

Hundreds of thousands of people with mental disorders are enmeshed in the criminal justice system.[11] Unfortunately, that system does not always treat them fairly or humanely. Police who may not be familiar with the symptoms of mental disorder often mishandle encounters with people who have mental problems, sometimes with disastrous consequences.[12] People who should be taken to a hospital may instead be taken to jail, where their mental health needs may be ignored or underserved.[13] Defense attorneys may fail to adjust their style of communication to take into account impairments of their clients,[14] or may focus solely on narrow legal issues when a more holistic approach might prove both more beneficial to their clients and less likely to miss key aspects of the relevant legal or psychological problems.[15] Prosecutors may assume that most people with mental disabilities are dangerous,[16] or may be reluctant to recognize the

11. In 1998, 283,800 of the people housed in American jails and prisons (16% of the total) suffered from serious mental disorders. PAULA M. DITTON, BUREAU OF JUSTICE STATISTICS, U.S. DEP'T OF JUSTICE, MENTAL HEALTH TREATMENT OF INMATES AND PROBATIONERS 1 (1999). Many experts estimate the number is much higher. Fox Butterfield, *Prisons Brim With Mentally Ill, Study Finds*, N.Y. TIMES (July 12, 1999), http://www.nytimes.com/1999/07/12/us/prisons-brim-with-mentally-ill-study-finds.html?_r=0.

12. *See* City & Cty. of S.F. v. Sheehan, 135 S. Ct. 1765 (2015) (involving a person with mental illness shot several times by police); Champion v. Outlook Nashville, Inc., 380 F.3d 893 (6th Cir. 2004) (involving the arrest of a man with autism who died after being pepper sprayed, handcuffed and bound).

13. *Mental Health Treatment in Jails and Prisons*, JUDGE DAVID L. BAZELON CENTER FOR MENTAL HEALTH LAW (Oct. 2000), http://www.bazelon.org/criminal3.html ("Mental health deteriorates in jail: Jails and prisons are inappropriate places for those with mental illnesses because of the stress of the environment and the lack of mental health services."); *see also* Christin E. Keele, Note, *Criminalization of the Mentally Ill: The Challenging Role of the Defense Attorney in the Mental Health Court System*, 71 UMKC L. REV. 193, 196 n.32 (2002) ("[T]he hostile and stressful environment within the jail system does not suffice to provide a therapeutic setting for those with mental illness.").

14. John Matthew Fabian, *Practice Points*, CHAMPION, June 2007, at 2–3 (noting that "the criminal defense attorney often does not have extensive background and training . . . regarding how to deal with clients who have mental illnesses, psychiatric diagnoses, and other impairments" because these clients may: have trouble understanding the process; make "unrealistic requests"; be "angry, distrustful" and not cooperative; be "passive and not involved in decision making"; refuse to accept advice; be fearful of being labeled 'crazy' or 'mentally ill'"; resist pretrial evaluation, a plea bargain or an insanity defense; and exhibit "radical beliefs").

15. Joanmarie Ilaria Davoli, *Physically Present, Yet Mentally Absent*, 48 U. LOUISVILLE L. REV. 313, 321 (2009) ("The crushing caseloads, combined with the attorneys' lack of familiarity with mental illness and the increasing number of seriously mentally ill criminal defendants, cause defense attorneys to brush aside or purposely ignore competency issues.").

16. Certainly media and culture reinforce that view. *See*, e.g., Patricia Stout et al., *Images of Mental Illness in the Media: Identifying Gaps in the Research*, 30 SCHIZOPHRENIA BULL. 543, 545–51 (2004) (finding that "[p]ersons with mental illness were depicted as being inadequate, unlikable, and dangerous . . . and as lacking social identity.").

treatment needs of a defendant or the mitigating impact of mental disorders.[17] Judges can be impatient with defendants who do not comprehend the court process.[18] They may also fail to recognize a defendant's important treatment needs; in particular, they may neglect to make sure that necessary treatment is continued once a defendant is returned to the community after restoration of trial competence,[19] or impose a sentence of incarceration without taking sufficient account of diversion programs and other alternatives to imprisonment.[20] Correctional personnel handling prisoners with mental disabilities may not properly diagnose such individuals or treat them.[21] Forensic mental hospitals for defendants found incompetent to stand trial or legally insane may retain individuals far beyond the time necessary,[22] and judges and lawyers can abet this neglect by putting such individuals at the tail end of the docket once he or she is hospitalized.[23]

17. *Cf.* Tennard v. Dretke, 542 U.S. 274, 289 (2004) (where the prosecutor argued that the defendant's intellectual disability was not relevant to mitigation, but only dangerousness).

18. MICHAEL L. PERLIN, LAW AND MENTAL DISABILITY 663–70 (1994) (asserting that trial court judges may use certain terms (e.g., "psycho-babble" or "headshrinkers") that reveal "their subconscious prejudices against mentally ill offenders," and also tend to believe such individual fabricate their symptoms and to display impatience towards mentally disordered defendants, incorrectly attributing their plight to "weak character or poor resolve.").

19. Keri K. Gould, *And Equal Participation for All . . . the Americans with Disabilities Act in the Courtroom*, 8 J.L. & HEALTH 123, 143 n.140 (1993-1994) (noting that defendants often go off medication after restoration to competence in the hospital and that this "revolving door syndrome may continue for years"); *see generally*, Katherine B. Cook, *Revising Assisted Outpatient Treatment Statutes in Indiana: Providing Mental Health Treatment for Those in Need*, 9 IND. HEALTH L. REV. 661, 668 (2012) (describing revolving door situations).

20. For a description of the problem and the assertion that problem-solving courts can be the solution, see Peggy Hora, *Problem-Solving Judge pts. 1–4*, CUTTING EDGE LAW, http://www.cuttingedgelaw.com/video/judge-peggy-hora-problem-solving-judge.

21. *See, e.g.*, Coleman v. Wilson, 912 F. Supp. 1282, 1320 (E.D. Cal. 1995) (finding with respect to the California prison system "substantial evidence in the record of seriously mentally ill inmates being treated with punitive measures by the custody staff to control the inmates' behavior without regard to the cause of the behavior, the efficacy of such measures, or the impact of those measures on the inmates' mental illnesses").

22. Gwen A. Levitt et al., *Civil Commitment Outcomes of Incompetent Defendants*, 28 J. AM. ACAD. PSYCHIATRY & LAW 349 (2010) (Defendants found not restorable were hospitalized without meeting the civil commitment criteria, had longer lengths of stay, and were more likely to be treated with psychotropic medications over their objection, when compared with other inpatients.).

23. Nicholas Rosinia, *How "Reasonable" Has Become Unreasonable: A Proposal for Rewriting the Last Legacy of* Jackson v. Indiana, 89 WASH. U. L. REV. 673, 689–90 (2012) (noting that over half the states either place no limit on the length of hospitalization permitted for attempting restoration or tie the limitation to the sentence associated with the charge).

The Standards address these and related concerns in a number of ways. The over-arching standard on this point, standard 7-1.2, is worth setting out in full:

> (a) Officials throughout the criminal justice system should recognize that people with mental disorders have special needs that must be reconciled with the goals of ensuring accountability for conduct, respect for civil liberties, and public safety.
>
> (b) Criminal justice officials should work with community mental health treatment providers and other experts to develop valid and reliable screening, assessment, diversion, and intervention strategies that identify and respond to the needs of individuals with mental disorder who come into contact with the justice system, whether the setting is traditional criminal court, problem-solving court, a diversion program, or post-adjudication supervision and monitoring.
>
> > (i) When appropriate, services should be configured to divert people with mental disorders from arrest and criminal prosecution into treatment, consistent with the [draft ABA Diversion Standards].
> >
> > (ii) Court systems should consider establishing special dockets for defendants with mental disorders, consistent with the [draft ABA Specialized Courts Standards].
> >
> > (iii) Criminal justice officials should consider consulting mental health professionals knowledgeable about the possible impact of culture, race, ethnicity, and language on mental health in designing strategies to respond to persons with mental disabilities in the criminal justice system.
>
> (c) Services should be available within correctional and mental health facilities to facilitate both evaluation and

> treatment during incarceration and planning for treatment upon release.[24]

Other standards provide more specific means of ensuring fair and humane treatment of people with mental disability in the criminal justice system. They are briefly described below.

A. The Roles of Police, Attorneys, and Judges in Assuring Treatment

As standard 7-1.2 states, every actor within the criminal justice system should be attentive to the treatment needs of people with mental disabilities. Part II of the Standards, entitled "Law Enforcement and Custodial Roles," sets out a number of provisions designed to ensure that police take appropriate actions when they encounter people with a mental disability. Standard 7-2.1 provides that police agencies establish training programs, staffed in part by qualified mental health professionals, designed to assist police "in identifying and responding to emergency incidents involving persons with mental disorders," and also calls for the creation of "specialized police response teams," often called "crisis intervention teams" ("CITs"), to deal with emergency situations.[25] It also encourages police agencies to create internal written policies governing police interaction with people with mental disabilities and to negotiate "memoranda of understanding" with community treatment entities that make clear when and how these entities can provide emergency treatment.[26] Standards 7-2.2 and 7-2.4 encourage police to seek voluntary treatment dispositions when appropriate,[27] and standard 7-2.3 limits coercive police action to situations where they have probable cause for arrest or believe the individual meets involuntary commitment criteria.[28] The latter standard also provides that custodial decisions concerning people with mental disability be made by CITs whenever possible,[29] and that police should "use only the physical control necessary to effect such custody, taking into consideration the obligation of law enforcement officers to protect the person, themselves, and others from bodily harm."[30]

24. CRIMINAL JUSTICE MENTAL HEALTH STANDARDS, *supra* note 9, std. 7-1.2 (entitled "Responding to Persons with Mental Disorders in the Criminal Justice System").

25. *Id.*, std. 7-2.1(c).

26. *Id.*, std. 7-2.1(d).

27. *Id.*, std. 7-2.2 (Preference for voluntary law enforcement disposition); std. 7-2.4(a)(ii).

28. *Id.*, std. 7-2.3(a).

29. *Id.*, std. 7-2.3(b)(i).

30. *Id*., std. 7-2.3(b)(ii).

Standards 7-1.4 to 7-1.6 focus on attorneys and judges. Consistent with the ABA's Resolution on Comprehensive Criminal Representation,[31] standard 7-1.4 admonishes defense attorneys to provide "inter-disciplinary" client-centered representation, which requires familiarity with local providers and programs that might serve as alternatives to incarceration,[32] as well as a willingness to consider mental health court (here, the standard cross-references to the ABA Standards on Specialized Courts, which express a preference for that mechanism for resolving disputes under certain circumstances).[33] The standard also reminds defense attorneys that they will need to be prepared to deal with "difficulties in communication that can result from the client's mental disorder or from transfers to a different locale necessitated by treatment needs."[34]

Standard 7-1.5 imposes a number of duties on judges and prosecutors. It states that they "should consider treatment alternatives to incarceration for defendants with mental disorders that might reduce the likelihood of recidivism and enhance public safety," "facilitate meetings among community organizations interested in assuring that services are provided to justice-involved persons with mental disorders," help create diversion and specialized court programs, and always consider "referring the defendant for treatment, either voluntarily or, if appropriate, pursuant to existing law relating to involuntary hospitalization or mandated outpatient treatment."[35] As with the police, the Standards strongly recommend training related to these issues, including programs "addressing the identification of and responses to individuals with mental disorders involved in or at risk of becoming involved in the criminal justice system," and "strategies to facilitate diversion from the criminal justice system to the community mental health treatment system before and after arrest, adjudication, and conviction."[36]

31. *See* HOUSE OF DELEGATES RESOLUTION 107C, AM. BAR ASSOC. (2012), www.americanbar.org/content/dam/aba/administrative/house_of_delegates/resolutions/2012_hod_annual_meeting_107c.doc (urging criminal defense organizations to establish connections with civil law and social service organizations, provide "re-entry and reintegration services" for clients, and train defense attorneys "how best to serve clients with civil legal and non-legal problems related to their criminal cases").

32. CRIMINAL JUSTICE MENTAL HEALTH STANDARDS, *supra* note 9, std. 7-1.4(a).

33. *Id.*, std. 7-1.4(e).

34. *Id.*, std. 7-1.4(b).

35. *Id.*, std. 7-1.5(a)–(e).

36. *Id*., std. 7-1.7(a).

B. Treatment within the Criminal Justice System

As these various provisions suggest, one of the primary goals of the Standards is to ensure that police, lawyers, and judges enable people with mental disorders to avoid criminal justice involvement and imprisonment where appropriate. The criminal justice system should never be used solely as a means of obtaining mental health treatment. Thus, for instance, standard 7-4.3(e) provides that:

> Neither party should move for an evaluation of competence in the absence of a good faith doubt that the defendant is competent to proceed. Nor should either party use the incompetence process for purposes unrelated to assessing and adjudicating the defendant's competence to proceed, such as to obtain information for mitigation of sentence, obtain a favorable plea negotiation, or delay the proceedings against the defendant. Nor should the process be used to obtain treatment unrelated to the defendant's competence to proceed; rather such treatment should be sought pursuant to [standard 7-2.5, described below], whether the defendant is in jail, the community, or an inpatient facility.[37]

As this language indicates, if a person with a mental disability *does* end up in a jail, the Standards seek to ensure that appropriately limited care takes place in this environment as well. To this end, standard 7-2.5 provides that jail personnel should be trained in identifying symptoms of mental disorder and that all individuals in jail be screened for such symptoms.[38] If discharge occurs, custodial staff are obligated to refer these individuals to appropriate treatment facilities.[39] If instead the individual remains in custody and treatment appears to be necessary, then jail personnel are charged with arranging for treatment in jail or for transfer to a treatment facility for those individuals who: (1) have been ordered by a court to undergo treatment; (2) validly "assent" to it;[40] or (3) lack capacity

37. *Id.*, std. 7-4.3(e).

38. *Id*., std. 7-5(a)–(b).

39. *Id*., std. 7-2.5(c).

40. Under standard 7-1.1(f), an assent is valid if the person has a "present understanding of the likely consequences of a particular course of action" and gives "an affirmative indication of agreement with [that] action, after an explanation of the likely consequences of the action." The definition is meant to recognize a shallow version of informed consent in order to facilitate treatment of people with mental disability in cases where there is not an objection. *See* Bruce J. Winick, *Competency to Consent to Voluntary Hospitalization: A Therapeutic Jurisprudence*

to assent but have been found by an administrative panel to be "experiencing extreme emotional distress or deterioration of functioning that requires immediate treatment [that] is likely to stabilize the detainee's condition, is the least intrusive method of doing so, and is medically appropriate."[41]

Similar treatment-oriented provisions apply at the sentencing stage. Consistent with the ABA's Standards on Sentencing,[42] standard 7-8.2 requires that a presentence report be prepared that describes: (1) the offender's condition and current and past treatment; (2) "programs or resources, such as treatment centers, residential facilities, vocational training services, educational and rehabilitative programs, and, in particular, community-based mental health services, that would be appropriate for the offender's condition;" (3) "any condition relating to the offender's likelihood of adhering to treatment;" (4) "whether assignment of a specialized probation officer or a case manager trained in monitoring offenders with mental disorder would be appropriate in the offender's case;" and (5) whether a comprehensive mental health evaluation is needed.[43] The judge may make mental health treatment a condition of probation, ideally supervised by a specialized probation officer;[44] at the same time, the standard provides that the judge should not deny probation simply to ensure the offender receives treatment that is only available in prison.[45]

The Standards are also attentive to treatment issues that occur during incarceration after conviction. Standard 7-10.1 states that correctional facilities should: (1) provide "appropriate and individualized mental health treatment to prisoners with mental disorder;" (2) ensure that correctional officers are appropriately trained about how to deal with prisoners who have mental disorder; and (3) only subject such individuals to isolation under very limited circumstances outlined in the ABA's Standards on Treatment of Prisoners.[46] Also tracking the latter standards, the Mental

Analysis of Zinermon v. Burch, 14 INT'L J.L. & PSYCHIATRY 169 (1991) (arguing for a presumption of competence in such circumstances).

41. CRIMINAL JUSTICE MENTAL HEALTH STANDARDS, *supra* note 9, std. 7-2.6(a)–(c).

42. CRIMINAL JUSTICE STANDARDS ON SENTENCING, std. 18-5.4 (AM. BAR ASS'N 1993), http://www.americanbar.org/publications/criminal_justice_section_archive/crimjust_standards_sentencing_toc.html.

43. CRIMINAL JUSTICE MENTAL HEALTH STANDARDS, *supra* note 9, std. 7-8.2(a)–(e).

44. *Id.*, std. 7-8.6(c)–(d).

45. *Id*., std. 7-8.6(a).

46. *Id.*, std. 7-10.1(a)–(c); *see* CRIMINAL JUSTICE STANDARDS ON TREATMENT OF PRISONERS, std. 23-3.8 (AM. BAR ASS'N 2010), http://www.americanbar.org/content/dam/

Health Standards set up procedures for emergency treatment (both after conviction and after sentencing), voluntary transfer, involuntary transfer of prisoners to a mental health facility, and return from that facility to prison.[47] The non-emergency involuntary hospitalization procedure requires clear and convincing proof of a need for treatment at an adversarial hearing in front of a judge or administrative hearing officer.[48] When a prisoner refuses psychiatric medication, standard 7-10.4 requires the same hearing process, except that a correctional official may be part of the decision-making panel.[49] Going beyond the protections required by Supreme Court case law,[50] the standard permits involuntary medication only "if the prisoner is suffering from a serious mental disorder, non-treatment poses a significant risk of serious harm to the prisoner or others, the treatment is medically appropriate, and no less intrusive alternative is reasonably available."[51]

C. Treatment of Defendants Found Incompetent or Insane

Finally, Part IV of the Standards, on competence issues, and Part VII of the Standards, dealing with disposition of persons found non-responsible due to mental disability (i.e., "insanity acquittees"), adopt a number of innovative procedures designed to ensure rational treatment of these two groups. First, a defendant who, because of confusion or an inability to communicate, is likely to be found either incompetent to proceed with the adjudication process or incompetent to make key decisions need not be adjudicated on that issue. Standard 7-4.8 provides that:

> [I]n lieu of or after a [competence] hearing, the parties may request that the court dispose of the case by either dismissing the charges without prejudice or placing the charges in abeyance, pending the defendant's successful participation in treatment, if (i) based on the reports of the

aba/publishing/criminal_justice_section_newsletter/treatment_of_prisoners_commentary_website.authcheckdam.pdf.

47. *See* CRIMINAL JUSTICE MENTAL HEALTH STANDARDS, *supra* note 9, std. 7-8.1 (entitled "Emergency Treatment"); std. 7-10.2 (entitled "Voluntary Transfer to Mental Health Facility"); std. 7-10.3 (entitled "Involuntary Transfer"); std. 7-10.6 (entitled "Return to Correctional Facility").

48. *Id*., std. 7-10.3(a).

49. *Id.*, std. 7-10.4(b).

50. *See* Washington v. Harper, 494 U.S. 210, 226 (1990) (permitting "medically appropriate" involuntary medication for a competent prisoner who is mentally ill and poses a substantial risk to himself or others, but not requiring that the medication be the least intrusive treatment).

51. CRIMINAL JUSTICE MENTAL HEALTH STANDARDS, *supra* note 9, std. 7-10.4(a).

> evaluators, it appears that the defendant is incompetent to proceed but would be a suitable candidate for mental health treatment, or (ii) the prosecutor and the defense attorney agree that such diversion would be preferable to an order for restoration of competence to proceed, and (iii) the defendant assents to such diversion.[52]

If such diversion does not occur and the court finds that the defendant is incompetent or that his or her competence depends upon the continuation of treatment, the Standards provide, consistent with the Supreme Court's decision in *Jackson v. Indiana*,[53] that the court may impose treatment to restore competence only if "there is a substantial probability the treatment will restore the defendant to competence in the foreseeable future."[54]

Treatment for restoration to competence is to be on an outpatient basis unless the court determines that no less restrictive treatment setting is available and an inpatient setting can provide the necessary treatment.[55] If the defendant is committed and later found competent, and then is convicted and sentenced, any period spent in treatment is credited toward the sentence.[56] Whether treatment occurs on an outpatient or inpatient basis, standard 7-4.11 requires the treating entity to develop a treatment plan within fourteen days.[57] While antipsychotic medication is often the treatment of choice in this situation, the standard permits medication over the defendant's objection only if, in conformance with the Supreme Court's holding in *Sell v. United States*:[58]

> (i) [T]he government's interests in prosecuting the defendant are important; (ii) the medication proposed is substantially likely to restore the defendant to competence and substantially unlikely to have side effects that will interfere significantly with the defendant's ability to assist counsel; (iii) the medication is necessary to restore

52. *Id.*, std. 7-4.8(e).

53. Jackson v. Indiana, 406 U.S. 715, 738 (1972) ("We hold . . . that a person charged by a State with a criminal offense who is committed solely on account of his incapacity to proceed to trial cannot be held more than the reasonable period of time necessary to determine whether there is a substantial probability that he will attain that capacity in the foreseeable future.").

54. CRIMINAL JUSTICE MENTAL HEALTH STANDARDS, *supra* note 9, std. 7-4.10(a)(i).

55. *Id.*, std. 7-4.10(b)(ii)–(iii).

56. *Id.*, std. 7-4.16.

57. *Id.*, std. 7-4.11(b).

58. Sell v. United States, 539 U.S. 166, 180–82 (2003) (detailing limitations on forcible medication).

> competence, and any less intrusive treatments are unlikely to achieve the same result; and (iv) the medication is in the defendant's best medical interests in light of the defendant's medical condition.[59]

The Standards also obligate the entity carrying out the treatment to make periodic reports on treatment progress and to alert the court if it is determined the defendant is unrestorable.[60] Upon such a report, and in any event within twelve to eighteen months, a competence hearing must be held.[61] If the court confirms the defendant has not been restored, then, per *Jackson*, the defendant must either be released or civilly committed, although commitment initially may be to a more secure forensic facility if the court deems that disposition appropriate.[62] If instead the defendant becomes competent, further adjudication can of course take place. To avoid the revolving door situation that can arise when a restored defendant is returned to jail or to the community and allowed to decompensate there awaiting trial, standard 7-4.11 provides that "the court should order as a condition of the defendant's return that the receiving facility or local treatment facility continue such treatment as the inpatient facility may recommend to maintain the defendant's competence," unless the facility is not competent to provide it.[63]

Part VII's provisions regarding persons found not guilty by reason of insanity also include several innovations. Consistent with the preference for noncriminal dispositions throughout the Standards, defendants acquitted on less serious offenses are subject only to general civil commitment.[64] Individuals acquitted of offenses "involving acts causing or creating a substantial risk of death or threatening serious bodily harm," in contrast, are subject to special commitment procedures that make initial post-verdict commitment relatively easy. However, at subsequent commitments, the state's burden increases.[65] Specifically, standard 7-7.5 provides that, at the

59. CRIMINAL JUSTICE MENTAL HEALTH STANDARDS, *supra* note 9, std. 7-4.11(d).

60. *Id.*, std. 7-4.12(a).

61. *Id*., std. 7-4.14(b).

62. *Id.*, std. 7-4.14(c).

63. *Id.*, std. 7-4.11(e).

64. *Id.*, std. 7-7.2 (differentiating between "offenses involving acts causing, threatening, or creating a substantial risk of death or serious bodily harm" and offenses that do not cause such harms or risks).

65. *Id*., std. 7-7.2(a).

initial hearing (which should usually take place within forty-five days of the verdict[66]), the individual is committable if the court finds:

> (i) [B]eyond a reasonable doubt that the acquittee committed the criminal act for which he or she was acquitted . . . , unless the trier of fact made such a finding at the acquittee's criminal trial . . . , and (ii) by a preponderance of the evidence that, due to mental disorder of the type [that supported the insanity defense], the acquittee is at risk for causing a substantial risk of bodily harm to others in the foreseeable future if not committed, or (iii) by a preponderance of the evidence that the acquittee does not meet the criteria in (b)(ii) due to the effect of treatment currently being received, in which case the acquittee may be committed unless the acquittee proves by a preponderance of the evidence that the acquittee will continue to receive such treatment following release for as long as the treatment is required.[67]

In contrast, at hearings that take place a year or longer after this initial hearing the state must prove either (ii) or (iii) by clear and convincing evidence.[68]

Standard 7-7.4 states that insanity acquittees should be committed to a forensic mental health facility only if they are unable to prove, by a preponderance of the evidence, that conditional release will "provide adequate protection of the community."[69] Standard 7-7.12 provides detailed guidance on the structure and process of conditional release programs, with the goal of ensuring both adequate treatment and protection of the community. To get a sense of the standard, consider its first section, which recommends that every state establish "conditional release programs (CRP) with sufficient staffing and resources" to discharge the following responsibilities:

> (i) Reviewing any proposed plan for conditional release and contacting all service providers named in the plan to determine their capacity and willingness to (a) provide the

66. *Id.*, std. 7-7.3(a) (requiring an evaluation within thirty days of the acquittal) & 7-7.3(d) (requiring a hearing within fifteen days of the evaluation).

67. *Id.*, std. 7-7.4(b).

68. *Id.*, std. 7-7.8(b).

69. *Id.*, std. 7-7.4(c).

> services specified in the plan, (b) submit periodic reports to the CRP regarding the acquittee's participation in services, and (c) immediately notify the CRP if an acquittee is non-compliant with or otherwise no longer appropriate for services from the provider;
>
> (ii) Monitoring an acquittee's compliance with the conditional release order by reviewing reports provided by service providers named in the order and maintaining accessibility to providers [twenty four] hours per day, [seven] days per week, to receive reports of non-compliance;
>
> (iii) Immediately notifying the prosecutor of any allegation or other indication that the acquittee has failed to comply with the conditions of a conditional release order or no longer is appropriate for conditional release;
>
> (iv) Before an acquittee's term of conditional release expires, arranging for providers serving the acquittee to assess the acquittee's likelihood of continuing to receive necessary services without a conditional release order in place and reporting the same to the court and the attorneys for the acquittee and the state; and
>
> (v) Organizing periodic training for service providers in the jurisdiction regarding the special service needs of individuals on conditional release and the procedures for reporting to the CRP.[70]

These and other provisions in the Standards are designed to facilitate transition of insanity acquittees into the community without undue risk.[71] Nonetheless, standard 7-7.10 gives the prosecutor authority to notify "relevant individuals and agencies" if full or conditional release of an acquittee occurs.[72]

70. *Id.*, std. 7-7.12(a).

71. *See id.*, std. 7-7.12(b) & (d) (calling for detailed release plans and incorporation of plan into court order); *id.*, std. 7-7.12(d) (requiring notification of prosecutor upon breach of condition).

72. *Id*., std. 7-7.10.

These commitment procedures for defendants found incompetent or insane, together with those governing the hospitalization of jail detainees and prison inmates described earlier, are the only criminal justice-related mechanisms for commitment recognized in the Standards. Thus, the Standards reject the reasoning of the Supreme Court's decision holding in *Kansas v. Hendricks*,[73] which upheld, against due process and other challenges, a statutory scheme that permitted commitment of offenders who have completed their sentence so long as they have a "mental abnormality" that "predisposes" them to commit violent sex offenses.[74] About twenty states have comparable statutes.[75] Standard 7-10.7 specifically prohibits this type of commitment, for reasons that have been well-explained in the literature.[76] It states that once a sentence has expired, commitment may occur only under the state's "general commitment statute" and calls for repeal of all "statutes that provide for post-sentence commitment of offenders using criteria that differ[s] from the general civil commitment criteria."[77] At the same time, standard 7-10.8 provides, consistent with the ABA's Standards on Treatment of Prisoners,[78] that procedures "ensuring a smooth transition to the community for prisoners with mental disorder[s]" should be adopted.[79]

D. Summary of Standards Regarding Treatment

As this account indicates, the ABA's Mental Health Standards are attentive to the treatment needs of people with mental disabilities at every stage of the process, but avoid making those needs an excuse for unnecessary confinement. All actors in the system, including police, correctional personnel, lawyers, and judges, are charged with acquiring adequate knowledge about, training on, and resources for meeting the treatment needs of people with mental disability in the criminal justice system.For individuals accused of minor crimes, diversion or handling through specialized courts is preferred. For those found incompetent or

73. Kansas v. Hendricks, 521 U.S. 346 (1997).

74. *Id.* at 371.

75. Cynthia Caulkins et al., *Sexual Violence Legislation: A Review of Case Law and Empirical Research*, 20 PSYCHOL. PUB. POL'Y & L. 443, 445–48 (2014).

76. *See* Ryan K. Melcher, *There Ain't No End for the "Wicked": Implications of and Recommendations for § 4248 of the Adam Walsh Act After* United States v. Comstock, 97 IOWA L. REV. 629, 661–63 (2012); Stephen J. Morse, *Protecting Liberty and Autonomy: Desert/Disease Jurisprudence*, 48 SAN DIEGO L. REV. 1077, 1120–24 (2011).

77. CRIMINAL JUSTICE MENTAL HEALTH STANDARDS, *supra* note 9, std. 7-10.7(b).

78. CRIMINAL JUSTICE STANDARDS ON TREATMENT OF PRISONERS, *supra* note 46, std. 23-8.9 (regarding transition to the community).

79. CRIMINAL JUSTICE MENTAL HEALTH STANDARDS, *supra* note 9, std. 7-10.8.

insane, treatment is provided, but placement in restrictive forensic units is either time-limited or restricted in other ways and forcible treatment with medication is tightly controlled. For defendants who are convicted, treatment is once again a priority, with a preference for treatment in the community or a mental hospital when appropriate. These provisions should ensure that, consistent with and limited by the goals of the criminal justice system, people with mental disability obtain adequate, humane services.

II. Goal #2: Reliable Outcomes

The second overarching goal sought by the ABA's Criminal Justice Mental Health Standards is a system designed to reach legally and morally valid outcomes. The Supreme Court has recognized that, for a number of reasons, people with mental disabilities may be at greater risk of wrongful conviction than others in the criminal process.[80] People with mental disorders are less likely to understand their rights during interrogation and are more likely to confess to crimes they did not commit.[81] They may have difficulty communicating exculpatory or mitigating facts to their attorney.[82] Impairment in the ability to understand witnesses may compromise their right of confrontation.[83]

The potential for unreliable outcomes is even greater when the focus moves from determining whether the defendant committed a criminal act to assessment of legally relevant mental states. Defendants are not necessarily the best source of information about their mental condition at

80. Atkins v. Virginia, 536 U.S. 304, 321 (2002).

81. *See* Richard Rogers et al., *Knowing and Intelligent: A Study of Miranda Warnings in Mentally Disordered Defendants*, 31 L. & HUM. BEHAV. 401, 408 (2007) (finding that only 10% of people with a mental disability had a good understanding of *Miranda* warnings); Morgan Cloud et al., *Words Without Meaning: The Constitution, Confessions, and Mentally Retarded Suspects*, 69 U. CHI. L. REV. 495, 590–91 (2002) (finding people with intellectual disabilities and even many individuals with IQs above 75 have great difficulty understanding *Miranda* warnings); Samuel R. Gross et al., *Exonerations in the United States 1989 through 2003*, 95 J. CRIM. L. & CRIMINOLOGY 523, 544–45 (2005) (finding that almost all false confessions came from juveniles or people with mental disability and that the latter group was more likely to confess falsely than the former).

82. *See* David A. Green, *"I'm OK-You're OK": Educating Lawyers to "Maintain a Normal Client-Lawyer Relationship" with a Client with a Mental Disability*, 28 J. LEGAL PROF. 65, 83–86 (2003-2004) (discussing the need for respectful discourse with people who have mental disabilities and recognizing such clients may have cognitive and communication limitations and might want to hide their disability).

83. *Atkins*, 536 U.S. at 320–21 ("Mentally retarded defendants may be less able to give meaningful assistance to their counsel and are typically poor witnesses . . . .").

the time of the crime.[84] Even where they are, an adequate defense usually requires assessment of that condition by qualified experts who are given full access to relevant information and who are not unnecessarily inhibited in reporting their opinions.[85] In addition, the substantive law regarding mental state issues needs to be defined in a way that permits full exploration of all possible exculpatory and mitigating factors.[86] The Standards contain a number of provisions designed to deal with these considerations.

A. Procedural Protections Generally

The typical method of protecting against inaccurate outcomes is to ensure that procedural mechanisms are in place. As indicated in Part I, the Standards provide such mechanisms in every context they address. For instance, the Standards require: (1) open adversarial hearings in connection with competency adjudications;[87] (2) emergency treatment;[88] (3) commitment of insanity acquittees;[89] and (4) prison-to-hospital and hospital-to-prison transfers,[90] although none of these procedures are as formalized as they would be at an insanity trial.[91]

84. *See* Andrew E. Taslitz, *A Feminist Approach to Social Scientific Evidence: Foundations*, 5 MICH. J. GENDER & L. 1, 19–25 (1998) (cataloguing the extent to which memory, confused desires, and self-deception can distort an accurate depiction of one's past mental states).

85. *See* Honorable Mark I. Bernstein, *Jury Evaluation of Expert Testimony under the Federal Rules of Evidence*, 7 DREXEL L. REV. 239, 264 (2015) (criticizing the federal rules of evidence, and in particular Rules 703 and 705, for "empower[ing] the expert to hide personal credibility judgments, to quietly draw conclusions, to individually decide what is proper evidence, and worst of all, to offer opinions without even telling the jury the facts assumed").

86. Providing detailed support for this proposition is beyond the scope of this article. *But see generally* WAYNE R. LAFAVE, CRIMINAL LAW 393–94 (5th ed. 2010) (describing justifications for a relatively broad insanity defense); *id*. at 286–87 (describing justifications for adopting subjective mens rea requirements); *id.* at 481–84 (describing justifications for adopting a partial responsibility doctrine); Lockett v. Ohio, 438 U.S. 586, 604 (1978) ("[T]he Eighth and Fourteenth Amendments require that the sentencer, in all but the rarest kind of capital case, not be precluded from considering, as a *mitigating factor*, any aspect of a defendant's character or record and any of the circumstances of the offense that the defendant proffers as a basis for a sentence less than death."); United States v. Lewinson, 988 F.2d 1005 (9th Cir. 1993) (holding that a mental disorder need not be "severe" to warrant downward departure as long as it resulted in "significant impairment" that affects "behavior and decision-making during the offense period").

87. *See* CRIMINAL JUSTICE MENTAL HEALTH STANDARDS, *supra* note 9, std. 7-4.9.

88. *Id*., std. 7-2.6 (detailing emergency treatment while in jail); std. 7-8.1 (explaining the standards for emergency treatment prior to sentencing).

89. *Id.*, std. 7-7.5 (regarding special commitment hearings).

90. *Id.*, std. 7-10.3(c).

91. For instance, at hearings to determine whether an insanity acquittee may be committed, an adverse inference may be drawn from noncooperation, *id.*, std. 7-7.5(e), and the other procedures mentioned may not require a judge or even an advocate. See standards described *supra* note 87–90.

Procedural protections during adjudication are important. However, when a person with mental disability is involved in the criminal justice system, adversarial hearings may not be enough to ensure against erroneous outcomes. For example, as noted above, interrogation is a significant source of inaccuracy in cases involving people with a mental disability. Standard 7-2.4(d) provides that:

> [L]aw enforcement officials who are considering interrogation of a detained person . . . should recognize that persons with mental disorders may be unusually susceptible to persuasion and should be alert to the possibility that official conduct may be more likely to constitute impermissible coercion or result in an invalid waiver of rights when an individual with mental disorder is questioned.[92]

Standard 7-5.4 also encourages courts to exclude statements that the court considers unreliable due to the effects of mental disorder even if no official misconduct is involved.[93]

Defense attorneys can also inadvertently cause inaccuracy or miss important facts because they do not realize how suggestible or confused some people with a mental disability can be.[94] Standard 7-1.4 reminds defense attorneys that they will need to be prepared to deal with "difficulties in communication that can result from the client's mental disorder or from transfers to a different locale necessitated by treatment needs."[95] This standard further requires that attorneys:

> [E]xplore all mental state questions that might be raised, including whether the client's capacities at the time of police interrogation bear on the admissibility or reliability of any incriminating statements that were made, whether the client is competent to proceed at any stage of the adjudication, and whether the defendant's mental state at the time of the offense might support a defense to the

92. *Id.*, std. 7-2.4(d).

93. *See id.*, std. 7-5.4(b) & (d).

94. *Cf.* BRYAN TULLY & DAVID CAHILL, POLICE INTERVIEWING OF MENTALLY HANDICAPPED PERSONS: AN EXPERIMENTAL STUDY 29–30 (1984) (finding that mentally handicapped individuals produce inaccurate information even when interviewed by police who, because they were being observed, presumably did not want to lead or mislead the subjects).

95. CRIMINAL JUSTICE MENTAL HEALTH STANDARDS, *supra* note 9, std. 7-1.4(b).

> charge, a claim in mitigation of sentence, or a negotiated disposition.[96]

Finally, Standard 7-1.4 notes that attorneys should talk with family members and other third parties who are able to provide relevant information about the defendant with a mental disorder.[97]

B. Assuring Competence to Proceed

In the course of these investigations, the defense attorney may conclude that the client's competence is in doubt, thus increasing the likelihood that the client will be unable to provide relevant information for investigative or confrontation purposes. The Standards refer to this issue as "competence to proceed" rather than competence to stand trial to indicate that, under the due process clause, an individual must be competent at all important proceedings to ensure an ability to assist counsel in challenging the state's evidence and arguments.[98] Thus, the Standards require competence in connection with trial, guilty plea hearings, sentencing, appeals, and collateral review.[99]

In all of these settings, the Standards adopt the test set out in the Supreme Court's decision in *Dusky v. United States*,[100] which states that, to be considered competent to proceed, a person must have "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."[101] While the test is the same in every proceeding, the Standards recognize that context matters. Thus, for example, in the guilty plea context the Standards highlight "the nature and complexity of the charges and the potential consequences of a conviction."[102] When the defendant is contemplating waiving counsel, the

96. *Id.*, std. 7-1.4(c).

97. *See id.*, std. 7-1.4(d).

98. *See id.*, std. 7-4.1(a) & (d).

99. *See id.*, std. 7-4.1(a) (requiring competence to proceed "In any criminal proceeding that takes place prior to or during adjudication of guilt and that requires the presence of the defendant, other than a proceeding pertaining to the defendant's competence to proceed and proceedings (such as bail hearings) where a competence requirement would seriously prejudice the defendant, the defendant must be competent to proceed."); std. 7-8.7 (requiring competence to proceed at noncapital sentencing); std. 7-8.8 (requiring competence to proceed on appeal); std. 7-9.8(a) (requiring competence to proceed at capital sentencing hearing); std. 7-9.9 (requiring competence at post-conviction proceedings).

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

101. *Id.* at 402.

102. CRIMINAL JUSTICE MENTAL HEALTH STANDARDS, *supra* note 9, std. 7-4.2(a)(ii).

relevant standard provides that the court should determine whether the defendant "has a rational and factual understanding of the possible consequences of proceeding without legal representation, including difficulties the defendant may experience due to his or her mental or emotional condition or lack of knowledge about the legal process."[103] The Standards do not, however, flesh out the competence test to any greater extent, given the considerable disagreement as to the precise factors that should be considered.[104]

The important point about these various standards for present purposes is that, with the goal of assuring a reliable process, standard 7-4.3 provides that all parties—the defense attorney, the prosecutor, and the judge—should seek an evaluation if they have a good faith doubt about the defendant's competence to proceed or make decisions.[105] Of particular note, the defense attorney with a good faith doubt as to the defendant's competence is required to seek evaluation of that issue even over the defendant's objection.[106] However, to avoid placing the defense attorney in the position of overt conflict with the client or revealing attorney-client communications, the standard gives the defense attorney discretion to accomplish this goal through an ex parte evaluation.[107]

Of course, even an ex parte defense-initiated evaluation of competence over the defendant's objection might cause tension between lawyer and client. It might also lead to evaluation and hospitalization in situations involving minor crimes when the alternative could be acceptance of a plea deal that results in immediate release.[108] The fact remains that if a defendant cannot communicate facts about the offense or mental condition to his or her attorney or cannot grasp the consequences of the proceeding at

103. *Id*., std. 7-5.3(b)(ii).

104. For a sampling of the literature, see E. Lea Johnston, *Setting the Standard: A Critique of Bonnie's Competency Standard and the Potential of Problem-Solving Theory for Self-Representation at Trial*, 43 U.C. DAVIS L. REV. 1605 (2010); Christopher Slobogin, *Mental Illness and Self-Representation: Faretta, Godinez and Edwards*, 7 OHIO ST. J. CRIM. L. 391 (2009).

105. CRIMINAL JUSTICE MENTAL HEALTH STANDARDS, *supra* note 9, std. 7-4.3; *see also* std. 7-5.2(c) (regarding decisions within the defendant's control).

106. *Id.* Also relevant here is standard 4-8(b), which provides that special counsel should be appointed to represent the defendant's position if counsel and the defendant continue to disagree on the competence issue. Whether original counsel continues after this hearing will depend on its outcome and the defendant's reaction to it.

107. *Id.*, std. 7-4.3(c). This is a modification of the original standards, which *required* the attorney to make a formal motion to the court when a good faith doubt exists and was one of the more hotly contested standards.

108. *See generally* Rodney Uphoff, *The Role of the Criminal Defense Lawyer in Representing the Mentally Impaired Defendant: Zealous Advocate or Officer of the Court*, 1988 WIS. L. REV. 65, 89–96 (making these points).

issue, the potential for an unreliable outcome significantly increases. Furthermore, a "good plea deal," however beneficial on the front-end, can have unforeseen consequences; convictions can adversely affect job prospects as well as sentences for subsequent crimes even if they don't result in immediate imprisonment.[109] Other provisions in the Standards should, if followed, alleviate defense attorney concern about unnecessary confinement. As noted in Part I of this article, the Standards encourage dismissal of charges and diversion in appropriate cases;[110] prohibit use of competence motions to obtain information for bargaining or sentencing purposes; seek treatment unrelated to competence restoration, or cause delay;[111] require that evaluation and treatment take place in the community whenever possible;[112] and place limits on the duration of the evaluation and treatment process.[113]

C. Recognizing Mental State Defenses and Mitigation at Sentencing

The criminal justice system must endeavor to ensure reliable outcomes not only with respect to the actus reus but also with respect to mental state defenses. The Standards adopt a fairly generous stance toward the relevance of mental disability to criminal responsibility, tempered by concerns about the ability of the behavioral sciences to provide relevant information. Thus, the Standards opt for a "liberal" version of the *M'Naghten* test by adopting a test that asks whether the defendant, as a result of mental disorder, "was unable to appreciate the wrongfulness" of the criminal conduct.[114] The word "appreciate" (rather than use of the word "know," as in the original *M'Naghten* formulation) permits exploration of the full range of cognitive dysfunction that might affect the defendant's understanding of the criminal nature of his or her conduct.[115] However, the

109. *See* Joanne Ilaria Davoli, *Diverting the Mentally Ill Out of the Virginia Criminal Justice System*, 11 GEO. MASON U. CIV. RTS. L.J. 109, 110 (2000) (noting that pleading guilty to a minor crime can produce a conviction that leads to later sentence enhancements and untreated illness, which can lead to further crime).

110. CRIMINAL JUSTICE MENTAL HEALTH STANDARDS, *supra* note 9, std. 7-4.8(e).

111. *Id*., std. 7-4.3(e).

112. *Id.*, std. 7-4.5(a) (regarding evaluation); std. 7-4.10(a) (regarding treatment).

113. *Id*., stds. 7-4.4(c), 7-4.5(b), and 7-4.12 (discussing periodic redetermination of incompetence).

114. *Id.* The original M'Naghten formulation read: "To establish a defense on the ground of insanity, it must be clearly proved that, at the time of the committing of the act, the party accused was laboring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing; or, if he did know it, that he did not know he was doing what was wrong." M'Naghten's Case, 8 Eng. Rep. 718, 722 (HL 1843).

115. Thus, the drafters of the Model Penal Code thought that, while "know" implies a superficial awareness, "appreciate" connotes a deeper emotional understanding. *See* MODEL

test does not recognize a defense based on volitional impairment, based in large part on the assumption (shared by the American Psychiatric Association and others) that determining the difference between an irresistible impulse and an impulse that cannot be resisted is difficult, if not impossible.[116] The Standards also make two other concessions to the difficulty of proving past mental states: they leave the burden of proof on insanity up to the jurisdiction (while still requiring that the standard of proof be a preponderance of the evidence)[117] and they exclude a defense based solely on the acute effects of intoxication or on a condition manifested solely by repeated antisocial conduct.[118]

While their formulation of the insanity defense is not as broad as that in some states,[119] the Standards also recognize several other means of according mental disability exculpatory or mitigating effect. Following the Model Penal Code (but only by about two-fifths of the states),[120] standard 7-6.2 permits expert testimony that "tends to show the defendant did or did not have the mental state required for the offense charged."[121] Standard 7-8.5 provides that mental disability should also have an impact on sentences, by recognizing that the following two types of conditions should be considered mitigating if they existed at the time of the offense:

> Significant limitations in both cognitive functioning and adaptive behavior, as expressed in conceptual, social, and practical adaptive skills, resulting from intellectual disability, dementia, or a traumatic brain injury [and]

PENAL CODE, § 4.01 cmt., app. C (AM. LAW INST. 1985) ("To appreciate the 'wrongfulness' of one's offending act is to 'understand the idea as a matter of importance and reality; to grasp it in a way that makes it meaningful in the life of the individual, not as a bare abstraction put in words.'").

116. *See* Stephen J. Morse, *Culpability and Control*, 142 U. PA. L. REV. 1587, 1600–01 (1994) ("[I]t is famously the case that even if impulses do have coercive motivational force, it is impossible to differentiate 'irresistible' impulses from those simply not resisted."); *see also* Richard Bonnie, *The Moral Basis of the Insanity Defense*, 69 A.B.A. J. 194, 196–97 (1983) (providing arguments against the volitional prong).

117. CRIMINAL JUSTICE MENTAL HEALTH STANDARDS, *supra* note 9, std. 7-6.9.

118. *Id*., std. 7-6.1(b).

119. *See* Clark v. Arizona, 548 U.S. 735, 750–51 (2006) (noting that seventeen states have some version of the volitional prong of the insanity defense).

120. PAUL H. ROBINSON, LOSS OF CONTROL AND DIMINISHED RESPONSIBILITY: DOMESTIC, COMPARATIVE AND INTERNATIONAL PERSPECTIVES 291 (A. Reed & M. Bohlander eds., 2011) (stating that about 40% of states allow evidence of mental disability when relevant to negate any mental state, 30% limit such evidence to specific intent or homicide prosecutions, and 30% bar it altogether).

121. CRIMINAL JUSTICE MENTAL HEALTH STANDARDS, *supra* note 9, std. 7-6.2.

> [S]evere mental disorder, not manifested primarily simply by repeated criminal conduct or attributable solely to the acute effects of voluntary alcohol or drug use, that significantly impaired the offender's capacity to appreciate the nature, consequences or wrongfulness of conduct, exercise rational judgment in relation to conduct, or conform conduct to the requirements of the law.[122]

Part IX on capital sentencing, which did not exist in the original Mental Health Standards, provides that the same two conditions should lead to *exemption* from the death penalty.[123] The first exemption—focusing on intellectual deficits—goes beyond the Supreme Court's decision in *Atkins v. Virginia*,[124] which prohibited the execution of people with an intellectual disability, by abandoning the requirement typically found in the definition of that diagnosis that the age of onset occur before eighteen.[125] The second exemption—focused on people with mental illness—encompasses a group that, because they are at least as impaired as most people with intellectual disability, should also be spared from the death penalty.[126] While these exemptions significantly expand the impact of mental disorder in capital cases, they are not an innovation with the Standards; they have been official ABA policy since 2006.[127] Also consistent with this policy, the Standards make clear that even if an individual does not meet the exemption criteria, mental disability should still be considered a mitigating circumstance that must be balanced against aggravating factors,[128] a requirement found in the capital sentencing schemes of most states.[129]

122. *Id.*, std. 7-8.5.

123. *Id.*, std. 7-9.2(a) & (b).

124. Atkins v. Virginia, 536 U.S. 304 (2002).

125. *Compare id.* at 308 (noting that mental retardation requires onset of intellectual disability before age 18) *with* Hall v. Florida, 134 S. Ct. 1986, 1993 (2014) (holding that the definition of intellectual for disability for death penalty purposes should parallel the definition of "professional societies").

126. *See* Christopher Slobogin, *What Atkins Could Mean for People with Mental Illness*, 33 N.M. L. REV. 293 (2003).

127. HOUSE OF DELEGATES RESOLUTION 122A, AM. BAR ASSOC. (2012), http://www.deathpenaltyinfo.org/node/1786.

128. CRIMINAL JUSTICE MENTAL HEALTH STANDARDS, *supra* note 9, std. 7-9.2(e).

129. Sam Kamin & Justin Marceau, *The Facts about* Ring v. Arizona *and the Jury's Role in Capital Sentencing*, 13 U. PA. J. CONST. L. 529, 550 (2011) (noting that virtually every death penalty scheme adopts this approach but that "the Supreme Court has held that the Eighth Amendment does not require any one particular means of balancing aggravating and mitigating factors").

D. Assuring Reliable Evaluations

All of the standards discussed in the previous section stand for the proposition that a criminal justice system that does not recognize the exculpatory and mitigating impact of a mental disability is not accurately calibrating the blameworthiness of individuals with a mental disorder. Just as important to the goal of enhancing reliable determinations of these issues are numerous other standards aimed at ensuring that the criminal justice system obtains the information it needs to resolve competency, insanity, dangerousness, and related issues. Most of these standards appear in Part III of the Standards, which is entitled, "Evaluations and Expert Testimony." They set forth five means of enhancing this information-gathering process.

First, standards 7-3.9 and 7-3.10 contain provisions regarding the necessary training and qualifications for the mental health professionals who participate in the criminal justice system and provide most of the data on mental health questions.[130] These standards divide forensic experts into three categories: court-appointed evaluators, evaluators who testify, and "scientific experts." Under standard 7-3.10, court-appointed *evaluators* who address competence issues should generally be psychiatrists, psychologists, social workers, or psychiatric nurses who have met the relevant licensing requirements, whereas court-appointed evaluators of mental state at the time of the offense or of future risk generally should be psychiatrists or psychologists.[131] All such evaluators must not only possess the necessary clinical knowledge, but also have received training on and possess sufficient "forensic knowledge" about the particular legal issue addressed in the evaluation; [132] even the most knowledgeable clinicians are not very useful to the law if they do not understand the relevant legal standards.[133] *Testifying* experts must either meet the same requirements or, if they are called to court because they have provided therapy to the person at issue, be limited to testifying about "matters concerning the defendant's general mental condition as presented during the therapeutic relationship."[134] All testifying experts must also have "performed an adequate evaluation, including a personal interview with the individual

130. CRIMINAL JUSTICE MENTAL HEALTH STANDARDS, *supra* note 9, std. 7-1.3(a) (defining roles of mental health professionals in the criminal justice system).

131. *Id.*, std. 7-3.10(c)(ii). However, the standard also permits a licensed physician and certified special education teacher, speech or language pathologist or audiologist to testify under certain circumstances. *See id*. std. 7-3.10(c) (iii)–(iv).

132. *Id.*, std. 7-3.9(a)(ii).

133. *See generally* Kirk Heilbrun & Stephanie Brooks, *Forensic Psychology and Forensic Science: A Proposed Agenda for the Next Decade*, 16 PSYCHOL. PUB. POL'Y & L. 219 (2010) (describing efforts to provide guidelines and training in forensic psychology).

134. CRIMINAL JUSTICE MENTAL HEALTH STANDARDS, *supra* note 9, std. 7-3.9(b)(ii).

whose mental condition is in question, relevant to the legal and clinical matter(s) upon which the witness is called to testify."[135] In contrast, *scientific* experts—the third category of expert—need not have evaluated the individual but must have the education and experience necessary to "present scientific or clinical knowledge" relevant to the particular issue in question.[136]

If the expert is testifying about risk or "dangerousness," as might occur in commitment proceedings involving insanity acquittees and perhaps in some sentencing proceedings, standard 7-3.8 outlines the factors the expert should consider when determining whether mental disability is a causal factor. These factors include:

> [1] the clinical significance of the individual's history and current behavior; [2] scientific studies involving the relationship between specific behaviors and variables that are objectively measurable and verifiable; [3] the possible psychological or behavioral effects of proposed therapeutic or other interventions; [4] the factors that tend to enhance or diminish the likelihood that specific types of behavior could occur in the future; and, finally, [5] the defendant's performance on validated instruments for assessing risk and need," but only when those instruments are "administered, scored, interpreted and presented in accordance with scientific and professional standards.[137]

Standard 7-1.5 also admonishes judges and prosecutors to rely, whenever possible, on valid and reliable structured appraisals of relevant risk and treatment (rather than unstructured clinical assessments) when determining which defendants should be selected for participation in diversion programs or specialized courts.[138]

Assume now that qualified experts are in place. As a second reliability-enhancing mechanism, Part III seeks to ensure defendants have recourse to this expert assistance, as required by the Due Process Clause and the Sixth Amendment's right to effective assistance of counsel.[139] Standard 7-3.3 provides that indigent defendants should have access to expert evaluators "if such services are reasonably necessary for an adequate

135. *Id.*, std. 7-3.9(b)(iii).

136. *Id.*, std. 7-3.9(c).

137. *Id.*, std. 7-3.8(b).

138. *Id.*, std. 7-1.5(e).

139. *Cf.* Ake v. Oklahoma, 470 U.S. 68 (1984).

defense," and also should have access to "consultative experts" if "good cause" is shown.[140] Other provisions echo this entitlement to expert evaluators in specific contexts.[141]

Third, the Standards admonish all parties—defense, prosecution, and the court—to assist experts in the evidence-gathering process. To avoid any confusion about the issues to be addressed, both the initiating party and the court order (when the evaluation is not ex parte) are required to inform the evaluator of the issue to be addressed.[142] The initiating party or, if the initiating party is the court, both the prosecution and defense, is further obligated to provide the evaluator with "all records and other information that . . . may be of assistance in facilitating a thorough evaluation on the matter(s) referred," including relevant medical and psychological records, social history, police and other law enforcement reports, confessions or statements made by defendant, investigative reports, autopsy reports, toxicological studies, and transcripts of pretrial hearings.[143] In particular, upon the request of the evaluator, the court is to "direct that the defendant's relevant health care records be released, . . . with or without the defendant's consent."[144]

Fourth, the Standards describe steps for assuring an accurate record of the evaluation is maintained. Standard 7-3.5 provides that, whenever feasible, all evaluations initiated by the prosecution or the court are to be recorded, preferably through video as well as audio.[145] At the same time, to avoid the possibility that lawyers will obstruct evaluator access to information, neither the prosecutor nor the defense attorney is entitled to be present during such evaluations, unless the evaluator requests the attorney's presence or the evaluation is focused on competence (and even then the lawyer "should actively participate only if requested to do so by the evaluator").[146] The Standards adopt the position that, other than when the evaluator needs the lawyer to be present to assess the attorney-client relationship or to facilitate communication, the presence of an attorney is more likely to harm rather than assist the evaluation process; further, the recording requirement should alleviate attorney concern that evaluators will

140. CRIMINAL JUSTICE MENTAL HEALTH STANDARDS, *supra* note 9, std. 7-3.3(a)–(b).

141. *See id.*, std. 7-4.3(a) (regarding judicial obligation to ensure competence); std. 7-8.3 (regarding expert assistance in noncapital sentencing); std. 7-10.3(b) (regarding prisoner's right to testimony of treating professional at a transfer hearing).

142. *Id.*, std. 7-3.4(a).

143. *Id.*, std. 7-3.4(b).

144. *Id.*, std. 7-3.4(e)(vi).

145. *Id.*, std. 7-3.5(d)(ii).

146. *Id.*, std. 7-3.5(c).

abuse that process. In contrast, the Standards encourage "joint evaluations" by both defense and state *experts* (or by a mutually agreed upon expert), on the theory that the same information base will reduce both the tendency of adversarial witnesses to emphasize facts relevant only to one side and the likelihood that defendants will strategically change their story or invalidate tests through practice effects.[147]

Fifth, to further enhance the information-gathering capacity of evaluators, the Standards seek to promote the defendant's full cooperation by adopting a strong position on the application of the privilege against self-incrimination.[148] Standard 7-3.2 prohibits the disclosure of information obtained during a forensic evaluation, as well as evidence or opinions derived from such evaluation, unless (1) the report relates solely to a competence issue (and even then the report should not include any *self*-incriminating information from the defendant), or (2) the defendant introduces or intends to introduce evidence on the issue addressed in the report.[149] This provision allows the evaluator to assure defendants that they and their attorneys control when evaluation results can be used on issues concerning guilt and innocence, and thus should encourage candid communication with the evaluator. Standard 7-3.2 also permits the evaluator to breach confidentiality in one other situation—when the evaluator concludes during the evaluation that the individual "presents an imminent risk of serious danger to him or herself or to another person or otherwise needs emergency intervention."[150] However, that information would be inadmissible in court except in the rare situation, perhaps at sentencing, where the defendant asserts he or she is not dangerous and the prosecution wishes to use the information in rebuttal.[151]

147. *Id.*, std. 7-3.5(e).

148. The Supreme Court has held that the Fifth Amendment applies in the forensic evaluation context. Estelle v. Smith, 451 U.S. 454, 468 (1981). For a fuller explication of both the Fifth Amendment and reliability rationales, see Christopher Slobogin, Estelle v. Smith*: The Constitutional Contours of the Forensic Evaluation*, 31 EMORY L.J. 71, 109–14 (1982).

149. CRIMINAL JUSTICE MENTAL HEALTH STANDARDS, *supra* note 9, std. 7-3.2(a).

150. *Id.*, std. 7-3.2(b)(ii). The standard states that such disclosure should be consistent with "applicable professional standards and statutory reporting requirements."

151. *See* United States v. Hayes, 227 F.3d 578, 579 (2000) (holding that there is not a "dangerous patient" exception to the clinician/patient privilege). If the defendant raises the issue of non-dangerousness, however, the patient-litigant exception to the privilege might apply. *See In re* Lifschutz, 467 P.2d 557 (Cal. 1970); *see generally* Deborah Paruch, *From Trusted Confidant to Witness for the Prosecution: The Case Against the Recognition of a Dangerous-Patient Exception to the Psychotherapist-Patient Privilege*, 9 U. N.H. L. REV. 327 (2011).

E. Assuring Proper Use of Evaluation Results

Once the evaluation is complete, the legal system should maximize use of its results. The Standards achieve this objective in two ways, having to do with discovery and communication of expert opinions. First, if, pursuant to the process just discussed, the defense decides to use evaluation results to address mental state issues, the Standards opt for reciprocal discovery, again in an effort to enhance reliable adjudication. The prosecution is entitled to a report from any defense expert who will testify and, in return, the defense must receive any as-yet undiscovered reports and information in the prosecution's possession "bearing on the issues addressed by the defense expert."[152] If a written report does not exist at the time the defense indicates an intent to introduce the expert, then one must be created.[153] Standard 3-3.6(c) admonishes attorneys to avoid modifying such reports "in any way that would compromise the report's integrity," although it also allows attorneys to correspond or converse with the expert "to clarify the meaning or implications of the evaluator's findings or opinions."[154]

This procedure also applies in the capital sentencing context, but with a twist, given the exemptions to death sentences mentioned earlier. Standards 7-9.3 through 7-9.5 establish separate procedures for when the defense is asserting an exemption based on intellectual disability and when, instead, it is asserting an exemption based on mental illness or a mitigation defense. In the former situation, the results of the evaluation are provided to the prosecution once notice is given.[155] In the latter situation, the results of any pre-trial evaluation are provided either to a "firewalled" prosecution "who may not share the reports or otherwise communicate about the evaluation with the prosecutor responsible for the sentencing phase of the trial" or, after conviction, to the prosecutor in charge of the sentencing phase.[156] The different procedures are necessary because, while an assessment of whether a person is intellectually disabled should not reveal any information about the offense,[157] an evaluation addressing the second exemption may reveal incriminating information that the trial prosecutor

152. CRIMINAL JUSTICE MENTAL HEALTH STANDARDS, *supra* note 9, std. 7-3.7(b).

153. *Id*., std. 7-3.7(b)(i).

154. *Id.*, std. 7-3.6(c).

155. *Id.*, std. 7-9.5(a).

156. *Id.*, std. 7-9.5(b).

157. At least, this statement is true under the Standards' definition of the exemption, which focuses solely on diagnosis. *See id*., std. 7-9.2(a). However, the Supreme Court will decide this term whether Texas' definition of intellectual disability for death penalty purposes, which can include an analysis of behavior during the offense, is constitutional. Moore v. Texas, 136 S. Ct. 2407 (2016). Under that definition, the procedure described in the text could not work.

should not see before trial. Based on the same rationale, the results of any pre-trial capital sentencing evaluation with regard to the second exemption go only to the firewalled prosecutor or, after conviction, to the prosecutor in charge of the sentencing phase.[158] While these procedures are in part based on Fifth Amendment concerns,[159] they also remove one disincentive to be forthright during the evaluation process.

A final mechanism for promoting reliable decision-making on forensic issues concerns the form in which expert opinions are delivered. At any hearing, whether it occurs prior to trial, at trial itself, or at commitment or sentencing, experts should be allowed to give their full opinion to the extent it is clinically feasible, legally relevant, and otherwise permissible. Thus, standard 7-3.11 provides that "the expert should identify and explain the theoretical and factual basis for the opinion and the reasoning process through which the opinion was formulated."[160] The standard continues:

> In doing so, the expert should be permitted to describe facts upon which the opinion is based, regardless of their independent admissibility under the rules of evidence, if the court finds that the Sixth Amendment to the U.S. Constitution and similar relevant state provisions permit admission of these facts and that: (i) they are of a type that is customarily relied upon by mental health professionals in formulating their opinions; (ii) they are relevant to serve as the factual basis for the expert's opinion; and (iii) their probative value outweighs their tendency to prejudice or confuse the trier of fact.[161]

Although the last clause is similar to language found in Rule 703 of the Federal Rules of Evidence,[162] it intentionally avoids that rule's placement of the word "substantially" before "outweighs," on the ground that the expert should be able to explain all probative facts underlying the

158. CRIMINAL JUSTICE MENTAL HEALTH STANDARDS, *supra* note 9, std. 7-9.6.

159. *Cf.* Estelle v. Smith, 451 U.S. 454, 468 (1981) (holding that "[a] criminal defendant, who neither initiates a psychiatric evaluation nor attempts to introduce any psychiatric evidence, may not be compelled to respond to a psychiatrist if his statements can be used against him at a capital sentencing").

160. CRIMINAL JUSTICE MENTAL HEALTH STANDARDS, *supra* note 9, std. 7-3.11(c).

161. *Id.*

162. *See* FED. R. EVID. 703 ("[I]f the facts or data would otherwise be inadmissible, the proponent of the opinion may disclose them to the jury only if their probative value in helping the jury evaluate the opinion substantially outweighs their prejudicial effect.").

opinion, unless they are subject to exclusion under the Supreme Court's confrontation jurisprudence.[163]

Another aspect of how expert opinions are communicated concerns the extent to which the expert should be allowed to address the "ultimate issue" (i.e., whether a person is "competent," "insane," or "dangerous").[164] Some have argued that such testimony is not the domain of mental health professionals because its import is solely legal.[165] The Standards' position is less absolute. Although standard 7-6.6 does state that experts should not opine whether a person is "sane" or "insane" unless the jurisdiction requires such testimony, in all other situations, standard 7-3.8 provides, "expert testimony, in an opinion or otherwise, should be admissible whenever the testimony is based on and is within the specialized knowledge of the witness and will assist the trier of fact."[166] That standard goes on to say that "[i]f the jurisdiction requires the evaluator to present his or her opinion on a question requiring a conclusion of law or a moral or social value judgment, the evaluator should use cautionary language to explain the boundaries of the expert's clinical expertise and the limitations of the opinion."[167]

F. Summary of Standards Aimed at Enhancing Reliability

Assuring reliable results in criminal cases involving people with mental disabilities can be a difficult undertaking. Symptoms of mental disability may not be discerned by attorneys or judges. Even if they are, governing law may not adequately account for or fairly adjudicate their effect, and attempts to assess and describe how they influence a criminal defendant may suffer from lack of information or proper framing. The

163. Under Crawford v. Washington, 541 U.S. 36 (2004), a witness may not recount a "testimonial" statement made by a third party unless that third party has been subject to cross-examination prior to trial or is a witness at trial. This ruling has been applied to third party statements relied upon by psychiatric experts. *See, e.g.*, People v. Goldstein, 843 N.E.2d 727, 733 (N.Y. 2005).

164. *See generally* Christopher Slobogin, *The "Ultimate Issue" Issue*, 7 BEHAV. SCI. & L. 259 (1989).

165. Stephen J. Morse, *Failed Explanations and Criminal Responsibility: Experts and the Unconscious*, 68 VA. L. REV. 971, 983 (1982) (noting that "experts should not be allowed to offer opinions on nonscientific, ultimate legal issues").

166. CRIMINAL JUSTICE MENTAL HEALTH STANDARDS, *supra* note 9, std. 7-3.8(a). Contrast this position with decisions construing Federal Rule of Evidence 704(b), which prohibit the expert from using the insanity test language even if it might also be based on specialized knowledge. *See, e.g.*, United States v. Manley, 893 F.2d 1221 (11th Cir. 1990) (prohibiting questioning an expert about whether a person with manic-depressive psychosis would "be able to appreciate the nature and quality or the wrongfulness of their actions").

167. *Id*., std. 7-3.8(c).

Standards address each of these concerns through a number of mechanisms designed to ensure that issues regarding competence, mental state defenses, and risk are recognized, fully evaluated, and competently explained by trained mental health professionals who are given full access to the relevant information consistent with constitutional guarantees.

III. Goal # 3: Autonomy and Dignity

Both mental health professionals and courts, echoing widely-held societal views, have often automatically equated mental disability with a lack of capacity to make decisions about important aspects of life.[168] *Parens patriae* civil commitment laws, guardianship statutes, and competency doctrines in the criminal justice setting are routinely construed to authorize deprivations of liberty and property for anyone who demonstrates significant pathology, without inquiry into the degree to which the person in question understands relevant risks and benefits or the specific reasons for a particular choice.[169]

The Standards assume, to the contrary, that people with mental disabilities can be autonomous actors. The standards governing competence discussed in Part II of this article all take as a given that if a person with a mental disability is competent with respect to the specific choice at issue, he or she should be accorded the same rights as other criminal defendants, regardless of other symptoms of mental disability the individual may evidence. Doing so is probably constitutionally required.[170]

168. Michael L. Perlin, *Pretexts and Mental Disability Law: The Case of Incompetency*, 47 U. MIAMI L. REV. 625, 656–57 (1993) (explaining that "[e]mpirical studies show that mental health professionals *overpredict* incompetence to stand trial, primarily because of the erroneous belief that this status is synonymous with psychosis" and asserting that judges usually go along with these types of opinions).

169. CHRISTOPHER SLOBOGIN, MINDING JUSTICE: LAWS THAT DEPRIVE PEOPLE WITH MENTAL DISABILITY OF LIFE AND LIBERTY 253–57 (2006) (noting that commitment and competency laws often permit deprivations of liberty based on a finding of "a substantial disorder of thought or mood that significantly impairs judgment, behavior, capacity to recognize reality, or ability to cope with the ordinary demands of life" without requiring an assessment of the specific reasons for making a decision).

170. The Supreme has held or strongly implied that a person with mental problems who is nonetheless competent to make the relevant decision is entitled to: (1) waive counsel and plead guilty, Godinez v. Moran, 509 U.S. 389, 400 (1993) (holding that a finding that a defendant is competent to stand trial and knowingly and voluntarily waives his rights is "all that is necessary before he may be permitted to plead guilty or waive his right to counsel"); (2) refuse medication, Sell v. United States, 539 U.S. 166, 183 (2003) (indicating that a person who is "competent to make up his own mind about treatment" should be allowed to do so); and (3) decide about voluntary hospitalization, Zinermon v. Burch, 494 U.S. 114, 138 (1990) (requiring a "valid consent" before voluntary hospitalization may take place). *See also* Rogers v. Comm'r of Dept. of Mental Health, 458 N.E.2d 308, 314 (Mass.1983) ("[A] mental patient has the right to make treatment decisions . . . until the patient is adjudicated incompetent by a judge . . . .").

Furthermore, it ensures that these people are treated with dignity even if their decision-making process, like that of many people who do not have a diagnosis, seems imprudent at times.[171]

While the Standards do not go beyond the *Dusky* "rationality" test in defining when a person is competent to make a particular decision, they do address the related issue of which decisions by a competent defendant are given controlling weight. In some jurisdictions, the decision about raising the insanity defense is viewed as a tactical one to be made by the attorney.[172] Standard 7-6.3 instead provides that this decision is controlled by the defendant, if he or she is competent to make it.[173] Consistent with case law on this issue,[174] the Standards also leave to the competent defendant the decisions about whether to plead guilty, waive the jury, and appeal.[175] However, the Standards allow the attorney to make the final call about whether to raise a mens rea defense, challenge the death penalty, and present mitigating evidence at the sentencing phase of a capital case.[176] These latter positions reflect the belief that, in contrast to the decision about insanity—which arguably goes to the core of a person's self-definition and can lead to negative dispositional consequences[177]—concerns about

171. *See generally* Bruce J. Winick, *Presumptions and Burdens of Proof in Determining Competency to Stand Trial, An Analysis of* Medina v. California *and the Supreme Court's New Due Process Methodology in Criminal Cases*, 47 U. MIAMI L. REV. 817, 859–60 (1993) (arguing for a presumption of competency because it promotes "respect for individual autonomy" and "psychological health").

172. *See* Robert D. Miller et al., *Forcing the Insanity Defense on Unwilling Defendants: Best Interest and the Dignity of the Law*, 24 J. PSYCHIATRY & L. 487, 504 (1996) (reporting, based on a survey of state attorneys general, that the defense can be raised over the defendant's objection or without the defendant's knowledge in seventeen states); David S. Cohn, *Offensive Use of the Insanity Defense: Imposing the Insanity Defense Over the Defendant's Objection*, 15 HASTINGS CONST. L.Q. 295, 299–301 n.31 (1988) (noting that a sizeable minority of courts leave the decision about whether to raise an insanity defense to the attorney).

173. CRIMINAL JUSTICE MENTAL HEALTH STANDARDS, *supra* note 9, std. 7-6.3(a).

174. *See* Jones v. Barnes, 463 U.S. 745, 753 n.6 (1983) (quoting with apparent approval American Bar Association Model Rule of Professional Conduct 1.2(a), which states that "[i]n a criminal case, the lawyer shall abide by the client's decision, . . . *as to a plea to be entered, whether to waive jury trial and whether the client will testify*") (emphasis added).

175. CRIMINAL JUSTICE MENTAL HEALTH STANDARDS, *supra* note 9, std. 7-5.2(a).

176. *Id.*, std. 7-6.3(a)(regarding mens rea defense); std. 7-9.8(b) (regarding death penalty challenges).

177. Frendak v. United States, 408 A.2d 364, 376–78 (D.C. 1979) (detailing reasons for prohibiting an insanity plea over a competent defendant's objection); H. Richard Uviller, *Calling the Shots: The Allocation of Choice Between the Accused and Counsel in the Defense of a Criminal Case*, 52 RUTGERS L. REV. 719, 726 (2000) (stating, in the course of arguing that the decision should be the defendant's, that the insanity defense entails "the client's 'essential self-presentation,'" and noting that it may be "peculiarly offensive to human dignity to argue for a defendant that he was mad when he wants to argue mistaken identification or justification,"

reliability should trump even the views of an autonomous individual where technical mental states and the ultimate penalty of death are involved.[178]

However, if the defendant insists on a different strategy than the attorney, then the Standards, again consistent with case law,[179] permit a competent defendant who wants to control the case to waive counsel.[180] The only issue then is whether, following the Supreme Court's decision in *Indiana v. Edwards*,[181] the defendant can in fact proceed pro se or whether, instead, the court may force counsel on the defendant on the ground that he or she is incompetent to carry out "basic [trial] tasks."[182] Standard 7-5.3 describes the inquiry as follows:

> A defendant who is competent to elect to proceed without representation by counsel may represent him or herself at trial unless the court finds that, as a result of mental disorder, (i) the defendant lacks the capacity to carry out the minimum tasks required for self-representation at trial to such a substantial extent as to compromise the dignity or fairness of the proceeding, or (ii) the defendant will significantly disrupt the decorum of the proceeding.[183]

In all other circumstances, the dignity and autonomy of the individual defendant is best promoted by allowing pro se representation.

Thus, the Standards resolve conflicts between the goal of honoring the defendant's autonomy and the goal of assuring reliable results largely in favor of the former goal. However, the Standards also recognize exceptions to the general rule that the defendant controls his or her own defense. Further, of course, they insist that control of these decisions be afforded only to those defendants who are competent to make them.

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although also rejecting the idea that the insanity defense is entirely different from many other defenses).

178. *See* Anthony J. Casey, *Maintaining the Integrity of Death: An Argument for Restricting a Defendant's Right to Volunteer for Execution at Certain Stages in Capital Proceedings*, 30 AM. J. CRIM. L. 75 (2002).

179. Faretta v. California, 422 U.S. 806, 835 (1975) (holding that a competent defendant has a Sixth Amendment right to self-representation).

180. *See* CRIMINAL JUSTICE MENTAL HEALTH STANDARDS, *supra* note 9, std. 7-5.3(a) (stating that a defendant who is not competent to waive counsel may not do so, indicating by negative inference that a competent defendant may do so).

181. Indiana v. Edwards, 554 U.S. 164 (2008).

182. *Id.* at 175–76 (indicating that a defendant proceeding pro se must be able to carry out "the basic tasks needed to present his own defense without the help of counsel").

183. CRIMINAL JUSTICE MENTAL HEALTH STANDARDS, *supra* note 9, std. 7-5.3(d).

Conclusion

The American Bar Association's Criminal Justice Mental Health Standards represent a comprehensive approach to the adjudication and treatment of people with mental disability who come into contact with the criminal justice system. The Standards' genesis in the 1980s and their revision in the past four years through the multistage vetting process required by the ABA has produced a set of provisions that should provide welcome guidance to the judges, prosecutors, defense attorneys, police, correctional officials, and mental health professionals who deal with this population. Although the nature of mental disability makes them complex, the Standards are a balanced attempt to promote fair and humane treatment without compromising public safety, accurate evaluations and adjudications consistent with constitutional and other legal prerogatives, and decision-making autonomy for people with mental disabilities that does not offend competing reliability goals.

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