THE AMERICAN BAR ASSOCIATION'S CRIMINAL JUSTICE MENTAL HEALTH STANDARDS

(Adopted August, 2016; revised commentary 2017 and 2024)

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INTRODUCTION

The criminal law has confronted mental disability for centuries, most notably in connection with the insanity defense but also through its doctrines regarding competence to stand trial and the mitigating effect of mental disability at sentencing. For those who administer the criminal system today, interaction with people suffering from mental illness, intellectual disability, and other conditions that impair mental processes is almost inevitable. Even persons untrained in such matters cannot help but recognize the mental and emotional distress so often exhibited by persons detained in police custody, arraigned and tried in criminal courts, and incarcerated in jails and prisons.

Although people with mental disability have always populated our criminal courts, only in the late 1970s did the American Bar Association's Criminal Justice Section set out to develop standards addressing the many issues that arise in cases involving individuals with mental disorders. Supported by a generous grant from the John D. and Catherine T. MacArthur Foundation, the ABA's Standing Committee on Association Standards for Criminal Justice established six task forces to study the issues. The task forces were interdisciplinary, including not only attorneys (prosecutors, defense lawyers, judges, and legal academicians) but also mental health professionals (psychiatrists, psychologists, and others). In all, seventy-nine nationally recognized experts in law and mental health participated. The task forces met for four years and produced ninety-six black letter standards, which the Association's House of Delegates adopted at its Annual Meeting on August 7, 1984.[1]

The Standards were published in 1986 as Chapter 7 of the Standards for Criminal Justice. Additional standards were adopted at the Association's Annual Meetings in 1987 (on competence and capital punishment) and 1988 (on competence and confessions).[2] In 2010, Standards on the Treatment of Prisoners was approved to supplement Chapter 7's standards governing prisoners with mental disability.[3] The bulk of the Standards, however, remained unchanged for

[1] American Bar Association, Criminal Justice Mental Health Standards (1986, 1989).
[2] Id. at 284-320.
[3] https://www.americanbar.org/groups/criminal_justice/publications/criminal_justice_section_archive/crimjust_standards_treatmentprisoners

more than three decades after their 1986 adoption. That period saw both substantial litigation over criminal mental health issues and vast increases in knowledge about the nature of mental disability and effective systems for treatment. Recognizing these developments, in 2012 the Criminal Justice Standards Committee (a standing committee of the Criminal Justice Section) established a task force to review the Standards in their entirety and draft proposed revisions to reflect current law and best practices.

The task force consisted of three law professors with both academic credentials and practical experience in mental health law; a judge who presided over a criminal and specialized mental health court docket; two defense attorneys (one in private practice, the other a public defender); two state prosecutors; and four mental health professionals (two psychiatrists and two psychologists, all with experience contributing to the development of guidelines for their own professional organizations). Also participating and making valuable contributions were liaisons from the National Association of Criminal Defense Lawyers, the National Alliance on Mental Illness, the Department of Justice, and the federal public defender service in Washington, D.C.[4] The Task Force met for three years, examining all the issues addressed by the original Standards, as well as new developments in law and science. It recommended significant revisions of the previous standards and proposed a number of new standards on emerging issues.[5] Its recommendations were reviewed by the ABA's Criminal Justice Section Standards Committee (in 2015) and the Criminal Justice Section Council (in 2016). Ultimately, the revised Standards were adopted by the ABA House of Delegates at the Annual Meeting in August

[4] The full membership of the Task Force is found in Appendix A.

[5] For instance, the standards in Part I, which govern professional and systemic roles, were substantially revised to reflect new ethical guidelines for mental health professionals and attorneys, new scientific developments that can improve forensic work, and an emphasis on diversion, specialty courts, and other alternatives to criminal prosecution. Part II on the police relies on new research on how police interact with people who have mental disability, and incorporates revised means of obtaining care for people with mental disability whom police take into custody. Part III, on the general evaluation process, was updated to reflect Supreme Court decisions regarding application of the Fifth Amendment and the Confrontation Clause, and also includes a change in ABA policy with respect to when defense counsel must raise the issue of competence to proceed. Parts IV and V, on all other competency issues, are reorganized to differentiate more cleanly between competence to proceed and decisional competency and includes a new provision on competence to waive counsel; additionally, previous policy calling for trial of individuals who are unrestorably incompetent is revised to preclude trial and instead require release or hospitalization in a forensic facility. In Part VI, on the mental nonresponsibility [insanity] defense and related doctrines, commentary reflects the ABA's response to the Supreme Court's decision in Kahler v. Kansas permitting abolition of the insanity defense, and changes the standard of proof with respect to exculpation based on mental disability to preponderance of the evidence, from beyond a reasonable doubt. Part VII's provisions regarding commitment of individuals found mentally nonresponsible were substantially rewritten to reflect the rationale behind such commitment. Part VIII, on sentencing in non-capital cases, was reorganized and now includes provisions on competence to be sentenced and clearer direction on the division of decision-making responsibilities between counsel and client on appeal. Part IX, dealing with capital sentencing issues, is almost entirely new and establishes several exemptions from the death penalty for people with mental disability. Part X, dealing with prisoners with mental disability, was rewritten be consistent with the ABA Standards on Treatment of Prisoners.

2016, for publication as the Fourth Edition of Chapter Seven of the *ABA Standards for Criminal Justice*. The commentary to the Standards was revised in 2017 and again in 2024.

This chapter and its revised 93 black letter standards are divided into ten parts, for the most part organized to follow the route an individual would take from first police contact through release from incarceration. The coverage is as follows:

- Part I: The Criminal and Mental Health Systems: Professional Roles
- Part II: Law Enforcement and Custodial Roles
- Part III: Evaluations and Expert Testimony
- Part IV: Competence to Proceed
- Part V: Competence in Specific Contexts
- Part VI: Nonresponsibility for Crime (Insanity)
- Part VII: Commitment of Nonresponsibility Acquittees
- Part VIII: Sentencing and Post-Conviction in Non-Capital Cases
- Part IX: Sentencing and Post-Conviction in Capital Cases
- Part X: Sentenced Prisoners with Mental Disorder

The standards within this ten-part chapter are meant to provide guidance to judges, lawyers, correctional officials and mental health professionals about how to address issues that arise when people with mental disability become enmeshed in the criminal legal system. They may also be a valuable teaching resource for the legal and mental health professions. The hope is that, if followed, these Standards will enhance the reliability, fairness and humaneness of the criminal system's treatment of people with mental disorder and lead to better interprofessional communications in ways that can improve understanding and performance.

PART I: THE CRIMINAL AND MENTAL HEALTH SYSTEMS: PROFESSIONAL ROLES

INTRODUCTION

Persons with mental disorders are disproportionately represented in the criminal justice system. Studies suggest that anywhere from 16 to 24% of people in jails and prisons have a serious mental illness.[1] This rate is three to 12 times higher than the rate of serious mental disability in the community,[2] and at least three times higher than the population in psychiatric hospitals.[3] It also represents a vast increase over the incarceration rate of people with mental disability 30 years ago, when the first edition of these Standards was promulgated.[4] If mental disorder is defined more broadly, to include personality disorders, the percentages involved in the criminal system skyrocket to over 50%.[5]

Some scholars attribute the higher rates of people with mental disability in criminal justice settings to the failure of mental health systems to serve those in need. Before the 1960s, public mental health services in the United States were provided almost exclusively in large state hospitals. In 1955, these facilities held nearly 600,000 patients. Today there are fewer than 45,000 hospitalized individuals, over a 90% decrease.[6] The forces behind deinstitutionalization are well known: (i) the advent of effective medications (enabling many patients to be treated outside an institution); (ii) the Community Mental Health Act of 1963 (calling for services and programs in the community); (iii) civil rights reforms (including both lawsuits over poor institutional care and legislation to tighten civil commitment standards); (iv) changes in the funding of services, in particular those that incentivized states to use community resources (e.g., Medicaid's rule banning use of federal funds to finance services for adults in mental institutions); and (v) most recently, managed care,

[1] Nat'l Comm'n on Correctional Health Care: The Health Status of Soon-to-be-Released Inmates: A Report to Congress (2002); Doris J. James & Lauren E. Glaze, Mental Health Problems of Jail and Prison Inmates, Bureau of Justice Statistics Special Report (2006).
[2] Seth J. Prins, Prevalence of Mental Illnesses in U.S. Prisons: A Systematic Review, 65 Psychiat. Serv. 862 (2014).
[3] Sasha Abramsky & Jamie Fellner, Ill-Equipped: U.S. Prisons and Offenders with Mental Illness, U.S. Dep't Justice, Office of Justice Programs (2003), available at https://www.ojp.gov/ncjrs/virtual-library/abstracts/ill-equipped-us-prisons-and-offenders-mental-illness.
[4] Council of State Governments Justice Center (2013), cited in Seth J. Prins, Why Determine the Prevalence of Mental Illnesses in Jails and Prisons? 65 Psychiat. Serv. 1074 (2014).
[5] Council of State Governments Just. Cent., Mentally Ill Offender Treatment and Crime Reduction Act (2015), available at https://csgjusticecenter.org/publications/fact-sheet-the-mentally-ill-offender-treatment-and-crime-reduction-act.
[6] Ted Lutterman et al., Trends in Psychiatric Inpatient Capacity: United States and Each State, 1970 to 2014 (2017) (also stating that, if all 24-hour psychiatric hospitals were included, the number would rise to 170,000).

which often limits the duration of inpatient stays.[7] Unfortunately, as the locus of treatment has shifted from hospitals to the community, the development of community-based services has not kept pace. Some critics charge that deinstitutionalization, meant to move individuals to nursing homes and residential placements, has instead had the effect of "transinstitutionalizing" care to the criminal justice system.[8]

A second possible reason for the prevalence of people with mental disability in the criminal system is that they are more likely to commit crime. Serious mental illness, when defined to exclude personality disorders and focus on psychotic symptoms, is by itself probably not a significant contributor to offending. Recent research suggests that only about 10%-12% of persons in jail who have a serious mental illness were charged with offenses directly caused by their symptoms.[9] However, a large percentage of people with mental disability are homeless, unemployed, and prone to substance abuse, which can be risk factors for crime.[10] In addition, some research suggests that people with serious mental illnesses in the criminal system have higher rates of antisocial attitude or other antisocial traits, possibly a consequence of living in communities where their associates are disproportionately antisocial.[11]

Whatever the reason for the large number of people with mental disability in the criminal system, their presence has not gone unnoticed. In 2000, the Council of State Governments (CSG), in partnership with the National Association of State Mental Health Program Directors (NASMHPD), launched the National Mental Health/Criminal Justice Consensus Project. Two years and much study later, a comprehensive National Consensus Project Report was released.[12] Carefully crafted

[7] See Christopher Slobogin, Thomas Hafemeister & Douglas Mossman, Law and the Mental Health System: Civil and Criminal Aspects 816-818 (2020).
[8] Matt Ford, America's Largest Mental Hospital is Jail, Atlantic Monthly (Nov. 15, 2016); Ashley Primeau, Deinstitutionalization of the Mentally Ill: Evidence for Transinstitutionalization from Psychiatric Hospitals to Penal Institutions, 2 Comp. Psychol. 1 (2013); Fuller Torrey, The Treatment of Persons with Mental Illness in Prisons and Jails: A State Survey (2014).
[9] Seth J. Prins et al., Criminogenic Factors, Psychotic Symptoms, and Incident Arrests Among People with Serious Mental Illnesses under Intensive Outpatient Treatment, 39 L. & Hum. Behav. 177 (2015).
[10] U.S. Dep't of Housing & Urban Development, Homeless Populations and Subpopulations Reports, 2023 (estimating that roughly 25% of people without housing, over 135,000, are seriously mentally ill).
[11] See Kevin Douglas et al., AP-LS Scientific Paper, Major Mental Illness and Violent Behavior (2024) (concluding, based on a survey of decades of research, that "major mental illness" (MMI) elevates the odds of violence by roughly five times relative to members of the general population without MMI but that there is reasonably good evidence for potential explanations of this association, including interaction with substance-related problems; delusions with associated angry or negative affect or threatening content; adverse childhood events; and recent victimization or other recent adverse experiences). See also, Jennifer L. Skeem et al., Applicability of the Risk-Need-Responsivity Model to Persons With Mental Illness Involved in the Criminal Justice System, 66 Psychiatric Services, 916 (2015); David A. Amora, Mai P. Tran & Fred C. Osher, in Achieving Positive Outcomes for Justice-Involved People with Behavioural Disorders 77, in Care of the Mentally Disordered Offender in the Community (Alec Buchanan & Lisa Wooton eds., 2017).
[12] See Nat'l Ass'n State Mental Health Program Dirs., National Consensus Project Report, available at https://csgjusticecenter.org/publications/the-consensus-project-report/.

to address not only mental health officials but also law enforcement agencies, correctional authorities, judges, and lawmakers, the report provided a blueprint for behavioral health services reform. Since release of the report, the CSG has continued its work on these issues, establishing the CSG Justice Center, which collects and disseminates information about effective programs and services. Other organizations have been active in this area as well, notably the GAINS Center for Behavioral Health and Justice Transformation.[13] With support from the federal Substance Abuse and Mental Health Services Administration (SAMHSA), GAINS has promoted (and, through its active technical assistance arm, helped establish) the development of diversion programs, in jail and in the community, across the country. Partly as a result of these efforts, the Mentally Ill Offender Treatment and Crime Reduction Act was enacted in 2004. Re-authorized periodically since then (although not always fully funded),[14] the Act has supported a variety of efforts to bring services to people involved with or at risk of involvement with the criminal justice system.

Another significant developed was the introduction, in 2006, of the "sequential intercept" model of programming services by Mark Munetz and Patricia Griffin. This model seeks to identify and divert (intercept) people with mental disorders at every (sequential) stage of the criminal justice continuum.[15] SAMHSA, through the GAINS Center, has promoted implementation of the model in states throughout the country. It is now not uncommon for a state to have police departments with specially trained crisis intervention teams, diversion programs within local crisis response centers (as well as in jails), courts with special mental health dockets, and re-entry programs to help link offenders to services upon release from incarceration.

Providing adequate support in the community for persons with serious mental disorders is challenging, whether or not a person is involved with the justice system. Some consumers of services refuse the medications they are prescribed, either because of undesirable side-effects (sometimes including serious nerve disorders, drowsiness, weight gain, irritability, or suppressed libido) or because they do not recognize their need for the drugs. Furthermore, medication management is just one part of mental health care. For persons with the kinds of serious, chronic mental illnesses so often seen in criminal justice settings, not only medications but a full array of social supports, including housing, supported employment, and case management, must be available (although these supports too are sometimes rejected by consumers).

[13] See https://www.samhsa.gov/gains-center. GAINS is an acronym for Gather, Assess, Integrate, Network, and Stimulate.
[14] 34 U.S.C. § 10101 (2004).
[15] Mark R. Munetz & Patricia A. Griffin, Use of the Sequential Intercept Model as an Approach to Decriminalization of People with Serious Mental Illness, 57 Psychiatric Serv. 544 (2006).

For all of these reasons, the challenges for mental health systems, and for criminal justice authorities who rely on the services they provide, are enormous. Increasingly, the two systems are working collaboratively to address these challenges. Specialized, "problem solving" courts, some with a mental health focus ("mental health courts"), have proliferated in many states.[16] Rather than focus exclusively on narrow psycho-legal questions like trial competence or mental nonresponsibility, many lawyers and clinicians, in both traditional and specialized courts, are seeking to cast a broader net and address the full range of a defendant's needs, in the interest of "therapeutic justice."[17] Many of the standards in Part I reflect these developments, as do other recent ABA policies on diversion and holistic lawyering, which are also referenced in these Standards. More specifically, the standards in this part delineate the roles of mental health professionals, lawyers, and judges who deal with justice-involved individuals with mental problems, stress the importance of interdisciplinary cooperation, and emphasize the need to ensure that all parties are properly educated about mental disorder, its effects, alternative ways of dealing with it, and each other's competencies and ethical obligations.

Standard 7-1.1. Terminology

(a) Unless otherwise specified, these Standards adopt the definition of "mental disorder" found in the current Diagnostic and Statistical Manual of the American Psychiatric Association.[*] In the settings addressed by the Standards, mental disorder is most likely to encompass mental illnesses such as schizophrenia, bipolar disorder, and major depressive disorders; developmental disabilities that affect intellectual and adaptive functioning; and substance use disorders that develop from repeated and extensive abuse of drugs or alcohol or some combination thereof.

(b) "Mental health professional," as used in these Standards, includes psychiatrists, psychologists, social workers and psychiatric nurses and other clinicians with expertise in the evaluation and treatment of mental disorders.

(c) "Mental health evaluation," appearing throughout the Standards as "evaluation," means an evaluation by a mental health professional of an individual accused of, charged with, or convicted of a criminal offense or detained by the police for the purpose of assessing:

[16] Center for State Courts, Mental Health Courts (2022), https://csgjusticecenter.org/projects/mental-health-courts

[17] David Wexler, Therapeutic Jurisprudence and the Criminal Courts, 35 Wm. & Mary L. Rev. 279 (1993).

[*] The current edition of the American Psychiatric Association's Diagnostic & Statistical Manual (5th ed.—Text Revision, 2022), states that "a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behavior (e.g., political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual, as described above." Id. at 15.

(i) mental competence, as defined in (f),

(ii) mental state at the time of the offense as it relates to the mental nonresponsibility [insanity][**] defense and other criminal responsibility issues, including mitigation at sentencing,

(iii) risk for reoffending (referred to as "risk assessment" herein) or

(iv) treatment needs.

(d) "Mental health treatment," appearing throughout the Standards as "treatment," includes but is not limited to the appropriate use of psychotropic medications, habilitation services, assertive community treatment, supported employment, family psychoeducation, self-management, and integrated treatment for co-occurring mental disorder and substance abuse.

(e) "Mental health facility" refers to a facility designated for treatment of individuals with mental disorder, such as public and private mental and medical hospitals, community mental health centers, and crisis intervention units, but not including jails or prisons. A "forensic" mental health facility is a secure government facility reserved for individuals who have been charged with or convicted of crime.

(f) "Mental competence," appearing throughout the Standards as "competence," is defined in detail in Parts IV and V of these Standards, but at a minimum requires present understanding of the likely consequences of a particular course of action. A valid "assent" requires only this minimal level of competence, accompanied by an affirmative indication of agreement with a particular course of action, after an explanation of the likely consequences of the action.

[**] The Standards will use the term "mental nonresponsibility defense" to refer to the insanity defense, although, as occurs here, the term will occasionally be followed by [insanity] to remind the reader of the term's meaning and to distinguish it from other mental state defenses. Terms like "insanity" and "criminally insane" conjure up visions of beastlike derangement. However accurate that perception may have been when the words were applied to "mad" individuals centuries ago, to perpetuate it today when symptoms of mental affliction often can be eliminated entirely though medication and other modem treatments is both offensive and stigmatizing. Moreover, the word insanity has lost its legal flavor and has become almost a "lay diagnosis." Use of the phrase mental nonresponsibility avoids distorted connotations and forces a focus on the moral nature of the inquiry into whether a person should be exculpated for his or her acts. Accordingly, these Standards will use the latter term other than when insanity appears in quoted remarks or the context makes its use necessary.

Commentary

Standard 7-1 defines terms used throughout the Standards. It adopts the definition of "mental disorder" found in the current Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association, which encompasses mental illnesses, intellectual disabilities,[18] developmental disabilities, cognitive disorders, and substance use disorders. Rather than use the cumbersome terms "mentally ill or intellectually disabled," "mental health or intellectual disabilities professional," or "mental health treatment or habilitation services," as the original edition of these Standards did, this definition section combines all disorders under the rubric of "mental disorder" and similarly streamlines other terms used throughout the Standards.

Paragraph (b) recognizes that clinicians from a broad array of disciplines may qualify as mental health professionals under these Standards. Paragraph (c) makes clear that the term "evaluation" is intended to refer solely to mental health evaluations of individuals involved in the criminal justice system, whether to address a specific psycho-legal question, like trial competence, or to assess an individual's general treatment needs.

Paragraph (d) recognizes a variety of services that may qualify as "mental health treatment," reflecting the broad range of modalities available in most communities today. Paragraph (e) makes clear that the term "mental health facilities" is not limited to inpatient institutions but may include other, community-based programs, so long as these programs are not housed in correctional institutions. The section also recognizes that many states segregate justice-involved patients in special facilities, known as "forensic" facilities, that offer greater security and (typically) are staffed by mental health professionals with specialized training and experience in serving this population.

Paragraph (f) establishes the minimum requirements necessary for competence to participate and make decisions in the criminal system, and also defines the special notion of "assenting" to a course of action. Informed consent, which traditionally has required understanding and appreciation of the risks and benefits of the proposed action and of any alternatives, as well as the ability to give rational reasons for any subsequent decision, should be required when seeking acquiescence for courses of action that carry substantial risk for an individual. But in other situations, less may be at stake. In these Standards, information gathering from third parties [see standard 7-1.4(d)], assistance from police officers [standard 7-2.2(a)], voluntary treatment while in custody [standard 7-2.6(a)] and diversion

[18] The original edition of these Standards used the term "mental retardation," a term commonly used at that time to refer to the condition now known as "intellectual disability."

[standard 7-4.8(e)], may take place if the individual understands the likely consequences of the action (after hearing an explanation of such consequences) and "assents" by indicating agreement.

Standard 7-1.2. Responding to persons with mental disorders in the criminal justice system

(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 American Bar Association's Standards on Diversion.

(ii) Court systems should consider establishing special dockets for defendants with mental disorders.

(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.

Commentary

For most of its history, the American criminal system's primary response when faced with a defendant believed to have a mental disorder was to refer the defendant for an evaluation of the defendant's competence to stand trial (referred to

in these Standards as "competence to proceed," as defined in Part IV). If defense counsel had concerns about a client's mental condition at the time of the offense, they might also raise the insanity defense. But little attention was given to the defendant's broader mental health needs. Psychiatric treatment might have been available, to a limited extent, in some correctional settings, but rarely did treatment play the dominant role in disposition of a case.

In the last several decades, this narrow perspective has begun to change, as the prevalence of mental disorder in criminal justice settings has increased in many states and the limitations of traditional prosecution for helping this population have become apparent. New models have emerged for handling justice-involved individuals with mental disorders, each aimed at identifying these individuals at the earliest opportunity and, where appropriate, diverting them away from criminal prosecution to services and supports in the community.[19] Consistent with these developments, standard 7-1.2(a) recognizes that persons with mental disorders have special needs that often can be best addressed outside the criminal system. At the same time, as this standard indicates, diversion and other alternatives must reflect consideration of an individual's accountability for criminal conduct and concerns for public safety, just as they must respect the individual's civil liberties (including, in some cases, the individual's wish to reject special treatment).

Paragraph (b) identifies a number of alternatives to traditional criminal prosecution. Diversion out of the system, addressed in detail in the ABA's Diversion Standards,[20] is referenced in subparagraph (b)(i). Subparagraph (b)(ii) further recommends that court systems consider special dockets for defendants with mental disorders. As noted above, many jurisdictions have established specialty mental health courts that allow for diversion under court supervision in cases where unfettered diversion would be inappropriate. The success (and limitations) of these approaches has been well-documented.[21] The thrust of this standard is to recommend consideration of these various approaches, without specifying a particular arrangement. An example of one such arrangement is a proposal by a multi-disciplinary group of experts that identifies five possible dispositions for people with mental disorder charged with crime, only one of which involves the traditional prosecution process. The other four dispositions contemplate: voluntary treatment and dismissal of charges; transfer to civil court and possible outpatient treatment,

[19] See Munetz & Griffin, supra note 15.

[20] American Bar Association Criminal Justice Standards (Chapter 27), Diversion (2022), available at https://www.americanbar.org/groups/criminal_justice/standards/diversion-standards/ (hereafter Diversion Standards).

[21] Compare Christine M. Sarteschi, Michael G. Vaughn & Kevin Kim, Assessing the Effectiveness of Mental Health Courts: A Quantitative Review, 39 J. Crim. Justice 12 (2011) to Lea Johnston, Theorizing Mental Health Courts, 89 Wash. U. L. Rev. 519 (2012). As discussed further in the commentary to standard 7-1.5(c), the ABA Standards on Diversion recommend early diversion or pre-plea diversion rather than the type of post-plea diversion that often takes place in mental health court. Diversion Standards, supra note 20, standard 27-1.2(e).

with charges dismissed upon completion of treatment; transfer to a diversion program for low risk offenders; and continued criminal or specialty court supervision of outpatient treatment, but with charges dismissed upon completion of treatment. Under this scheme, the specific alternative chosen depends on the interaction of the following five factors: the nature of the crime, the degree of mental impairment, the degree of risk posed by the individual, the individual's treatment needs, and whether the individual is willing to undergo treatment voluntarily.[22]

Subparagraph (b)(iii) recommends that, in all of these contexts, criminal justice officials recognize the importance of cultural competency among mental health providers. These providers, and forensic evaluators as well, should understand the influence of culture, race, ethnicity, language, and trauma history on a subject's presentation and receptivity to services.[23] Without such understanding, intentions and demeanor can be misinterpreted and dispositions inadequately attuned to the individual's needs.

Finally, paragraph (c) calls for services to be available within both correctional facilities and mental health settings to facilitate evaluation for treatment during incarceration and planning for treatment upon release. The importance of re-entry planning is addressed more directly in standard 7-10.8.

Standard 7-1.3. Roles of mental health professionals in the criminal justice process

(a) Mental health professionals serve the administration of criminal justice by:

(i) Evaluating and offering legally relevant expert opinions and testimony about a particular person's past, present or future mental or emotional condition, capacities, functioning or behavior, and about the effects of interventions, treatments, services or supports on the person's condition, capacities, functioning or behavior (evaluative expert role);

(ii) Offering opinions and testimony, with or without an evaluation, within their respective areas of expertise concerning present scientific or

[22] The Equitas Project, Model Legal Processes to Support Clinical Intervention for Persons with Serious Mental Illness and Pathways to Care: A Roadmap for Coordinating Criminal Justice, Mental Health Care, and Civil Court Systems to Meet the Needs of Individuals and Society (August, 2022).

[23] Michael L. Perlin & Valeria McClain, "Where Souls are Forgotten": Cultural Competencies, Forensic Evaluations, and International Human Rights, 15 Psychol., Pub. Pol'y & L. 257 (2009) (stating that "[c]ultural competency is critical in criminal forensic evaluations.").

clinical knowledge that is relevant to a criminal case (scientific expert role);

(iii) Providing consultation about strategy to the prosecution or defense (consultative role);

(iv) Providing treatment for individuals charged with or convicted of crimes (treatment role).

(v) Providing consultation with the courts, the bar, correctional agencies, legislatures and other stakeholders aimed at establishing appropriate and effective responses to individuals with mental disorder who are involved in the criminal justice system (policy role).

Because these roles involve differing and sometimes conflicting obligations and functions, the nature and limitations of each should be clarified by mental health professionals, courts, attorneys, and criminal justice agencies. The professional's performance within these roles should be limited to the individual professional's area of expertise and, while responsive to legal obligations, should be consistent with that professional's ethical principles.

(b) ***Evaluative expert role*****. When evaluating the condition, capacities, functioning or behavior of a person involved in the criminal justice system, the professional, no matter by whom retained, has an obligation to make a thorough and impartial assessment based on sound evaluative methods and to reach an objective opinion on each specific matter referred for evaluation. The qualifications of a professional to serve as a court-appointed evaluator are set out in Standard 7-3.9(a). The qualifications of a professional to offer expert testimony about a person's mental or emotional condition, capacities, functioning or behavior are set out in Standard 7-3.9(b). Disclosure of information obtained during the evaluation is governed by limitations set forth in Standards 7-3.2, 7-3.4(b) & (c), and 7-3.7 and presentation of expert testimony is governed by Standard 7-3.11.**

(c) ***Scientific expert role*****. When offering expert opinions and testimony concerning scientific or clinical knowledge, the witness, no matter by whom retained, should function impartially within the professional's area of expertise. The qualifications of a witness to offer expert testimony on present scientific or clinical knowledge are established in Standard 7-3.9(c).**

(d) ***Consultative role*****. Mental health professionals serving as consultants to the prosecution or defense have the same obligations and**

immunities as any member of the prosecution or defense team, except as may be limited by law.

(e) *Treatment role*. When providing treatment for a person charged with or convicted of a crime, the obligations a mental health professional owes a patient and society derive primarily from those arising in the ordinary treatment relationship. Correctional and behavioral health agencies, facilities and programs should respect that professional relationship to the maximum extent consistent with public safety and sound institutional management. When establishing a therapeutic relationship, mental health professionals should advise the person of known limitations on the professional relationship arising from the person's involvement in the criminal process or placement in an institutional setting.

(f) *Policy role.* Mental health professionals have at their disposal a wealth of empirical and practical information about the nature of mental disorders, the methods of assessing the treatability of and the risk presented by people with mental disorder, the effectiveness of treatment programs, and the operation of the mental health system. This knowledge can help policymakers make informed judgments in enacting statutes, regulations and guidelines that will improve the criminal justice system's treatment of people with mental disorder. Mental health professionals should be encouraged to provide this information to the relevant stakeholders through testimony, contributions to the legal literature, formal and informal consultation, and other mechanisms.

(g) The prosecutor and defense counsel should respect the mental health professional's professional obligations, whatever role the professional is serving, and as early as possible ascertain how such obligations might affect the legal process. Attorneys should not attempt to compromise either a mental health professional's legal obligations (by, for instance, knowingly encouraging an expert to violate a statutory reporting requirement) or ethical obligations (by, for instance, knowingly providing misleading information to an evaluator, or refusing to pay an expert unless favorable conclusions are reached).

Commentary

Standard 7-1.3(a) identifies the roles that mental health professionals play in the criminal justice system. The most prominent function of mental health professionals is performing evaluations for the courts and lawyers. But mental health professionals may also play a scientific role, a consultative role, a treatment role, and a policy role. In fulfilling these roles, mental health professionals are bound by the ethics of their profession and their own personal ethical precepts, as well as by law.

The standard implores prosecutors and defense counsel to respect the professional's ethical and professional standards, whatever the role being served, and considers any attempt to compromise these standards or the professional's legal obligations potentially unprofessional conduct.

All mental health professionals, whether or not involved in the justice system, are governed by general ethical codes developed by discipline-based associations.[24] These codes have been developed and refined primarily to promote professionals acting in the best interests of individuals they serve. More recently, professional societies have developed specific guidelines for forensic practice.[25] While the subspecialties of forensic psychiatry and forensic psychology have developed separate guidelines, they endorse the same general ethical principles. For instance, each requires clinicians to practice within their scope of competence, to strive for objectivity, and to be honest when acting in scientific, evaluative, or consultative roles and, when they engage in treatment, to inform the recipient of services about the limits of confidentiality.

These guidelines leave considerable scope for mental health professionals to apply personal judgment. Most importantly, in deciding whether to participate in any of the specified roles, professionals will need to consider whether the tasks they are called on to perform fall within their professional expertise. For instance, a mental health professional who has competently conducted evaluations of mental state at the time of the offense may not be qualified to carry out risk assessments for sentencing purposes. Ethical difficulties can also arise for professionals serving in the criminal justice system if a third party asserts a competing claim on professional loyalty. For example, professionals may decide that the disclosures about treatment progress required by a court order so severely compromise the therapist-patient relationship that they are unwilling to function as treatment providers. A third ethical scenario arises when professionals choose not to participate in some cases due to personal values or ethics. For example, a mental health professional opposed to capital punishment as a matter of personal morality may refuse to conduct a forensic evaluation for sentencing purposes in a capital case. Or a professional may only agree to perform defense-initiated evaluations, in the belief that this practice accords with the ethical obligation to help and not to harm.

[24] See, e.g., American Psychiatric Association, The Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry (2013) (hereafter Principles of Medical Ethics); American Psychological Association, Ethical Principles of Psychologists and Code of Conduct (2017) (hereafter Ethical Principles of Psychologists).
[25] American Academy of Psychiatry and Law, Ethics Guidelines for the Forensic Assessment (2015) (hereafter AAPL Guidelines); American Psychological Association, Specialty Guidelines for Forensic Psychology (2013) (hereafter APA Guidelines).

The evolution of subspecialty guidelines is a significant development in the forensic field. These guidelines signal the growing expertise and professionalism of the mental health professionals involved in the criminal justice system.

Professionals as Evaluators

To the extent they address mental health professionals, most of these standards relate to their role as evaluators of a defendant's mental condition relevant to a legal issue. Paragraph 7-1.3(b) makes clear that, whether retained by the defense, the prosecution or the court, the evaluator must behave in a non-partisan manner, perform a thorough evaluation, and prepare an objective report. It is not unusual for a mental health professional who accepts an evaluation referral from an attorney to feel an obligation to formulate a professional opinion favorable to the referring attorney's case.[26] Paragraph (b) clarifies that evaluators should avoid being influenced in this manner. Further, no attorney, whether prosecutor or defense, should seek to influence an evaluator's data, reasoning, or conclusions (beyond seeking clarification of written material or correction of factual errors). Consistent with this view are standard 3-3.5 in the Prosecution Function Standards and standard 4-4.4 in the Defense Function Standards, both of which provide that prosecutors and defense counsel who engage an expert to formulate an opinion are to respect the expert's independence and avoid seeking to influence the expert's professional opinion on the subject matter of the evaluation.

The general stipulation that reports be thorough and objective is developed further at several points in these Standards. In particular, several standards in Part III are meant to assist evaluators in achieving the goal of impartiality. For instance, to ensure evaluators obtain the information they need, standards 7-3.4 and 7-3.5 provide that professionals should be informed in writing of the specific matters to be addressed and that they be provided the records and other information necessary for a thorough evaluation on each referred matter. To encourage a defendant's full cooperation, standard 7-3.2 precludes the prosecution's use of incriminating disclosures made during an evaluation as evidence of guilt, standard 7-3.7 precludes the prosecution from discovering evaluation reports containing self-incriminating information until the defense gives notice of its intent to place the defendant's mental state in issue, and standard 7-3.5 (through a cross-reference to standard 7-6.4) authorizes the court to exclude professional testimony in support of a defendant who has not cooperated with a prosecution-initiated evaluation on mental state at the time of the offense.

[26] See Marcus T. Boccaccini, David Marcus & Daniel C. Murray, Allegiance Effects in Clinical Psychology Research and Practice, in Psychological Science Under Scrutiny: Recent Challenges and Proposed Solutions ch. 16 (Scott Lilienfeld & Irwin D. Waldman eds., 2017).

In addition to seeking to remain objective in their reports and testimony, evaluators have ethical obligations toward the evaluee (who is not, and should not be called, a "patient"). They must explain to persons undergoing evaluation the nature of the evaluation process and the evaluator's role. This notice should include making clear that the goal of the evaluation is typically to address a legal issue, not benefit the subject by identifying or treating a mental health problem. The subject of evaluation should also be told that a treatment relationship is not being initiated and that the protections of confidentiality ordinarily accorded in a clinical relationship do not apply. For some individuals, the notion of mental health professionals as caregivers and the keeper of confidences may be deeply engrained. They may lose sight of the adverse legal implications of disclosures during the course of evaluation. Should this become evident, mental health professionals may find it necessary to continue to remind the defendant about the nature and purpose of the evaluation, and that the professional is working for the court or the lawyer, not the defendant.[27] This latter admonition is also important as a reminder to evaluators of their limited role in the evaluation setting. Mental health professionals need to remember that their training and experience in eliciting cooperation and trust is in tension with their ethical responsibilities to the subjects of forensic evaluations. [28]

As this discussion indicates, the focus of the forensic evaluation is usually much narrower that of an ordinary clinical assessment. The evaluator will usually be assessing an individual's past, present, or future mental state as it relates to a legal issue in dispute (such as mental state at the time of an offense in the past, competence to stand trial at present, or likelihood to commit violence in the future). Often, the individual's treatment needs are irrelevant. As compared to a clinical interview aimed solely at determining an individual treatment needs, a forensic evaluator is more neutral and detached toward the individual, more likely to consult third party sources and challenge the individual's account, and less likely to run batteries of medical or psychological tests.[29]

Nonetheless the forensic evaluation process still involves application of specialized knowledge and skills used in the clinical evaluation process. The forensic evaluator will (or at least should) always conduct an interview and a mental status examination. The interview will usually cover the onset and progression of symptoms; mental health history; developmental history; medical history, including medications prescribed; and substance use history, although the depth on inquiry on these issues might vary depending on, for instance, whether the legal issue is

[27] See Daniel Shuman, The Use of Empathy in Forensic Evaluations, 3 Ethics & Behav. 289 (1993).
[28] See generally, Graham D. Glancy, Sumeeta Chatterjee & Daniel Miller, Ethics, Empathy, and Detached Concern in Forensic Psychiatry, 49 J. Am. Acad. Psychiat. & L. 246 (2021); Stuart Greenberg & Daniel Shuman, Irreconcilable Conflict Between Therapeutic and Forensic Roles, 28 Prof. Psychol.: Res.& Prac. 50 (1997).
[29] See Gary Melton et al., Psychological Evaluations for the Courts: A Handbook for Mental Health Professionals and Lawyers 42-46 (4th ed. 2017).

competency, which focuses on discreet aspects of present functioning, or insanity or degree of risk, which usually requires a wide-ranging investigation. The mental status examination covers assessments of the individual's cognitive functioning, mood, range and intensity of emotion, thought process and content, presence of delusions, perceptual disturbances (such as hallucinations), speech, judgment, insight, and thoughts of harm to self or others. In rare cases, a physical examination may be necessary and psychological or neuropsychological testing, imaging studies and laboratory tests may be needed to supply additional information.[30] Often crucial is information about past mental and medical treatment and information from family or other third parties.[31] These and other aspects of the forensic evaluation process are detailed throughout these Standards.

Mental health professionals sometimes are asked to perform forensic evaluations on individuals with whom they have a current or past treatment relationship, especially if the region has few forensic mental health professionals. Legal professionals may also want such an evaluator in the belief that a prior treatment relationship lends credibility to the forensic opinion. Professional guidelines do not proscribe such evaluations; however, they do point out several problems related to mixing the therapeutic and clinical roles.[32] The therapeutic relationship may be harmed by the clinician's testimony when the clinician forms a forensic opinion that is adverse to the patient's interests, testifies about diagnoses or other opinions that may disturb the relationship, or reveals intimate information obtained during therapy. Taking on this dual role can also threaten the integrity of the forensic evaluation process. While many treating clinicians will have training or experience in performing forensic evaluations, they may find difficult remaining objective and formulating an opinion that answers the legal question when it may not help the treatment goals of their patient. Further, treating clinicians who have developed a relationship with the defendant as a patient may be reluctant to obtain information from third parties necessary to verify the defendant's account.

Professionals as Scientific Experts

Mental health professionals or behavioral scientists sometimes serve solely as experts on the state of the science (e.g., the usual symptoms of schizophrenia or the validity of risk assessments) rather than as an expert evaluator of a defendant; in other words they are providing general information relevant to the case, not

[30] Id. at 46-52 (discussing when special tests may be required).
[31] See Randy Otto, Christopher Slobogin & Stuart Greenberg, Legal and Ethical Issues in Accessing and Utilizing Third Party Information, in Forensic Psychology: Emerging Topics and Expanding Roles 190 (Alan M. Goldstein, 2007).
[32] See, e.g., AAPL Guidelines, supra note 25, Principle 4; APA Guidelines, supra note 25, §§ 7.01 to 7.03; Larry H. Strasburger, Thomas G. Gutheil & Archie Brodsky, On Wearing Two Hats: Role Conflict in Serving as Both Psychotherapist and Expert Witness, 154 Am. J. Psychiat.448 (1997).

individualized information about the defendant.[33] In this situation, paragraph (c) indicates that they are obligated to function impartially. Attorneys should ensure that their experts understand the legal purposes for which a scientific review is requested, that such reviews are to be conducted independently and in conformity with the ethical and professional standards of the evaluator's professional discipline, and that any opinions that may be provided in court must be objective.

Professionals as Consultants

Mental health professionals and behavioral scientists may also serve as consultants to the prosecution or defense. For instance, a professional may provide a review of the scientific or professional literature, assist at client interviews, assess client credibility, evaluate client ability to withstand cross-examination, provide information helpful in jury selection, and offer advice and suggest strategy and tactics on other issues important to the litigation. A consultant may also advise an attorney about the relative strengths and weaknesses of opinions offered by other professionals who have evaluated a defendant and may propose useful strategies for examining or cross examining these professionals when they testify.

Paragraph (d) recognizes that professionals serving as consultants function as agents of the attorneys who retain them. It stresses that consultants have duties identical to those imposed on other members of a prosecution or defense team. For example, a defense consultant assumes the same obligation as defense counsel under the ABA Model Rules of Professional Conduct to preserve client confidences except when disclosure is permitted by those rules.[34] Thus, the attorney-client privilege and the work-product doctrine govern consultants. Confidential communications to, and information obtained by, consultants and their professional opinions are not subject to discovery except as envisioned by other standards (see, in particular, standards 3-5.4 and 3-7.3 in the Standards on the Prosecution Function, dealing with the prosecutor's obligation to disclose evidence to the defense supporting innocence or mitigating the offense).

When only one expert can be afforded, the roles of consultant and evaluator/in-court testifier might need to be combined. Ideally, however, the consultant would be a separate individual from the evaluator. Although paragraph (d) reminds attorneys that personal value systems and professional standards governing mental health professionals and behavioral scientists are not to be compromised in the course of consultations, a consultant, as part of the lawyer's

[33] See John Monahan, Laurens Walker & Gregory Mitchell, The Limits of Social Framework Evidence, 8 Law, Probability and Risk 307, 309 (2007) (arguing that scientific expert witnesses "be precluded from linking general research findings to the facts of a case").
[34] See ABA Model Rules of Professional Conduct, Rule 1.6.

"team," is likely to see their primary goal to be helping that side win, and thus their objectivity may more easily be compromised.

Professionals as Treatment Providers

Many individuals who become involved in the criminal system will have a serious mental illness yet may not be actively engaged in treatment or have discontinued necessary treatment. Some will have acute psychotic symptoms, substance abuse disorders, or be at risk for withdrawal, conditions that could be life-threatening. Incarceration removes these individuals from the few social supports they have. They may find the adjustment to a custodial environment difficult and may become the target of other inmates or even correctional staff. Even more so than other inmates, they may find arrest and incarceration stressful and are at high risk for suicide, psychiatric decompensation and behavioral disturbances.[35]

Treatment providers have an obligation to provide health care, including mental health care to custodial inmates, whether in jail, prison or a forensic hospital, as well as to individuals diverted from the criminal system to the community. But in fulfilling this obligation, they face special challenges, which paragraph (e) seeks to ensure correctional authorities recognize. They need to be conversant with laws and rules relevant to the carceral environment, they may need specialized training and experience, and they may need to resist pressures from custodial authorities primarily concerned about security rather than treatment. They will also need to communicate effectively with community providers to establish or reestablish treatment regimens, to effectuate treatment plans for diversion or other types of community treatment, and to obtain information about inmates who are often reluctant to provide it. Discharge plans can be hard to craft because custodial periods are uncertain. Further, resources are often limited, and local laws can prevent or significantly limit medication over objection.[36]

When professionals function as either evaluators, scientific experts, or consultants, they are not involved in a therapeutic or habilitative relationship with defendants and their primary duty is to the court or the retaining attorney. In a purely treatment relationship, in contrast, a professional owes loyalty to the person undergoing treatment; the purpose is to serve the needs of the individual. Situated in a gray area between these two roles is the mental health professional who is involved in treatment in a forensic setting.

[35] See generally Doris J. James & Lauren E. Glaze, Mental Health Problems of Jail and Prison Inmates, Bur. Just. Stats. (2006).
[36] See generally Steven K. Hoge, Providing Transition and Outpatient Services to the Mentally Ill Released from Correctional Institutions, in Public Health Behind Bars: From Prisons to Communities 461 (Robert Greifinger, ed. 2007).

Paragraph (e) offers guidance to professionals who may experience conflicting loyalties when serving justice-involved individuals. In a treatment role, the professional's relationship with a defendant should be guided by (a) professionally-applicable ethical and legal standards, and (b) case-specific legal standards and relevant institutional policy. The most important difference between the traditional treatment role and the forensic treater is with respect to the confidentiality of patient or client communications. If the individual is in custody, for example, therapists may be required by their contract of employment to alert authorities to any plan the individual may have to escape. Additionally, if the individual is on probation, parole, or conditional release, special reporting requirements may apply (see also standard 7-3.2(b)(ii), regarding reporting imminent risk, standard 7-8.6, regarding treatment during probation, and standard 7-10.1, regarding treatment of prisoners). Paragraph (e) provides that the client be informed about these exceptions when the therapeutic relationship is established.

Mental Health Professionals in a Policy Role

Mental health professionals and their organizations possess a wealth of knowledge that can, as paragraph (f) indicates, "help policymakers make informed judgments in enacting statutes, regulations and guidelines that will improve the criminal justice system's treatment of people with mental disorder." Examples at the national level, from the American Psychiatric Association alone, include its task force reports on: *Jail and Prison Standards*, *The Use and Misuse of Psychiatric Testimony in the Legal System*, and *Outpatient Forensic Services*; its position papers on *Use of Jails to Hold Person without Criminal Charges Who are Awaiting Civil Psychiatric Beds*, on *Treatment of Substance Use Disorders in the Criminal Justice System*, and on *Competence Evaluation and Restoration Service and the Interface with the Criminal Justice and Mental Health Systems*, and its amicus briefs in important cases. The American Psychological Association has produced similar work; for example, two white papers it produced in 2023-2024 focused on mental illness and violence and risk factors for false confessions.[37] These efforts on the part of mental health professional organizations can be crucial sources of information about how the system affects people with mental disability and ways of improving how they are treated.

[37] American Psychology-Law Society, Scientific Review Paper, Major Mental Illness and Violence (April, 2024); AP-LS, Scientific Review Paper, "Police-Induced Confessions, 2.0: Risk Factors and Recommendations (July, 2023).

Standard 7-1.4. Roles of the attorney representing a defendant with a mental disorder

(a) Consistent with the ABA Resolution on Comprehensive Criminal Representation, attorneys who represent defendants with mental disorders should provide client-centered representation that is interdisciplinary in nature. These attorneys should be familiar with local providers and programs that offer mental health and related services to which clients might be referred in lieu of incarceration, in the interest of reducing the likelihood of further involvement with the criminal justice system.

(b) Attorneys who represent defendants with mental disorders should work particularly closely with their clients to ensure that the clients understand their options. Attorneys should 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.

(c) Attorneys who represent defendants with mental disorders should explore 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 charge, a claim in mitigation of sentence, or a negotiated disposition.

(d) Attorneys who represent defendants with mental disorders should seek relevant information from family members and other knowledgeable collateral sources. Attorneys should share information about their clients with family members and knowledgeable collateral sources only with their clients' assent, and in a way that does not compromise the attorney-client privilege.

(e) Attorneys who represent defendants in specialized courts should be familiar with and abide by the relevant provisions in the ABA Diversion Standards. Because a defendant may relinquish substantial rights in a specialized court, the attorney's role as counselor is particularly important in this setting.

Commentary

Standards 7-1.4 describes the role of defense counsel in cases involving defendants with mental disorders. Defense counsel are directed to provide interdisciplinary, client-centered representation in a manner consistent with ABA

Resolution 107C on Comprehensive Criminal Representation. That Resolution calls on defense counsel to: "(1) Establish and facilitate … linkages and collaborations with civil practitioners, civil legal services organizations, social service program providers and other non-lawyer professionals who can serve, or assist in serving, clients in criminal cases with civil legal and non-legal problems related to their criminal cases, including the hiring of such professionals as experts, or where infrastructure allows, as staff; [and] (2) … provide re-entry and reintegration services to clients in criminal cases including expungement, reestablishment of rights and certificates of reliefs of civil disabilities."[38] Thus, as stated in paragraph (a), counsel's role includes not only exploring all mental state questions that might be raised (as directed in paragraph (c)), but also becoming familiar with local mental health resources that might provide treatment alternatives to incarceration. Counsel should be active advocates for their client's treatment needs, whether the client is in custody, under supervision in the community, or diverted out of the system entirely.

Counsel may find that some of their clients with serious mental disorders are poor communicators. Some clients may have difficulty following the course of a conversation or sharing their thoughts in a logical, sequential fashion. Their thinking may be tangential or circumstantial. Other clients may be distrustful. Some may be suspicious of or paranoid about counsel. Others may simply have unrealistic expectations. Paragraph (b) instructs counsel to work closely with such clients to develop trust and establish dialogue. Building this type of relationship can be challenging. As one commentator observed, "The crushing caseloads, combined with the attorneys' lack of familiarity with mental illness and the increasing number of seriously mentally ill criminal defendants, cause some defense attorneys to brush aside or purposely ignore competency issues."[39]

The difficulties of working with a client with mental disability can be exacerbated if the client requires psychiatric hospitalization during the pretrial period, particularly if, as is often the case, the hospitals that serve justice-involved individuals are located far from the court of jurisdiction. Yet it is incumbent on counsel to find a way to meet with these clients, investigate their needs, and provide counsel. A number of jurisdictions have developed teleconferencing technologies that can facilitate client-attorney (and clinician-defendant) communications.[40] As suggested in the discussion of standard 1.3(d), concerning consultants, in cases where a client's communication difficulties raise concerns about the client's trial competence, a social worker or other mental health professional might be assigned to

[38] See Resolution 107C (Aug. 6-7, 2012), available at https://www.americanbar.org/content/dam/aba/directories/policy/annual-2012/2012-annual-107c.pdf.
[39] Joanmarie Ilaria Davoli, Physically Present Yet Mentally Absent, 48 U. Louisville L. Rev. 313, 321 (2009).
[40] But see Taylor Benniger et al., Virtual Justice? A National Study Analyzing the Transition to Remote Criminal Court 33, 108-11 (2012) (finding that many defense attorneys perceived that building relationships with their clients was more difficult over the Internet).

the case to facilitate communication, a measure which could possibly obviate an adjudication of incompetence and avoid the delay of restoration services.[41]

Defendants with serious mental disorders sometimes are poor record keepers and, combined with memory difficulties, may be unable to provide counsel with a complete or accurate picture of their psychiatric history. This history can be vitally important to the client's defense. Yet, attorneys may be hesitant to contact third parties out of concern they will violate the attorney-client privilege. Further, even if clients are willing to authorize counsel to reach out, counsel may be concerned that their clients lack full capacity to consent to such contact. Paragraph (d) addresses this conundrum by permitting counsel to proceed if the client "assents," meaning, under standard 7-1.1(f), that the client understands the request for information and does not object to it. Given the potential importance of the information third parties can share, its unavailability in the absence of client affirmance, and the fact that counsel can safeguard the information and protect against its misuse, this rule provides adequate protection of the client's interests. Furthermore, of course, family members and others who know a defendant may initiate the contact and provide information. In either case, the attorney should not divulge what is learned to others unless, again, the client assents.

As discussed earlier, specialized mental health and drug courts have been established in many states. Sometimes called problem-solving courts, these courts focus on the treatment needs of the defendant and aim to determine a disposition that serves those needs, consistent with public safety. In these settings, the roles of counsel tend to be less adversarial. Defendants may be encouraged to speak with mental health evaluators, who will share their findings with the court. Guilty pleas may be encouraged, without a full assessment of the client's competence (see standard 7-5.2). Case dispositions may require that clients participate in treatment programs and comply with program rules, including taking prescribed medications. The rationale is that clients can be required to relinquish some of their rights in exchange for avoiding jail or prison. This standard does not take a position on the advisability of these practices. However, in paragraph (e) they do dictate that attorneys who represent defendants in mental health courts and other problem-solving courts be familiar with the ways in which these courts are different and require attorneys to counsel their clients accordingly, including notifying them of the possibility that overall incarceration may increase if the treatment plan is not followed.[42] The standard also directs attorneys to the ABA's Diversion Standards, which address such specialized proceedings in detail.[43]

[41] See Paul R. Pace, Social Workers Key Players in Criminal Justice System, SocialWorkBlog.org. (2012), [https://perma.cc/Q66S-469T].
[42] See E. Lea Johnston & Conor P. Flynn, Mental Health Courts and Sentencing Disparities, 62 Vill. L. Rev. 685 (2017) (suggesting that the increased supervision associated with such courts leads to more incarceration).
[43] See standards 27-6.1 to 27.7.5.

Standard 7-1.5. Role of the judge and prosecutor in cases involving defendants with mental disorders

(a) Judges and prosecutors should consider treatment alternatives to incarceration for defendants with mental disorders that might reduce the likelihood of recidivism and enhance public safety.

(b) Courts and prosecutor offices should facilitate meetings among community organizations interested in assuring that services are provided to justice-involved persons with mental disorders, including local law enforcement agencies, correctional authorities, and the bench and bar, as well as treatment providers, representatives of the public mental health authority, professional organizations, and other community leaders and governmental officials.

(c) Courts and prosecutor offices that help create diversion programs or specialized courts should be guided by the ABA Standards on Diversion.

(d) When making charging or dispositional decisions about a defendant who has a mental disorder, judges and prosecutors should consider referring the defendant for treatment, either voluntarily or, if appropriate, pursuant to existing law relating to involuntary hospitalization or mandated outpatient treatment.

(e) In determining which defendants should be selected for participation in diversion programs or specialized courts and which forms of intervention to use, judges and prosecutors should, whenever possible, rely on evidence-based practices, including valid and reliable appraisals of relevant risk and treatment needs.

Commentary

Standard 7-1.5 describes the role of prosecutors and judges in cases involving defendants with mental disorders. Like defense attorneys, prosecutors and judges may know little about mental disorder and the systems in place to treat it. Prosecutors may assume defendants with mental disorders pose an unusually higher risk of harm to others and are thus poor candidates for diversion or for other community-based dispositions like probation. Judges may be impatient with these defendants, particularly if they see them in their courtrooms repeatedly and are provided no explanation of why mental disability may contribute to that problem.

In communities where the bench and bar have collaborated successfully with the mental health community, prosecutors and judges recognize the value of treatment alternatives to incarceration for defendants with mental disorders, as well as the potential these services have for reducing the likelihood of recidivism. But success requires much more than simply referring a defendant for treatment. The goals of the mental health system, which is focused on treatment, do not naturally synchronize with those of the criminal justice system, which must also be concerned with justice and public safety. In some jurisdictions mental health courts may be the answer. In others, better synchronization of the disparate systems involved, without creation of a separate court, may be the better path.

In either case, the judge's role includes facilitating meetings among community organizations interested in making services available for justice-involved persons with mental disorders, including not only mental health and criminal justice organizations but also housing authorities and other social services agencies. Mental health providers who participate should be accompanied by administrators within their systems and leaders from professional and consumer advocacy organizations. All of the different criminal justice agencies, including law enforcement, state and local corrections, and probation and parole authorities have a particularly large role to play, because system resource and service limitations need to be understood. Because the kinds of reforms that are discussed at these meetings may require interagency agreement or legislation, the standard also recommends that upper-level government officials from these agencies be included.

Judges are in a particularly good position to facilitate these meetings. Not only can they ensure that criminal justice agencies will participate, but their stature in the community (and, often, their political connectedness) tends to command the attention of public mental health officials. A large share of public mental health care today is devoted to justice-involved individuals.[44] If a judge wishes to meet and explore more fruitful ways to collaborate, mental health officials may well be eager to cooperate.

Paragraph (c) directs judges and prosecutors interested in developing diversion programs to be guided by the ABA Standards on Diversion. As defined there, " 'Diversion' refers to any opportunity for a person who meets established eligibility criteria to avoid arrest, to negate or reduce charges, to avoid a conviction,

[44] Because they are required to provide health care, correctional facilities in the United States are probably the largest provider of mental health services in the nation. Jennifer M. Reingle & Nadine M. Connell, Mental Health of Prisoners: Identifying Barriers to Mental Health Treatment and Medication Continuity, 104 Am. J. Pub. Health 2328 (2014) (a survey of over 18,000 prisoners finding that 26% had a diagnosed mental disorder, but only 18% of these individuals were receiving medication); Kenneth Adams & Joseph Ferrandino, Managing Mentally Ill Inmates in Prison, 35 Crim. Just. & Behav. 913 (2009) (reporting that "mentally ill inmates now comprise a substantial portion of the prison population").

or to reduce a sentence, by fulfilling a prescribed set of conditions, by agreeing to a referral to services, or by receiving assistance or release with no further criminal consequences."[45] While those standards recognize that diversion programs can be coercive and limit the state's leverage over participants, they conclude that these burdens may often be outweighed by their benefits to individual participants and the public.[46] Benefits to the individual include avoiding or reducing collateral consequences related to arrest, charges, conviction and sentencing, such as lost jobs, disrupted families, and the impact of incarceration on physical and mental health.[47] . Benefits to the public can include enhancements to public safety and the reduced overall costs that successful treatment can bring. To accomplish these goals, the Diversion Standards set out three "categories" of diversion, "Early Diversion, Pre-plea Diversion, and Post-plea Diversion,"[48] and provide that "diversion can occur at different intercept points."[49] This is an implicit recognition of the "sequential intercept" model mentioned in the introduction to these Standards,[50] a programming model that allows referral to services at any point in the criminal justice continuum, from first encounter with law enforcement to release from correctional confinement.

Standard 7-1.5(c) also recognizes that some courts will want to do more than promote diversion from traditional courts and instead establish specialty mental health courts for dealing with defendants with mental disorders. Some of these courts deal with individuals before they plead. Others are in essence "post-plea diversion programs" that dismiss or vacate the conviction, reduce charges or reduce the sentence if the person successfully completes the program. The Standards on Diversion favor the former type of court, reasoning that "[t]he post-plea diversion space does not deviate significantly from the traditional criminal system. As a result, these programs tend to build in features of the criminal system that are often contrary to the objectives of diversion, and which lead to significant collateral consequences."[51] Again, these Standards do not take a firm position on this debate, but rather, through paragraph (c), direct judges establishing diversion programs or specialized courts to be guided by the Diversion Standards and their provisions on specialized courts.

Standard 7-1.5 (d) anticipates that judges releasing defendants and prosecutors who dismiss charges will refer defendants believed to have a mental disorder for treatment, either voluntarily or, if appropriate, pursuant to existing laws relating to involuntary hospitalization or mandated outpatient treatment. As

[45] Diversion Standards, supra note 20, standard 27-1.2(a).
[46] Id., standard 27-1.1(c) & (d).
[47] Id. standard 27-1.1(a).
[48] Id. standard 27-1.1(b).
[49] Id. standard 27-1.3(f).
[50] Munetz and Griffin, supra note 15.
[51] Diversion Standards, supra note 20, standard 27-1.2(e).

indicated above, the specific disposition chosen may depend on the type of mental impairment, the risk posed, and willingness to undergo treatment voluntarily. In making these decisions, paragraph (e) counsels judges and prosecutors to rely on "evidence-based" means of assessing risks and treatment needs, meaning instruments or protocols that are based on valid research. More is said about evidence-based assessments in the commentary to standard 7-3.8, which discusses current knowledge and risk and needs assessments.

Standard 7-1.6. Joint professional obligations for improving the administration of justice in criminal cases involving individuals with mental disorders

(a) National, state, and local judicial, legal, and mental health agencies and professional organizations should work cooperatively to monitor the interdependent performance within the criminal process of their members and constituents, and to improve the overall quality of the administration of justice in criminal cases involving mental health issues, including the quality and availability of services for justice-involved individuals with treatment needs.

(b) Appropriate professional organizations and governmental agencies, including licensing and accreditation bodies, should establish programs and evidence-based practices, including peer review, for monitoring the performance of mental health professionals participating in the criminal process. Existing professional ethics boards and committees should develop specific criteria and special review procedures designed to address the ethical questions that may arise when mental health professionals participate in the criminal process.

(c) Appropriate professional, scientific, and governmental organizations should sponsor and disseminate the results of empirical research concerning:

(i) the validity and reliability of mental health evaluations employed in criminal cases;

(ii) the development of standardized protocols for conducting evaluations in criminal cases;

(iii) the application and practical effect of substantive rules and procedures in cases involving people with mental disorder;

(iv) the development of programs and services for individuals with mental health conditions, including diversion from arrest and prosecution to mental health treatment, treatment during periods of correctional confinement, and transition from correctional confinement to treatment post-release; and

(v) the quality and impact of participation by mental health professionals in the criminal process.

Commentary

Paragraph (a) of this standard recognizes that effectively monitoring professional conduct and enforcing relevant guidelines in the forensic setting requires a multi-level, interdisciplinary effort. The courts and the mental health professions cannot assure competent, ethical and legal professional forensic work unless they work together. Nor is it likely that a single national, state or local entity can accomplish the systemic changes discussed here on its own. Judicial, legal, and mental health agencies and organizations should work cooperatively to promote accountability of, improvements in, and expansions of services at all levels of government.

That being said, the thrust of paragraph (b) is that, when it comes to evaluating and monitoring the activities of their members, state licensing boards and professional mental health organizations have the primary responsibility. While courts and the legal profession obviously have obligations to ensure mental health professionals follow the law, professional ethics boards are the best entities for addressing the special ethical problems that arise when mental health professionals function as part of the criminal process. Professional organizations should also provide ongoing review of their members' professional competence and adherence to ethical standards.

Standard 7-1.6(c) recognizes that empirical research relating to activities of mental health professionals the criminal justice system is needed in each of the listed areas. Examples of this research can be found in a number of texts and treatises,[52] as well in the commentary to these Standards. But it is important to remember that researchers are constantly updating and revising empirical work.

[52] See, e.g., Melton et al., supra note 29; Thomas Grisso, Evaluating Competencies: Forensic Assessments and Instruments (2d ed. 2003); Kirk Heilbrun, Thomas Grisso & Alan Goldstein, Foundations of Forensic Mental Health Assessment (2008).

Standard 7-1.7. Education and training

(a) Interdisciplinary cooperation. Judicial, legal, and mental health professional associations, organizations, and institutions at national, state, and local levels should cooperate in promoting, designing, and offering basic and advanced education and training 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. Such programs should include a focus on developing strategies to facilitate diversion from the criminal justice system to the community mental health treatment system before and after arrest, adjudication, and conviction. Such education and training programs should be offered to audiences working in both the criminal justice and mental health systems, including judges, attorneys, mental health professionals, and to students and trainees within these disciplines.

(b) Lawyers.

(i) Law schools should provide the opportunity for students, as a part of their formal legal education, to become familiar with the issues raised in these Standards. In addition to the relevant law, these issues might include the nature and prevalence of mental disorder, methods of screening for and identification of individuals with mental disorders who are involved in the justice system, risk assessment, problem-solving strategies (including jail diversion programs and mental health courts), the role of mental health professionals in the justice system, and the essential elements of a comprehensive system of care.

(ii) Bar associations, law schools, and other organizations responsible for providing continuing legal education should develop and regularly conduct programs offering advanced instruction on the topics described in (b)(i), and should be tailored to local needs and resources. Prosecutors, public defenders, and other attorneys who specialize in, or regularly practice, criminal law should participate in these programs.

(c) Judges. Each jurisdiction's highest appellate tribunal or its judicial supervisory authority with responsibility for continuing judicial education should develop and regularly conduct education and training programs on the topics identified in (b)(i). Additionally, such programs should include strategies for presiding over judicial proceedings involving defendants or witnesses with mental disorders, methods of identifying and communicating with participants in the courtroom who have a mental disorder, and the role of judges in criminal

justice/mental health collaborations. Judges who preside over criminal proceedings should participate in these programs.

(d) Mental health professionals.

(i) Professional and graduate schools that train mental health professionals should afford the opportunity for students and trainees to become familiar with the issues concerning the participation of mental health professionals in the criminal process and the potential involvement of individuals with mental disorders in the criminal justice system.

(ii) These professional and graduate schools should also provide advanced instruction for students and trainees who desire to meet the minimum criteria established by Standard 7-3.9(a) for qualifying as court-appointed evaluators and by Standard 7-3.9(b) for qualifying as expert witnesses testifying about a person's mental condition.

(iii) Professional and graduate schools and other appropriate organizations, including governmental agencies having responsibility for continuing education for and licensure or certification of mental health professionals, should develop and regularly conduct programs offering instruction on the participation of such professionals in the criminal process designed to:

(A) enable those professionals to meet the minimum criteria established by Standard 7-3.9(a) for qualifying as court appointed evaluators and by Standard 7-3.9(b) for qualifying as expert witnesses testifying about a person's mental condition; and,

(B) inform all participants of developments in law and criminal practice, including problem-solving strategies such as diversion programs and mental health courts, in order to improve the competence of those who play scientific, evaluative, consultative, treatment, or policy-making roles in the criminal process. Mental health professionals who participate in the criminal process should enroll in these programs.

(e) These Standards should be included among the instructional materials used in all of the training described in this Standard. Judges, lawyers, mental health professionals and their professional organizations should disseminate these Standards widely to policy makers and others responsible for

improving services for individuals with mental disorders who are involved in the criminal justice system and to representatives of the media investigating matters concerning this population or the systems they populate.

Commentary

As with improvements and reform of the criminal justice mental health system, education and training is an interdisciplinary effort. Standard 7-1.7 addresses the importance of specialized training and on-going education for judges, lawyers, and mental health professionals. Consistent with the emphasis in earlier standards on diversion and specialty courts, paragraph (a) emphasizes the importance of providing education about alternatives to the criminal system in cases involving people with mental disorder. But many other types of education are necessary as well. Paragraphs (b), (c), and (d) all embody a two-tiered approach: (1) a basic educational component designed to familiarize students in each discipline with these issues; and (2) an advanced educational component for professionals who anticipate participation in criminal justice activities. Both tiers should apply to law school students, to students in psychiatry, psychology, social work and other clinical disciplines, and to judges and legal and clinical practitioners involved in professional continuing educational programs.

Beginning with those whose training is in the law, both judges and attorneys have ethical obligations to understand the proper roles of mental health professionals and the limits of their technical knowledge when they testify in legal proceedings. The ABA's Code of Judicial Conduct requires judges to maintain professional competence in the law.[53] Attorneys are required by the Model Rules of Professional Conduct to provide competent representation for their clients.[54] Yet in some settings, judges and lawyers have perhaps too commonly deferred to mental health professionals.[55] Because the law, not behavioral science, governs the resolution of issues concerning competence to stand trial, insanity and the like, and because the admissibility of evidence and proper procedure are clearly ultimately legal matters, judges and lawyers should not allow mental health professionals to exert undue influence on them through testimony exceeding the bounds of their expertise (see e.g., standard 7-6.6, limiting testimony about mental nonresponsibility). To avoid undue deference and accompanying ethical difficulties for mental health professionals, attorneys who appear in, and judges who preside over, criminal trials

[53] Code of Judicial Conduct, Canon 3A(1).
[54] Model Rules of Professional Conduct 1.1.
[55] For instance, "studies have repeatedly shown that judges agree with clinicians' competence opinions in more than 90% of cases." Melton et. al, supra note 29, at 130.

embracing issues of mental health should have education and training necessary to understand the relevant issues and the proper uses of expert testimony.[56]

Thus, law schools should provide their students with at least some opportunity to become familiar with cross-disciplinary issues. Similarly, bar associations, perhaps relying on law professors, should offer advanced instruction for attorneys specializing in criminal cases. The language of standard 7-1.7(b) does not purport to dictate law school curricula. But it does offer guidance for law schools desiring to offer advanced instruction in this field. Ideally, a curriculum should allow classroom exploration of all of the listed issues, from both a theoretical and practical standpoint.[57]

Professional ethical standards for the mental health professions also mandate interdisciplinary training. For example, the American Psychiatric Association has stated that "a psychiatrist who regularly practices outside his/her area of professional competence should be considered unethical."[58] The American Psychological Association has declared, "The maintenance of high standards of competence is a responsibility shared by all psychologists in the interest of the public and the profession as a whole."[59] Professional education and training on matters in which the professional intends to practice are prerequisites to competent professional performance.[60] Professionals participating in the criminal justice process require specialized forensic knowledge because "standard mental status evaluations, assessments as to presence of or absence of a psychotic disorder, or other such clinical psychiatric or psychological considerations do not translate readily into the specific legal concerns."[61] Professional schools and training programs should therefore provide specialized training to ensure that students and professionals acquire the requisite forensic knowledge.

Beyond these programs are specialized certification programs for forensic mental health professionals in psychiatry and psychology that are designed to ensure practitioners have the necessary legal, scientific and clinical knowledge to carry out

[56] See Richard Bonnie, Morality, Equality, and Expertise: Renegotiating the Relationship Between Psychiatry and the Criminal Law, 12 Bull. Am.Acad.Psychiat. & L. 5, 5-6 (1984) ("If judges and juries are confused or misled by expert testimony, this usually means there has been poor lawyering. If experts give conclusory testimony, encompassing so-called ultimate issues—and fail to explain the bases for their opinions—the fault lies with the bench and bar, not with the experts. If forensic evaluators do not have access to the same information and reach different opinions for this reason, the fault lies with the legal system, not with the experts.").
[57] See, e.g., Christopher Slobogin, Thomas Hafemeister & Douglas Mossman, Law and the Mental Health System, chapters 6 through 9 (7th ed. 2020).
[58] Principles of Medical Ethics, supra note 24, § 2, annot. 3.
[59] Ethical Principles of Psychologists, supra note 24, § 2.01(a).
[60] Id. at § 2.01(b); AAPL Guidelines, supra note 25, Principle 1.
[61] Saleem Shah, Legal and Mental Health Systems Interactions, 4 Int'l J. L. & Psychiat. 219, 249 (1981) (emphasis omitted).

effective forensic evaluations.[62] Such advanced training for mental health professionals desiring to qualify as court-appointed evaluators or expert witnesses should enable professionals to (1) understand the substantive, procedural, and evidence law doctrines bearing on the performance of evaluations or expert opinion testimony and (2) apply clinical skills relating to those legal doctrines. For example, advanced training programs for mental health professionals should include the following: a description of the judicial structure of the jurisdiction; basic elements of the adversary process and the roles of participants in that process; evaluation techniques; legal requirements governing written reports; the nature and limits of expert testimony; and coverage of other matters dealt with in Part III of this chapter.[63]

This standard also contemplates that, within both the legal and behavioral science disciplines, *continuing* professional educational programs should be offered. Programs of this nature should inform participants about new legal and practice developments, thus enhancing their level of professional competence. They should be available not only to criminal law practitioners and mental health professionals functioning within the criminal justice system but also judges of courts with criminal jurisdiction.

Finally, paragraph (e) recommends that these Criminal Justice Mental Health Standards be included among the instructional materials used for both lawyers and mental health professionals. Further, it provides that their professional organizations disseminate the Standards widely to policy makers and others responsible for improving services for justice-involved individuals with mental disorders and to representatives of the media covering this population or the systems in which they can be found.

[62] The American Board of Psychiatry and Neurology provides accreditation in forensic psychiatry, and the American Board of Forensic Psychology provides board certification as a forensic psychologist. See https://abfp.com.

[63] See standards 7-3.1 through 7-3.15 and commentary. Although the courses described in the commentary may be offered in a residency or advanced training program, they may also constitute part of a separate fellowship program. The Joint Committee on Accreditation of Fellowship Programs in Forensic Psychiatry has suggested guidelines for a post residency program in psychiatry. Standards for Fellowship Programs in Forensic Psychiatry, 10 Bull. Am. Acad. Psychiat. 285 (1982).

PART II. LAW ENFORCEMENT AND CUSTODIAL ROLES

INTRODUCTION

Police play an ill-defined and unenviable role in responding to public disturbances and other incidents involving persons with mental disorders. Unfortunately, police encounters with people experiencing mental difficulties can result in tragedy; nearly a quarter of the people killed by law enforcement officers had a mental disorder of some type.[1] Police reluctance or inability to deal with people with mental disorder stems from a number of factors: unclear laws and policies defining law enforcement officer responsibilities and authority in dealing with people who have mental difficulties; limited police understanding of mental disorder and how to respond to an individual experiencing a mental health crisis; inadequate community facilities and programs that can receive persons with mental disorders; cumbersome logistics that discourage seeking treatment for such individuals.

Correctional authorities may likewise be unsure how to manage persons with mental disorder in their custody. Their primary responsibility is security; they may not recognize their responsibility or authority to refer such an individual for treatment. Further, they must deal with the fact that mental disorder and incarceration are risk factors for suicide and other types of self-harm.[2] Correctional staff may not have the know-how or capacity to deal with this problem, either on-site or through diversion.

Part II focuses on the appropriate roles of police and custodial personnel in interacting with persons with mental disorders. Resources available to law enforcement and correctional agencies vary substantially from one community to another. Smaller jurisdictions, in particular, may be ill equipped to adopt all of the recommendations appearing here. The Standards reflect this fact, encouraging agencies to act as resources allow.

Given the many stages of the pre-adjudication process, an overview of this part will be useful. Standard 7-2.1 calls for specialized training for all officers and custodial personnel who may encounter an individual with a mental health emergency, the creation of memoranda of understanding between law enforcement agencies and local mental health authorities regarding available treatment services, and the development of policies and procedures to guide practice. Standard 7-2.2

[1] Hasan T. Arslan, Examining Police Interactions with the Mentally Ill in the United States, National Public Health Emergency Collection (Sept. 18, 2020), doi: 10.1007/978-3-030-61452-2_7.
[2] Leah Wang, Rise in Deaths in Jail Populations, Prison Policy Initiative, June 23, 2021) ("Suicide is the single leading cause of death for people in jails, accounting for almost 30% of deaths. Someone in jail is more than three times as likely to die from suicide as someone in the general U.S. population").

states that, when such an encounter occurs, police should first consider a voluntary disposition either to a facility or to family or friends. Standard 7-7.3 sets out the circumstances and the manner in which an officer may take persons with a mental disorder into custody and calls for law enforcement officials and local treatment authorities to develop guidelines and policies for their admission to a treatment facility. Standard 7-2.4 offers options for officers to follow when processing an individual with a mental disorder, distinguishing between those who are charged with a minor, non-violent offense and those charged with a more serious offense. It also cautions officers who interrogate detained suspects with mental disorders to be alert to their susceptibility to persuasion and confusion about their rights. Standard 7-2.5 calls for custodial personnel to ensure appropriate treatment for people with mental disability who are in their charge, including: screening of new detainees for symptoms of a mental disorder; providing them with treatment services at the jail or transferring them to a treatment facility (under the criteria and following the procedures prescribed in standard 7-2.6); and referring detainees who are not transferred to community-based services, as appropriate, upon their release from confinement. Standard 7-2.6 addresses criteria and procedures for obtaining voluntary and involuntary treatment of detainees within the detention facility or through transfer to a mental health facility. It also sets limits on the admissibility of information collected during an individual's evaluation or treatment. Standard 7-2.7 protects against unauthorized access to records concerning the evaluation or treatment of detainees with mental disorders.

Standard 7-2.1. Specialized training and crisis intervention strategies

(a) All law enforcement agencies and detention facilities should provide specialized training to their personnel to assist them in identifying and responding to emergency incidents involving persons with mental disorders. Qualified mental health professionals and consumers of mental health treatment and their families should be involved in curriculum preparation and training.

(b) As an adjunct to training, all law enforcement agencies should promulgate written policies detailing department procedures for intervening in emergency situations involving persons with mental disorders.

(c) Where resources allow, law enforcement agencies should establish specialized police response teams, consisting of officers who have been trained in responding to emergency situations involving individuals with mental disorders. Police dispatchers should be trained to alert these teams whenever a crisis develops requiring police response.

(d) Law enforcement agencies should develop memoranda of understanding with local mental health authorities regarding the availability of specialized police response teams, crisis beds, and other treatment services available for individuals the police encounter who require prompt referral for evaluation or treatment. These memoranda should specify convenient locations where an officer may transport an individual needing attention.

(e) All custodial personnel, whether civilian or sworn, as well as dispatchers and other personnel who are involved in interventions should receive training in identifying and responding to the symptoms and behaviors, including self-injurious behavior, associated with mental disorders. Emphasis should be placed on those symptoms and behaviors that arise or are aggravated by incarceration, particularly as they relate to suicide prevention. Explicit guidelines for responding to emergency situations, providing first aid, and preventing individuals from harming themselves should be published and made available to all facility personnel.

Commentary

Paragraph (a) recommends specialized training for personnel of law enforcement agencies and detention facilities to help them identify and respond to incidents involving persons with mental disorders. Notably, it calls for the involvement of mental health professionals, consumers of mental health services, and families of consumers in preparing and presenting the training materials. Training organizers have a variety of resources to tap in developing this training, including the National Alliance on Mental Health, SAMHSA's GAINS Center for Behavioral Health and Justice Transformation (operated by Policy Research Associates, Inc.), and the Council of State Governments' Justice Center, which offers "Law Enforcement-Mental Health Learning Sites" as a resource for agencies to tailor training models to their own distinct problems and circumstances.[3]

Paragraph (b) urges the development of written policies relating to emergency intervention in cases involving person with mental disorders. Such policies would both shape the training provided and inform other criminal justice officials and members of the public about appropriate police responses in emergencies. This recommendation is in line with the current movement toward

[3] See NAMI, Crisis Intervention Teams, available at https://www.nami.org/advocacy/crisis-intervention/crisis-intervention-team-cit-programs; https://www.samhsa.gov/gains-center (training and resource materials); CSG, Program Overview: Law Enforcement-Mental Health Learning Sites, available at https://bja.ojp.gov/library/publications/program-overview-law-enforcement-mental-health-learning-sites#:~:text=The%20Council%20of%20State%20Governments%20%28CSG%29%20Justice%20Center%2C,law%20enforcement%20and%20persons%20with%20mental%20health%20.

requiring police departments to develop written policies governing all of the ways police interact with the public.[4]

Paragraph (c) encourages law enforcement agencies to establish teams of officers with specialized training to respond to emergencies. In recent years, "crisis intervention teams" (CIT) have proliferated in law enforcement agencies throughout the country and abroad. The original CIT program was developed in 1988, in Memphis as a response to a police shooting of a man with a history of mental disorder and substance abuse.[5] By 2019, it was estimated that there were 2,700 CIT teams nationwide.[6] As the standard recognizes, a key component of CIT deployment is ensuring that dispatchers are trained to recognize when an individual appears to be experiencing a mental health crisis requiring a police response.

The goal of CIT programs is two-fold: to increase the safety of encounters between law enforcement officers and persons with mental disorders, and to promote diversion of the latter individuals to treatment services when appropriate. In addition to extensive training of officers and dispatchers, these programs require the establishment of convenient "drop-off" treatment facilities where officers may transport a candidate for diversion with minimal disruption.[7] Paragraph (d) anticipates this last component, calling for law enforcement to collaborate (and develop memoranda of understanding) with mental health authorities to identify crisis beds and other treatment services for individuals needing prompt attention. The models for crisis response vary from community to community and may reflect the availability and distribution of resources. For instance, many cities now operate crisis services consisting entirely of mental health professionals as first responders, unless officers need to be involved.[8] Thus, it is important that a community's plan for crisis response reflect careful collaboration between law enforcement and mental health authorities.

Paragraph (e) addresses the responsibility of custodial personnel to observe, report, and respond appropriately when a detainee exhibits signs or symptoms of mental disorder, including self-injurious and self-destructive behavior. It urges appropriate training for all custodial personnel, whether they are sworn officers or civilian employees. It also recommends special attention be paid to indications of

[4] See, e.g., American Law Institute, Principles of Policing, ALI Principles of Policing, § 1.05 (calling for written rules, policies and procedures to govern all aspects policing).
[5] The University of Memphis: Overview of CIT, available at, http://www.cit.memphis.edu/overview.php?page=1.
[6] Id., http://www.cit.memphis.edu/overview.php?page=7.
[7] Id., http://www.cit.memphis.edu/overview.php?page=3. See generally, Frank M. Webb, Criminal Justice and the Mentally Ill: Strange Bedfellows, 49 Tex. A & M. L. Rev.817, 824-842 (2017) (explaining why CIT training is necessary and describing its content).
[8] See CAHOOTS, Crisis Assistance Helping Out on the Streets, https://whitebirdclinic.org/cahoots; Esteban L. Hernandez, "Denver's STAR Program, Sending Mental Health Pros on Certain Calls Instead of Police Officers Is About to Get Bigger," Denverite, https://denverite.com/2021/08/30/denver-star-mental-health- police-program/.

suicidal or self-destructive tendencies that can be exacerbated by incarceration. Preventing suicide is a collaborative responsibility of a jail's administrative, custodial, and clinical staff.[9]

Standard 7-2.2. Preference for voluntary law enforcement disposition

(a) Department guidelines should authorize, but not require, law enforcement officers with appropriate training to provide assistance to any person with mental disorder who, in the officer's discretion, requires care and assents to such care. The guidelines should stress that even where involuntary detention is permitted under Standard 7-2.3 officers should seek a voluntary disposition whenever feasible and appropriate.

(b) Voluntary disposition may consist of referral to a mental health facility but may also involve alternatives to treatment, such as summoning the assistance of the person's friends or family.

Commentary

Paragraph (a) recommends the adoption of department guidelines that encourage law enforcement officers to assist anyone they believe needs care, *if* the person agrees to such care. On the premise that involuntary deprivations of liberty are to be avoided when possible, and also because treatment is likely to be more successful if it is sought,[10] the standard also adopts a presumption in favor of a voluntary disposition even when involuntary detention might be permissible by law. Note, however, that the standard only requires "assent," not fully informed consent, as a measure of voluntariness. As defined in standard 7-1.1(f), this term recognizes that some individuals, because of their mental disorder, may be unable to provide informed consent to treatment, yet be willing to accept an officer's offer of assistance without objection. As long as the individual understands what the officer is proposing, an assent adequately protects the rights of the individual and at the same time facilitates a therapeutic disposition.

Paragraph (b) is a reminder that a formal referral for treatment may not always be necessary. In many cases, family or friends are available who might assist

[9] Anasseril Daniel, Preventing Suicide in Prison: A Collaborative Responsibility of Administrative, Custodial and Clinical Staff, 34 J. Am. Acad. Psych. & L. 165 (2006); National Comm'n on Correctional Health Care, Suicide Prevention Resource Guide (2019), available at https://www.ncchc.org/new-suicide-prevention-resource-guide-for-corrections/.

[10] See Bruck Winick, Competency to Consent to Voluntary Hospitalization: A Therapeutic Jurisprudence Analysis of Zinermon v. Burch, 14 Int'l J.L. & Psychiat. 169, 191-198 (1991) (surveying cognition and social psychology literature suggesting that people who "feel personally committed" to a goal are more likely to achieve it).

the individual. They may often provide a less intrusive alternative to formal treatment.

Standard 7-2.3. Law enforcement detention of people with mental disorders for purposes of evaluation and treatment

(a) Authority for law enforcement officers to take people with mental disorders into custody for purposes of referral for evaluation or treatment should be statutorily defined and limited to circumstances in which an officer has probable cause to believe that the person has committed a criminal offense or meets criteria for emergency evaluation under applicable state law. Law enforcement agencies should promulgate written procedures to guide the exercise of this authority.

(b) Departmental guidelines should stipulate that when custodial disposition is appropriate under (a), police should:

(i) be appropriately trained in crisis intervention or utilize, whenever feasible, the services of mental health professionals to assist them in effecting custody of individuals with mental disorders in emergency situations, and

(ii) 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.

(c) Law enforcement officials and administrators of treatment facilities in each locality should cooperate in developing joint guidelines and policies regarding the admission of persons in police custody to mental health facilities for appropriate evaluation or treatment. These guidelines should be widely disseminated to law enforcement, mental health professionals, and mental health facility personnel. The guidelines should require law enforcement officials to notify administrators and other appropriate officials when facility officials decline to accept a person in police custody for evaluation or treatment.

(c) Law enforcement officials and administrators of treatment facilities should periodically conduct a joint review of such guidelines and policies to evaluate performance and effect operational changes and improvements.

Commentary

Standard 7-2.3 addresses circumstances in which a law enforcement officer is permitted to take an individual into custody for purposes of evaluation or treatment of a mental disorder. All states have a statute authorizing the involuntary hospitalization of persons with mental disorder to a psychiatric facility or, in some states, to mandatory treatment in the community. Most states' commitment laws provide for emergency custody, pending formal commitment proceedings, of persons believed to pose a significant risk of harm to self or others because of a mental disorder.[11] These statutes usually permit law enforcement officers, as well as family members and mental health professionals, to initiate such commitments.[12] Paragraph (a) recommends that every state provide law enforcement with this authority, by statute.

Paragraph (a) provides that states should authorize emergency custody of persons whom officers believe have a mental disorder and have committed a crime. Of course, with the exception of minor offenses which they have not personally observed, law enforcement officers generally have authority to take custody of persons they have probable cause to believe have committed a crime, usually even if they do not have a warrant. But the purpose of such custody is detention pending prosecution. Here, custody is for the purposes of referral for evaluation or treatment. The standard takes the position that probable cause to believe that an individual with a mental disorder has committed a crime is sufficient ground for emergency custody, pending proceedings for commitment. As paragraph (a) states, such authority requires statutory definition. Moreover, to guard against misuse, law enforcement agencies should produce written procedures that guide an officer's exercise of this authority, consistent with paragraphs (a) and (b).

One way to implement the provisions in this standard is to adopt a special commitment track for justice-involved individuals with mental disorder, designed to avoid entirely the individual's placement in jail. Stephen Hoge and Richard Bonnie have proposed such a commitment track, intended to expedite treatment for individuals with mental disorders who historically have languished in jails while awaiting trial or in forensic mental health facilities while being treated to restore their competence to proceed.[13] Under Hoge and Bonnie's proposal, a person taken into custody would not be evaluated for competency or prosecuted but instead be subject to commitment to a civil hospital targeted at treating their condition if: (i) the person has a serious mental disorder as defined by state law for traditional civil commitment; (ii) there is clear and convincing evidence that the person engaged in

[11] Leslie C. Hedman, et al., State Laws on Emergency Holds for Mental Health Stabilization, 67 Psychiat. Serv. 529, 530 (2016).
[12] Id. (noting that all jurisdictions permit police detention in emergency situations and 38 states explicitly authorize police to initiate "emergency holds" in the hospital).
[13] Steven K. Hoge & Richard J. Bonnie, Expedited Diversion of Criminal Defendants to Court-Ordered Treatment, 49 J. Am. Acad. Psych. & L. 1 (2021).

criminal conduct that was clinically related to a serious mental disorder; (iii) the person poses a significant likelihood of continued offending in the absence of treatment interventions; and (iv) there is a reasonable likelihood, based on expert evidence, that mental health treatment and accompanying community interventions and services will reduce the individual's risk of reoffending. The committing court would have the option of ordering placement in an inpatient facility or mandating treatment in the community.[14] Community treatment orders could include, as appropriate, assertive community treatment, residential services, day treatment, or other community services or supports. The order would also include estimates of the anticipated length of mandated treatment, not to exceed the period of the maximum sentence the person would have received if convicted of the offense charged (and thus, Hoge and Bonnie suggest, would not exceed six months for most misdemeanor charges, would be limited to three years for less serious felonies, and set at five years for violent felonies). Hoge and Bonnie proposed commitment scheme illustrates one way a jurisdiction might divert out of the criminal system a person taken into custody on criminal charges whose circumstances call for treatment rather than prosecution, and as such is consistent with the call for creation of diversion programs in standards 7-1.2 and 7-1.5.

Paragraph (b) requires that law enforcement agencies establish guidelines to protect against the abuse of persons taken into custody under paragraph (a). The standard recommends that these guidelines mandate that officers undergo specialized training in crisis intervention or, if that is not possible, require that mental health professionals be involved as first responders. Officers are cautioned to use no more force than necessary to effect custody, consistent with the safety of the person, themselves, and others. In line with this standard, some authors have called for detentions of people with mental disorder to be carried out by plainclothes officers in unmarked cars whenever possible, and for officers to avoid routine use of shackles and other restraints.[15] As noted earlier, other jurisdictions try to avoid law enforcement involvement entirely unless the situation calls for armed force. In Eugene, Oregon, a team of professionals and former patients respond to about 20% of all dispatcher calls and call in the police in less than 1% of those cases.[16]

[14] About 32 states also permit commitment, usually on an outpatient basis, on a predicted deterioration standard that does not require proof of imminent danger but rather proof that the person is incompetent to make treatment decisions and likely to become imminently dangerous if not treated. See Rachel A. Scherer, Toward a Twenty-First Century Civil Commitment Statute: A Legal, Medical, and Policy Analysis of Preventive Outpatient Treatment, 4 ind. Health L. Rev. 361, 405 (2007).

[15] Larry Fitch & Jeffrey Swanson, SAMSHA Report—Civil Commitment and the Mental Health Care Continuum: Historical Trends and Principles for Law and Practice 33 (2019), available at https://www.samhsa.gov/ebp-resource-center.

[16] Scottie Andrew, This Town of 170,000 Replaced Some Cops with Medics and Mental Health Professionals: It's Worked for Over 30 Years, CNN, https://cnn.it/3jmQmrr.

Paragraph (c) recommends that law enforcement officials and the administrators of treatment facilities in their service areas develop and widely disseminate to their personnel joint guidelines and policies for the admission of persons under police custody. The standard recognizes that if these agencies (with their differing and sometimes conflicting philosophies) are to work together effectively, there must be a shared understanding among all staff of the purpose of the process and the role each person is expected to play. Reflecting concern that some facility staff may resist admitting persons suspected of committing a crime, the standard also recommends that guidelines require officers to notify facility administrators and other officials who are entitled to receive confidential health information of any person in custody who is turned away from the facility, with the goal of discouraging unnecessary and harmful criminalization of people with mental disorder.

Because of the many system challenges, compounded by a paucity of resources in many communities, paragraph (d) provides that law enforcement officials and facility administrators periodically review their protocols and evaluate performance, making changes and improvements as indicated.

Standard 7-2.4. Custodial processing of persons with mental disorders by law enforcement officers

(a) When arrest of an individual with a mental disorder is based exclusively on minor non-violent criminal behavior, law enforcement officers should follow one of the following options:

(i) in cases where the law enforcement officer reasonably believes that the mental disorder did not contribute to the crime or is not serious, processing the person in the same manner as any other criminal suspect;

(ii) facilitating a voluntary disposition under Standard 7-2.2, or

(iii) immediately transporting the person to an appropriate facility for evaluation and treatment under Standard 7-2.3.

Disposition under (ii) and (iii) does not preclude prosecution.

(b) When a person has been arrested for a crime not covered by Standard 7-2.4(a), law enforcement officers should process the person in the same manner as any other criminal suspect notwithstanding the fact that the arresting officer has reasonable grounds for believing that the person's behavior meets statutory and departmental guideline requirements for emergency

detention for mental evaluation. In such cases, however, law enforcement officers should notify custodial personnel as required in 7-2.5 unless, in the officers' judgment, the need for mental health intervention is so urgent that the evaluation required in 7-2.5 would be insufficiently timely and immediate transfer to a mental health facility under 7-2.3(a) is necessary.

(c) Upon initial presentation to the mental health facility, detention facility, the prosecutor or the court, the arresting officer should reveal fully those facts which suggest that the arrestee has a mental disorder and is in need of evaluation or treatment and should document the relevant information for reference in future proceedings.

(d) Consistent with Standard 7-5.4, law enforcement officials who are considering interrogation of a detained person under this Standard 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.

Commentary

Standard 7-2.4 clarifies how officers should attend to the mental health needs of persons they arrest, either by facilitating a treatment disposition from the outset or by following the usual criminal justice process but alerting jail staff or other officials of their concerns. Paragraph (a) offers officers who have arrested an individual for a minor, non-violent offense three options for how to proceed: (1) they may arrange for a voluntary disposition, as provided in standard 7-2.2; (2) they may take the person to a facility for evaluation and treatment, possibly initiating a civil commitment proceeding, as provided in standard 7-2.3; or (3) they may process the person in the same manner as any other suspect. Option three, however, would be available only if the officer reasonably believed that the person's mental disorder was not serious or did not contribute to the crime, a difficult decision that police officers are rarely equipped to make; thus, normally, the officer would be obliged to pursue a treatment disposition. Note that, despite this preference for one of the two treatment options, paragraph (a) provides that individuals who have been arrested and referred for treatment in lieu of standard criminal justice processing still may be prosecuted.

Paragraph (b) addresses the initial processing of individuals arrested for more serious crimes. These individuals would be processed in the same manner as other criminal suspects, unless the arresting officer believes the need for a mental health intervention is so urgent that an immediate transfer to a mental health facility is necessary. In this instance, the officer would process the individual as provided in

standard 7-2.3(a), essentially initiating a civil commitment proceeding. If the individual is processed in the usual manner, paragraph (b) calls for the officer to notify custodial personnel as anticipated by standard 7-2.5(b). This notice would trigger further consideration of the individual's needs, including the possibility of treatment in the detention or holding facility or transfer to a mental health facility under procedures provided in standard 7-2.6.

Paragraph (c) requires officers who bring an arrested individual to a mental health facility, detention facility, prosecutor, or court to disclose all the facts supporting their belief that the person needs treatment. Although this initial notification may be oral in the interest of time, the standard provides that officers subsequently document the relevant information for possible use in subsequent proceedings. Other standards protect against use of this information in any way that might prejudice the interests of the individual in court.[17]

Paragraph (d) references standard 7-5.4, which provides in part that statements made to police by suspects who have a mental disorder may be inadmissible if they were rendered "involuntary" by the nature of police questioning or were made during the course of a custodial interrogation without a valid *Miranda* waiver. The standard alerts officers who would interrogate a suspect with mental disorder that the person's symptoms may make him or her more susceptible to persuasion and that official conduct that is acceptable in the usual case may, when the suspect is mentally disordered, constitute impermissible coercion or result in an invalid waiver of rights. Commentary to standard 7-5.4 addresses these issues in greater detail.

Standard 7-2.5. Obligations of custodial personnel to detainees

(a) Custodial personnel should ensure that treatment services are available to detainees. To this end, and pursuant to the provisions of Standard 7-2.1, training for all custodial personnel, and especially for personnel responsible for processing newly detained persons, should include instruction in the identifying persons with mental disorder.

(b) Custodial personnel should screen all detained individuals upon intake for symptoms or behaviors indicative of a mental disorder and, if such symptoms are observed, should promptly report those observations to the official in charge of detention at the holding facility. Such a report should also be made at any other time custodial personnel observe, or are told by the arresting officer about, a detainee whose conduct or demeanor is indicative of a

[17] See 7-2.6 (e), which cross-references to standard 7-3.2(a)'s prohibition on using information obtained during treatment for adjudication purposes except under limited circumstances.

mental disorder and whose behavior is self-injurious or is indicative of the possibility of suicide. Upon receiving such a report, the official in charge, after promptly confirming the need to do so, should summon a mental health professional to provide emergency evaluation and treatment, pursuant to Standard 7-2.6.

(i) Defense counsel should be notified of the evaluation results, whether the evaluation takes place before or after counsel's appointment. The court and the prosecutor should be notified of the fact of the evaluation and treatment, without reference to any findings or opinions resulting from the evaluation or treatment.

(ii) When the mental health professional determines that a confined person requires immediate evaluation or treatment not available in the holding or detention facility, the detainee should be transferred to a facility capable of providing such services in accordance with Standard 7-2.6.

(c) If treatment or transfer does not occur pursuant to Standard 7-2.6 and the person is subsequently discharged from custody, custodial personnel should arrange necessary referrals for mental health treatment and related services (including housing if necessary). If a detainee is believed to meet criteria for civil commitment, custodial officials should initiate proceedings for the detainee's commitment prior to discharge.

Commentary

Custodial authorities have a constitutional obligation to see that persons held in local detention facilities, like prisoners generally, receive adequate health care, including mental health treatment.[18] This duty is particularly important in this context, because sudden incarceration may exacerbate an individual's mental health symptoms and heighten the need for evaluation or treatment.[19] Paragraph (a) makes specific to this early stage of the criminal process the more general duty, reflected throughout these Standards, to attend to the mental health needs of justice-involved persons. To implement this duty, it recommends that all custodial personnel,

[18] See standard 7-10.2 in these Standards as well as the ABA Standards on Treatment of Prisoners, standard 23-1.2 and commentary. The National Commission on Correctional Health Care Standards, available at https://www.ncchc.org/mental-health-2/, and the American Psychiatric Association's Psychiatric Services in Correctional Facilities (3d ed. 2016), reflect many of the requirements in the standard.

[19] See E. Lea Johnson, Vulnerability and Just Desert: A Theory of Sentencing and Mental Illness, 103 J. Crim. L. & Criminol. 147, 158-183 (2013) (describing the many negative effects of incarceration on people with mental disability).

particularly those responsible for processing newly received prisoners, be provided instruction in identifying symptoms and behaviors indicative of mental disorder.

Paragraph (b) calls for a routine mental health screening of all detainees upon intake. If symptoms are observed, the standard calls for a report to the facility administrator, or other person in charge. A similar report should be made if custodial personnel subsequently observe or learn about conduct or demeanor indicative of mental disorder or suicidal tendencies. The standard also provides that the official receiving such a report has a duty to investigate and that, if the report appears justified, the official summon a mental health professional to evaluate the detainee and to provide treatment, if appropriate, in accordance with standard 7-2.6 (which deals with in-custody treatment). If the needed treatment is not available or cannot be provided effectively within the local detention facility, subparagraph (b)(ii) confirms the responsibility of facility administrators to transfer the individual to a facility capable of providing such services.

Subparagraph (b)(i) provides that defense counsel be notified of the results of any evaluation of the detainee. This information may suggest defense strategies related to the client's mental condition and, as explained in detail in the commentary to standard 7-2.6(c), may become crucial if counsel needs to represent the client should the facility propose treatment or transfer over the client's objections. More generally, defense attorney requires information about the client's needs because of the mandate under standard 7-1.4 that counsel take a holistic approach to representation.

Subparagraph (c) addresses the detention facility's responsibilities upon discharging a detainee who has been identified as having a mental disorder. Consistent with other standards in Chapter 7 (in particular, standard 7-10.8), as well as standard 23-8.9 of the Standards on the Treatment of Prisoners, the facility should arrange referrals for the individual to receive necessary services and support in the community, including housing. If custodial personnel believe the individual requires involuntary hospitalization, paragraph (c) requires that officials initiate commitment proceedings before discharging the individual.

Many jail detainees who are discharged with referrals for "aftercare" services in the community do not appear for their appointments. Accordingly, some communities arrange for providers to meet with detainees before their discharge and to facilitate the transition to community-based care. A few go so far as to provide a "warm handoff" that involves having a provider pick up the individual at the jail at

the time of discharge and transport them directly to services.[20] This type of re-entry procedure, if desired and feasible, should be made formal policy.

Standard 7-2.6. Treatment of detainees; voluntary and involuntary transfer; notice to counsel

(a) A detainee who in the opinion of a mental health professional who has evaluated the detainee assents, as defined in Standard 7-1.1(f) (i.e., understands the nature and purpose of a recommended treatment and agrees to such treatment), may be treated in the detention or holding facility or may be transferred to a treatment facility in conformity with the statutes or rules governing voluntary treatment and hospitalization. If treatment takes place in the detention or holding facility, custodial personnel should endeavor to maintain any treatment the detainee was receiving at the time of detention.

(b) If a detainee lacks the capacity to assent to recommended treatment or transfer to a treatment facility as defined in paragraph (a), treatment or transfer may be provided only if:

(i) a court has ordered treatment to restore the detainee's competence pursuant to Standard 7-4.10(b); or

(ii) a court or state law has authorized treatment or transfer; or

(iii) an administrative panel composed of the treating professional and another qualified treatment professional find that the detainee is experiencing extreme emotional distress or deterioration of functioning that requires immediate treatment in the detention or holding facility or in a treatment facility and that the proposed treatment is likely to stabilize the detainee's condition, is the least intrusive method of doing so, and is medically appropriate. When treatment is provided pursuant to this provision, the continued need for treatment beyond [15 days] should be subject to judicial review under procedures prescribed by statute.

(c) If a detainee who has the capacity to consent to treatment or transfer as defined in paragraph (a) refuses treatment or transfer, treatment or transfer may be provided only if a court has:

[20] See SAMHSA, Intercept 4--Reentry, available at https://www.samhsa.gov/criminal-juvenile-justice/sim-overview/intercept-4.

(i) ordered treatment to restore the detainee's competence pursuant to Standard 7-4.11(b); or

(ii) authorized treatment or transfer pursuant to the jurisdiction's civil commitment law.

(d) The director of the detention or holding facility should notify the detainee's attorney and the prosecuting attorney whenever the detainee is transferred to a mental health or medical facility; when possible, this notice should precede the decision to transfer.

(e) Information obtained during the course of the evaluations or treatment described in this Standard is admissible in subsequent criminal proceedings only as provided in Standard 7-3.2(a).

Commentary

As noted in the introduction to Part I, people with mental disorders are disproportionately represented in the nation's jails. It has been estimated that, at the time of admission to jail, fully 14.5% of men and 31% of women have a serious mental illness.[21] Although, consistent with the import of previous standards, some of these individuals will be diverted, many jail inmates will require treatment during their stay. Standard 7-2.6 provides procedures for providing this treatment.

The premise of this standard is that jails have a duty to attend to the serious mental health treatment needs of their inmates. To deny needed treatment may implicate the Eighth Amendment's prohibition against cruel and unusual punishment, at least for sentenced offenders who are in jail.[22] For pretrial detainees, denial of needed treatment may amount to punishment without due process, under the Fourteenth Amendment's due process clause.[23] While the jail's responsibility to provide needed treatment is generally not in dispute, there may be disagreement about the manner in which such treatment is provided. This standard distinguishes between detainees who are incapable of providing consent but who may be able to "assent" to treatment, detainees who are incapable of providing assent, and detainees who are capable of providing (or withholding) consent to treatment.

Paragraph (a) would allow detainees who assent to be treated voluntarily in the jail or to be transferred to an outside treatment facility. Under standard 7-1.1(f),

[21] Henry J. Steadman, et al., Prevalence of Mental Illness Among Jail Inmates, 60 Psychiatric Services 761 (2009).
[22] Estelle v Gamble, 429 U.S. 97 (1976); Bowring v. Godwin, 551 F.2d 44 (4th Cir., 1977).
[23] Bell v. Wolfish, 441 U.S. 520, 535 (1979).

"assent" in this circumstance would require that the detainee affirmatively agree to the treatment or transfer, with a "present understanding of the likely consequences" of the agreement, after having those consequences explained. Where the detainee not only has no objection to the treatment proposed but agrees to it, with an understanding of its likely consequences, proceeding with involuntary treatment would be undesirable and might even be counterproductive, as it may cast the detainee and the treatment providers as adversaries.

Under paragraph (b), detainees who are unable even to give assent may be subject to treatment or transfer in any of three ways. First, under (b)(i), if the individual has been found incompetent to proceed in the criminal case, the court may order treatment to restore the individual's competence, as provided in standard 7-4.10(b). Second, under (b)(ii), if a court or the law of the jurisdiction (e.g., the state's civil commitment law) authorizes the treatment, treatment may proceed. Third, under (b)(iii), the jail may develop and invoke an administrative process in which two treatment professionals—the professional who proposes the treatment or transfer, and another qualified professional—convene as an administrative panel and find: (1) that the detainee is experiencing extreme mental or emotional distress or deterioration of function that requires immediate treatment in the detention or holding facility or in a treatment facility; and (2) that the proposed treatment (i) is likely to stabilize the detainee's condition; (ii) is the least intrusive method of doing so; and (iii) is medically appropriate. Treatment ordered under this administrative procedure would require judicial review after 15 days; continued treatment would require a court order under procedures prescribed by statute.

The administrative process described in subparagraph (b)(iii) specifies fewer procedural protections than are typically found in laws for the involuntary treatment of prison inmates or for their transfer to a psychiatric hospital. In *Washington v. Harper*,[24] the U.S. Supreme Court approved an administrative procedure for determining that a prison inmate could be medicated over objection. And in *Vitek v. Jones*,[25] the Court approved an inmate's hospitalization by order of an administrative panel comprised of prison personnel. However, in each of the procedural regimes the Court considered in these two cases, the inmate was entitled to a hearing with notice and the right to appear, to present witnesses, and to cross examine witnesses in opposition. In addition, the Court held that the inmate is entitled to the assistance of a qualified and independent lay advisor, although not necessarily a lawyer. Nothing in subparagraph (b)(iii) would preclude a detention facility from according these additional procedural rights, but this standard does not require them in the narrow circumstance at issue here.

[24] 494 U.S. 210 (1990).
[25] 445 U.S. 480 (1980).

Under paragraph (c), detainees who have the capacity to consent to treatment but refuse it are accorded greater procedural protection than under either (a) or (b). They may be subject to treatment or transfer only if it is (i) ordered by the criminal court for purposes of restoring the detainee's competence to proceed, under standard 7-4.11(b), or (ii) authorized pursuant to civil commitment law. Civil commitment laws in every state accord a panoply of rights, including the right to counsel, the right to a hearing (with notice, etc.), and the right not to be committed unless the state proves committability by clear and convincing evidence.[26] Although, under *Vitek*, not all these rights are guaranteed in a proceeding to commit an incarcerated person, this standard assumes that if a detainee has the capacity to consent—understands the nature, risks, and benefits of the services proposed, and of any alternatives—he or she may have legitimate reasons for objecting and, thus, should be entitled to challenge the proposed treatment or transfer in a full civil commitment proceeding (unless, again, the treatment or transfer proposed is to restore the detainee's competence to proceed, as provided under Part IV).

Paragraph (d) calls for the detention facility director to notify the detainee's attorney and the prosecuting attorney whenever a detainee is transferred to a treatment facility. The standard expresses a preference for notice *prior* to the decision to transfer, which is particularly important if a detainee's counsel wishes to contest the transfer. Note that the standard makes no exception to the notice requirement for detainees who would prefer to keep this information private. Notice must be provided whether or not the detainee agrees.

Multiple reasons underlie this notice requirement. The earlier that defense counsel learns of the client's serious mental health needs, the sooner counsel may raise questions about the client's competence to proceed, avoiding subsequent delays. Additionally, counsel may be prompted to explore grounds for a mental nonresponsibility [insanity] defense or other defense based on the client's mental condition, a difficult task in every case but one made easier if the client's recollections and those of witnesses are accessed while fresh. Or counsel may wish to use the information underlying the jail's request for transfer to argue for diversion, or to make a case in mitigation at sentencing, if it occurs. Beyond these strategic concerns, counsel with an awareness of a client's mental condition may marshal the support of friends and family members to improve the client's morale and help make incarceration more bearable; moreover, if the client or the client's family has sufficient financial resources, counsel may be able to obtain private medical or mental health care superior to that available from the transfer facility.

The provision for notice to prosecuting authorities reflects, in part, the fact that they may provide legal representation for county or local governmental units like

[26] Fitch & Swanson, supra note 15, at 12-13.

sheriff's departments or municipal police departments that were involved in the initial arrest. The earlier they are advised about a detainee's proposed transfer, the better they can discharge their advisory, consultative, and representational functions as counsel to governmental units. In addition, early notice that a detainee has a serious mental condition may alert the prosecutor to information he or she has a duty to share, under these Standards and as a constitutional matter, due to its mitigating or exculpatory potential (e.g., statements of witnesses concerning the defendant's aberrant behavior at the time of the offense, which may support a claim of mental nonresponsibility or reduced responsibility).[27]

Finally, paragraph (e) provides a reminder that information obtained during the course of a pretrial evaluation or treatment under this standard may be admitted into evidence in a subsequent criminal proceeding against the defendant only in accordance with standard 7-3.2. In brief, that standard limits use of information to situations in which the defense opens the door by first using the evidence. That standard also provides for limited disclosure when a defendant threatens a third party.

Standard 7-2.7. Law enforcement and custodial records of contacts with persons with mental disorders

(a) Records of significant contacts with persons with mental disorders who are not charged with a crime should be filed separately from arrest records and should be subject to a high degree of confidentiality.

(b) Records of mental health treatment provided to the detainee should be maintained separately from other records pertaining to the detainee, and access to them should be limited to the professionals providing treatment, the detainee's attorney, and the detainee except as otherwise provided. Custodial personnel, including supervisory personnel, should not examine these records without prior authorization of the detainee or the detainee's attorney.

(c) Detainees' access to treatment records maintained by a detention facility should be governed by rules similar to those applicable to patient access to treatment records maintained by other health institutions.

Commentary

Under ethical standards rooted in the Roman Hippocratic Oath, physicians and other mental health professionals ordinarily must protect the confidentiality of information patients share with them in the course of the provider-patient

[27] Cf. Brady v. Maryland, 373 U.S. 83, 87 (1963) (requiring, as a matter of due process, that prosecutors disclose information material to the defense); also see standards 3-1.2, 3-3.11, and 3-5.6.

relationship. Most states have statutes that guarantee these protections, with exceptions provided in special circumstances.[28] Additionally, federal law enacted in 1996, the Health Insurance Portability and Accountability Act (HIPAA), includes privacy regulations that address the confidentiality of healthcare information in various settings and circumstances.[29] Whether police departments or jails are "covered entities" subject to HIPAA is not always clear and may depend, in part, on the extent to which these agencies provide health care and bill third parties electronically for the care they provide.[30] Nonetheless, these agencies are expected to treat the "protected health information" of people they encounter with a high degree of confidentiality, in keeping with national standards. The National Commission on Correctional Health Care's Standards for Health Services in Jails, for example, states that discussion of detainee-patient information and clinical encounters should be conducted in private and "carried out in a manner designed to encourage the patient's subsequent use of health services."[31]

Standard 7-2.7 applies these principles to two forms of criminal justice agency records: (1) records relating to significant contacts with persons with mental disorders who are not charged with crimes (paragraph (a)), and (2) records concerning mental health treatment provided to detainees (paragraphs (b) and (c)). In contrast, arrest records of people with mental disorders and other agency records governing their detention are not subject to special regulation under this standard.

Because persons who come into contact with law enforcement officers but are not arrested are not under criminal justice jurisdiction, police agencies have no ground to keep information about the contact among the records they maintain on persons who have been arrested. Paragraph (a) thus advises law enforcement agencies to separate the two categories of documents and maintain significant contact records under a high level of security. Although the standard does not delineate access control rules, an appropriate analogy may be regulations governing access to ordinary medical records governing access to the records of civil patients.

Paragraphs (b) and (c) relate to even more sensitive records, those pertaining to mental health treatment provided to detainees charged with crimes. Paragraph (b) envisions only four classes of persons who should be allowed access to these records:

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[28] See, e.g., Maryland's Medical Records Act, Md Code Ann., §§ 4-301--4-309, 8-601.
[29] 42 U.S.C. § 1320d et. seq.
[30] See 45 C.F.R. § 164.512 (providing exceptions to HIPAA's requirements when disclosures are "required by law" (e.g.., a court-issued subpoena), when necessary to assist in criminal investigation or when the person is confined to psychiatric institution for correctional reasons or "under a mandate from the criminal justice system").
[31] See National Commission on Correctional Health Care, Standards for Health Services in Jails 15-16 (2008). The American Public Health Association (APHA) has also addressed the confidentiality of prisoners' health information, stating that "[p]risoner-patients should be provided the same privacy of healthcare information as patients in the community." APHA Task Force on Correctional Health Care Standards, Standards for Health Services in Correctional Institutions 7 (2003).

(i) the mental health professionals who provide the treatment; (ii) the detainee's attorney; (iii) the detainee, subject (under paragraph (c)) to the jurisdiction's and federal statutes and regulations governing access to treatment records by patients in public mental health institutions; and (iv) detention facility administrators and custodial personnel, provided they receive advance authorization from either the detainee to whom the file relates or the detainee's counsel.

PART III. EVALUATIONS AND EXPERT TESTIMONY

Introduction

The standards in Part I identified the roles and responsibilities of mental health professionals in the criminal process. This part articulates more specifically the general principles governing mental health professional activity of two sorts: evaluation of mental condition and expert testimony. The manner in which these general principles apply to pretrial, trial and sentencing issues are addressed in subsequent parts.

The standards in this part have several objectives. One is an assurance that mental health professionals perform thorough and competent evaluations consistent with the rights of defendants undergoing examination. A second is a delineation of the roles and functions of mental health professionals, lawyers, and judges in assuring that evaluators and witnesses exercise professional expertise appropriately. A third is promotion of a balance between prosecution and defense interests and concerns.

Standards 7-3.1 provides a roadmap of the types of evaluations mental health professionals perform for the criminal legal system and when they may occur. Standard 7-3.2 establishes limits on the admissibility and disclosure of information obtained during pretrial evaluations, consistent with constitutional mandates. Standard 7-3.3 recognizes the need for expert assistance for defense attorneys. Standard 7-3.4 requires that attorneys provide relevant information to evaluators and standard 7-3.5 requires that they inform evaluators of the legal and factual issues to be addressed, the rules governing disclosure, and the applicable evidentiary privileges. The latter standard also recommends that attorneys not be present during state-arranged evaluations (except competency evaluations when the presence of the defense attorney could enhance evaluation of client-attorney interaction) and that recordings be made, whenever feasible, of all evaluations initiated by the prosecution or the court.

Standard 7-3.6 requires that mental health professionals prepare complete a written report for every type of forensic evaluation except when they are retained by defense counsel and counsel does not plan to call the professional as an expert witness. The standard also details the contents of evaluation reports. Standard 7-3.7 addresses the discovery of written reports, generally requiring the defense to provide the prosecution with a written report from any evaluator whom the defense intends to call as an expert and for the prosecution to provide not only its evaluators' reports

but any other information it has bearing on the issues addressed by the defense expert.

Standards 7-3.8 through 7-3.12 cover expert testimony by mental health professionals. Standard 7-3.8 conditions the admissibility of expert testimony on a showing that it is based on specialized knowledge and will assist the trier of fact. The standard also recommends that experts avoid unilaterally addressing the ultimate legal issue and that, in the event the court asks them to address it (or any other issue requiring a moral or social value judgment), they explain the boundaries of their expertise and the limitations of their opinion. Standard 7-3.9 requires that evaluators have sufficient education and clinical training as well as sufficient forensic knowledge and standard 7-3.10 specifies the minimum qualifications for professionals who serve as experts. Standard 7-3.11 covers the presentation of expert trial testimony and the use of hearsay evidence by experts and expresses a preference that mental health professionals explain the bases for and reasoning behind their expert opinions whenever legally permissible. Standard 7-3.12 identifies the judge's role in instructing juries concerning mental health experts' testimony, which includes clarifying for juries the purpose of such testimony, the weight to be accorded expert opinions, and the jury's function in arriving at a result concerning the issues in a case.

Standard 7-3.1. Authority to obtain mental health evaluations

(a) Pre-trial evaluations; when permitted.

(i) Law enforcement and prosecution authorities may not seek or obtain a mental health evaluation, as defined in Standard 7-1.1(c), unless the subject of the evaluation has been taken into custody or arrested.

(ii) Law enforcement and prosecution authorities may seek and obtain a pretrial evaluation of an individual who has been taken into custody or arrested only under the circumstances referenced in (b), (c), (d) and (e)(i) & (ii) below, or if authorized by the individual's attorney.

(b) Evaluations to determine whether treatment is warranted for individuals who have been taken into custody or arrested are governed by Standards 7.2-3 through 7.2-7.

(c) Evaluations of a defendant's competence to proceed are governed by parts IV and V of this chapter.

(d) Evaluations of a defendant's mental condition at the time of the alleged crime:

(i) Defense-initiated evaluations are governed by Standard 7-6.4(a).

(ii) Prosecution-initiated evaluations are governed by Standard 7-6.4(b).

(e) Evaluations on dispositional issues:

(i) Evaluations of individuals found not guilty by reason of mental nonresponsibility [insanity] are governed by Standard 7-7.2.

(ii) Presentence evaluations of defendants convicted of non-capital crimes are governed by Standards 7-8.1 and 7-8.3.

(iii) Presentence evaluations of defendants charged with or convicted of capital crimes are governed by Standards 7-9.3.

(iv) Evaluations of prisoners being considered for voluntary or involuntary transfer to treatment facilities are governed respectively by Standards 7-10.2 and 7-10.3.

Commentary

Ordinarily mental health evaluations of persons involved in the criminal justice system are triggered by defense counsel, with state- or court-initiated evaluations taking place only in response to defense motions. Sometimes, however, law enforcement seeks an evaluation to determine whether an individual who appears to be experiencing a mental health crisis should be diverted to mental health treatment, or prosecutors or courts seek an evaluation of competency to proceed independently of, and perhaps contrary to, defense preferences. To protect Fifth Amendment, liberty, and privacy interests, standard 7-3.1(a)(i) makes clear that no evaluation should be initiated by law enforcement or by the prosecution unless the subject of the evaluation has been taken into custody or arrested. Once an individual is in custody or under arrest, subparagraph (a)(ii) permits a pretrial or dispositional evaluation at the request of law enforcement or the prosecution only under the circumstances referenced in paragraphs (b) through (e), which also list the standards governing defense-initiated evaluations. Paragraph (b) identifies the standards relevant to evaluations on need for treatment while in custody or in lieu of custody, paragraph (c) the standards regarding evaluations on competence to proceed,

paragraph (d) the standards on evaluations of mental condition at the time of the alleged offense, and paragraph (e) the standards governing evaluations on dispositional issues. Each of these standards specify the circumstances under which an evaluation may be initiated and how its results may be used.

Standard 7-3.2. Uses of disclosures or opinions derived from pretrial evaluations or treatment

(a) Admissibility of disclosure or opinions in criminal proceedings. No statement made by or information obtained from a person, or evidence derived from such statement or information during the course of any pretrial evaluation or treatment described in 7-3.1, and no opinion of a mental health professional based on such statement, information, or evidence is admissible in any criminal proceeding in which that person is a defendant unless it is otherwise admissible and:

(i) it relates solely to the defendant's present competency to proceed and the use of such disclosure or opinion conforms to the requirements of Standard 7-4.7; or,

(ii) it is relevant to an issue raised by the defendant concerning the defendant's mental condition and the defendant introduces or intends to introduce the testimony of a mental health professional to support the defense claim on this issue.

(b) Duty of evaluator to disclose information concerning defendant's present mental condition that was not the subject of the evaluation.

(i) If, in the course of any evaluation, the evaluator concludes that the defendant may be incompetent to proceed, the evaluator should notify the defendant's attorney and, if the evaluation was initiated by the court or prosecution, should also notify the court and prosecution.

(ii) If in the course of any evaluation, the evaluator concludes that the defendant presents an imminent risk of serious danger to him or herself or to another person or otherwise needs emergency intervention, the evaluator should take appropriate precautionary measures in accordance with applicable professional standards and statutory reporting requirements.

Commentary

Standard 7-3.2 protects against the misuse of disclosures made by persons subjected to mental evaluations. It provides that such disclosures and any expert opinions based on them are admissible only in criminal proceedings that address current mental competency or that address a past or future mental condition that the defendant has raised and supported with professional testimony. The standard also clarifies the duty of mental health professionals conducting forensic evaluations (as opposed to treating professionals) to disclose information about a defendant's mental condition that was not the subject of the evaluation.

Admissibility of Disclosures or Opinions

Standard (a)(i)'s provision allowing information obtained during a pretrial evaluation to be disclosed in connection with determining the defendant's competence is grounded on two rationales. First, as the Supreme Court recognized in *Estelle v. Smith*,[1] the Fifth Amendment only protects against the use of self-incriminating information to convict or enhance a sentence. A competency hearing addresses neither guilt nor punishment; it focuses solely on whether the defendant is fit to stand trial or plead. Second, the state has an overriding interest in reaching an accurate determination of whether a defendant is competent. As Part IV makes clear, the defendant has both a due process and a Sixth Amendment right to be tried only while competent. But even if the defendant were to waive the right be tried while competent, the government has an obligation to ensure a reliable, dignified proceeding. The practical consequence of this analysis is that mental health professionals retained by the court and the prosecution can evaluate a defendant's competence without restrictions on the types of questions they may ask (as long as the questions are focused on determining competency), thus assuring a full exploration of the issue without infringing the constitutional right to remain silent. Indeed, evaluators who are limited to examining competency issues need not give the defendant *Miranda* warnings or their equivalent.[2] However, as provided in standard 7-3.5(b), evaluators *should* alert defendants to the nature of the evaluation and how the results will be used—i.e., to address competence and nothing else, unless and until the defense decides to use the results for some other purpose.

[1] Estelle v. Smith, 451 U.S. 454, 462-463, 468 (1981) (holding that the Fifth Amendment applies not only to trial but also to capital sentencing proceedings, but also stating that "[i]f, upon being adequately warned, respondent had indicated that he would not answer [the state evaluator's] questions, the validly ordered competency examination nevertheless could have proceeded upon the condition that the results would be applied solely for that purpose.").

[2] See id. For elaboration of these points, see Christopher Slobogin, Estelle v. Smith: The Constitutional Contours of the Forensic Evaluation, 31 Emory L.J. 71, 87-114 (1982).

This latter point is captured in subparagraph (a)(ii), which restricts the admissibility of a defendant's disclosures during a pretrial mental health evaluation to issues the defense raises. As with subparagraph (a)(i), this standard reconciles competing defense and prosecution interests by prohibiting affirmative prosecution use of potentially incriminating information (such as proving the elements of the offense or any aggravating circumstances at a sentencing hearing), while promoting the easy availability of information and expert opinion on the defendant's mental condition for both defense and prosecution when it is relevant to an issue that is properly under consideration. It applies whether an evaluation was initiated by the defense, court or prosecution.[3]

The disclosure rule outlined in subparagraph (a)(ii) is also consistent with the law in most jurisdictions and probably constitutionally required. Courts generally have held that defendants who raise a mental state issue using psychiatric evidence waive the privilege against self-incrimination, but only with respect to mental evaluations and expert opinions bearing on that issue.[4] Thus, they conclude, if the defense has raised a particular mental condition issue, the state may obtain an evaluation on that issue, and professionals who evaluate defendants at the prosecution's request may testify about it, but not on unrelated issues. Similarly, the applicable federal rule provides that federal courts may order mental evaluations by government experts, but that the evidence thus obtained may only be admitted "on an issue respecting mental condition on which the defendant has introduced testimony."[5] Many state statutes or rules follow suit.[6] Further, some jurisdictions have enacted statutes requiring an instruction to juries cautioning them not to use such statements to infer guilt.[7]

The Supreme Court has held that the Constitution requires at least some version of these rules. In *Smith,* the U.S. Supreme Court concluded that if an expert's conclusions do not rest simply on observations of the defendant but rather on the defendant's personal accounts of the crime—including statements and omitted details—the Fifth Amendment privilege governs.[8] It then precluded the use of statements made during a prosecution-requested competency evaluation at Smith's capital sentencing proceeding, because Smith had not proffered any evidence from the competency evaluation or any other evaluation at that

[3] Note that standard 7-3.4(c) requires the defendant who raises a mental state claim to cooperate in a prosecution-initiated evaluation on that issue.
[4] Estelle v. Smith, 451 U.S. 454 (1981); United States v. Cohen, 530 F.2d 43 (5th Cir.), cert. denied, 429 U.S. 855 (1976); United States v. Albright, 388 F.2d 719 (4th Cir. 1968).
[5] Fed. R. Crim P. 12.2(c).
[6] See, e.g., Fla.R.Crim. Procc. 3.211(e); Colo. Rev. Stat. §16-8-107 (1.5a) (1978); Ill. Ann. Stat. ch. 725, §5/115-6; Mass. Gen. Laws. Ch. 233, §23B.
[7] See, e.g., Mo. Stat. Ann. §552.030(6).
[8] 451 U.S. at 464-465.

proceeding.[9] The *Smith* majority concluded: "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."[10]

However, this language also strongly implies that once a defendant has raised a mental condition issue and signaled an intent to introduce expert opinion evidence, the prosecution may present in rebuttal any otherwise admissible information from previous evaluations of the defendant's mental condition. In subsequent cases, the Court has held that *any* defense raised by the defense opens the door to use of previous psychiatric evaluation results, whether the initial evaluation was requested by the prosecution or the defense,[11] and even if the specific defense presented at trial (e.g., a voluntary intoxication defense) is not a psychiatric defense.[12] Paragraph (a)(ii)'s language limiting disclosure to matters "relevant to an issue raised by the defendant concerning the defendant's mental condition" is consistent with these rulings, but also indicates that the prosecution should be limited to rebutting the precise issue raised by the defense. Thus, for instance, if the defendant presents expert testimony on past mental state in support of mitigation at sentencing, the prosecution should be able to counter that evidence with its own expert testimony, whether it is based on a competency evaluation or a past mental state evaluation, and even if the evaluation was granted at the behest of the defense.[13] But it should not be able to present expert evidence on the separate issue of dangerousness unless the defense does so as well.

Duty to Disclose Information Concerning Defendant's Present Mental Condition

Normally, evaluators should assess and report on only those issues the initiating party or court order requests be evaluated. However, standard 7-3.2(b) requires evaluators to disclose information that was not the subject of an evaluation under two circumstances: (1) where the evaluator concludes that the defendant is incompetent to proceed (for instance, during an evaluation that is supposed to focus solely on past mental state); and (2) where the evaluator concludes that the defendant presents an imminent risk of serious danger to self or others or otherwise requires emergency intervention, and either legal reporting requirements or applicable professional standards call for the mental health professional conducting the evaluation to take precautionary measures to protect the person at risk.

[9] Id. at 466.
[10] Id. at 468.
[11] Buchanan v Kentucky, 483 U.S. 402 (1987); Penry v. Johnson, 532 U.S. 782 (2001).
[12] Kansas v Cheever, 571 U.S. 87 (2005) (holding that the prosecution could use expert testimony based on a competency evaluation evidence to rebut a voluntary intoxication defense).
[13] Note, however, that standards 7-3.2(a)(ii) and p 7-3.7(b)(i), the prosecution will only be entitled to discover the results of such evaluations if they are conducted by an expert the defense plans to use at trial.

When the evaluator concludes that the defendant may be incompetent to proceed, the evaluator's duty is to notify the defense attorney and, if the evaluation was initiated by the prosecution or the court, to notify those entities as well. As noted above, all parties before the court have an interest in assuring that the proceedings are fair. Thus, all have an interest in the evaluator's conclusions regarding the defendant's competence.

The duty to take precautionary measures when a defendant is thought to pose an imminent risk derives from *Tarasoff v. Regents of University of California.*[14] There, the California Supreme Court held that psychotherapists have a duty to protect third parties from threats of serious danger posed by patients under their care. Many states have since codified this duty, although they have limited it in various ways, with many requiring disclosure only when a potential victim is identifiable.[15] In addition, virtually every state has mandatory reporting statutes designed to protect abused individuals.[16] The mental health professions have recognized an analogous ethical duty. The American Psychiatric Association permits psychiatrists, as a matter of medical ethics, to reveal confidential information disclosed by a patient "[w]hen, in the clinical judgment of the treating psychiatrist, the risk of danger is deemed to be significant."[17] Principle 5 of the American Psychological Association Ethical Principles of Psychologists permits psychologists to reveal confidential information to "protect the client/patient, psychologist, or others from harm."[18]

While these court rulings and ethical rules are focused on treating professionals and are premised on the conclusion that they have the necessary expertise to assess risk and the capacity to minimize that risk, they should apply to evaluators as well, because they have the same expertise and capacity as therapists. Thus, as standard 7-3.2 (b)(ii) provides, evaluators who conclude that the defendant presents an imminent risk of serious danger or otherwise needs emergency intervention should take appropriate preventive measures, which can include disclosures to the defense attorney, disclosure to jail or prison staff or, in rare

[14] 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (1976).
[15] See National Conference of State Legislatures, "Mental Health Professionals' Duty to Warn," available at www.ncsl.org/issues-research/health/mental-health-professionals-duty-to-warn.aspx (noting differences between virtually all jurisdictions).
[16] See Lawrence R. Faulkner, Mandating the Reporting of Suspected Cases of Elder Abuse: An Inappropriate, Ineffective and Ageist Response to the Abuse of Older Adults, 16 Fam. L.Q. 69, 75 (1982) (describing child and elder abuse reporting statutes).
[17] American Psychiatric Association, Principles of Medical Ethics § 4, point 8 (2013) (hereafter, Medical Ethics).
[18] American Psychological Association, Ethical Principles of Psychologists and Code of Conduct § 4.05(b)(3) (2010) (hereafter Ethical Principles).

instances, a petition for commitment.[19] Compliance with the standard should serve to immunize professionals against civil, criminal, or administrative liability.

Standard 7-3.3. Defense, prosecution and court access to mental health professional assistance and evaluation

(a) The right to defend oneself against criminal charges includes an adequate opportunity to explore, through a defense-initiated evaluation, the availability of any defense to the existence or grade of criminal liability relating to one's mental condition. Accordingly, for defendants who cannot afford such an evaluation, each jurisdiction should make available funds in a reasonable amount to pay for an evaluation by a qualified mental health professional or professionals selected by the defendant.

(b) In such cases a defense attorney who believes that an evaluation could support a defense claim based on mental disorder should move for the appointment of a professional or professionals in an ex parte hearing. The court should grant the defense motion if such services are reasonably necessary for an adequate defense.

(c) The court should grant a defense motion for a consultative expert, as defined in Standard 7-1.3(d), when the defense attorney can establish good cause that such an expert is necessary for an adequate defense.

(d) Prosecution and court access to the defendant for purposes of an evaluation by a mental health professional depends upon the nature of the evaluation and is governed by the Standards referenced in Standard 7-3.1.

Commentary

Standard 7-3.3 recognizes that mental state issues cannot be adequately addressed unless the defense has access to expert evaluation and testimony. The U.S. Supreme Court provided a constitutional basis for this basic principle of fairness in *Ake v. Oklahoma*.[20] There it held that if a defendant makes a preliminary showing that mental state at the time of the commission of an alleged offense is likely to be a significant factor at trial and the defendant is financially unable to retain a mental health expert, due process requires the state to provide access to a mental health expert who will evaluate the defendant and assist in the preparation and presentation of a defense. Although *Ake* was a capital case, the Court's rationale did not turn on

[19] A third option often applicable in the treatment context–disclosures to an identifiable potential victim–may also be appropriate in rare instances but is usually best left to the discretion of the attorneys, since the evaluator's relationship to a potential victim is much more attenuated than in the treatment context.
[20] 470 U.S. 68 (1986).

that fact but rather on the need for psychiatric expert assistance in cases raising a plausible claim of mental nonresponsibility.[21]

A second constitutional basis for this standard is the Sixth Amendment, which guarantees the right to effective assistance of counsel. That right requires access to an adequate forensic mental health evaluation that can assist counsel in preparing and presenting a potential mental condition defense. As one court noted, a mental health professional not only provides necessary testimony at trial, but also "attunes the lay attorney to unfamiliar but central medical concepts and enables him, as an initial matter, to assess the soundness and advisability of offering the defense . . . and perhaps most importantly . . . permits a lawyer inexpert in the science of psychiatry to probe intelligently the foundations of adverse testimony."[22] Another court characterized as "foolhardy" any lawyer who determines tactical and evidentiary strategy in a case involving psychiatric issues without the guidance and interpretation of psychiatrists and other mental health experts.[23]

Accordingly, paragraph (a) provides that jurisdictions need to ensure the availability of resources sufficient to support mental health experts for criminal defendants and to alert judges to the obligation to provide counsel with the necessary expert assistance. Paragraph (b) requires courts to authorize state-paid experts when they are "reasonably necessary for an adequate defense," language that is similar to that found in federal and many state rules governing expert support for indigent defendants."[24] Paragraph (b) also provides that this showing should be made to the court ex parte, to avoid premature exposure of defense strategy to the prosecution. In many cases, a single mental health professional will be sufficient; indeed, *Ake* made clear that the defense is normally entitled to only one state-paid expert, even if the expert chosen is an employee of the state and even if the expert assigned the defense does not support the defense case.[25] However, the Court's subsequent decision in *McWilliams v. Dunn*,[26] discussed further below, suggests that in some cases a single expert will not meet due process requirements. In any event, paragraph (b)

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[21] See id. at 82-83 ("When the defendant is able to make an ex parte threshold showing to the trial court that his sanity is likely to be a significant factor in his defense, the need for the assistance of a psychiatrist is readily apparent. . . . In such a circumstance, where the potential accuracy of the jury's determination is so dramatically enhanced, and where the interests of the individual and the State in an accurate proceeding are substantial, the State's interest in its fisc must yield.").

[22] State v. Pratt, 284 Md. 516, 398 A.2d 421, 424 (1979) *(*quoting United States v. Taylor, 437 F.2d 371, 377 n.9 (4th Cir. 1971)).

[23] United States ex rel. Edney v. Smith, 425 F. Supp. 1038, 1047 (E.D.N.Y. 1976), aff'd without opinion, 556 F.2d 556 (2d Cir.), cert. denied, 431 U.S. 958 (1977).

[24] See 18 U.S.C. § 3599(f) ("Upon a finding that investigative, expert, or other services are reasonably necessary for the representation of the defendant, whether in connection with issues relating to guilt or the sentence, the court may authorize the defendant's attorneys to obtain such services on behalf of the defendant and, if so authorized, shall order the payment of fees and expenses."); Fed.R.Crim.Pro. 17(b); Nev. Rev. Stat. 7-135; Hawai'I Rev. Stat. § 802-7; Kan. Stat. Ann. § 22-4508.

[25] *Ake*, 470 U.S. at 78-79.

[26] 582 U.S. 183 (2017).

contemplates that, when "reasonably necessary," the defense may be entitled to more than one state-paid expert.

The Court in *Ake* envisioned the role of the defense expert to be broader than simply evaluating the defendant and reporting an opinion: "By organizing a defendant's mental history, examination results and behavior, and other information, interpreting it in light of their expertise, and then laying out their investigative and analytic process to the jury, the psychiatrists for each party enable the jury to make its most accurate determination of the truth on the issue before them."[27] The Court reiterated this position in *Dunn*, stating that "*Ake* does not require just an examination. Rather, it requires the State to provide the defense with 'access to a competent psychiatrist who will conduct an appropriate [1] *examination* and assist in [2] *evaluation*, [3] *preparation*, and [4] *presentatio*n of the defense)."[28] Consistent with *Dunn*, paragraph (c) provides that the defense should be able to obtain, in addition to an evaluator, an expert consultant at state expense, for good cause shown. In some cases, particularly those in which the defendant's clinical presentation or behavioral history is complicated, an adequate defense may require consulting with experts who can advise counsel regarding strategies for the most effective presentation of the evidence or for cross-examining opposing experts to identify inaccuracies in their testimony that could mislead the trier of fact.

Standard 7-3.3(d) refers to standard 7-3.1 (and via that standard, the various standards governing state access to defendants and discovery of defense material) for direction regarding prosecution and court access to the findings and reports of experts appointed under this standard. In brief, the results of an *Ake* evaluation should only be sent to the defense, and need be disclosed to the prosecution only if and when the defense decides to rely on those results in subsequent proceedings.[29]

Standard 7-3.4. Procedures for initiating evaluations

(a) The party that initiates an evaluation of defendant's mental condition should inform the evaluator of each matter to be addressed in the evaluation.

(b) The attorney initiating an evaluation should obtain and provide to the evaluator all records and other information that the attorney believes may be of assistance in facilitating a thorough evaluation on the matter(s) referred. The attorney should also take appropriate measures to obtain and provide to the evaluator information that the evaluator regards as necessary for

[27] 470 U.S. at 81.
[28] Id. at 184.
[29] See standards 7-3.2(a)(ii), 7-3.7(b), 7-6.5(b), 7-8.4 and 7-9.5.

conducting a thorough evaluation on the matter(s) referred. If the evaluation is initiated by the court, both the defense attorney and the prosecutor conducting a thorough evaluation on the matter(s) referred. If the evaluation is initiated by the court, both the defense attorney and the prosecutor should obtain and provide the information. Such information may include 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. If a record provided to the evaluator contains highly sensitive information, either attorney may request a protective order limiting its further disclosure.

(c) Consistent with discovery laws, the rules of evidence, and the treatment needs of the defendant, reports resulting from the evaluations described in this Standard, and the records and other information relied on by mental health professionals preparing such reports, should be kept confidential until such time as the record is admitted into evidence. On the motion of either attorney, these reports and records should be sealed.

(d) An evaluation of the defendant's present competence should not be combined with an evaluation of the defendant's mental condition at the time of the alleged crime, or with an evaluation for any other purpose, unless the defendant so requests or, for good cause shown, the court so orders. If an evaluation addresses such discrete issues, a separate report should be prepared on each issue.

(e) When an evaluation is conducted pursuant to court order, that order should:

(i) identify the initiating party;

(ii) identify the purpose(s) of the evaluation;

(iii) describe the circumstances under which statements or other information obtained during the course of the evaluation, and any opinions of the mental health professional based on the evaluation, may be disclosed or used for any purpose in any criminal proceeding;

(iv) explain all applicable evidentiary privileges;

(v) specify whether the evaluator is required to prepare a written report, and, if so, delineate the scope, content, and disposition of the written report; and

(vi) direct that the defendant's relevant health care records be released, upon request, to the attorney for the defendant or the mental health professional conducting the evaluation, with or without the defendant's consent.

(f) Each jurisdiction should promulgate standard court orders designed to inform mental health professionals who conduct evaluations of the laws and procedures within the jurisdiction applicable to such evaluations.

Commentary

In years past, many referrals to mental health professionals failed to identify the reason for the referral, which often led to confusion as to how to proceed.[30] Today, fortunately, the practice in most jurisdictions is to use standard court orders that more precisely state the purpose of the evaluation.[31] To ensure this practice in all jurisdictions, paragraph (a) requires that the evaluator be informed about the specific matters to be addressed in the evaluation.

Paragraph (b) imposes on the attorney who initiates an evaluation an obligation to provide the evaluator with records and other information necessary to conduct the evaluation. (If the court initiates the evaluation, both attorneys must provide this background information.) Because evaluators are expected to perform a thorough, objective, and impartial evaluation, they require access to background information. Unlike ordinary "intake" admission evaluations for individuals entering into treatment, where the focus may be the individual's current clinical presentation and treatment history, forensic evaluations will often be more concerned with the individual's thinking and behavior at some time in the past (e.g., at the time of the offense, or at the time of a police interrogation). Further, as explained in Part I,[32] because defendants subject to evaluation may have difficulty communicating, be unable to remember important facts, or dissemble about them, evaluators need third party information for corroboration purposes. Without these materials, an evaluator may be unable to conduct or even begin the thorough evaluation required.

[30] E.J. Balcanoff &: A. McGarry, The Role of the Psychiatrist in Pretrial Evaluations, 126 Am. J. Psychiat. (1969).

[31] For an example from Virginia, see Gary Melton et al., Psychological Evaluations for the Courts: A Handbook for Mental Health Professionals and Lawyers 108 (4th ed. 2017).

[32] See commentary to standards 7-1.3 and 7.14. See also Randy Otto, Christopher Slobogin & Stuart Greenberg, Legal and Ethical Issues in Accessing and Utilizing Third Party Information, in Forensic Psychology: Emerging Topics and Expanding Roles 190 (Alan M. Goldstein, ed., 2007) (explaining the importance of third party information).

Paragraph (c) directs the evaluator to maintain the confidentiality of these records, along with reports resulting from the evaluation and any other information relied on by the evaluator, until such time as they may be entered into evidence. This information may be sensitive both legally and clinically. Mental health records typically include highly personal information that, under ordinary circumstances, is subject to strict confidentiality protection. Records pertaining to a criminal defendant's thinking and behavior at the time of the offense (or previous offenses) may be highly prejudicial. The evaluator has access to these records for the limited purpose of addressing a specific legal question and has no authority to disclose or refer to these records or any report that results from the evaluation unless authorized to by legal process. This standard provides that, upon the appropriate motion, the court should ensure confidentiality by sealing them, that is, by ordering that they not be disclosed except via court order.

Paragraph (d) states a preference that evaluations of a defendant's competence to proceed not be combined with evaluations addressing other issues. If the defense or court order nonetheless requests that these evaluations be combined, the standard recommends that the evaluator prepare separate reports on each issue. Reports addressing competence to proceed typically will be reviewed by the prosecutor and the court prior to trial. Because their focus is on the defendant's present ability to understand the proceedings and cooperate with counsel, they ordinarily will not contain detailed discussion of the defendant's thinking and behavior at the time of the offense that could provide incriminating statements or leads. To *ensure* they do not do so, some states forbid the inclusion of statements the defendant makes to the evaluator about the period of the alleged offense in competence to proceed reports,[33] a position adopted in standard 7-3.7(a) on the ground that such information is not crucial to determinations of present mental state.

That precaution would not be appropriate for many other types of evaluations, however. For instance, evaluations of mental nonresponsibility [insanity] almost always focus on the defendant's thinking and behavior at the time of the offense and, if acquired, this information must *always* be included in any thorough report. Thus, such a report should be produced separately so that it does not automatically go to the prosecution along with the competency report. Instead, as occurs in many states, and as required under standard 7-3.7(b), reports on past mental state should be withheld from the prosecution or the court until such time as the defense decides to proceed with a mental state defense. By segregating competence to proceed reports from reports addressing other issues, the risk that

[33] See, e.g., Va. Code § 19.2-169.1(D) ("No statements of the defendant relating to the time period of the alleged offense shall be included in the report.").

incriminating or otherwise prejudicial information will be shared unnecessarily is minimized.

To facilitate the evaluation process, paragraph (e) imposes an obligation on an authorizing court to communicate, through the authorizing order, information that will help professionals understand their role and carry out a thorough evaluation with efficiency. Indicating the identity of the initiating party tells the evaluator who is likely to be most helpful in providing third party information. Identifying the purpose(s) of the evaluation is crucial for the evaluator, both to avoid unnecessary and potentially prejudicial inquiries and because it allows the evaluator to be clear to the defendant what the evaluation will cover (a point emphasized in standard 7-3.5 as well). Making clear the circumstances under which statements or other information obtained during the evaluation may be disclosed (consistent with standard 7-3.2) may also affect the content of the evaluation and the report. Indicating whether a written report is required (virtually always when the evaluation is prosecution or court-initiated, but not always for defense-requested evaluations),[34] how it should be formatted (see standard 7-3.6(b)), and how it will be used is of obvious importance to the evaluator. Finally, the order should authorize transmission of relevant mental health records about the defendant to avoid having to seek such authorization later in the process on a record-by-record basis.

Paragraph (f) urges the adoption of standardized forms for court orders that can assist and inform mental health professionals who are examining the defendant. The form should include all of the elements in standard (e), tailored to the jurisdiction's rules and legal standards. For example, such a form should clearly distinguish evaluations bearing on present mental competency from those relating to mental state at the time of an alleged offense and from those that are to focus solely on dispositional issues. Evaluators ordered to conduct evaluations of present mental competency should be informed that they are to assess the defendant's ability to understand the nature of the proceedings and assist and work with defense counsel, while evaluation orders in mental nonresponsibility cases would provide the relevant standard, and dispositional evaluations might reference queries about treatability and risk. The order form might also include, in those jurisdictions with such a rule, that self-incriminating statements made during a competency exam should not be included in the report.

[34] Note, however, that standard 7-3.6(a) requires a report even for defense-initiated evaluations when defense counsel decides to use the expert for adjudication purposes.

Standard 7-3.5. Procedures for conducting evaluations

(a) The party that initiates the evaluation should inform the mental health professional conducting the evaluation and ensure that the professional understands:

(i) specific legal and factual matters relevant to the evaluation;

(ii) rules governing disclosure of statements or information obtained during the evaluation and governing disclosure of opinions based on such statements or information; and,

(iii) applicable evidentiary privileges.

(b) In any evaluation, whether initiated by the court, prosecution, or defense, the defense and the mental health professional conducting the evaluation have independent obligations to explain to the defendant and to ensure that the defendant understands to the extent possible:

(i) the purpose and nature of the evaluation;

(ii) the potential uses of any disclosures made during the evaluation;

(iii) the conditions under which the prosecutor will have access to information obtained and reports prepared, as provided in Standards 7-3.2 and 7-3.7; and,

(iv) the consequences of defendant's refusal to cooperate in the evaluation as provided for in Standard 7-6.4(b).

(c) Presence of attorneys during evaluations that result in reports to the prosecution or court.

(i) When the scope of the evaluation is limited to the defendant's competence to proceed, the defense attorney is entitled, but not required unless mandated by law, to be present at the evaluation. If present, the attorney should actively participate only if requested to do so by the evaluator.

(ii) When the scope of the evaluation is not limited to defendant's competence to proceed, the defense attorney should be present at the evaluation only at the request of the evaluator for reasons relating to the

effectiveness of the evaluation. If present the attorney may actively participate only if requested to do so by the evaluator.

(iii) Attorneys who are present during an evaluation when psychological testing is administered should be aware that test content is protected by law and that disclosure of that content can undermine the test's validity as a measure of a person's functioning.

(iv) The prosecutor may not be present at any evaluation of defendant.

(d) Recording the evaluation

(i) The defense has no obligation to record a defense-initiated evaluation under Standard 7-3.3. However, if the defense records an evaluation of mental state at the time of the offense, copies should be provided promptly to the prosecution when the defendant gives notice, under Standard 7-6.3(b), of an intent to call the mental health professional who conducted the evaluation as an expert witness on the defendant's mental condition at the time of the alleged offense.

(ii) Whenever feasible, recordings should be made of all court-ordered evaluations of defendants initiated by the prosecution or the court. Copies of such recordings should be provided promptly to the defense attorney and the prosecution.

(iii) Jails and other correctional facilities should maintain equipment that evaluators may use to make audio and video recordings of evaluations they conduct in such facilities. The equipment should be available, on request of the evaluator, for use in a private room when feasible and consistent with security requirements. Alternatively, facilities should allow evaluators to use their own equipment.

(iv) If an evaluation is recorded, video recording should be considered preferable to audio recording.

(e) Joint evaluations should be encouraged. They should be permitted when agreed upon by the prosecutor and the defense attorney. A joint evaluation involves either an evaluation conducted by two or more behavioral health professionals or an evaluation by a mental health professional agreed on by both parties.

Commentary

Standard 7-3.5 addresses the duties of the attorneys to communicate with evaluators and the duty of both defense counsel and the evaluator to communicate with evaluees. The standard also prohibits the presence of prosecutors during court- or defense-initiated evaluations and the presence of defense attorneys during evaluations focused on issues other than competence, except under special circumstances. When attorneys are present, the standard cautions that the contents of standardized tests are protected by law and that disclosure of that content can undermine a test's validity over time. Finally, the standard clarifies the rules regarding recording of evaluations.

Duty of Attorney

Paragraph (a) is meant to ensure adequate communication between legal actors and mental health professionals who perform evaluations. If, for example, an evaluation is to be performed to reconstruct a defendant's mental state at the time of an alleged offense, the evaluator needs to know the nature of that crime and the legal test for mental nonresponsibility in the jurisdiction. Further, the evaluator needs to understand the degree to which constitutional or evidentiary privilege may shield the evaluator's findings from disclosure. If the evaluation is conducted pursuant to court order, the previous standard's stipulations about the content of the order should also provide all of this information. But even in such cases it is incumbent upon the attorney to ensure that evaluators understand their role.

Duty to Explain Evaluation to Defendant

Paragraph (b) embodies the premise that both defense counsel and the evaluator have a duty to explain to a defendant the nature and purpose of the evaluation. The attorney's obligation stems from the responsibility to advise an accused client about all aspects of the case.[35] A mental health professional's obligation flows, at least in part, from professional ethical standards. For example, the Principles of Medical Ethics require psychiatrists to "promote" informed decisions,[36] and the American Association of Psychiatry and Law's Guidelines state that "[t]he informed consent of the person undergoing the forensic evaluation should be obtained when necessary and feasible."[37] Similarly, both the Specialty Guidelines for Forensic Psychology and the Ethical Guidelines for the Practice of Psychology and Code of Conduct obligate psychologists to obtain informed consent for

[35] American Bar Association, Criminal Justice Standards on the Defense Function, standard 4-5.1(b).
[36] Medical Ethics, supra note 17, at § 8, ann. 4.
[37] American Association of Psychiatry & Law, Guidelines for the Forensic Assessment, Principle 5.2 (2015) (hereafter, AAPL Guidelines).

assessments, evaluations, or diagnostic services, although, as the AAPL Guidelines also imply, they recognize that fully informed consent is not required for evaluations mandated by law.[38] Mental health professionals are also required to inform defendants about legal limitations on confidentiality governing an evaluation.[39] Finally, the evaluator should caution the defendant that refusal to cooperate with the evaluation could result in sanctions, including disallowance of any evidence from the expert and other experts (see standard 7-6.4 (b)).

Presence of Defense Attorney at Evaluation Interview

Paragraph (c) addresses the difficult issue of whether the defendant has a right to have an attorney present during a mental health evaluation. Two different types of evaluations must be distinguished in this context. The first is an evaluation limited to a defendant's competence to proceed, which includes consideration of the defendant's capacity to consult with counsel (see standard 7-4.1(b)). Having counsel present at the interview may provide the opportunity for the evaluating professional to observe attorney-client interactions and consider the defendant's understanding of defense strategies counsel may be considering. For this reason, the standard would allow, but not require, defense counsel to be present. The standard also states, however, that unless requested by the evaluator, counsel who are at the interview must remain passive, on the premise that evaluations are likely to be more thorough and professional if uninterrupted by unwanted attorney objections and suggestions.

The second type of evaluation addresses broader issues, typically including the defendant's mental state at the time of the alleged offense or future risk. Courts have divided as to whether a defendant's attorney has a right to be present at this type of evaluation. Many courts begin their analysis with *United States v. Wade*,[40] in which the Supreme Court stated that the Sixth Amendment requires counsel at any pretrial confrontation in which "the presence of counsel is necessary to preserve the defendant's basic right to a fair trial as affected by his right meaningfully to cross-examine the witnesses against him and to have effective assistance of counsel at the trial itself."[41] Under *Wade*, three factors govern whether a particular confrontation requires counsel: "First, the confrontation must pose potentially substantial adverse consequences for the defendant…. Second...the nature of the confrontation must be

[38] Ethical Principles, supra note 18, § 3.10(a) (noting an exception "when conducting such activities without consent is mandated by law or governmental regulation . . ."); Specialty Guidelines for Forensic Psychology § 9.03 (a) (hereafter Specialty Guidelines) (noting exceptions when testing is mandated by law or governmental regulations or "one purpose of the testing is to evaluate decisional capacity.").
[39] See Medical Ethics, supra note 17, § 4, ann. 6 (requiring psychiatrists to describe fully "the nature and purpose and lack of confidentiality of the examination to the examinee at the beginning of the examination"); Ethical Principles, supra note 18, § 4.02; Specialty Guidelines, supra note 38, §§ 3.10(c); 4.02(a).
[40] 388 U.S. 218(1967).
[41] Id. at 227..

such that its reconstruction at trial would prove difficult….[T]hird…the confrontation...must also inherently involve the risk of error."[42]

Given the vagaries of assessing mental states, all three of the conditions apply to forensic evaluations. For these reasons, in *Lee v. County Court*,[43] the New York Court of Appeals held that defense counsel is entitled to attend a pretrial mental health evaluation to enhance the prospects of effective defense cross-examination at trial, although the attorney is limited to an "observer" role,[44] a decision later codified by the New York legislature.[45] The supreme courts of Oregon[46] and Alaska[47] have also held that the Sixth Amendment entitles defense counsel to be present at court-ordered evaluations, with the Alaska court adding that such evaluations should be tape recorded "in their entirely."[48]

Nevertheless, most courts have held that the Sixth Amendment right to counsel does not mandate defense counsel's presence at a prosecution-initiated evaluation of the defendant.[49] In *Estelle v. Smith*,[50] the U.S. States Supreme Court appeared to reach the same conclusion. It agreed with Smith's claim that a defendant's Sixth Amendment right to the assistance of counsel is abridged if a defendant is denied an opportunity to consult with counsel before a psychiatric evaluation.[51] However, in a footnote, the Court specifically reserved for later consideration the question of whether the Sixth Amendment permits defense counsel to witness the evaluation.[52] Quoting from the Fifth Circuit decision in *Smith*, the Court noted that counsel's presence could contribute little to and might seriously disrupt the interview process.[53] Other courts have also commented that a defense attorney's presence at a prosecution-initiated evaluation, even as an observer, may adversely affect an evaluator's ability to obtain.[54]

The American Psychiatric Association has stated that too little is known about the potentially disruptive effect of counsel's presence at the examination, or the efficacy of other procedures, to confidently assess whether the perceived need

[42] Slobogin, supra note 2, at 117-118.
[43] 27 N.Y.2d 432, 267 N.E.2d 452, 318 N.Y.S.2d 705, cert. denied, 404 U.S. 823 (1971).
[44] Chief Justice Fuld, dissenting, would have allowed defense counsel to take an active role in order to provide effective assistance of counsel during an interview. Id. at 446-447, 267 N.E.2d at 460, 318 N.Y.S.2d at 717 (Fuld, C.J., dissenting in part).
[45] N.Y. Code Crim. Pro. §250.10(3).
[46] State ex rel. Ott v. Cushing, 289 Or. 695, 617 P.2d 610 (1980).
[47] Houston v. State, 602 P.2d 784, 795 (Alaska 1979).
[48] Id. at 796.
[49] Slobogin, supra note 2, at 115-127.
[50] 451 U.S. 454 (1981).
[51] Id. at 471.
[52] Id. at 470 n.14.
[53] Id.
[54] See, e.g., Gibson v. Zahradnick, 581 F.2d *75, 79* (4th Gr.), cert. denied, 439 U.S. 996 (1978); United States v. Baird, 414 F.2d 700, 711 (2d Cir. 1969); United States v. Albright, F.2d 719, 726 (4th Gr. 1968).

for such safeguards out-weighs their possible costs; it also noted that although some examiners may find that their examination is not disturbed or impaired by the use of certain procedures, others may find that the same procedures do inhibit a thorough and valid psychiatric evaluation.[55] Standard 3.5(c)(ii) accordingly states that at such evaluations counsel should be present "only at the request of the evaluator for reasons relating to the effectiveness of the evaluation" and further provides that in such situations, "the attorney may actively participate only if requested to do so by the evaluator."

If counsel is not allowed to attend, the defendant's Fifth Amendment interest in avoiding self-incrimination and Sixth Amendment right to adequate representation by counsel can be safeguarded in other ways. With respect to protection of Fifth Amendment interests, standard 7-3.2 prohibits prosecution use of evaluation results to prove the defendant's commission of the charged offense. And the Sixth Amendment right is protected by the requirement in subparagraph (d)(ii) of this standard that all court-ordered evaluations initiated by the prosecution or the court be recorded, whenever feasible, and that a copy of the recording be supplied to defense counsel.[56]

Subparagraph (d)(i) imposes no analogous requirement on defense counsel to record evaluations initiated by the defense. However, when such a recording is made, counsel is expected to share a copy with the prosecution if the defense moves forward with a mental condition defense. Subparagraph (d)(iii) recognizes that it may be impractical, given security concerns, for evaluators to bring recording equipment with them when they evaluate a defendant in a jail or hospital. Accordingly, the standard encourages jails and other correctional facilities to keep recording equipment on hand and to make it available to evaluators on their request. Alternatively, evaluators should be permitted to use their own equipment. Finally, paragraph (d)(iv) provides that if an evaluation is recorded, video recording is preferred to audio recording.

Some have argued that recording devices may inhibit evaluation interviews or fail to convey their nuances.[57] However, this standard takes the position that, overall, recordings enhance accuracy and provide a good substitute for the potentially disruptive presence of counsel.

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[55] Amicus Curiae Brief for American Psychiatric Association on Appellant's Petition for Rehearing 6-7, Byers for United States, No 78-1451 (1981).

[56] A third possible protection—allowing defense counsel to be outside the evaluation room, available for consultation—avoids any direct interference. But it could be equally disruptive if defendants repeatedly decide to take the opportunity to consult. A compromise is to inform clients that the attorney is available to answer questions about legal rights, leaving it up to the defendant to decide when it is necessary to do so through a phone call or similar communication.

[57] See AAPL Task Force, Video Recording of Forensic Psychiatric Evaluations (May, 2013) (discussing advantages and disadvantages of taping and calling for further research on its effects).

Joint Evaluations

Paragraph (e) encourages joint evaluations, if agreed upon by the defense and the prosecution. Joint evaluations may involve either multiple evaluators, assigned by both the defense and the prosecution, or one evaluator agreed on by the parties. This practice promotes efficiency. It also may reduce the likelihood that experts will disagree based on disparate facts or that attorneys will exaggerate differences between their experts' findings and opinions.

Standard 7-3.6. Preparation and contents of written reports of mental evaluations

(a) Promptly upon concluding the evaluation, the mental health professional should prepare a complete, written report, unless the professional is retained by the defendant and the defense attorney decides that the professional will not be called as an expert witness.

(b) Contents of written report.

(i) The written evaluation report should:

(A) identify the specific matters referred for evaluation;

(B) describe the procedures, tests, and techniques used by the evaluator;

(C) consistent with Standards 7-3.8 and 7-6.6, state the evaluator's clinical findings and opinions on each matter referred for evaluation and indicate specifically those questions, if any, that could not be addressed;

(D) identify the sources of information and present the factual basis for the evaluator's clinical findings and opinions; and,

(E) present the reasoning by which the evaluator utilized the information to reach the clinical findings and opinions.

(ii) Except as limited by Standard 7-3.7(a), the evaluator should include in the written report any statements or information that serve as necessary factual predicates for the clinical findings or opinions, even

if the statements or information are of a personal or potentially incriminating nature.

(c) The attorney who requested the evaluation should not edit, modify, or otherwise revise the report in any way that would compromise the report's integrity. However, after the report has been completed and submitted to the attorney, the attorney may correspond in writing or converse with the mental health professional in order to clarify the meaning or implications of the evaluator's findings or opinions.

(d) Each jurisdiction should promulgate written guidelines regarding the law and procedures within that jurisdiction governing the preparation of written reports in order to inform mental health professionals serving as evaluators.

Commentary

Paragraph (a) directs mental health professionals to prepare a complete, written report promptly upon completion of an evaluation unless they are retained by defense counsel and counsel requests an oral report. Defense counsel might make the latter request when they want to explore whether there is a basis for developing a mental state defense without documenting potentially unhelpful. However, if defense counsel intends to call the evaluator as an expert witness, a written report will be necessary, to comply with the discovery requirements in standard 7-3.7.

Paragraph (b) lists the matters to be included in an evaluation report. The report should: (1) identify the specific matters referred for evaluation; (2) describe the procedures, tests, and techniques used in the evaluation; (3) state the evaluator's clinical findings and opinions on each referred matter and indicate any referral issues that cannot be addressed; (4) identify the sources and nature of the information on which the clinical findings rest, so that defense counsel and the prosecuting attorney may pursue follow-up investigation if they wish; and (5) set forth the reasoning that links this information to the clinical findings and opinions.

Subparagraph (b)(ii) requires an evaluator to include all statements and information that are a necessary basis for the report's conclusions, even if they are personal in nature or tend to incriminate the defendant. An exception is made, however, for evaluation reports addressing solely the question of competence to proceed. As provided in standard 7-3.7(a), these reports should not contain any statements the defendant may have made about involvement in the offense or any other offense.

Under the standards for the defense function,[58] a lawyer "should respect the independence of the expert and should not seek to dictate the substance of the expert's opinion on the relevant subject." This principle makes clear that an independent report is consistent with effective advocacy. In accordance, standard 7-3.6 (c) provides that reports of mental health professionals should not be edited or modified in any way that would compromise the report's integrity. Professional evaluators may not be aware of or agree with changes an attorney makes in their reports, which could lead to awkwardness, or worse, later in the process, especially if the evaluator finds out about the discrepancy on the stand. If an attorney believes that an evaluating professional is confused or wrong about certain facts, subsequent correspondence can clarify the professional's opinion without compromising the integrity of the evaluation and the initial report.

Finally, in the interest of educating mental health professionals who would serve as evaluators and enhancing the value of their service, paragraph (d) suggests that each jurisdiction promulgate written guidelines for the preparation of reports, reflecting the jurisdiction's applicable law. Standard 7-3.4's description of report contents can be of assistance in this regard.

Standard 7-3.7. Discovery of written reports

(a) When the court has ordered a pretrial evaluation on any past or present competency issue, the evaluator should prepare a separate report on that issue even if other issues have also been referred for evaluation. The report should not contain information or opinions concerning either the defendant's mental condition at the time of the alleged offense or any statements made by the defendant regarding the alleged offense or any other offense. Upon satisfying itself that the report does not contain information or opinions that should have been excluded, the court should promptly provide copies to the prosecutor and to the defense attorney.

(b) When the defendant gives notice of an intent to rely on an expert,

(i) the defense should promptly provide to the prosecution all written reports on the issue in question prepared by any mental health professional whom the defendant intends to call as an expert witness. If the defendant intends to call an expert witness who has not previously prepared a written report, a written report conforming to Standard 7-3.6 (b) should be prepared and promptly provided to the prosecution.

[58] ABA, Standards on the Defense Function, standard 4-4.4(d).

(ii) the prosecution should promptly provide to the defense all information, including written reports prepared by mental health professionals, bearing on the issues addressed by the defense expert that have not already been provided through the discovery process.

(c) Upon a showing of good cause by the defendant, the court may order that the delivery of a report or reports be denied, restricted, or deferred until a time certain before trial. The court may order the defendant to promptly disclose to the prosecutor a list of the sources of information relied upon in any report whose delivery has been denied, restricted, or deferred.

(d) Each jurisdiction should establish, by statute or court rule, detailed guidelines governing discovery of written reports prepared by mental health professionals.

Commentary

To protect the defendant's Fifth Amendment and Sixth Amendment interests, a report relating to a defendant's competence to proceed should not contain investigatory leads, information bearing on the defendant's thinking or behavior at the time of an alleged crime, or information that reveals the possible deals the defendant would accept from the prosecution. Rather, the evaluation should focus on the defendant's present mental condition and the degree to which the defendant may have difficulty navigating the criminal justice process. To forestall the misuse of competence evaluations as a source of prosecution information about matters relating to guilt, and consistent with standard 7-3.4(d), paragraph (a) provides that an independent report be prepared on the issue of competence (even if the referral calls for an evaluation on multiple issues) and that this report include no information or opinions concerning either the defendant's mental condition at the time of the alleged offense or statements the defendant may have made regarding the offense or any other offense. Moreover, the court should satisfy itself that this requirement has been met before copies are provided to the prosecuting attorney and defense counsel.

It is true that, as pointed out in the commentary to standard 7-4.1, evaluating a defendant's ability to communicate with the attorney may require some inquiry into the defendant's ability to describe his or her behavior at the time of an alleged offense. Even so, the evaluator need not provide this detail in the report, but rather can simply opine that the defendant was (or was not) able to discuss the time of the alleged offense; usually, a statement that the defendant can (or cannot) recount facts pertinent to the offense should be sufficient. Moreover, if more detail is critical to the court's determination of competence, it may be elicited in testimony at the competence hearing, conditioned on a court ruling that these facts may not be entered into evidence at trial to show that the defendant committed the offense (cf.

standard 7-3.2). These steps not only assure that a court-ordered evaluation will avoid providing self-incriminating details. They also encourage candor from the defendant, who otherwise might be reticent about talking about the offense.

Paragraph (b) seeks to protect the same interests by withholding discovery of reports about mental state defenses until the defense has given notice of an intent to raise a mental condition defense (pursuant to standard 7-6.3(b)). By precluding a prosecutor's discovery of reports before the defense gives notice of an intent to claim a mental condition defense, this provision avoids premature disclosure of self-incriminating statements. It also protects Sixth Amendment interests by encouraging openness from defendants, who can be told that nothing they say will be shared unless they make the strategic decision to go forward with the defense (and that, even if they do go forward, their disclosures cannot be used to support the prosecution's affirmative case). Without this protection, a defendant understandably might forego a bona fide defense out of concern that exploring the defense could result in the disclosure of information that would tip the scales toward conviction.

Once the notice required by standard 7-6.3 has been transmitted, the ensuing discovery is broad under this standard. The defense must provide the prosecution with a written report from any expert whom the defense intends to call as witnesses. The prosecution must provide the defense with its experts' reports, along with any other information bearing on the question at hand that it has not already provided. Note that the defense disclosure requirement does not include material prepared for the defense that would be considered work product. Thus, a report of a mental health professional employed as a defense consultant is protected against disclosure by the attorney-client privilege, unless, of course, the defense later calls that professional to testify. Further, paragraph (c) allows the defense to defer or restrict disclosure of reports, in full or in part, when the defense can show such disclosure would reveal strategies that the defense, at the time of discovery, is not sure it will pursue. However, any such restriction should not prevent the prosecution from access to the information (as opposed to opinions) contained in the report.

Paragraph (d) urges jurisdictions to establish guidelines governing the discovery of reports prepared by mental health professionals that are consistent with these rules. Jurisdictions' rules may vary. Without clear direction, evaluators may not know when they are expected to provide a report or, alternatively, maintain its confidentiality.

Standard 7-3.8. Admissibility of expert testimony concerning a person's mental condition or behavior

(a) Expert testimony, in the form of an opinion or otherwise, concerning a person's past or present mental condition 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 on an issue relevant to the adjudication.

(b) Expert testimony relating to the person's future mental condition or behavior, including risk of reoffending, should be admissible when relevant to any criminal proceeding or special commitment hearing if the testimony is within the specialized knowledge of the witness and is based on reliable techniques and practices, which may include consideration of:

(i) the clinical significance of the individual's history and current behavior;

(ii) scientific studies involving the relationship between specific behaviors and variables that are objectively measurable and verifiable;

(iii) the possible psychological or behavioral effects of proposed therapeutic or other interventions;

(iv) the factors that tend to enhance or diminish the likelihood that specific types of behavior could occur in the future, or

(v) the defendant's performance on validated instruments for assessing risk and need only when administered, scored, interpreted and presented in accordance with scientific and professional standards.

(c) If 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.

Commentary

Standard 7-3.8 addresses the admissibility of expert testimony by a mental health professional. Generally, it allows such testimony if it is within the witness's specialized knowledge and will assist the trier of fact in determining an issue

relevant to the adjudication. But in connection with testimony about risk and its management, it additionally identifies special considerations relevant to admissibility. The standard also requires experts to explain the boundaries of their expertise and express appropriate caveats when asked to offer an opinion requiring a conclusion of law or a moral or social value judgment.

Expertise of Mental Health Professionals on Present or Past Mental State

Paragraph (a), modeled after rule 702 of the Federal Rules of Evidence, permits a witness to offer an expert opinion on present or past mental state if it addresses a subject not within common lay knowledge and the witness is qualified as an expert through knowledge, skill, experience, training, or education. Building on the Supreme Court's opinion in *Daubert v. Merrell Dow Pharmaceuticals*[59]--which requires that expert testimony have a "reliable" basis, as measured by scientific testing, peer review, degree of acceptance within the relevant community or other means of verification—Rule 702 also requires that any testimony offered by the expert be the product of reliable principles and methods and that the expert have reliably applied the principles and methods to the facts of the case. Although this standard does not include the latter language, it is consistent with it.

In practice, courts routinely admit testimony from mental health professionals about present and past mental states, whether they follow *Daubert* or the competing "*Frye* rule,"[60] which focuses on whether proposed testimony is "sufficiently established to have gained general acceptance in the particular field in which it belongs."[61] However, some have questioned this easy acceptance of mental health professional expertise, especially with respect to past mental condition. A few commentators suggest that the theories underlying the opinions mental health professionals provide lack scientific verification, and that reconstructing past mental states is difficult if not impossible, rendering these opinions unreliable.[62] These commentators advocate an evidentiary rule that would limit expert witnesses' testimony to descriptions of behavior they have observed.[63]

[59] Daubert v. Merrell Dow Pharmaceuticals Inc., 509 U.S. 579 (1993).
[60] 293 F. 1013, 1014 (D.C. Cir. 1923).
[61] Daniel W. Shuman, Expertise in Law, Medicine and Health Care, 26 J. Health Policy & L. 267, 282 (2001) (as of 2001, there have been "no reported *Daubert* challenges to retrospective psychiatric assessments of criminal responsibility"); see also Henry F. Fradella et al., The Impact of *Daubert* on the Admissibility of Behavioral Science Testimony, 30 Pepperdine L. Rev. 403, 421-23, 431-34 (2003).
[62] See, e.g., David Faust, Ziskin's Coping with Psychiatric and Psychological Testimony (6th ed. 2012); Stephen J. Morse, Failed Explanations and Criminal Responsibility: Experts and the Unconscious, 68 Va. L. Rev. 971 (1982).
[63] Stephen J.. Morse, Crazy Behavior, Morals, and Science: An Analysis of Mental Health Law, 51 So. Cal. L.Rev. 527, 600-626 (1978); Comment, The Psychologist as Expert Witness: Science in the Courtroom?, 38 Md. L. Rev. 539 (1979).

Most mental health professionals, attorneys, and judges disagree, however.[64] Reflecting the majority perspective, Bonnie and Slobogin wrote:

> According to the weight of authority, . . . the fact that opinion testimony is uncertain does not by itself justify exclusion, as long as the evidence rises above mere conjecture or speculation. If it has any tendency to prove a fact, and is otherwise qualified as expert opinion, the evidence is admissible unless some overriding reason requires exclusion. The rationale for this position is that many observations, both scientific and lay, can be expressed only in terms of 'probabilities' or 'possibilities'; to deny the factfinder such evidence on this ground alone might deplete seriously the amount of information available."[65]

This standard endorses that position. Well-trained mental health professionals obviously have more knowledge than jurors about mental and emotional processes and abnormal behavior, psychological aberrations, and motivations for criminal behavior. Their specialized knowledge should be available to assist factfinders. Consequently, the present standard, instead of advocating the exclusion of or severe limitations on expert testimony, endorses the use of such testimony as long as it is within the sphere of specialized knowledge of properly qualified experts. However, this and other standards in this part seek to ensure that factfinders are aware of the limitations inherent in mental health professional testimony[66] and to improve the quality of expert opinion evidence.[67]

Another such limitation is expressed in paragraph (c) of this standard, which addresses "ultimate issue" testimony. In many states, the expert is allowed to opine not only on the defendant's symptoms and diagnosis, but also on whether, according to the applicable legal standard, the defendant was or was not legally competent, legally nonresponsible at the time of the alleged offense, or sufficiently high risk to warrant commitment. However, the practice of submitting conclusory opinions on such legal issues has been criticized as a usurpation of the roles and responsibilities of the court and jury.[68] Consistent with that view, Rule 704(b) of the Federal Rules of Evidence provides that an expert witness "must not state an opinion about whether the defendant did or did not have a mental state or condition that

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[64] See Richard E. Redding et al., What Judges and Lawyers Think about the Testimony of Mental Health Experts: A survey of the Courts and Bar, 19 Behav. Sci. & L. 583 (2001).

[65] Richard A. Bonnie & Christopher. Slobogin, The Role of Mental Health Professionals in the Criminal Justice Process: The Case for Informed Speculation, 66 Va. L. Rev.. 427, 461-462 (1980).

[66] See standard 7-3.15.

[67] See standards 7-1.2, 7-1.3, 7-3.10 through 7-3.15.

[68] Compare Melton et al., supra note 31, at 17 ("questions as to criminal responsibility, committability, and so forth are not based on 'specialized' knowledge, but are legal and moral judgments outside the expertise of mental health professionals qua mental health professionals.") with Richard Rogers & Charles Patrick Ewing, The Prohibition of Ultimate Opinions: A Misguided Enterprise, 3 J. Forensic Psychol Prac. 65 (2003) and Christopher Slobogin, The "Ultimate Issue" Issue, 7 Behav. Sci. & L. 259 (1989) (arguing that ultimate issue testimony is most damaging when proceedings are not adversarial, as in many competency contexts).

constitutes an element of the crime charged or of a defense. Those matters are for the trier of fact alone." Standard 7-6.6 takes a similar stance, prohibiting testimony that a defendant was "sane" or "insane," unless such testimony was required by the jurisdiction. Paragraph (c) of the present standard states the general principle behind this stance and applies it to all testimony that addresses a moral or social value judgment lying outside the professional's training, experience, or theoretical constructs.

Yet many courts and lawyers are likely to resist such a prohibition. Seeing much to gain from an expert's statement that agrees with their theory of the case, lawyers may demand that professionals proffer not only their clinical opinion but also make clear its legal implications, and judges may agree. Paragraph (c) provides that if the jurisdiction or the court does require such ultimate issue testimony, the evaluator should use cautionary language to explain the boundaries of the expert's clinical expertise and the limitations of the expert's opinion.[69]

Expertise of Mental Health Professionals on Future Mental Condition

Mental health professionals long have been asked to predict whether an individual is "dangerous." Expert testimony on dangerousness may be relevant at capital sentencing, at non-capital sentencing to determine whether the offender requires incapacitation in a secure facility or can instead be released to the community on probation, and in host of other criminal and quasi-criminal settings, including commitment following a verdict of mental nonresponsibility. The question of dangerousness (or risk of harm) is simply inescapable in courtrooms today. The closely related inquiry into whether this risk of harm can be reduced (or "managed") through treatment is also frequently raised.

The same admissibility requirements that control present and past mental state testimony from mental health professionals should apply here as well. Testimony about risk should be based on scientific or specialized knowledge and be the product of reliable principles and methods reliably applied to the case at hand. However, given developments in the science of risk assessment, more needs to be said about how these rules apply in this setting, beginning with a description of the three basic types of risk assessment.

Assessments of risk can be based on a mental health professional's unstructured "clinical judgment," an actuarial risk tool, or "structured professional judgement" (SPJ).[70] All three techniques focus on factors that increase risk (risk

[69] See Melton et al, supra note 31, at 603-604, for examples of such language.
[70] See John Monahan & Jennfier Skeem, Modern Scientific Evidence, ch. 9 (2023) for a description of these types of risk assessments and their risk and benefits.

factors) and factors that can reduce it (protective factors). With unstructured clinical risk assessment, the risk and protective factors that are considered and the weight accorded them vary from case to case. In contrast, actuarial instruments are empirically-derived from a validation sample in an effort to identify up front, and for all cases, the most predictive risk and protective factors; once identified, those factors are assigned weights or scores which are then combined to produce a quantified probability estimate about risk.[71] SPJ instruments also identify risk and protective factors based on research, but do not assign specific weights to them; rather, they require the clinician to arrive at an overall impression of whether the individual poses a high, medium or low risk.[72]

On average, unstructured risk assessments are probably the least accurate of the three techniques.[73] Furthermore, their non-quantified nature, usually expressed in terms of whether the individual is "likely" or "unlikely" to reoffend, gives them an undeserved aura of certainty. Yet the courts remain willing to hear opinions based on such an approach.[74]

Actuarial and SPJ tools (often called "risk assessment instruments" or RAIs) tend to produce more accurate results than unstructured prediction strategies. But they have their own sets of challenges. Beginning with actuarial RAIs, a central issue is whether the group on which the RAI is validated is "empirically" relevant to the case at hand; an RAI validated on mostly Caucasian adults using a seven-year followup period and including any arrest as an indicator of recidivism will probably not be useful in predicting violent recidivism among a diverse population of young people within the next two years.[75] Second, even if well-validated for a particular legal setting, an actuarial RAI can only place an individual within a group, X% of which are likely to recidivate. One reason unstructured clinical prediction is sometimes preferred by the courts is that it appears to be more "individualized" compared to an RAI that does not capture everything that a clinical predictor would think explains the person's behavior. Third, many of the risk factors in actuarial RAIs are immutable, or "static." Sentencing someone to a longer period of

[71] Commonly used actuarial instruments in legal proceedings include the Violence Risk Appraisal Guide, the Legal Service Inventory-Revised, the COMPAS, Level of Service Inventory-Revised, and the STATIC-99.
[72] Well-known SPJ instruments are the HCR-20 and the Psychopathy Checklist-Revised.
[73] See Sarah J. Desmarais, Kiersten L. Johnson & Jay P Singh, Performance of Recidivism Risk Assessment Instruments in U.S. Correctional Settings, 13 Psychol. Serv., 206 (2016) ("there is overwhelming evidence that risk assessments completed using structured approaches produce estimates that are more reliable and more accurate than unstructured risk assessments").
[74] Barefoot v Estelle, 463 U.S. 880 (1983) (holding that such testimony is not barred by the due process clause even in a death penalty proceeding). See Christopher Slobogin, Constitutional and Evidentiary Issues Concerning Risk Assessment ch. 4, in Handbook of Violence Risk Assessment (Kevin Douglas & Randy Otto eds., 2d ed. 2021).
[75] See Donna Cropp Bechman, Sex Offender Civil Commitments: Scientists or Psychics? 16 Crim. J. 24, 29 (2001).

imprisonment because they are dangerous based on factors—such as age, gender, or diagnosis—that are beyond their control and not subject to change is controversial.[76]

For these sorts of reasons, some risk assessment strategies temper the results of an actuarial instrument with professional judgment, in an effort to individualize the assessment. This "adjusted actuarial" method has its own problems, however. If the "individualized" factors have not been empirically tested, incorporating them may actually decrease the validity of the judgment.[77]

The third risk assessment strategy, structured professional judgment RAIs, consider a limited number of empirically-derived risk and protective factors, as does an actuarial instrument, but these factors tend to be less objectively defined, and they are not combined in a pre-set way to arrive at a numerical risk score. Further, these instruments are more likely than actuarial instruments to include "dynamic" factors that may be subject to change with appropriate treatment or other services.[78] At the same time, their less objective, non-quantified nature requires heavy reliance on a clinical assessment about the ultimate level of risk. This assessment can vary significantly between evaluators,[79] a feature which resembles (but is more evidence-based than) the traditional clinical prediction.

A final concern that can taint every type of risk assessment is the impact of racial and other types of bias, either on the part of the evaluator or because of reliance on biased data, such as arrest records for misdemeanors that are skewed by racialized policing, or on other risk factors, such as location or socio-economic status, that can be heavily correlated with race. Research suggests that eliminating or correcting for these types of risk factors significantly reduces racial bias, and that RAIs are better at doing so than unstructured techniques.[80] Even so, courts, lawyers and evaluators must bear in mind that the reliability requirements in this standard include ensuring that risk assessments are not unduly skewed by "dirty data."[81]

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[76] See Christopher Slobogin, Just Algorithms: Using Science to Reduce Incarceration and Inform a Jurisprudence of Risk 99-104 (2021) (describing and rebutting this claim).

[77] J. Stephen Wormith et al., The Predictive Validity of a General Risk/Needs Assessment Inventory on Sexual Offender Recidivism and an Exploration of the Professional Override, 39 Crim. Just. & Beh. 1511 (2012 (finding that a professional override by probation officers, psychologists, or social workers on the result suggested by an RAI "led to a slight, but systematic, deterioration in the predictive validity").

[78] Well-known SPJ instruments are the HCR-20 and the Psychopathy Checklist-Revised.

[79] Nicolas Scurich, The Case Against Categorical Risk Assessments, 37 Beh. Sci. & L. 554, 556=557 (reporting a study in which the "high risk" designation among clinicians ranged from 38 percent to 100 percent, and a study finding a range of to 5 to 100 percent among a sample of judges and forensic clinicians asked to define high risk).

[80] Jennfier Skeem & Christopher Lowenkamp, Using Algorithms to Address Trade-Offs in Predicting Recidivism, 38 Beh. Sci. & L. 259 (2020) (showing how risk assessment instruments can be constructed to reduce the "proxy" effect of race).Crystal Yang & Will Dobbie, Equal Protection Under Algorithms: A New Statistical and Legal Framework, 119 Mich. L. Rev. 291 (2020).

[81] See Wisconsin v. Loomis, 881 N.W.2d 749, 764 (2016) (holding that presentence reports must remind courts that "some studies of . . . risk assessment scores have raised questions about whether they disproportionately classify minority offenders as having a higher risk of recidivism").

Paragraph (b) does not take a stance on which, if any, of these modes of risk assessment is preferable. Instead, it permits expert testimony concerning a person's future mental condition or behavior, including the person's risk for violence, if the testimony is relevant, is within the witness's specialized knowledge, and is based on reliable techniques and practices. The paragraph then identifies some of the assessment "considerations" a court should look for in determining whether the techniques and practices used in making the proffered assessment are reliable.

Finally, as with expert evaluations of past mental state, experts should minimize conclusory language. Because numerous non-clinical variables—ranging from the nature of the proceeding to the legal threshold for considering a person high risk—may be relevant, experts should not be expected to opine that an individual "is" or "is not" dangerous.[82] Rather, the expert should, if possible, estimate the probability that the individual, or individuals with characteristics like the defendant, will act in a particular way, leaving to the trier of fact the determination whether that risk crosses dangerousness' legal threshold. As with present and past mental state, however, courts and lawyers may demand ultimate conclusions from experts. Once again, under paragraph (c), if the jurisdiction requires testimony whether or not a person is dangerous, the evaluator should use cautionary language to explain the boundaries of the expert's clinical expertise and the limitations of the expert's opinion.

Standard 7-3.9. Qualifications for evaluating and testifying mental health professionals

(a) Court-appointed evaluators. No professional should be appointed by the court to evaluate a person's mental condition unless the court determines that the professional's qualifications include:

(i) sufficient professional education and clinical training as set out in Standard 7-3.10, as well as sufficient experience, to establish the clinical knowledge required for the specific type(s) of evaluation(s) being conducted; and,

(ii) sufficient forensic knowledge, gained through specialized training or an acceptable substitute therefor, necessary for understanding the relevant legal matter(s) and for satisfying the specific purpose(s) for which the evaluation is being ordered.

[82] Consider, for instance; which of the following more clearly qualifies as "dangerousness:" a 5% risk that a person will kill someone in the next 5 years, or a 40% risk that a person will steal from a store in the next 12 months? These questions are not within the specialized knowledge of a mental health professional.

(b) Evaluators who testify. No witness should be qualified by the court to present expert opinion testimony on a person's mental condition unless the court determines that the witness:

(i) has sufficient professional education and clinical training as set out in Standard 7-3.10, as well as sufficient experience, to establish the clinical knowledge required to formulate an expert opinion; and,

(ii) has either:

(A) acquired sufficient knowledge, through forensic training or an acceptable substitute therefor, relevant to conducting the specific type(s) of mental evaluation actually conducted in the case, and relevant to the substantive law concerning the specific matter(s) on which expert opinion is to be proffered; or,

(B) has had a professional therapeutic relationship with the person whose mental condition is in question and will limit the testimony to matters concerning the defendant's general mental condition as presented during the therapeutic relationship; and

(iii) has performed an adequate evaluation, including a personal interview with the individual whose mental condition is in question, relevant to the legal and clinical matter(s) upon which the witness is called to testify.

(c) Scientific experts. As indicated in Standard 7-1.3(b), expert testimony may involve issues of present scientific or clinical knowledge and may be presented by an expert who has not evaluated the defendant. No witness should be qualified by the court to present expert testimony on issues of present scientific or clinical knowledge unless the court determines that the witness:

(i) has a degree in an appropriate medical or scientific discipline; and,

(ii) has relevant clinical or research experience and demonstrated familiarity with current scientific or clinical information on the specific issue on which the witness is called to testify.

(iii) Professional credentials and general practical experience should not, in and of themselves, constitute a demonstration of expertise

sufficient to warrant qualification as an expert witness on issues of present scientific or clinical knowledge.

Commentary

Standard 7-3.9, which works in tandem with standard 7-3.10, confirms the courts' obligation to ensure that mental health professionals appointed to evaluate and testify about a defendant's mental condition possess the expertise requisite for a competent evaluation. Paragraph (a) deals with the qualifications for evaluators, paragraph (b) with the qualifications for expert witnesses who testify about the defendant, and paragraph (c) with the qualifications for experts who testify about general scientific information relevant to the case.

Forensic Evaluators

A court must of course be satisfied that an evaluator's professional education, training, and experience are sufficient to ensure a clinically sound evaluation. That is the subject of standard 7-3.10. This standard emphasizes that the evaluator must also be conversant with the legal concepts on which an evaluation order rests and able to formulate an opinion relevant to them. Indeed, it is unethical for psychiatrists to practice outside their area of expertise.[83] The American Psychological Association likewise requires its members to maintain currency in developments directly related to the services they render and to limit their practices to their demonstrated areas of professional competence.[84] Thus, a prerequisite to appointment as a professional evaluator to assess a person's present mental condition must be an understanding of the jurisdiction's legal standard for present mental competency. Similarly, knowledge of the jurisdiction's test for mental nonresponsibility is an indispensable requirement for those professionals appointed to reconstruct a defendant's mental state at the time of an alleged offense. Ideally, evaluators will have acquired the requisite forensic knowledge through formalized training courses such as those described in standard 7-1.7(d).

Witnesses on Defendants' Mental State

Traditionally, educational attainments have been the focus of judicial inquiry into expert witness qualifications. However, just as with evaluators, it should be recognized that "the scope of the training of the [mental health professional] is of critical importance [and] many factors other than academic degrees go to the admissibility and weight of the expert testimony;"[85] thus, familiarity with the

[83] Medical Ethics, supra note 17, ann. 3.
[84] Ethical Principles, supra note 18, § 2.01.
[85] Jenkins v. United States, 307 F.2d 637, 650 (D.C. Cir. 1962) (Burger, J., concurring).

relevant legal inquiry and appropriate methods for addressing it is also crucial. Further, even well-educated and well-trained professionals may do such a poor job evaluating the defendant that they are not qualified to offer an opinion in the case at hand. Accordingly, under paragraph (b), three criteria should govern the qualification of mental health professionals to testify as expert witnesses. First, the professional should meet certain clinical educational and training requirements, as detailed in standard 7-3.10. Second, as with evaluators, the professional should have acquired specialized forensic knowledge on the substantive and procedural legal principles to which the expert testimony will relate.[86] Third, a mental health professional should have conducted a thorough evaluation, including a personal interview, addressing the legal and clinical matters at issue.

Paragraph (b)(ii)(B) creates an exception to the second of these requirements where the professional's relationship with the defendant has been therapeutic rather than forensic in nature. In this instance, the witness need not have forensic education nor training. But, concomitantly, such a professional's testimony must be limited to the defendant's general mental condition. Mental health professionals in a treatment relationship with a patient may help the trier of fact gain a deeper understanding of the range of symptoms the patient has experienced and their effect on the patient's general thinking and behavior. However, such testimony should not substitute for testimony provided by a properly trained forensic professional who has conducted an evaluation focused on the legal matter in question; rather, it should serve as adjunct to such testimony, intended to enhance an understanding of the individual's underlying condition without addressing specifically how that condition might bear on the legal matter.

The position expressed in subparagraph (b)(iii) is that a personal interview with the subject of expert testimony is a prerequisite to qualification as a mental health expert witness. Such personal contact is a given if the witness has been the individual's therapist. But courts have long permitted forensic experts to express their opinions in response to hypothetical questions about individuals they have not evaluated; these courts have reasoned that the lack of a personal interview bears on the weight and not the admissibility of the expert's opinion.[87] Subparagraph (b)(iii) rejects this view, and instead states that a personal interview is indispensable to a valid opinion about a given individual. This position is aligned with ethical principles recognized by the mental health professions.[88] It is also consistent with a

[86] So, for example, a mental health professional asked to assess a defendant who has raised the mental nonresponsibility defense should have not only clinical training in evaluating mental disorders, but also training in the reconstruction of a person's mental condition at some time in the past and application of the jurisdiction's legal test for nonresponsibility.

[87] See, e.g., Comm. v. Lawrence, 313 A.3d 265 (Pa. 2024); State v. Skaggs, 120 Ariz. 467, 586 P.2d 1279 (1978); People v. Bassett, 69 Cal. 2d 122, 443 P.2d 777, 70 Cal. Rptr. 193 (1968).

[88] Medical Ethics, supra note 17, §7, ann. 3; Ethical Principles, supra note 18, § 9.01(b).

number of legal sources. Although the Supreme Court has not imposed a constitutional barrier to hypothetical questions,[89] other courts and many commentators have recognized the importance of direct communications with the defendant in formulating expert psychiatric and psychological opinion.[90] The commentary to Federal Rule of Evidence 705, while permitting hypothetical queries, also questions the practice, which is seen as "encouraging partisan bias, affording an opportunity for summing up in the middle of the case, and as complex and time consuming." In the psychiatric context, it can be added that hypotheticals are unlikely to capture the nuances of mental conditions that a good mental health evaluator would consider important. Only through an evaluation that includes a personal interview can the professional acquire the necessary basis to formulate a competent opinion about a defendant's mental condition.

Witnesses on Present Scientific or Clinical Knowledge

If expert opinion is not focused on a particular criminal defendant, but rather is limited to an issue of present scientific or clinical knowledge as described in standard 7-1.3(c), the witness need not satisfy the requirements recommended in paragraphs (a) and (b). For example, an expert who offers only an opinion on the physiological effects of a neuroleptic medication, the key features of schizophrenia, or the risk factors for suicide does not have to be aware of the legal tests at issue in the case, have completed forensic training, or have conducted a personal interview with a defendant. Nor need the expert determine whether the defendant has taken particular medication, has schizophrenia, or is suicidal.

However, expert opinion concerning matters of current scientific or clinical knowledge is only admissible if, as with other types of expert testimony, it will assist the trier of fact to understand evidence more fully or to determine a disputed fact. Courts must be satisfied that sources of expert opinion on matters of current scientific or clinical knowledge are qualified sources. Traditionally, in this context, the only qualification courts have imposed has been possession of a medical or other relevant professional degree, with deficiencies in experience or familiarity with current scientific or clinical knowledge going to the weight and not the admissibility of the testimony. Paragraph (c) recommends the rejection of that practice. Courts should inquire into a proffered expert's professional qualifications to present

[89] Barefoot v. Estelle, 463 U.S. 880, 904-905 (1983) (upholding hypothetical opinions in a death penalty case against a due process challenge).

[90] For instance, Chief Judge David L Bazelon described a personal interview as "the basic tool of psychiatric study." Rollerson v. United States, 343 F.2d 269, 274 (D.C. Cir. 1964) (citing texts and articles); Doctor Bernard Diamond and Professor David Louisell have characterized clinical testimony in response to hypothetical questions as "of doubtful worth and often of dubious ethical quality." Bernard Diamond & David Louisell, The Psychiatrist as an Expert Witness: Some Ruminations and Speculations, 63 Mich. L. Rev. 1335, 1347 (1965) (characterizing clinical testimony in response to hypothetical questions as "of doubtful worth and often of dubious ethical quality.").

relevant expert opinion evidence before allowing the expert to testify. Such an inquiry necessitates an evaluation of a proposed witness's clinical or research experience and familiarity with current scientific knowledge that is germane to the specific matter on which the witness has been called to testify.

Standard 7-3.10. Establishing minimum professional education and clinical training requirements for evaluators and expert witnesses; recommended requirements

(a) Every jurisdiction should establish, by statute, regulation, or court rule, minimum professional education and training requirements necessary to qualify persons for the performance of roles identified in Standard 7-3.9.

(b) In developing such minimum requirements, jurisdictions should take the following general factors into consideration:

(i) Necessary and desirable education and training requirements should differ according to the specific subject matter of the evaluation(s) being performed and the specific legal purpose(s) for which expert opinion is being solicited; and,

(ii) Sufficient flexibility should be provided to permit the courts to utilize persons who clearly demonstrate the requisite knowledge notwithstanding their lack of the formal education or training that may be specified in the requirements. However, experience in performing evaluations or in testifying as an expert should not, by itself, constitute a sufficient demonstration of the requisite clinical knowledge.

(c) In establishing minimum professional and education and clinical training requirements, each jurisdiction should strive for the highest possible qualifications and should adopt the following recommended minimum requirements, their foreign equivalent, or such higher requirements as may be feasible and appropriate:

(i) When an evaluation concerns a person's competence to proceed and other mental conditions at the time of the evaluation or a person's need for treatment, evaluators and expert witnesses should be either:

(A) a licensed physician who has successfully completed at least two years of postdoctoral specialty training in a psychiatric residency program approved by the American Board of Psychiatry

and Neurology (or one year of internship and one year of such residency training) or its foreign equivalent; or,

(B) a psychologist who has received a doctoral degree in psychology from an educational institution accredited by an organization recognized by the Council on Postsecondary Accreditation or its foreign equivalent, and who is licensed as a psychologist if the jurisdiction requires licensure; or,

(C) a clinical social worker who has received a master's degree in social work with an emphasis on clinical practice from an educational institution accredited by the Council on Social Work Education or its foreign equivalent, and who has completed a minimum of two years or three thousand hours of postgraduate supervised clinical experience in the diagnosis, assessment, and treatment of mental disorders in an appropriate clinical setting, and who is licensed or certified as a social worker if the jurisdiction requires licensure or certification; or,

(D) a clinical specialist in psychiatric nursing or a psychiatric nurse, who has received a master's degree in psychiatric nursing from an educational institution accredited by an organization recognized by the National League of Nursing or its foreign equivalent, and who is licensed or certified if the jurisdiction requires licensure or certification for the respective discipline.

(ii) When an evaluation concerns a person's mental condition at the time of an alleged crime, or a person's future mental condition or behavior when these issues arise within a sentencing proceeding or a special commitment proceeding held pursuant to Standard 7-4.14 or Standard 7-7.4, the evaluator or expert witness should be either:

(A) a licensed physician who has completed the postdoctoral specialty training in a psychiatric residency program approved by the American Board of Psychiatry and Neurology or its foreign equivalent; or,

(B) a psychologist who has received a doctoral degree in psychology from an educational institution accredited by an organization recognized by the Council on Postsecondary Accreditation or its foreign equivalent, and who is licensed as a psychologist if the jurisdiction requires licensure.

(iii) A licensed physician who does not meet the requirements of specialty training in psychiatry established in this Standard but who has completed the postdoctoral training requirements of another medical specialty, may, upon performing an adequate evaluation, qualify to testify as an expert witness regarding any physical condition or any organically based mental disability within the scope of the professional's specialized knowledge.

(iv) A certified special education teacher, speech or language pathologist, or an audiologist, who is licensed or certified if the jurisdiction requires licensure or certification for the respective discipline, may, upon performing an adequate evaluation, qualify to testify as an expert witness regarding a disability within the scope of the professional's specialized knowledge.

Commentary

Paragraph (a) sets forth the principle that each jurisdiction should specify minimum professional education and clinical training requirements for persons serving as court-appointed evaluators and expert witnesses in the criminal and criminal commitment proceedings governed by this chapter. Differing requirements, however, may be appropriate depending on whether the proceeding is a criminal trial, a sentencing hearing or a commitment proceeding, and depending on whether a court or jury makes the relevant legal determination. The standard also recognizes that education and training requirements cannot be uniform throughout the nation because the numbers and existing qualifications of mental health professionals vary widely; other factors such as urban and rural demography and geographical size of a jurisdiction also must be considered in setting standards for qualification.

Paragraph (b) recognizes that the subject matter of evaluations and the legal purposes for which expert opinions are solicited should be taken into account in formulating professional education and training requirements. Evaluations or expert opinions for one purpose (e.g., reconstruction of past mental state) may require different education and training than another purpose (e.g., use of an actuarial instrument aimed at assessing risk). Moreover, the standard advocates flexibility in administering education and training requirements, so that persons with demonstrably acceptable levels of knowledge are considered qualified even though they lack the formal education and training that might be required for members of their profession by statutes, regulations, or court rules; for instance, masters level clinicians might be qualified to testify about risk even though, in the jurisdiction in

question, psychiatrists have traditionally been the source of this type of testimony.[91] At the same time, paragraph (b) provides that the fact that one has performed evaluations or testified in the past, by itself, should be insufficient to qualify as an expert witness on mental state issues.

Paragraph (c) provides concrete elaboration of these views by recommending aspirational minimum educational requirements. The standard recognizes that formulating pattern statutes or codes on this issue is difficult, particularly in light of the diversity of American jurisdictions. Such proposals are vulnerable to criticism from the polar extremes of those who believe that too high a standard will result in a class of qualified professionals that will be unrealistically small and those who maintain that too low a standard will enable unqualified individuals to participate. The task of formulating criteria is complicated further if different education and training requirements govern separate types of evaluations. Despite these difficulties, the standard provides that the model incorporated in paragraph (c) is a proper starting point for implementation in various jurisdictions. The standards in Part III can have a lasting impact only if courts and legislators acknowledge the inadequacy of existing standards governing professional evaluations and expert testimony and improve them as swiftly as possible.

At the same time, paragraph (c) acknowledges that qualifications can vary significantly depending on the issue. For instance, it assumes that the qualifications necessary to carry out assessments of competence to proceed or other issues of present mental condition may be met more easily than those requiring a reconstruction of mental condition at the time of an alleged crime or a prediction of future mental condition or behavior. Therefore, it requires fewer education and training requirements for assessments of present mental condition than for other evaluations, and thereby enlarges the pool of potential evaluators and expert witnesses on competence questions (which are by far the most numerous evaluations, as Part IV makes clear). Not only doctoral level psychologists but social workers and psychiatric nurses with master's degrees may be qualified to perform these evaluations. Subparagraph (c)(i)(A) takes the same position with respect to physicians who have completed two years of postdoctoral specialty training in a psychiatric residency program; however, that provision also declares insufficient for competence evaluations and expert opinion testimony completion of only the first postdoctoral year, commonly known as the internship year, because frequently it is focused solely on internal medicine.

[91] See, e.g., In re Commitment of Dodson, 311 S.3d 194 (Tex. 2010) (permitting person with a master's degree in counseling and psychotherapy, a doctorate in family sciences, twelve years of experience working with sex offenders, and experience using actuarial instruments to testify about mental abnormality and risk in a sex offender commitment proceeding, where the statute provides that "no person shall be committed as a person of unsound mind except on competent medical or psychiatric testimony.").

Qualifications should be more demanding for evaluators and expert witnesses on issues of past or future mental state. In these two areas, only psychiatrists who have completed at least two years of postdoctoral specialty training in a residency program approved by the American Board of Psychiatry and Neurology, or its foreign equivalent (or one year of residency training plus a year of internship), and clinical or counseling psychologists with a doctorate in psychology from an educational institution accredited by an organization recognized by the Council on Post-Secondary Accreditation, or its foreign equivalent, should be considered competent. The policy embodied in this restricted view of professional qualifications responds to criticisms levied against professionally inadequate expert opinion evidence on these more complicated matters.

Subparagraph (c)(iii) recognizes that some physicians who do not specialize in mental health issues—for example, neurologists—nevertheless may testify on medical questions within their area of expertise. A special education teacher, a speech and language pathologist, or an audiologist may be helpful in evaluating a defendant's ability to communicate, understand, and learn. Subparagraph (c)(iv) recognizes that professionals in these fields should be considered qualified to testify as expert witnesses in appropriate cases.

Standard 7-3.11. Presentation of expert testimony

(a) An attorney intending to call an expert witness should assist the expert in preparing for trial consistent with Standard 7-3.6(c).

(b) The expert's opinion should be presented in a form consistent with Standard 7-3.8.

(c) The expert should identify and explain the theoretical and factual basis for the opinion and the reasoning process through which the opinion was formulated. 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; and

(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.

(d) Every jurisdiction should promulgate written guidelines designed to inform and advise mental health professionals called to testify as expert witnesses about all aspects of the law and procedure within that jurisdiction applicable to the effective presentation of expert opinions.

Commentary

Standard 7-3.11 promotes improved mental health expert testimony by calling on attorneys to prepare their experts for direct and cross-examination and calling on experts to explain their data and the rationales underlying their opinions.

Preparing Expert Witnesses for Trial

The Standards for the Prosecution Function and the Standards for the Defense Function impose an obligation on attorneys to "explain to the expert his or her role in the trial as an impartial expert called to aid the factfinders and the manner in which the examination of witnesses is conducted."[92] An attorney's unexplained failure to adequately prepare a mental health expert witness may constitute ineffective assistance of counsel,[93] and subject the attorney to professional discipline. Standard 7-3.11(a) confirms the responsibility of attorneys to prepare the expert, albeit with the caveat that such preparation be consistent with standard 7-3.6(c)'s stipulation that the attorney not coach or try to distort the expert's opinion.

The nature and duration of this preparation will depend upon the familiarity of each party with the other's role and the forensic expert's knowledge of relevant law and the appropriate scope of expert testimony. At its most basic level, the attorney should explain the legal implications of the expert's clinical observations, so that the expert can explain the opinion in a way that effectively advocates for the expert's (albeit not necessarily the attorney's) view. Counsel should also apprise the witness of the likely course of direct and cross-examination, evidentiary privileges that may affect the scope of testimony, such as the attorney-client privilege, work-product privilege, and professional-patient/client privilege, and the implications of the hearsay rule (discussed further below). Additionally, as paragraph (b) indicates, a professional should know the requirements for qualifying as an expert set out in

[92] See Standards for the Prosecution Function, standard 3-3.3(a) and Standards for the Defense Function, standard 4-4.4(a). The commentary to those standards clarifies the requirement by stating that the prosecutor and defense attorney "should explain the workings of the adversary system and the expert witness' role within it as an independent and impartial expert."

[93] See, e.g., Boykins v. Wainwright, 737 F.2d 1539, 1541-1542 (11th Cir.), reh'g denied, 744 F.2d 97 (11th Cir. 1985).

standard 7-3.8, which requires specialized knowledge that can assist the trier of fact and recommends that the expert use cautionary language if asked to express legal or moral, rather than clinical and scientific, judgments.[94] Experts should understand that, even if they are called by a particular side, they are impartially providing their opinion, not the opinion of the party that puts them on the stand.

Presenting the Bases for Expert Opinions

Paragraph (c) requires that mental health professionals who testify explain the theoretical and factual bases for their opinions and the reasoning process through which they arrived at those opinions. The premise of this provision is that presenting a conclusory opinion without providing all the supporting data is impermissible. Factfinders must be given a full opportunity to evaluate the credibility of an expert's opinion. They can do so only if the theoretical and the predicates for and the rationale underlying the opinion are explained to them.

This requirement can be in tension with evidentiary and constitutional rules, which often exclude out-of-court declarations. Mental health professionals frequently make use of information that the law considers hearsay (e.g., chart notes, interviews of third parties such as relatives or employers) in conducting evaluations. It is not uncommon for an evaluator to interview members of a defendant's family, the defendant's acquaintances, mental health professionals who have treated the defendant in the past, witnesses to the alleged offense, and security staff who have observed the defendant in detention, and then to rely on the statements these individuals provide in formulating an opinion. Whether a court should allow the professional to refer to these data in courtroom testimony, without having the source of the information available in court for cross-examination, is controversial.

Generally, a mental health expert will be permitted to rely on such third-party information in reaching an opinion and refer to this information in testimony explaining their opinion if: (1) the information is of a type customarily relied on by other qualified professionals in the expert witness's profession to formulate opinions and (2) the court determines the probative value of the evidence outweighs its prejudicial effect. For instance, Rule 703 of the Federal Rules of Evidence provides: "The facts or data in the particular case upon which an expert bases an opinion or inference may be those perceived by or made known to the expert at or before the hearing. If of a type reasonably relied upon by experts in the particular field in forming opinions or inferences upon the subject, the facts or data need not be admissible in evidence in order for the opinion or inference to be admitted. Facts or data that are otherwise inadmissible shall not be disclosed to the jury by the proponent of the opinion or inference unless the court determines that their probative

[94] Standard 7-3.9(a).

value in assisting the jury to evaluate the expert's opinion substantially outweighs their prejudicial effect." The language in paragraph (c) is similar to the language in Rule 703, but it intentionally avoids that rule's placement of the word "substantially" before "outweighs," on the ground, explained above, that the expert should explain, and be allowed to explain, all probative facts underlying the opinion.

Of course, if the facts do not meet the probative value threshold, they should not be relied on in the first place.[95] But assuming this threshold is met, paragraph (c) urges experts to describe the factual basis of their opinions unless it is subject to exclusion under the Supreme Court's Confrontation Clause jurisprudence barring prosecution use of "testimonial" statements, a term the U.S. Supreme Court has generally interpreted to mean statements made in anticipation of trial by a person who has not been subject to cross-examination prior to trial and is not a witness at trial.[96] Although statements made to a forensic evaluator are usually made in anticipation of trial, judicial treatment of prosecution experts' reliance on hearsay has been variable.[97] In *People v Goldstein*,[98] the New York Court of Appeals ruled that the defendant's Sixth Amendment right to confront witnesses against him was abridged by the introduction, through the state's expert, of third party information (i.e., statements obtained by the evaluator from a police officer, a roommate, a landlady, and a the girlfriend of a former roommate). At the same time, the court allowed the state's expert to share her opinion without referring to the third-party information. Similarly, in *United States v. Lombardozzi*,[99] the Second Circuit held that an expert could rely on testimonial statements, but could not communicate them or directly convey their substance to the jury.[100] In contrast, the Fourth Circuit, in *United States v. Johnson*,[101] held that experts are permitted to describe not only their opinion but the hearsay underlying it unless the expert "is used as little more than a conduit or transmitter for testimonial hearsay, rather than as a true expert whose considered opinion sheds light on some specialized factual situation."[102] The Fourth Circuit repeated this reasoning in *United States v. Ayala*,[103] explaining that "the question when applying *Crawford* to expert testimony is 'whether the expert is, in essence, giving an independent judgment or merely acting as a transmitter for testimonial hearsay.'"[104]

[95] See Note, Hearsay Bases of Psychiatric Opinion Testimony: A Critique of Federal Rule of Evidence 703, 51 S.Cal. L. Rev. 129 (1977) (arguing that much of the third party information relied on by mental health experts—including statements from third parties--should be subjected to adversarial testing).
[96] See, e.g., Crawford v. Washington, 541 U.S. 36, 51-52 (2004); Ohio v. Clark, 576 U.S. 237, 246-251 (2015)..
[97] Ian Volek, Federal Rule of Evidence 703: The Back Door and the Confrontation Clause, Ten Years Later, 80 Fordham L. Rev. 959, 995 (2011).
[98] 6 N.Y.3d 119, 843 N.E.2d 727, 810 N.Y.S.2d 100 (2005),
[99] 491 F.3d 61 (2d Cir. 2007).
[100] Id. at 74 (but also holding that the revelation of the testimonial evidence did not affect the defendant's "substantial rights").
[101] 587 F.3d 625 (4th Cir. 2009).
[102] Id. at 635.
[103] 601 F.3d 256 (4th Cir. 2010).
[104] Id. at 275.

In light of these developments, experts must anticipate that attorneys for the opposing party will object to their description of third party statements, on either Confrontation Clause or hearsay/Rule 703 grounds. Experts who rely on such statements (and the attorneys who call them as witnesses) should be ready to explain why they are probative and that they will be disclosed for the sole purpose of explaining the expert opinion. If the objection is nonetheless sustained, one response is to make sure the relevant third parties are in court and repeat the statements they made to the expert, subject to cross examination. In cases where the Confrontation Clause is not an issue (because, for instance, the expert is testifying for the defense), another option, subscribed to in paragraph (c), is to permit the hearsay to be described if it can be shown that the expert reasonably relied on it (because, for instance, corroborating evidence is provided or the evidence is otherwise clearly reliable). If neither of these options are available, the expert may be forced to give an opinion that cannot be fully supported and that the jury cannot adequately evaluate. Whether doing so is ethical under the mental health professions' rules is unclear.[105]

Paragraph (d) calls on jurisdictions to promulgate written guidelines addressing these and other issues, in order to advise mental health professionals called to appear as experts about all aspects of the law and procedure applicable to their effective participation in court.

Standard 7-3.12. Jury instructions

(a) The court should instruct the jury concerning the functions and limitations of mental health professional expert testimony. As provided for in Standard 15-4.4(d), preliminary instructions should be given prior to the introduction of the expert testimony. The jury should be informed that the purpose of such testimony is to identify for the trier of fact the clinical factors relevant to the issues of past, present, and future mental condition or behavior that are under consideration.

(b) Jurors also should be informed that they are not asked or expected to become experts in medicine, psychology, or other behavioral sciences and that their task is to decide whether the explanation offered by a mental health professional is persuasive. In evaluating the weight to be given a mental health professional's opinion, the jury should consider the qualifications of the witness, the theoretical and factual basis for the mental health professional's

[105] See Ethical Principles of Psychologists and Code of Conduct, supra note 18, at § 9.10 (psychologists should "take reasonable steps to ensure that explanations of results are given to the individual or designated representative").

opinion, and the reasoning process by which the information available to the expert was utilized to formulate the opinion. In reaching its decisions on the ultimate questions in the trial, the jury is not bound by the opinions of expert witnesses. The testimony of each witness should be considered in connection with the other evidence in the case and given such weight as the jury believes it is fairly entitled to receive.

Commentary

Jurors require guidance concerning the nature of mental health professional testimony, which they are most likely to hear when the defendant is asserting a mental state defense at trial or mitigation at capital sentencing. Paragraph (a) provides that they should be given preliminary instructions immediately before such testimony is offered,[106] advising them that it is meant to assist them in evaluating the defense argument by providing opinions based on specialized knowledge and by explaining the reasoning behind those opinions. Jurors should also be told that the opinions are not to be taken as dispositive, but instead are aimed at providing possible explanations for the defendant's behavior and thinking. As Professors Bonnie and Slobogin have noted, while mental state testimony is seldom provably accurate, "[e]xpert opinion can offer valuable assistance not only by suggesting explanations for puzzling behavior, but also by gathering and integrating information that otherwise might appear random or of questionable significance. The expert may suggest a conceptual framework that, if accepted by the factfinder, can serve as an organizational and interpretational tool that neither the factfinder nor counsel could have supplied."[107]

Paragraph (b) provides that appropriate instructions should also cover the jury's role in evaluating mental health expert testimony once given. They should be reassured that they need not become experts in psychology, but rather must rest their decision on all of the evidence, including expert opinion testimony. They can be told that they may find some experts more credible than others, may give one expert's opinion more weight than another's, or may reject all of the expert testimony and rely, instead, on the other evidence in the case and any instructions regarding its use.

[106] Cf. standard 6-2.6(b) ("The trial judge should conduct the trial in such a way as to enhance the jury's ability to understand the proceedings and to perform its fact-finding function.").
[107] Bonnie & Slobogin, supra note 65, at 488.

PART IV. COMPETENCE TO PROCEED: GENERAL PROVISIONS

INTRODUCTION

Part IV addresses the general test for competence to proceed, procedures for evaluating and adjudicating the issue, and rules governing the disposition of those defendants found incompetent. The Standards use the term "competence to proceed" rather than "competence to stand trial" in part to underscore that competence concerns much more than the defendant's ability to participate in a trial process. Given that most defendants plead guilty, typically as part of a negotiation with the prosecutor, a defendant's abilities to work with counsel prior to trial may be of greater significance than how he or she would fare in a trial. Defendants must also be competent to be sentenced and participate in other post-adjudication proceedings. Thus, "competence to proceed" more accurately characterizes the question. The competency standard presented in standard 7-4.1 applies "when the defendant is represented by counsel." Standards for competence to waive representation by counsel and to proceed pro se are found in standard 7-5.3. Post-adjudication competence to proceed is addressed in standards 7-8.7, 7-9.7 and 7-9.8.

Background

Many members of the public—and some attorneys, judges, and mental health professionals as well—conflate incompetency to proceed with the "insanity" defense (which is called the mental nonresponsibility defense in these Standards). Yet the two doctrines are clearly distinct as to their purpose, their governing tests, the procedures associated with raising and determining relevant issues, and the disposition of defendants who meet the relevant test. The defense of mental nonresponsibility is an affirmative defense to criminal charges that, if established, declares that the defendant is not criminally responsible because of an impaired mental state at the time of the offense. The doctrine of incompetence to proceed, in contrast, has no bearing on guilt or innocence, but rather is focused on the defendant's mental state after prosecution for an offense begins. It determines when society is foreclosed from pursuing criminal charges against defendants who, because of mental disability, cannot understand the nature of the proceedings or are unable to assist in their defense. Although the defense of mental nonresponsibility attracts far more controversy and commentary, in purely quantitative terms the determination of incompetence to proceed affects a far larger number of criminal defendants, with one survey indicating that the annual rate of commitment to a state psychiatric hospital of defendants found incompetent is ten times higher than the annual commitment rate of those acquitted by reason of mental nonresponsibility.[1]

[1] W. Lawrence Fitch, White Paper for NASMHPD: Forensic Mental Health Services in the United States 8, 17 (2014) (45 state survey comparing hospitalizations for competency evaluations and insanity evaluations).

Development of Incompetence to Proceed Doctrine

The doctrine that defendants should not be tried while mentally incompetent had its origins in the common law, dating to medieval times in England. Blackstone noted that a defendant should neither plead nor be tried if "mentally defective."[2] Although English courts did not articulate specific criteria establishing the degree of defect necessary to avoid trial, the common law expressed two philosophical bases for the doctrine: (1) conviction and punishment of a "lunatic" would not deter future criminal acts; and (2) it was fundamentally unfair to try a defendant who might be unable, because of mental incapacity, to present evidence in defense.[3]

The British common law rules preventing trial of mentally incompetent defendants were transposed virtually intact into early nineteenth century United States jurisprudence.[4] By the end of that century, the doctrine had achieved constitutional status. In *Youtsey v. United States*,[5] the Sixth Circuit Court of Appeals, citing common law authorities, stated that "it is not due process of law to subject an insane person to trial upon an indictment involving liberty or life;" the court also held that the trial judge had a duty to investigate and decide the issue once "tendered" by counsel.[6] Seven years after *Youtsey*, *United States v. Chisholm* further defined the applicable standard in terms of whether "the mental impairment of the prisoner's mind . . . disables him . . . from fairly presenting his defense."[7] Following *Chisholm*, and throughout the first half of the twentieth century, most jurisdictions affirmed the need to inquire into a defendant's understanding of the trial process and ability to assist in the defense, a trend that accelerated as the medical discipline of psychiatry became increasingly sophisticated.[8] In 1960, the United States Supreme Court entered the arena with its landmark decision in *Dusky v. United States*,[9] which established the legal definition of competence to proceed that governs today: "[T]he test must be whether [a defendant] has sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding — and whether he has a rational as well as factual understanding of the proceedings against him."[10]

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[2] 4 W. Blackstone, Commentaries 24 ("[I]f a man in his sound memory commits a capital offence, and before arraignment for it, he becomes mad, he ought not to be arraigned for it; because he is not able to plead to it with that advice and caution that he ought. And if, after he has pleaded, the prisoner becomes mad, he shall not be tried: for how can he make his defence?").
[3] Frith's Case, 22 Howell's St. Trials 1281 (1800).
[4] United States v. Lawrence, 26 F. Cas. 887, 889-891 (D.C. Cir. 1835).
[5] 97 F. 937 (6th Cir. 1899).
[6] Id. at 944.
[7] 149 F. 284, 289 (S.D. Ala. 1906).
[8] See Ira Mickenberg, Competency to Stand Trial and the Mentally Retarded Defendant: The Need for a Multi-Disciplinary Solution to a Multi-Disciplinary Problem, 17 Cal. West. 365, 371-72, 375 (1981) ("[t]he historical development of the competency doctrine can thus be viewed as a progression from a rough concept of basic fairness to a complex issue requiring expert medical and legal judgment.").
[9] 362 U.S. 402 (1960).
[10] Id. at 402.

Supreme Court cases since *Dusky* have confirmed this formulation and elaborated on the procedures for determining whether it is met. In *Pate v. Robinson*,[11] the Court held that, as a matter of due process, a hearing is mandated whenever the "evidence raises a bona fide doubt as to the defendant's competence to stand trial."[12] In *Drope v. Missouri*,[13] the Court reiterated the *Robinson* holding, and explicitly recognized a trial judge's constitutional obligations to resolve competence issues and to be alert before and during trial to evidence suggesting that the defendant cannot understand or participate in the proceedings.[14] *Jackson v. Indiana*[15] applied the equal protection and due process clauses to the disposition of defendants found incompetent, holding that the Constitution permits confinement of such individuals in a forensic facility only for the period of time reasonably necessary to restore them to competence, at which point, if restoration has not occurred, release or civil commitment are the only options.[16] *Godinez v. Moran*[17] reaffirmed *Dusky* and adopted its test in determining when a person is competent to plead guilty and waive counsel.

The competence requirement not only protects the defendant's interests, but also imposes duties on the government, duties that may sometimes conflict with the defendant's goals. *Drope* made this clear in its instruction to judges to be alert to signs of incompetency before and during trial and to suspend proceedings in appropriate circumstances, even if defense counsel has not raised the issue.[18] As one commentary noted, "[t]he adversary form of the criminal proceeding necessarily rests on the assumption that the defendant will be a conscious and intelligent participant; the trial of a defendant who cannot fulfill this expectation appears inappropriate and irrational. . . Trial should a reasoned interaction between an individual and his community," not an "invective against an insensible object."[19] This societal interest explains why, among other things, the state may raise the competency issue over the defendant's objection and why defendants found incompetent may be treated involuntarily (see standards 7-4.3 and 7-4.11).

Misuse of the Incompetence Process

Although the question of a defendant's competence to proceed is narrowly focused and meant to be raised only when there are legitimate concerns about a

[11] 383 U.S. 375 (1966).
[12] Id. at 385.
[13] 420 U.S. 162 (1974).
[14] Id. at 181.
[15] 406 U.S. 715 (1972).
[16] Id. at 738.
[17] 509 U.S. 389 (1993).
[18] *Drope*, 429 U.S. at 181-182).
[19] Note, Incompetency to Stand Trial, 81 Harv. L. Rev. 454, 457-458 (1967).

defendant's triability, both defense counsel and prosecutors have been known to broach it with other agendas in mind. Defense counsel may raise the issue hoping that the court will order a mental health evaluation that will turn out to be useful in plea negotiations, mitigation of sentence, or a later proceeding to determine mental nonresponsibility. In other cases, counsel may believe commitment after an incompetency finding better serves the client's interests than proceeding to trial and facing a substantive determination of guilt or innocence. Even if raising the question of competence does not result in the withdrawal of criminal charges, defense counsel may hope it will delay the proceedings, avoid potentially unfavorable media coverage or allow the defense more time to prepare for trial.[20] Prosecutors, in turn, might raise the competence question as means of assuring custody of a defendant (typically in a secure psychiatric hospital) when pretrial release might otherwise occur or the case is weak. According to one review of practices in the 1970s, they may also use a competency evaluation "as a means of curbing anticipated violent behavior; as a form of 'preventive detention' or legal strategy; and, finally, as a way of dealing with individuals when there seems to be no other legal recourse."[21]

The Standards take a strong position against these misuses of the competence process (see in particular, standard 7-4.3(e)). Fortunately, they "are not as pervasive as they once were,"[22] possibly because many state systems have moved from inpatient to outpatient evaluations and treatment, thereby diminishing some of the perceived benefits of a competency motion.

The Standards in Part IV

Part IV of the Standards addresses the various issues that arise when a defendant's competence to proceed is questioned. This part first addresses, in standards 7-4.1 and 7-4.2, the criteria for a finding of incompetence to stand trial and to plead, incorporating almost without change the test set forth in the case of *Dusky v. United States*. The standards make clear that the issue of competence is a legal one, and that mental incompetence may result from any mental disorder or condition that causes the requisite functional impairment. At the same time, having a mental disorder, no matter how serious, does not necessarily render a defendant incompetent.

[20] Gerald Bennett, Symposium of the ABA Criminal Justice Mental Health Standards: A Guided Tour Through Selected ABA Standards Relating to Incompetence to Stand Trial, 53 Geo. Wash. L. Rev. 375, 381-383 (1985) (citing studies).

[21] Jeffrey L. Geller & Eric D. Lister, The Process of Criminal Commitment for Pre-trial Psychiatric Examination and Evaluation, 135 Am J. Psychiat. 53 (1978). Ronald Roesch & Stephen Golding, Competency to Stand Trial (1980) (reporting similar findings in a study of North Carolina practices).

[22] See Gary Melton et al., Psychological Evaluations for the Courts: A Handbook for Mental Health Professionals and Lawyers 129 (4th ed. 2017).

Standard 7-4.3 addresses several complex issues bearing on the responsibility of counsel and courts to raise incompetence issues. It adopts the Supreme Court's reasoning in *Pate* and *Drope* that the primary obligation to raise and alleviate doubts about competence falls upon trial courts. The standard further rests on the premise that incompetency examinations exist for a single purpose—the determination of competency—and that it is improper for either a prosecuting attorney or defense counsel to use them for unrelated purposes. It then addresses the difficult ethical problems that arise when defense counsel believes a client to be incompetent but the client objects to raising the competency question.

Standards 7-4.4 through 7-4.10 deal with procedures for evaluating and adjudicating competency. Among the more important aspects of these standards is a prohibition on the traditional practice of automatic commitment for evaluation of competence, the encouragement of outpatient evaluations, the protection of information obtained during the competency evaluation, and the specific findings that must be made by evaluators and courts before a defendant may be labeled incompetent and subject to restorative treatment. Standard 7-4.11 addresses the incompetent defendant's right to refuse treatment, including treatment with psychoactive medications, relying heavily on the U.S. Supreme Court's opinion in *Sell v. United States*.[23] The remaining standards deal with the disposition of defendants found incompetent. They too encourage outpatient alternatives. They also provide concrete implementation of *Jackson's* limitations on treatment to restore competence. Most significantly, while these standards are consistent with *Jackson* in requiring that defendants found to be unrestorable in the foreseeable future be released or subjected to civil commitment, they allow commitment to take place in a forensic hospital rather than hospitals typically reserved for those subject to civil commitment.

Standard 7-4.1. Competence to proceed; rules and definitions

(a) 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.

(b) The test for determining the defendant's competence to proceed when the defendant is represented by counsel should be whether the defendant has sufficient present ability to consult with counsel with a reasonable degree of rational understanding and otherwise to assist in the defense, and whether the

[23] 539 U.S. 166 (2003).

defendant has a rational as well as factual understanding of the proceedings.

(c) The tests for determining whether the defendant is competent to waive representation by counsel and to proceed pro se are specified in Standard 7-5.3.

(d) The terms *competence* and *incompetence* as used with Part IV of this chapter refer to mental competence or mental incompetence. A finding of incompetence to proceed may arise from any mental disorder or condition as long as it results in a defendant's inability to consult with defense counsel or to understand the proceedings.

Commentary

Standard 7-4.1 addresses two fundamental issues: (1) the basic rule that defendants who are incompetent to proceed may not be tried; and (2) the legal criteria for determining such incompetence. The first principle, captured in paragraph (a), conforms to the apparent conclusion of the Supreme Court that the prohibition is absolute: A defendant determined to be incompetent to stand trial can never be tried on substantive issues of guilt. In *Drope v. Missouri*,[24] the Court characterized this rule as "fundamental to an adversary system of justice."[25] In *Pate v. Robinson*,[26] the Court noted and concurred with the government's stipulation "that the conviction of an accused person [who] is legally incompetent violates due process . . . and that state procedures must be adequate to protect this right."[27] While *Jackson v. Indiana*,[28] did contemplate that some peripheral proceedings could take place "despite the defendant's incompetency" (such as motions to dismiss based on statutes of limitations), it notably omitted any reference to proceedings relevant to determinations of guilt.[29]

Adoption of the position that a defendant who is incompetent can never be tried on guilt-related issues will prevent resolution of a non-trivial number of cases and could possibly undermine public safety.[30] Nonetheless, this standard accepts that rule because, as the Court has made clear, it is required as a matter of fundamental fairness. It promotes the integrity of the process, by ensuring the defendant is able to put forth his or her version of the facts and confront the state's witnesses, the dignity of the defendant, by preventing public adjudications of individuals who cannot fully

[24] 420 U.S. 162 (1974).
[25] Id. at 172.
[26] 383 U.S. 375 (1966).
[27] Id. at 378.
[25] 406 U.S. 715 (1972).
[29] Id. at 740.
[30] Although standard 7-4.14 regarding the secure disposition of those who are unrestorably incompetent should mitigate the latter concern.

participate in them, and the autonomy of the defendant, by ensuring his or her decisions are the product of rational reasoning.[31] Paragraph (a) also makes clear that this competence requirement applies in any criminal proceeding, prior to and during adjudication of guilt,[32] that requires the defendant's participation. The one exception, for obvious reasons, is a proceeding to determine the defendant's competence to stand trial.

Standard 7-4.1(b) sets forth a test for incompetence to proceed taken virtually verbatim from the decisions in *Dusky v. United States*[33] and *Drope*.[34] As noted in the introduction to this Part, in *Dusky* the Court established the standard in these terms: "[The] test must be whether [a defendant] has sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding and . . . a rational as well as factual understanding of the proceedings against him."[35] Standard 7-4.1(b) adds to the *Dusky* formulation language taken from *Drope* requiring that a defendant be able to "assist in his defense,"[36] to emphasize that the defendant should not only be able to communicate with counsel but also have some grasp of the facts that might be relevant to the case. One of the fundamental reasons for the rule is to promote accurate factual determinations of guilt or innocence by enabling the defendant and counsel to collaborate in the preparation and presentation of available defenses. Thus, under this standard, to be competent defendants must be able to: (1) to communicate with defense counsel in a rational manner, (2) "otherwise assist in the defense" by providing counsel information relevant to available defenses, and (3) rationally understand the nature of criminal proceedings and the possible consequences of either conviction or acquittal.

Even with the added language about assisting the defense in paragraph (b), the *Dusky* test is sparse. Several courts and legislators have attempted to identify the abilities a defendant must have to be competent. One of the initial and most elaborate efforts in this regard came from the district court in *Wieter v. Settle*,[37] which held that, to be competent:

> (1) A defendant must have the mental capacity to appreciate his or her presence in relation to time, place, and things; (2) A defendant's elementary mental processes must be adequate to comprehend (a) that the defendant is in a court of justice charged with a criminal offense; (b) that a judge is on the

[31] Richard Bonnie, The Competence of Criminal Defendants: A Theoretical Reformulation, 10 Behav. Sci. & L. 291, 295 (1992).
[32] As noted in the introduction, competence at post-adjudication stages of the process are addressed in standards 7-8.7, 7-9.7 and 7-9.8.
[33] 362 U.S. 402 (1960).
[34] 420 U.S. 162 (197).
[35] *Dusky*, 383 U.S. at 402.
[36] *Drope*, 420 U.S. at 171.
[37] 193 F. Supp. 318 (W.D. Mo. 1961).

> bench; (c) that a prosecutor is present who will seek to convict the defendant of a criminal charge; (d) that the defendant has a lawyer who will undertake to defend against that charge; (e) that the defendant is under no duty to testify in personal but that, if he or she chooses to testify, the defendant will be expected to relate to the best of his or her mental ability the surrounding facts at the time and place of the alleged criminal violation; and (f) that there will or may be a jury present to pass upon evidence adduced as to guilt or innocence of the charge; (3) A defendant must have the mental capacity to participate in an adequate presentation of his or her defense; (4) A defendant electing to enter into plea negotiations or plead guilty must comprehend the consequences of a guilty plea and be able knowingly, intelligently, and voluntarily to waive rights that legally are no longer applicable upon entry of a guilty plea.[38]

Another elaboration on the *Dusky* test is found in the Florida Rules of Criminal Procedure, which require courts to assess whether the defendant has the capacity to: (1) appreciate the charges or allegations; (2) appreciate the range and nature of possible penalties that may be imposed in the proceedings; (3) understand the adversary nature of the legal process; (4) disclose to counsel facts pertinent to the proceedings; (5) manifest appropriate courtroom behavior; and (6) testify relevantly, as well as "any other factors deemed relevant y the experts."[39]

These ways of operationalizing *Dusky* are useful. However, they may fall short in addressing two fundamental questions: (1) whether the defendant's understanding of the proceedings is "rational" (a word that appears twice in the *Dusky* test and in standard 7-4.1); and (2) the defendant's capacity to assist beyond being able to "disclose pertinent facts." An inquiry into whether a defendant "comprehends the consequences of plea," as contemplated in *Wieter*, is deficient if it merely ensures the defendant knows the sentence associated with the plea, without investigating whether the reasons for accepting it are based on delusions. Lists of relevant functional abilities, as occurs with the Florida rules, may be extremely helpful in guiding experts and judges in assessing competence. But in applying these criteria, courts should be careful to avoid substituting judgments on discrete and (often) superficial aspects of a defendant's mental state (such as the capacity to understand charges and recount pertinent facts) for the more important over-arching inquiry into how this defendant, with his or her strengths and weaknesses, will fare in this case, given its circumstances and the particular demands it may place on the defendant.[40] Thus, standard 7-4.1(b), rather than formulating specific sub-criteria to

[38] Id. at 321-322.
[39] Fl.R. Cr. P. 3.211(2).
[40] For instance, Florida law requires that every competency report address all six criteria listed above. Fl. R. Crim. Pro. 3.211(2). But those criteria do not necessarily address other relevant considerations, such as the defendant's ability to relate to counsel, appraise the state's case, be motivated to defend oneself and make rational decisions.

be addressed by courts and evaluators, recognizes that the Supreme Court in *Dusky* and *Drope* has established a basic norm, understandably and necessarily imprecise, that permits individual judges to evaluate each case in the light of an individual defendant's level of functioning in relation to the complexity of that case. As paragraph (c) signals with its cross-reference to the standard on competence to waive counsel, the contextual nature of the competence construct is one reason these Standards contain separate provisions not only on that issue but also regarding competence to plead (see standard 7-4.2).

Both *Dusky* and paragraph (b) use language that makes clear that competence is a legal, not a medical or psychological, question; they focus on the defendant's capacity to perform certain functions, such as communicating with counsel and demonstrating an understanding the legal system, not mental disorder per se. Standard 7-4.1(d) emphasizes that point, by establishing a a clear dichotomy between mental disorder and the legal construct of incompetency. If defendants are capable of meeting the requirements for competence, the presence of a mental disorder is irrelevant. While a diagnosis of mental disorder might help corroborate a claim of incapacity (by, for instance, suggesting that a defendant's misunderstanding of the charges is based on delusions and not malingered), it is never dispositive; the dysfunctions identified in *Dusky* must still be present.

Conversely, a transitory inability to repeat one's charges or their consequences is not, in itself, a demonstration of lack of capacity. Incompetency must be the result of mental impairment, not simply failures on the part of the court or defense counsel to apprise the defendant of the reason for prosecution and the means of pursuing it. Paragraph (d) makes clear that this mental disorder does not have to be associated with a particular type of diagnosis, as long as it causes the legally relevant dysfunction. Again, a determination of competence or incompetence is functional in nature, context-dependent, and pragmatic in orientation, and should be viewed as such by both courts and mental health professionals.[41]

Standard 7-4.2 Competence to Plead

(a) No plea of guilty or nolo contendere should be accepted from a defendant who is incompetent to proceed.

(i) Absent additional information bearing on the defendant's competence, a finding that the defendant is competent to proceed should be sufficient to establish the defendant's competence to enter a plea of guilt or nolo contendere.

[41] Melton et al., supra note 22, at 124-125.

(ii) The test for determining mental competence to proceed with pleading should be whether the defendant has sufficient present ability to consult with defendant's lawyer with a reasonable degree of rational understanding and whether, given the nature and complexity of the charges and the potential consequences of a conviction, the defendant has a rational as well as factual understanding of the proceedings relating to entry of a plea of guilty or nolo contendere.

(b) Evaluations of persons believed to be incompetent to proceed with pleading and treatment of persons found incompetent to proceed with pleading should take place in accordance with this part.

Commentary

Standard 7-4.2 addresses a defendant's competence to plead guilty or nolo contendere. Common law criminal procedure recognized that defendants had to be competent to submit pleas of guilty as well as to undergo trial.[42] That tradition is vested today in the due process clauses of the Constitution, which bar the entry of a judgment of conviction based on a plea of guilty or nolo contendere tendered by a mentally incompetent defendant.[43]

In *Godinez v. Moran*,[44] the Supreme Court assumed that competence to stand trial and competence to plead guilty are inseparable inquiries. Subparagraph (a)(i) of this standard recognizes that, absent additional information bearing on a defendant's competence, a finding that the defendant is competent to proceed generally is sufficient to establish the defendant's competence to enter a plea of guilty or nolo contendere. Nonetheless, subparagraph (a)(ii) draws attention to the factors that matter most when determining a defendant's competence at the pleading stage, by referring not only to "whether the defendant has sufficient present ability to consult with defendant's lawyer with a reasonable degree of rational understanding" but also to whether, "given the nature and complexity of the charges and the potential consequences of a conviction, the defendant has a rational as well as factual understanding of the proceedings relating to entry of a plea of guilty or nolo contendere." This context-dependent approach is taken throughout the standards on competence (in this part, in Part V's standards on competency to waive counsel and proceeding pro se, and in Parts VIII and IX dealing with competency in the sentencing context).

[42] Blackstone, supra note 2, at 24.
[43] See Drope v. Missouri, 420 U.S. 162, 172 (1975).
[44] 509 U.S. 389 (1993).

In the specific context of deciding whether to plead, there has been some support for an independent test for competency. As Professor Bonnie has pointed out, while the requirement that a person be competent to undergo trial is meant to protect the reliability of the proceedings by ensuring the defendant understands the process and can communicate with counsel ("adjudicative competence"), pleading guilty not only requires these abilities but also the ability to make a rational autonomous decision ("decisional competence").[45] Consistent with that view, the Ninth Circuit opinion in *Moran* held that competency to waive constitutional rights, as occurs with a guilty plea, "requires a higher level of mental functioning than that required to stand trial," namely "the capacity for 'reasoned choice' among the alternatives available to him."[46]

The U.S. Supreme Court reversed the Ninth Circuit on this point, making clear that a higher level of competence for pleading guilty is not necessary because even defendants who plead not guilty "may be required to make important decisions once criminal proceedings have been initiated."[47] But *Dusky's* test (and this standard) still require a "rational" ability to consult with counsel and a "rational understanding" of the process. *Moran* itself added that, to be valid, the decision to plead guilty by a competent defendant must be "knowing and voluntary," which requires inquiry into "whether the defendant actually does understand the significance and consequences of a particular decision and whether the decision is uncoerced."[48] It also bears repeating that competence is necessarily context dependent and can vary depending upon the demands on the defendant. For example, a defendant charged with a simple assault may not require the same ability to consult with an attorney and decide how to plead as one charged with tax fraud or racketeering. A defendant who has an anxiety disorder and a history of panic attacks in highly stressful situations may be incompetent to proceed if a contested trial is in the offing and the defendant's testimony will be required, but the same defendant may be competent to consult with counsel in the negotiation of a guilty plea. The additional language in standard 7-4.2(a)(ii) is intended to help focus the court's attention on those aspects of the defendant's competence of greatest moment.

In keeping with *Moran*, these Standards acknowledge that, procedurally, defendants who are incompetent to proceed need be treated no differently whether the defense plan is to go to trial or plead. Accordingly, paragraph (b) provides that the procedures that govern evaluations of a defendant's competence to plead or treatment of a defendant found incompetent to plead are the same as those that apply in cases of general incompetence to proceed. Further guidance on this issue is

[45] Bonnie, supra note 31, at 301.
[46] Moran v. Godinez, 972 F.2d 263, 267-268 (9th Cir. 1992).
[47] 509 U.S. 389, 398 (1993).
[48] Id. at 401 n. 12.

provided in Part V (specifically standard 7-5.2), which deals generally with situations in which the defendant has authority to make decisions but may be incompetent to do so.

Standard 7-4.3. Responsibility for raising the issue of competence to proceed

(a) The court has a continuing obligation, separate and apart from that of counsel for each of the parties, to raise the issue of incompetence to proceed at any time the court has a good faith doubt as to the defendant's competence, and may raise the issue at any stage of the proceedings on its own motion.

(b) The prosecutor should move for evaluation of the defendant's competence to proceed whenever the prosecutor has a good faith doubt as to the defendant's competence. The prosecutor should further advise defense counsel and the court of any information that has come to the prosecution's attention relative to defendant's incompetence to proceed.

(c) Defense counsel may seek an ex parte evaluation or move for evaluation of the defendant's competence to proceed whenever counsel has a good faith doubt about the defendant's competence, even if the motion is over the defendant's objection.

(d) A motion for evaluation should be in writing and contain a certificate of counsel indicating that the motion is based on a good faith doubt about the defendant's competence to proceed consistent with (f). Defense counsel should make known to the evaluator the specific facts that have formed the basis for the motion.

(e) 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 Part II of these Standards, whether the defendant is in jail, the community, or an inpatient facility.

(f) In making any motion for evaluation, or, in the absence of a motion, in making known to the court information raising a good faith doubt of

defendant's competence, the defense counsel should not divulge confidential communications or communications protected by the attorney-client privilege.

Commentary

Standard 7-4.3 addresses the relative obligations of courts, prosecuting attorneys, and defense counsel to raise the issue of competence to proceed and sets forth the appropriate procedure to do so. Paragraph (a) reflects the common law obligation of trial courts to respond to indications that defendants might not be competent, whether or not the issue is raised by a party. This obligation was expressly reaffirmed by the U.S. Supreme Court in *Pate v. Robinson*[49] and *Drope v. Missouri*;[50] in each case, a judgment of guilt was reversed because of the trial court's failure to order an evaluation of the defendant's competence despite observing evidence sufficient to raise concerns about it. The standard adopts "good faith doubt" as the prerequisite criterion for initiating such an evaluation, a standard that is intended to be equivalent to the "bona fide doubt" standard of *Robinson* and *Drope*. The court need not be convinced that a defendant is incompetent to proceed before ordering an evaluation, because the objective of an evaluation is to help make that determination.

Paragraph (b) permits the prosecution to move for a competence evaluation on the same good faith ground. While the introduction to Part VI noted that abuses of this power are possible, it also pointed out that the government owes a duty to courts and society at large to ensure fair and dignified criminal proceedings, which aligns with the prosecutor's role as a minister of justice whose interests go beyond mere criminal convictions. Potential abuses can be minimized through protections against disclosure of incriminating information obtained during the evaluation (see standard 7-3.2), prohibiting misuse of competency inquiries (see standard 7-4.3(e)); imposing time limits on evaluations (see standard 7-4.4(e)), and preferencing outpatient evaluations (see standard 7-4.5). Paragraph (b) also makes clear that the prosecuting attorney has a duty to disclose information indicating incompetence, which may well be required by the Constitution.[51] This obligation, once again reflecting the prosecutor's obligation to seek justice and the society interest in ensuring reliable and fair trials, flows both to the court and to defense if the information does not appear to be in defense counsel's possession.

Standard 7-4.3(c) deals with one of the most difficult ethical questions addressed in these Standards, because it involves a potential conflict between the

[49] 383 U.S. 375 (1966).
[50] 420 U.S. 162 (1975).
[51] Brady v. Maryland, 373 U.S. 83 (1963) (holding a due process right to exculpatory information in the possession of the prosecution). See also standard 11-2.1, explicating the prosecutorial duty to disclose.

obligation of defense counsel to represent a client's best interests and counsel's duty to reflect candor toward the tribunal. The standard provides that defense counsel may seek an evaluation, even over a client's objection, whenever a good faith doubt arises about a client's competence to proceed. This evaluation can be ex parte (that is, privately arranged, with the results forwarded only to defense counsel) or it can be "court-ordered," with the results to go to the prosecution and the court. However, in contrast to the previous version of this standard, this version leaves the decision to move for a court-ordered evaluation to counsel's discretion.

Defense counsel might decide against officially raising the competency issue even in the face of a bona fide belief the defendant is incompetent for several reasons. First, if the defendant insists, despite the motion, that no evaluation is necessary and refuses to cooperate with the evaluator, sanctions can result,[52] given that there is no right to remain silent in a jurisdiction that properly limits use of the evaluations results (see standard 7-3.2). Second, defense counsel might be concerned that, even if the law protects against a prosecutor's *misuse* of statements made during an evaluation, it may not always protect against the prosecutor's *access* to them. Thus, proceeding with an evaluation risks the disclosure of information that may be prejudicial to the defense. Third, if the prosecution's case against a defendant is weak and counsel believes the defendant's assistance will not be necessary to mounting a defense, counsel may be reluctant to raise the competence question. Fourth, should the defendant be found incompetent, it is likely that the court will order commitment to a hospital for restoration services. In all but the most serious felony cases, this confinement could extend beyond the time the defendant would have been confined in jail or prison had the case proceeded directly to adjudication and conviction (see commentary to standard 7-4.14). Even in more serious cases, some defendants may prefer a determinate period of confinement in a correctional facility to an indeterminate period in a psychiatric hospital. They may also regard a finding of incompetence and psychiatric commitment to be more stigmatizing than a criminal conviction. Or they may have had previous unpleasant experiences in psychiatric treatment or fear forcible medication during a hospital stay. Finally, a competence evaluation and a finding of incompetence and subsequent hospitalization could prevent acceptance of a time-limited" plea offer that might result, for instance, in dismissal of all charges in exchange for voluntary treatment.

However, the argument that defense counsel has a duty to raise the competence issue is equally compelling. Because the trial of an incompetent defendant necessarily is invalid as a violation of due process, a defense lawyer's duty to maintain the integrity of judicial proceedings may require that a trial court be advised of the defendant's possible incompetence. Further, to permit defense counsel

[52] Cf. United States v. Greer, 158 F.3d 228 (1998) (permitting enhanced of sentence when defendant "malingered" incompetency).

to proceed to trial with incompetent clients deprives defendants of their personal right to participate in and control the thrust of their defense. It also assumes that defense attorneys have properly determined the best interests of their clients, which may not be furthered even by a deal dismissing charges if, for instance, rearrest occurs, treatment is not obtained, or the deal results in a record of conviction that could enhance future sentences. Concerns about self-incrimination, confinement during competence restoration, and related matters can be dealt with in other ways. For instance, in addition to standard 7-3.2(a)'s restriction on using competency results to prove guilt, standard 7-3.7(a) calls for the segregation of competence and past mental state reports and prohibits inclusion of self-incriminating statements in competency reports; standards 7-4.4(d), 7-4.5(a) and 7-4.14(b) set strict limits on the length and location of evaluations and treatment to restore competence; and standard 7-4.8(e) allows for dismissal of the charges against a defendant found incompetent, pending the defendant's participation in treatment.

Standard 7-4.3(c) attempts to reconcile these competing considerations by allowing defense counsel to seek an ex parte assessment, as an alternative to moving for a court-ordered evaluation. Such an approach protects against disclosure of prejudicial information and hospitalization for evaluation purposes, while providing counsel with more information about the extent of the defendant's impairment and treatment needs before deciding whether to formally raise the issue. Note that if the defense decides to move for a court-ordered evaluation—either after its ex parte evaluation or in the absence of one—and the defendant objects, standard 7-4.8(b) recommends dealing with any resulting conflict of interest through the appointment of special counsel.

While defense attorneys are thus given discretion to avoid making a motion for a competence evaluation even when they think their client is incompetent, they should not have discretion to make such a motion when it is *not* called for. As discussed in the introduction to this part, defense attorneys have been known to misuse the competence evaluation process to delay proceedings, discover information about a client's mental condition for plea negotiation or mitigation of sentence, or secure treatment unrelated to the competence issue. Similarly, as documented in the introduction to this Part, prosecutors have occasionally invoked the incompetence process to forestall trial in cases in which they lack sufficient evidence to convict or to achieve pretrial detention of defendants whom they wish to remove from the streets pending trial. Paragraphs (d) and (e) expressly condemn use of the incompetence evaluation process for any purpose other than determining competence to proceed and state clearly that it is improper conduct for either the prosecuting or defense attorney to move for evaluation for other reasons. To ensure that motions are properly submitted, standard 7-4.3(d) provides that attorneys submit such motions in writing and include facts making clear why the evaluation is needed

(excepting, as standard 7-4.3(f) provides, those facts protected by the attorney-client privilege), and also requires that the motion be accompanied by a certificate that it is based on a good faith doubt about the defendant's competence. Standard 7-4.3(e) then lists various purposes for which motions for competency evaluations should not be used.

Standard 7-4.4. Judicial order for competence evaluation

(a) Whenever, at any stage of the proceedings, a good faith doubt is raised as to the defendant's competence to proceed and the requirements below are met, the court should order an evaluation and conduct a hearing into the competence of the defendant to proceed. The court should follow this procedure whether the doubt arises from a motion of counsel, from information supplied by counsel, from the court's own observation of the defendant, or from any information otherwise known to the court.

(i) The court should not order an evaluation of a defendant's competence to proceed before there has been a determination of probable cause by a judge, grand jury or prosecutor unless an earlier evaluation is requested by defense counsel. If it is determined that probable cause for criminal prosecution does not exist, there should be no further inquiry into the defendant's competence to proceed.

(ii) An evaluation to determine competence to proceed should not be ordered before the defendant is represented by counsel who has had an opportunity to consult with the defendant and to be heard by the court.

(b) The evaluator(s) appointed to perform the evaluation of the defendant's competence to proceed should be qualified by training and experience to offer testimony to the court on matters affecting competence. A mental health professional who is appointed as an evaluator should have the qualifications set forth in Standard 7-3.9.

(c) The order for evaluation should specify the nature of the evaluation to be conducted and should specify the legal criteria to be addressed by the evaluator in accordance with the requirements set forth in Standard 7-3.4(e). Unless requested by the defendant, or for good cause shown in accordance with Standard 7-3.4(d), the evaluation should not include an evaluation into the defendant's mental condition at the time of the offense or other matters collateral to the issues of competence to proceed.

(d) Each jurisdiction should establish time periods by which the evaluation should be concluded and a report returned to the court. Such periods normally should not exceed [fourteen] days unless good cause is shown that an extension is necessary for an adequate evaluation. Such extensions should last no longer than [fourteen] days.

Commentary

The obligation of trial courts to resolve doubts about defendants' procedural competence has long been established as a matter of due process of law.[53] Standard 7-4.4(a) stipulates that this duty exists whether or not defense counsel has raised the issue; as previous commentary explained, this duty, based on society's independent interest in ensuring reliable proceedings, allows the court or the prosecutor to make such a motion even over defense objection. However, standard 7-4.4(a)(i) also makes clear that, when it is the court or the prosecutor rather than the defense requesting the evaluation, there must be a finding of probable cause that the defendant has committed an offense. The probable cause threshold is derived from the Supreme Court decision in *Gerstein v. Pugh*,[54] which held that, under the Fourth Amendment, a finding of probable cause must underlie any pretrial detention or "significant restraint on liberty."[55] Because competency evaluations can involve hospitalization and subsequently lead to compelled treatment in a hospital aimed at restoring competency, *Gerstein* is easily applicable in this setting.

Standard 7-4.4(a)(ii) sets forth a second requirement before a competency evaluation may be ordered at the best of the prosecution or the court: the defendant must be represented by counsel. In *Coleman v. Alabama*,[56] the Supreme Court established the principle that counsel is required at any "critical stage" of the proceedings, defined as any part of the proceedings at which important rights might be affected.[57] The standard recognizes that a court order authorizing a competence evaluation is such a "critical stage," because of the infringements on liberty already mentioned as well as the stigma associated with the incompetency label and the potential for abusing such motions. This stance is also consistent with the Supreme Court's decision in *Estelle v. Smith*, which requires that defense counsel be notified before a court-ordered evaluation takes place.[58] A further practical consideration is that, when the court or prosecution initiates the evaluation process, defense counsel should have an opportunity to meet with the client first. If the two can work together in a meaningful way, no evaluation may be necessary, a possibility the attorney can

[53] Drope v. Missouri, 420 U.S. 162 (1975); Pate v. Robinson, 383 U.S. 375 (1966).
[54] 420 U.S. 130 (1975).
[55] Id. at. 103.
[56] 399 U.S. 1 (1970).
[57] Id. at 9.
[58] 451 U.S. 454, 471 (1981).

make clear to the court; if, instead, there are impediments, the attorney will be in a position to identify them for the evaluator, sharpening the evaluation's focus.

Standard 7-4.4(b) confirms that evaluators should be qualified by training and experience to conduct competence evaluations and testify as experts, in accordance with standard 7-3.9, which specifies the qualifications required of experts on the issues addressed in these Standards. Under paragraph (c), an appointing court should specify the nature of the evaluation to be conducted and the legal criteria to be addressed by the evaluator, consistent with the general principles laid out in standards 7-3.4 and 7-3.5. The same paragraph confirms the premise, also found in standard 7-3.4, that competency evaluations should not extend to collateral matters, like mental nonresponsibility, unless a defendant has requested a multipurpose examination or good cause has been shown for one.

The same liberty interests that support the probable cause and counsel requirements also dictate that competency evaluations be promptly concluded and reported to the appointing court. Paragraph (d) recommends a fourteen-day time limitation, with allowance for an extension of fourteen additional days if good cause is shown that an extension is necessary for an adequate evaluation. Such limits may be difficult to meet, but are important means of preventing abuse, fighting inertia, and freeing up hospital beds.[59]

Standard 7-4.5. Location of competence examination

(a) Whenever feasible, evaluation of a defendant's competence to proceed should be conducted in the locality in which the defendant is charged. A defendant should be evaluated in jail only when the defendant is ineligible for release to the community. A defendant may be evaluated in an inpatient facility only when:

(i) an outpatient evaluation of the defendant determines that the defendant must be admitted to the facility for a professionally adequate evaluation to be completed

(ii) the defendant is admitted to the facility for treatment unrelated to the evaluation, or

[59] See Trueblood v. Washington Dep't of Soc. & Health Serv. *12-*13, 2016 WL 4268933 (requiring that competency evaluations be completed within 14 days and exploring the liberty and efficiency interests at stake); Trueblood v. Washington Dep't Soc. & Health Serv, 2017 WL 4700326 (describing state's failure to meet this requirement).

(iii) the defendant will not submit to outpatient examination as a condition of pretrial release.

(b) Confinement authorized under (a) may continue for such time as is necessary for the evaluation to determine competence, consistent with Standard 7-4.4(c).

(c) Pendency of proceedings to determine competence to proceed should not postpone judicial determination of eligibility for pretrial release.

Commentary

The days of routine hospital admission for a competence evaluation are long over in most states. A 2014 study found that the majority of competence evaluations nationally are conducted on an outpatient basis in the community.[60] In some states, however, the practice of evaluating defendants in inpatient facilities endures. And in a few states, lengths of hospital stay for competence evaluations are long, often exceeding three months,[61] well beyond the limit recommended by standard 7-4.4(d).

Standard 7-4.5(a) provides that competence evaluations should be conducted in the locality in which the defendant is charged whenever possible, in jail only when the defendant is otherwise ineligible for release, and in inpatient facilities only under very limited circumstances. This provision is meant to ensure that bail is not denied for persons with mental impairments simply because they need to be evaluated, and also aims to minimize the practice of automatically hospitalizing defendants for competence evaluations.[62] The denial of pretrial release, for whatever reason, constitutes a restriction on fundamental rights justifiable solely on the basis of a compelling state interest. If less restrictive alternative means exist to accomplish an objective—here, evaluating and determining a defendant's competence to proceed–

[60] See Fitch, supra note 1, at 9 (finding that such evaluations are "regularly" done in all but 3 of 45 responding states).
[61] Id. (finding that among the 29 states that provided "useful responses" about average length of stay of defendants evaluated in the hospital, 12 states kept defendants less than a month, 11 states between one to three months, six states from three months to six months, and one state over six months).
[62] Michael L. Perlin, "For the Misdemeanor Outlaw": The Impact of the ADA on the Institutionalization of Criminal Defendants with Mental Disabilities, 52 Ala. L. Rev. 193, 202-02 (2000) (noting that "[a]lthough more forensic cases of all sorts are being treated in the community than was common a decade or more ago, a substantial number of incompetency cases (both evaluations and post-*Jackson* commitments) are still treated as a matter of course in maximum security forensic settings," and arguing that this practice violates the Americans with Disabilities Act).

they should be employed.[63] As the practice in many states attests, a less intrusive alternative—outpatient evaluation—usually does exist.[64]

However, a period of inpatient commitment may be necessary for some evaluations, for example where a defendant's clinical presentation requires extended observation or specialized testing that is not available in the community. Paragraph (a) would permit such commitment only after an outpatient evaluation finds it necessary (in the report that goes to the court under standard 7-4.6(b)), the defendant is already hospitalized for other treatment purposes, or the defendant is unwilling to be evaluated on an outpatient basis as a condition of release. To avoid prolonged hospitalization simply out of inertia in these situations, paragraph (b) provides that inpatient evaluation should last only as long as necessary to complete the evaluation. At that point, the defendant should be transferred back to the community, and should be housed in jail only if pretrial detention is independently authorized.

Paragraph (c) emphasizes that courts should consider and rule on motions for competency evaluations and on pretrial detention issues separately. Pretrial release or detention should be determined in accordance with the principles elaborated in Chapter 10's Standards on Pretrial Release, unaffected by concurrently pending motions for competency evaluations. Paragraph (c) confirms that principle by cautioning against delay in reaching pretrial release or detention decisions because of the pendency of proceedings to determine competence.

Standard 7-4.6. Report of evaluator

(a) The first matter to be addressed in the report should be the defendant's competence to proceed. If the opinion of the evaluator is that the defendant is competent to proceed, issues relating to treatment should not be addressed. If the opinion of the evaluator is that the defendant is not competent to proceed, or that the defendant is competent to proceed but that continued competence is dependent upon maintenance of treatment, the evaluator should then report on the treatment necessary for the defendant to attain or maintain competence, with a presumption that such treatment should take place in the community.

[63] See standard 10-1.2 ("In deciding pretrial release, the judicial officer should assign the least restrictive condition(s) of release that will reasonably ensure a defendant's attendance at court proceedings and protect the community, victims, witnesses or any other person.").
[64] See Melton et al., supra note 22, at 140 (summarizing studies and concluding that "high . . . levels of psychometric rigor can be achieved in an outpatient examination" and that "[q]uality is not diminished when trained community-based clinicians conduct examinations; indeed, quality may even improve.").

(b) If the evaluator determines that treatment is necessary for the defendant to attain or maintain competence, the report should address the following issues:

(i) the condition causing the incompetence;

(ii) the treatment required for the defendant to attain or maintain competence and an explanation of appropriate treatment alternatives in order of choice;

(iii) the availability of the various types of acceptable treatment in the local geographical area. The evaluator should indicate the agencies or settings in which such treatment might be obtained, including the jail. Whenever the treatment would be available on an outpatient basis in the community, the evaluating expert should make such fact clear in the report;

(iv) the likelihood of the defendant's attaining competence under the treatment and the probable duration of the treatment.

(c) If the evaluator determines that the only appropriate treatment requires that the defendant be taken into custody or involuntarily hospitalized, then the report should include the following:

(i) an analysis of the defendant's treatment needs that require attention in a custodial or inpatient setting;

(ii) whether the defendant, because of the condition causing incompetence, meets the criteria for placement in an inpatient setting, as set forth by law;

(iii) whether there is a substantial probability that the defendant will attain competence to proceed within the reasonably foreseeable future;

(iv) the nature and probable duration of the treatment required for the defendant to attain competence;

(v) alternatives to involuntary confinement the evaluator considered and the reasons for the rejection of such alternatives.

Commentary

Standard 7-4.6(a) sets out the issues that a report on competency to proceed should address. The standard should be read in conjunction with standard 7-3.6, which provides more general criteria for evaluator reports. The recommended report format corresponds to the sequence of determinations the court must make when addressing the competence. Evaluators should first address the issue of competence. Only if the defendant appears to be incompetent or competent but in need of treatment to maintain competence should treatment issues be discussed. If treatment issues are addressed, they should focus entirely on treatment needed to restore or maintain competence. This format protects against the disclosure of irrelevant information about the defendant's mental condition that may be embarrassing, stigmatizing, or prejudicial. If other types of treatment are necessary, they should be provided pursuant to standard 7-2.6 (which provides for treatment of people who are detained).

If the evaluator believes the defendant is incompetent or needs treatment to maintain competence, standard 7-4.6(b) delineates the issues the report should then address: the condition causing incompetence; the needed treatment; whether that treatment can occur in the community; and the likelihood that the treatment will be successful in restoring competence. The information about treatment potential is especially important because of the U.S. Supreme Court's holding in *Jackson v. Indiana*,[65] which held that defendants committed for treatment to restore competence may be held only for the "reasonable period of time necessary to determine whether there is a substantial probability that [they] will attain that capacity in the foreseeable future . . . ." and also held that "continued commitment must be justified by progress toward that goal."[66] Under *Jackson*, therefore, courts have a constitutional responsibility to ensure that the individual is restorable (if not, *Jackson* held, release or commitment are the only options); they must further find that any treatment they authorize is provided solely to help the defendant achieve competence. Evaluator reports provide crucial information in this regard.

These Standards throughout express a preference not only for outpatient evaluations but for outpatient treatment of those found incompetent. However, many defendants may require hospitalization if restoration is to be effective. To ensure inpatient treatment is necessary, standard 7-4.6(c) provides that if the evaluator concludes inpatient treatment is called for, the report should specifically address a number of factors (here listed in a different order than appears in the standard): the defendant's treatment needs that require inpatient attention; alternatives to commitment that the evaluator considered and the reasons for their rejection; the

[65] 406 U.S. 715 (1972).
[66] Id. at 738.

nature and probable duration of the inpatient treatment indicated; whether this treatment will enable the defendant to attain competence in the reasonably foreseeable future; and whether the defendant meets the jurisdiction's statutory criteria for placement in an inpatient setting. This last consideration can be an obstacle in those jurisdictions that require a finding of dangerousness before commitment may occur. Some defendants who are incompetent and need inpatient treatment may not be dangerous under a strict definition of that term. Ideally, as provided in standard 7-4.10(a)(iii), states with such statutes can adjust them to ensure inpatient treatment is available to those defendants who need it for restoration purposes.

Standard 7-4.7. Use of reports

(a) Any information or testimony elicited from the defendant at any hearing or examination on competence or contained in any motion filed by the defendant or any information furnished by the defendant to the court or to any person evaluating or providing mental health services, and any information derived therefrom, and any testimony of experts or others based on information elicited from the defendant, should be considered privileged information and should be used only in a proceeding to determine the defendant's competence to proceed and related treatment issues unless the privilege is waived.

(b) The defendant waives the privilege established in (a) by using or indicating an intent to use the report or parts thereof for any other purpose. Upon such waiver, the prosecutor should be permitted to use the report or any part of the report to address the mental condition issue for which the defendant uses the report, subject only to the applicable rules of evidence.

(c) If the privilege is not waived pursuant to (b), the report should be put under seal after its use to determine competence and may only be unsealed if subsequent proceedings relitigate that issue.

Commentary

Standard 7-4.7 balances the conflict between the judicial system's need to compel defendant cooperation in court-ordered competency evaluations against defendants' privilege against self-incrimination. If a court has a good-faith doubt about a defendant's competence to proceed, it is obliged to resolve the issue promptly. This in turn requires an accurate professional assessment of mental condition that must rest, at least in part, on information supplied by the defendant; this information, of course, may include incriminating statements concerning the alleged offense. Because evaluators are mental health professionals whose allegiance,

in other settings, is to their patients, defendants may fail to recognize that they share no "doctor-patient" relationship with the professional assigned to assess their competence. Even if an evaluator explains the special nature of the relationship and the limits on confidentiality as required by standard 7-3.5(b), defendants may unhesitatingly share information with evaluators that they would conceal from law enforcement officers or investigators whom they recognize as adversaries. To require defendants to cooperate in evaluations of this sort might well infringe on the privilege against self-incrimination, unless suitable safeguards are established.

The Supreme Court addressed the matter in *Estelle v. Smith*,[67] which arose from the prosecution's use, at the capital-penalty phase of a murder prosecution, of statements made by Smith to a prosecution-retained psychiatrist who was ordered by the court to evaluate Smith's competence to proceed. The Court ruled that use of incriminating statements Smith made during the evaluation to support the prosecution's case-in-chief at his death sentencing proceeding infringed Smith's privilege against self-incrimination. But the Court also noted that, had the results of the competency evaluation been used only to resolve competency, no Fifth Amendment issue would have arisen.[68]

Consistent with *Smith* and standard 7-3.2, standard 7-4.6(a) provides the quid pro quo for compelled cooperation on the part of defendants like Smith, in the form of a strict prohibition against prosecution or judicial use of incriminating admissions made during competency evaluations for any purpose other than a determination of competence, unless the defense waives the privilege. This bar is meant to apply to all defendant disclosures made to the evaluator and to any professionals who provide treatment to defendants who have been found incompetent, as well as any information derived from such disclosures.[69] However, paragraph (b) provides that if a defendant decides to submit an expert's report on some issue other than present competence this privilege is waived, thereby opening up the report to prosecution use on the mental condition issue for which the defendant uses the report (as permitted by the evidence rules of the jurisdiction). In this way, the protection envisioned in the standard is coextensive with the privilege against self-incrimination. To ensure that protection, paragraph (c) provides that the competency report should be put under seal after it is used to determine competence to proceed, pending waiver or a subsequent competency hearing in the same case.

[67] 451 U.S. 454 (1981).
[68] Id. at 468 (noting that "a validly ordered competency examination" may proceed over a Fifth Amendment objection "upon the condition that the results would be applied solely for that purpose.").
[69] Note also that standard 7- 3.7(a) instructs evaluators to avoid including self-incriminating statements from the defendant in their reports.

Standard 7-4.8. Necessity for hearing on competence to proceed

(a) In every case in which a good faith doubt of the defendant's competence to proceed has been raised and as soon as practical after receipt of the reports of the evaluators, the court should conduct a hearing on the issue of competence to proceed unless all parties stipulate that no hearing is necessary and the court concurs. If the defendant has been confined for examination, the hearing should be held within [seven] days of the receipt of the report of the evaluators; if the defendant is at liberty it should be held within [thirty] days.

(b) If, after the competence evaluation, defense counsel and the defendant disagree about whether a plea of incompetence should be asserted, special counsel should be appointed to represent the defendant's position during the competency hearing.

(c) If the parties agree on the issue of competence to proceed or issues related to treatment, a stipulation containing the factual basis for the agreement may be accepted by the court. The court, after review of the factual basis for the stipulation, should enter the appropriate order on the basis of the stipulation. In the absence of stipulation by the parties and concurrence by the court, a hearing on the issues should occur.

(d) Trial by jury should not be required for the hearing on competence to proceed, provided that in those jurisdictions which authorize trial by jury for determination of issues of involuntary civil commitment, jury trial should be available to a defendant to determine issues of competence to proceed and of involuntary confinement for treatment to restore competence.

(e) In lieu of or after a 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 evaluators, it appears that the defendant is incompetent to proceed but would be a suitable candidate for mental health treatment,

(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.

Commentary

Standard 7-4.8(a) rests on the premise that both the prosecuting attorney and the defendant have an absolute right to a competency hearing. Only if the parties stipulate that no hearing is necessary, and the court concurs, should competence be determined without a hearing. This position follows from the Supreme Court's decision in *Drope v. Missouri*, which held that "[t]rial courts have the obligation of conducting a hearing whenever there is sufficient doubt concerning a defendant's competence."[70] There are also compelling policy grounds supporting the conclusion that determinations of competency should not rely solely on uncontested evaluator reports, even if all of those reports reach a consensus view. As noted throughout these Standards, competence is a legal, not a medical or psychological determination. Although evaluation reports are important to the extent they recount evaluator observations, explain the significance of symptoms, and help a court understand the degree to which a defendant's relevant functional abilities may be compromised, evaluators' attempts to translate their observations into legal conclusions should not be considered dispositive. Accordingly, both parties must have the right to have a hearing on the report, to question evaluator conclusions, and to require judicial findings on the issues of competence and (if the defendant is incompetent) treatment or other restoration services.

Standard 7-4.8(b) addresses the difficult situation that arises when the defendant and the defense attorney disagree over whether to plead incompetence after one or more evaluation reports indicate that plea is indicated. For the reasons discussed in the commentary to standard 7-4.3, including the stigma associated with an incompetency finding and the possibility of a lengthy psychiatric commitment upon such a finding, some defendants may prefer to go to trial rather than be labeled "incompetent" and hospitalized. Requiring counsel to disregard the client's wishes in this regard may so disrupt the attorney-client relationship that effective assistance of counsel is impossible thereafter. Accordingly, paragraph (b) provides that where the defendant and counsel disagree about asserting the incompetence plea, special counsel should be appointed to represent the defendant's position during the hearing. After the hearing, initial counsel would resume responsibility for the defendant's representation.

While paragraph (a) contemplates that the parties may stipulate as to the defendant's competence or incompetence, standard 7-4.8(c) recognizes that such a waiver of the right to a hearing could be seen as an inappropriate delegation of judicial decision-making authority to the parties and evaluators. Thus, the

[70] Godinez v. Moran, 509 U.S. 389, 408 (1993) (Kennedy, J., concurring) (citing Drope v. Missouri, 420 U.S. 162, 180–181 (1975).

requirements for waiver are strict. Both the prosecution and defense counsel must agree on the waiver and provide the court with a stipulation containing the factual basis for their agreement. The court independently must determine that adjudication of competence without a hearing is proper based on factual proffers from the parties. In effect, given the societal interest in accurately addressing the competency issue, all must agree that a competence hearing will be merely a waste of time and resources. A court may not abdicate its responsibilities by rubber-stamping an evaluation report and either ordering a defendant to proceed to trial or finding the defendant incompetent and ordering restoration services. With that understanding, the parties should also be able to waive discrete aspects of the hearing, rather than the entire proceeding. For example, a defense attorney who accepts a client's lack of present mental competence, but who is dissatisfied with the treatment plan proposed by an evaluator, should have the ability to stipulate to the evaluation report as it bears on competence but simultaneously require the examiner to undergo examination and cross-examination on the matter of disposition.

A few states require or permit the competency issue to be determined by a jury.[71] However, standard 7-4.7(d) takes the position that, despite the potential deprivation of liberty, a jury determination of competence is not constitutionally required. A defendant's triability is a matter peculiarly within the province of a court, given its dependence on the precise charges at issue (see commentary to standard 7-4.2) and the decisions about treatment that must be made if the defendant is found incompetent. However, in some jurisdictions, civil commitment authorizing involuntary hospitalization for treatment is considered a matter appropriate for a jury determination. In those jurisdictions, it may deny equal protection to mandate a non-jury determination of cognate issues solely because of the pendency of a criminal charge. Therefore, under these circumstances—where a defendant would have the right to a jury determination of committability upon a finding of incompetence– paragraph (d) allows for a jury determination of *both* the question of incompetence and the question of committability.

Standard 7-4.8(e) addresses a conundrum defense counsel often face when representing defendants who are incompetent to proceed on minor charges. Typically, in these cases the defendant is found incompetent and committed for a period of treatment to restore competence; then, once restored to competence, the defendant is returned to court, only to be released because so much time has passed that proceeding to trial would be pointless. Instead of this inefficient process—one that may also be detrimental to the defendant, given the stigma associated with a finding of criminal competence—this standard provides that if an evaluation report indicates the defendant is incompetent but a suitable candidate for treatment and defense counsel, and the defendant and the prosecution agree that diversion of the

[71] See, e.g., Ga. Stat. Ann. § 17-7-130(b)(2); Tex. Crim. Pro. Art. 46B.051.

defendant to services in the community is a preferable remedy, charges could be dismissed (without prejudice) or placed in abeyance, pending the defendant's successful participation in treatment. This agreement could go into effect either in lieu of or after a competency hearing; for instance, it could be structured along the lines of the charge-dismissal diversion option discussed in standard 7-2.3, which occurs *before* a competency evaluation is ordered. More generally, the diversion this paragraph promotes is consistent with standard 7-1.2, which calls for the configuration of services to divert people with mental disorders from criminal prosecution into treatment whenever appropriate. That policy goal also justifies paragraph (e)(iii), which permits the defendant's agreement to the diversion upon a simple "assent" rather than full informed consent.[72]

Standard 7-4.9. Hearing on competence; defendant's rights, evidence, and priority of issues

(a) In all hearings regarding competence, a defendant should have:

(i) the right to be present at the hearing, to fully cross-examine witnesses, to call independent expert witnesses, to have compulsory process for the attendance of witnesses, and to have a transcript of the proceedings. Either party should have the authority to call and examine any person identified by the evaluators as a source of information for the evaluative report other than the defendant or the defense attorney.

(ii) the right to adequate notice and time to prepare for the hearing, including timely disclosure of the report of appointed evaluators and, if necessary, opportunity to interview or, in those jurisdictions that so provide, to depose the evaluators before the hearing.

(b) Evidence presented at the hearing should conform to rules of evidence applicable to criminal cases within that jurisdiction. The evaluators, whether called by the court or by either party, should be subject to examination.

(i) Defense counsel may elect to relate to the court personal observations of and conversations with the defendant to the extent that counsel does not disclose the substance of confidential communications or violate the attorney-client privilege; counsel so electing may be cross-examined to that extent. Such testimony does not disqualify the attorney from representing the defendant.

[72] As defined in standard 7-1.1 (f), assent requires a present understanding of the likely consequences of the action (after those consequences have been explained), accompanied by an affirmative indication of agreement.

(ii) The court may properly inquire of defense counsel about the attorney-client relationship and the client's ability to communicate effectively with counsel. The defense counsel, however, should not be required to divulge the substance of confidential communications or those that are protected by the attorney-client privilege. Defense counsel responding to inquiry by the court on its own motion should not be subject to cross-examination by the prosecutor.

(c) At the hearing, the court should consider separately each discrete issue raised and should first consider the issue of the defendant's competence to proceed.

(i) The party raising the issue of incompetence should have the burden of going forward with the evidence to show incompetence.

(ii) If the court, after hearing the evidence, finds by a preponderance of the evidence that the defendant is competent to proceed the matter should proceed to trial; if the defendant is found not competent, the court should proceed to issues of treatment to restore competence.

Commentary

Standard 7-4.9 covers the procedural rights available to defendants undergoing competence hearings, which essentially are those governing other stages of criminal proceedings. The baseline of standard 7-4.9(a) is that all rights afforded criminal defendants in the course of criminal proceedings (other than the right to jury trial, per standard 7-4.8(d)) apply to competence hearings because of the significant restrictions on liberty at stake, which include the possibility of commitment to an institution or an order to report to an outpatient facility. Thus, this provision mandates the rights to adequate advance notice to prepare for hearings, discovery of information underlying evaluation reports, compulsory process for witnesses (including the right to call independent experts), confrontation and cross-examination, and access to transcripts of competence hearings.

Standard 7-4.9(b) provides that the usual evidence rules should govern this phase of a criminal proceeding. Either party or the court may insist that an evaluator appear and be subject to examination. Thus, the standard rejects the historical practice (in some jurisdictions) of courts summarily ruling on a defendant's competence based solely on an evaluator's written report, a position that is consistent with standard 7-4.9(c)'s prohibition against pro forma stipulations on the competency issue in the absence of an independent judicial review. A key reason for confirming that confrontation principles govern evaluator expert testimony is that competence

opinions have often been couched in conclusory legal terms, and courts too frequently have accepted them uncritically.[73] This standard recognizes that the parties need to be able to probe evaluator opinions at competency hearings just as they would at a trial.

Paragraph (b) also regulates in-court statements by the defense attorney, which can sometimes be crucial in determining the defendant's ability to assist counsel but should not require revelation of the "substance" of attorney-client communications. For example, an attorney may describe such nontestimonial matters as the defendant's physical characteristics, demeanor, and coherence of communications. But confidential conversations—conversations the client intended to be private or privileged—should not be disclosed. These limitations, while dictated by professional ethics and traditional concepts of evidence law, may be considered undesirable by some judges who want access to all information bearing on a defendant's competence. But the standard takes the view that the important traditional interest in protecting the confidentiality of counsel-client communications strongly outweighs any immediate advantages to trial courts in resolving competency issues. With this caveat, the prosecutor may cross-examine defense counsel who choose to testify and the court may ask questions of defense counsel who do not testify. Note that the prerogative of testifying is defense counsel's alone; the prosecutor may not call the defense attorney as a witness.

Standard 7-4.9(c) cautions courts to consider separately the issues of competence and treatment in response to incompetency, just as standard 7-4.6 insists evaluators separate out these issues in their reports; if a defendant is found competent, treatment issues need not be addressed. Subparagraph (c)(i) follows traditional practice in providing that whichever party makes the motion for evaluation bears the burden of production on the competency issue. The burden of proof, however, is a different matter. The U.S. Supreme Court has ruled that it is permissible to create a presumption of competence and to place the burden of proving otherwise on the party raising the issue, by a preponderance of the evidence.[74] Subparagraph 7-4.9(c)(ii) takes a different view. In contrast to most issues arising in the course of adversarial criminal proceedings, the burden of resolving the competence issue rests on the trial court for reasons explained in the commentary to standard 7-4.8. Indeed, the court may have raised the issue sua sponte, with neither side signaling a desire to do so. Similarly, a failure of the

[73] See, e.g., Patricia A. Zapf et al., Have the Courts Abdicated Their Responsibility for Determination of Competency to Stand Trial to Clinicians, 4 J. Forensic Psychol. Practice 27 (2004) (noting research findings that courts agree with evaluators well over 90% of the time and reporting a study in Alabama in which judges accepted evaluators' findings in all but one case, despite generally poor quality reports).

[74] Medina v. Calif., 505 U.S. 437 (1992) (holding that the burden may be placed on the party asserting incompetence); Cooper v. Oklahoma, 517 U.S. 348 (1996) (holding unconstitutional a statute that placed the burden on the defendant to show incompetency by clear and convincing evidence).

defense to advance evidence showing incompetence should not of itself legitimate a judicial determination of competency; the latter judgment should rest on the court's independent consideration of all the facts in evidence. Thus, subparagraph (c)(ii) adopts the preponderance of evidence standard of proof but does not place the burden of meeting this standard on either party, instead leaving this issue up to the court.

Standard 7-4.10. Hearing on competence; dispositional issues

(a) Once the court has found that the defendant is not competent to proceed or that competence depends on continuation of treatment, the court should consider issues relating to treatment to restore competence.

(i) A defendant may be ordered to undergo treatment if the court finds that there is a substantial probability the treatment will restore the defendant to competence in the foreseeable future.

(ii) The court may order treatment be administered on an outpatient basis (including as a condition of pretrial release), at a custodial facility, or at an inpatient mental health facility.

(iii) A defendant should not be involuntarily hospitalized to restore or sustain competence unless the court determines by clear and convincing evidence that:

(A) treatment appropriate for the defendant to attain or maintain competence is available in the facility; and

(B) no appropriate treatment alternative is available that is less restrictive than placement in the facility.

(b) At the conclusion of the hearing the court should enter its written order for treatment to restore competence. The order should contain the following:

(i) written findings of fact setting forth separately and distinctly the findings of the court on the issues of competence, treatment, and involuntary hospitalization, if applicable;

(ii) information sufficient for a professional involved in providing treatment to ascertain the charge against the defendant and the nature of the condition causing the incompetence;

(iii) a finding that the institution, program, or provider to which the defendant is to be committed or referred is sufficiently staffed and equipped to meet that defendant's treatment needs, or a finding that the ordered disposition is the best available option; and

(iv) when reports will be required under 7-4.12 from the professionals providing treatment.

(c) An order adjudicating the defendant incompetent to proceed should be an appealable order.

Commentary

Previous standards have emphasized that courts should separately consider the defendant's competence to proceed and the circumstances of treatment, should the defendant be found incompetent. This standard addresses the court's responsibilities once a defendant has been found incompetent (or in need of treatment to maintain competence). Although the Supreme Court in *Jackson v. Indiana*[75] did not expressly mandate a hearing on matters relating to treatment, it did require that any treatment that is compelled to restore competence "bear a reasonable relation to the purpose for which the individual is committed . . ." and it also required that there be a "substantial probability" that the treatment will result in restoration in the "foreseeable future."[76] Thus, trial courts are responsible for ensuring that these conditions are met before commitment for treatment occurs. Unfortunately, in many states, even today, defendants found to be incompetent are automatically committed to inpatient facilities.[77]

Paragraph (a) aims to subvert that tendency. Subparagraph (a)(i) reflects the finding that *Jackson* requires before any treatment, inpatient or outpatient, may be ordered. Subparagraphs (a)(ii) and (a)(iii) mandate outpatient treatment unless appropriate services are not available in the community and are available in an inpatient setting. Note that the latter provision does not adopt the standards and procedures that govern ordinary civil commitment, which usually requires a finding that the individual's mental disorder renders the person dangerous in some sense.[78] No such finding is necessary for commitment to restore competence, because attenuating dangerous is an irrelevant consideration. If (but only if) inpatient treatment is necessary to restore a defendant's competence, such treatment may be ordered in the absence of a showing of dangerousness.

[75] 406 U.S. 715 (1972).
[76] Id. at 738.
[77] Fitch, supra note 1, at 11-12.
[78] See Christopher Slobogin, Thomas Hafemeister & Douglas Mossman, Law and the Mental Health System 816 (7th ed. 2020).

Paragraph (b) delineates the contents of a court order for treatment to restore competence. Not only must the order include a rationale for the court's actions, but it should also provide direction for the professionals assigned to provide restoration services. Typically, these professionals will not have been involved in the initial evaluation of the defendant. They may be unaware of the charges against the defendant, the information the court relied on in finding the defendant incompetent, and the objectives of the treatment for which the defendant was referred. To ensure that their treatment program is aligned with *Jackson*, paragraph (b) provides that orders include: factual findings supporting the court's determination of the issues (of competence, treatment, and involuntary hospitalization, if ordered); information apprising treating professionals of the basis for the commitment order and the limited objectives of the services they are to provide; a finding that the institution, program, or provider designated to provide the restoration services is sufficiently staffed and equipped to do so or, if not, that there are no other better options available; and the schedule for reports to the court regarding the defendant's progress in treatment, as called for in standard 7-4.12.

Under paragraph (c), a court order adjudicating a defendant incompetent to proceed should be appealable. In many jurisdictions, defendants wishing to contest findings of competence must await a guilty verdict and then appeal on the basis of indications in the trial record that they did not meet constitutional measures of triability. This standard takes a contrary view. Because of the constraints on a defendant's liberty that may follow a finding of incompetence, it provides for interlocutory appeal of an incompetency finding.[79]

Standard 7-4.11. Right to treatment and to refuse

(a) A defendant determined to be incompetent to proceed has a right to prompt and adequate treatment to restore competence and a right to have such services administered by competent and qualified professionals.

(b) Within [fourteen] days after entry of an order detaining or committing a defendant for treatment or directing that a defendant report for treatment on an outpatient basis, and assuming the person is not already restored to competence, the professional providing such services should develop and file with the court, copies being made available to both parties, an

[79] Cf. Stack v. Boyle, 342 U.S. 1, 6 (1951) (permitting interlocutory appeal of denial of bail because that determination is a "final decision," independent of the substantive guilt issue and one that would be moot after conviction, in the sense that illegitimate pretrial detention would have already occurred). See also 18 U.S.C. § 3145(c).

individualized plan of treatment. Each treatment plan should contain the following:

(i) a statement of the specific causes of defendant's incompetence including, where appropriate, diagnosis and description of any mental disorder, and reference to any other factors causing the incompetence to proceed;

(ii) a statement of the planned treatment, whether medical, psychological, educational, or social, appropriate to restore competence;

(iii) a statement setting forth any restrictions to be placed on the defendant and the reasons for imposing such restrictions;

(iv) a statement of the expected duration of treatment required to restore the defendant's competence.

(v) provision for periodic review of the plan's efficacy.

(c) A defendant has a right to treatment in the least restrictive setting appropriate to restore competence to proceed.

(i) If the criteria for commitment to an inpatient facility in Standard 7-4.10(a) (iii) are met, a defendant may be treated in a forensic facility or a general treatment facility whose staff have training and experience in the treatment of persons under criminal charges.

(ii) Whenever a defendant who is incompetent to proceed has been denied pretrial release or is unable to meet the release conditions imposed, that defendant may be detained in jail only if adequate treatment to restore competence is provided in that setting. Otherwise treatment must be in a mental health facility.

(d) A defendant determined to be incompetent to proceed and committed for treatment should have the right to refuse any treatment that has an unreasonable risk of serious, hazardous or irreversible side effects. Otherwise, such a defendant may be subject to psychoactive medication over objection if:

(i) the 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 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.

(e) If a defendant found incompetent to proceed is treated with medication in an inpatient facility, becomes competent, and is returned to jail or to the community to await further legal proceedings, 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. Only if such treatment in the local facility is clearly not feasible should the court consider ordering the defendant returned to the inpatient facility pursuant to Standard 7-4.10 (a) (iii) until proceedings against the defendant are ready to commence.

Commentary

Standard 7-4.11(a) rests on the premise, established in *Jackson v. Indiana*,[80] that persons found incompetent to proceed have a right to treatment to help them attain competence. Services must be readily available, and providers must be competent and qualified.

Paragraph (b) advocates a duty on the part of professionals providing competence restoration services to develop and file with the court an individualized treatment plan addressing: the specific causes of a defendant's incompetence, including a diagnosis and description of any pertinent mental disorder; the planned treatment, including any medical, psychological, educational, or social services that might be indicated; any restrictions that need to be imposed on the defendant and the reasons for them; and the anticipated duration of treatment required to restore the defendant's competence. The requirement that a treatment plan be submitted promptly (within a recommended fourteen days) has four objectives: (i) to assure the court that services are narrowly tailored to address concerns about competence, not broader issues like "dangerousness" or generalized treatment needs; (ii) to provide a basis for the court's ongoing review of the defendant's progress toward restoration,

[80] *Jackson*, 406 U.S. at 738 ("At the least, due process requires that the nature and duration of commitment bear some reasonable relation to the purpose for which the individual is committed.").

under standard 7-4.12, and as required by *Jackson*;[81] (iii) to allow defense counsel and prosecutors (who must receive copies) to monitor the plan for and delivery of services (which facilitates challenging such services if they deviate from the objective of competence restoration or fail to advance the defendant's restoration); and (iv) to alert courts and attorneys if a defendant is uncooperative in treatment and may require an order compelling treatment under paragraph (d).

Paragraph (c) addresses the situs of treatment to restore competence, reiterating that such treatment must be provided in the least restrictive setting that is appropriate to the purpose. Subparagraph (c)(i) addresses the placement of defendants who require inpatient treatment. Recognizing that services intended to restore a defendant's competence are different from the kinds of services ordinarily provided in therapeutic facilities, the standard calls for the defendant's placement either in a "forensic" facility (i.e., one that serves only justice-involved patients) or in a general (non-forensic) treatment facility whose staff have specialized forensic training and experience. In nearly every state, at least some defendants committed for inpatient restoration services are admitted to state "civil" psychiatric hospitals.[82] Indeed, as the number of civil patients in such hospitals has fallen in recent decades, the forensic patients who remain represent the largest category of patients in many states.[83] Requiring that inpatient competence restoration services be provided only in forensic facilities would impose an unnecessary (and undue) burden on many states. Not all civil facilities have staff with the requisite credentials, however; this standard seeks to rectify that situation by requiring that hospital staff have training and experience in dealing with criminal defendants.

Subparagraph (c)(ii) envisions treatment in detention facilities for defendants who are incompetent to proceed and do not qualify for pretrial release, but may not require restoration services at a hospital-level care. Jail-based competence restoration programs exist in many U.S cities.[84] If a defendant can attain competence without undergoing commitment to an inpatient facility, precious beds in these facilities will be preserved for others whose needs are greater and defendants may be spared the disruption and possible stigma of involuntary commitment to a distant location. However, adequate competence restoration services are not available in every jail. In that circumstance, subparagraph (c)(ii) requires the defendant's transfer to a mental health facility and for competence restoration services to take place there. Note that

[81] Id. ("even if it is determined that the defendant probably soon will be able to stand trial, his continued commitment must be justified by progress toward that goal.").
[82] Fitch, supra note 1, at 11.
[83] Id. at 12.
[84] See Graham Danzer, Competency Restoration for Adult Criminal Defendants in Different Environments, 47 J. Am. Acad. Psychiat. & L. 68 (2019) (describing various jail-based restoration programs and concluded that "[j]ail-based restoration may be a reasonable first step in the process toward restoration, prior to initiating hospitalization, and possibly even in cases of psychosis (if jails were sufficiently resourced and authorized to administer medication over objections).").

under standard 4.12(a), a committing court is under a duty to monitor treatment to restore competence wherever it occurs.

Standard 7-4.11(d) addresses the defendant's right to refuse treatment proffered by staff to restore competence. Reflecting the U.S. Supreme Court's ruling on the issue in *Sell v. United States*,[85] the standard first provides an absolute right to refuse treatments that carry an unreasonable risk of serious, hazardous, or irreversible side effects. Fortunately, such treatments—which might include experimental procedures or psychosurgery—are rarely used today and are highly unlikely to be proposed to restore a defendant's competence in any event.

Competence restoration of people with mental illness is much more likely to involve psychotropic medication, which is the subject of the remainder of standard (d). These medications are less likely to cause "serious, hazardous or irreversible" side effects. But they can cause nerve disorders, drowsiness, weight gain, irritability, suppressed libido and other troublesome side effects.[86] As a result, in many states individuals subject to ordinary civil commitment—commitment to benefit the person rather than to restore triability—have a right to refuse such medications unless a finding is made that they are unable to weigh the risks and benefits of the treatment and thus unable to provide informed consent.[87]

This standard, consistent with *Sell*, adopts a less robust right to refuse treatment in the context of restoring a criminal defendant's competence. *Sell* recognized that defendants may have legitimate reasons for objecting to the administration of psychoactive medications, such as avoiding undesirable side effects. At the same time, the Court pointed to the important governmental interests at stake in this setting that do not arise in the civil commitment context, principally the state's interest in (fair) adjudication of criminal charges. Balancing these interests, the Court concluded that defendants have a general right to refuse medications, including medications for the purpose of restoring competence, but that the right is qualified and may be overridden upon a showing that: (i) important governmental interests are at stake (i.e., the charges against the defendant are serious, and the defendant's confinement while incompetent is unlikely to be so lengthy as to constitute sufficient "punishment"); (ii) the medication in question is substantially likely to render the defendant competent to proceed and, at the same time, is substantially unlikely to have side effects that will interfere significantly with the defendant's ability to assist counsel, thereby rendering the trial unfair; (iii) the

[85] 539 U.S. 166 (2003).
[86] See John Muench & Ann M. Hamer, Adverse Effects of Antipsychotic Medications, 81 Am. Family Physician 617 (2010).
[87] Dora W. Klein, Memoir As Witness to Mental Illness, 43 Law & Psychol. Rev. 133, 150–51 (2019) ("People who are being detained under traditional civil commitment statutes retain the right to refuse medications, except in emergency situations or if found incompetent to make their own medical treatment decisions.").

medication is necessary to restore the defendant's competence, and the court has concluded that alternative, less intrusive means of restoring the defendant's competence (including other medications or a court order enforced by the contempt power) are unlikely to achieve substantially the same results; and (iv) administration of the medication is medically appropriate (i.e., is in the defendant's best medical interest in light of his or her medical condition and the likely side effects). Standard 7-4.11(d) adopts this standard practically verbatim.

Sell also recognized other grounds on which a person found incompetent may be subject to involuntary medications, specifically "dangerousness" to self or others,[88] and general incompetence to make treatment decisions, as in a guardianship proceeding.[89] It suggested that courts, before overriding a defendant's treatment refusal based on *Sell*, courts should first determine whether the government has sought permission for forced medication on these other grounds. Because some defendants found incompetent to proceed meet dangerousness criteria and almost all of them are probably also incompetent to make treatment decisions, these two government interests may often apply. However, courts should ensure that they are not used as pretexts to force medication on a person who has a right to refuse medication under *Sell*.[90]

Defendants who respond favorably to treatment in an inpatient setting and regain their competence are usually returned to jail or to the community to await trial. If the medication or other treatment is not continued upon release, the defendant's condition may deteriorate, necessitating a redetermination of incompetence and recommitment to the facility. Such "revolving door" commitments are not uncommon, frustrating efforts to recommence judicial proceedings and wasting valuable mental health and judicial resources.[91] Standard 7-11(e) addresses this problem by providing that when a defendant has been treated with medications in an inpatient facility and becomes competent, the court should order as a condition of the defendant's return to jail or to the community that the receiving facility or a local treatment facility continue the defendant's treatment, as recommended by the inpatient facility. Only if such treatment is not feasible (e.g., the jail has no capacity for carrying out the treatment, or the defendant refuses the treatment recommended

[88] 539 U.S. at 182 (citing Washington v. Harper, 494 U.S. 210, 225–226 (1990).
[89] Id. (noting that "[e]very State provides avenues through which, for example, a doctor or institution can seek appointment of a guardian with the power to make a decision authorizing medication—when in the best interests of a patient who lacks the mental competence to make such a decision.").
[90] See Christopher Slobogin, *Sell's* Conundrums: The Right of Incompetent Defendants to Refuse Anti-Psychotic Medication, 89 Wash. U. L. Rev. 1523, 1526-1535 (2012).
[91] See Margaret W. Smith, Restore, Revert, Repeat: Examining the Decompensation Cycle and the Due Process Limitations on the Treatment of Incompetent Defendants, 71 Vand. L. Rev. 319, 329-331 (2018) (detailing the "decompensation cycle," noting that hundreds of defendants are affected by it each year, and describing the harms it causes to defendants).

and no mechanism exists in the jail or community for treatment over objection) may the defendant be returned to the inpatient facility pending further proceedings.[92]

Standard 7-4.12. Periodic redetermination of incompetence

(a) A defendant's continuing incompetence to proceed should be periodically redetermined by the court without the necessity of motion by either party. The facility or person responsible for treatment should therefore be required periodically to file with the court a report on the defendant's current status, with copies to the prosecutor and defense counsel and with notice to the defendant. The report should be filed:

(i) any time the treating facility or person responsible for treatment concludes that the defendant has attained competence to proceed;

(ii) any time the treating facility or person responsible for treatment concludes that there is not a substantial probability that the defendant will attain competence within the foreseeable future; or

(iii) at the following intervals: 30 days, 90 days, 180 days, and every 180 days thereafter.

(b) The report should contain the following:

(i) a reevaluation of those issues required by Standard 7-4.6 to be contained in the initial report to the court;

(ii) a description of the treatment administered to the defendant;

(iii) an evaluation of the defendant's continued progress toward attaining competence within the reasonably foreseeable future, if the report concludes that the defendant remains incompetent to proceed.

(c) Either party should have the right to contest the report or any issues addressed in the report within such time as is established in that jurisdiction and the right to demand a hearing on the issues contested, pursuant to Standard 7-4.10.

[92] Another solution is to keep the defendant at the hospital until proceedings are ready to resume. See id. at 352-355 (advocating for telemedicine as a means of avoiding the revolving door of restoration of competency, return to the community where decompensation occurs, and return to the hospital for re-restoration).

(i) Before the hearing, upon motion of either party and upon cause shown, the court should order that the defendant be evaluated by independent mental health professionals and that reports be submitted;

(ii) Each party should have the right to present evidence at the hearing. At the conclusion of the hearing the court should enter its written order setting forth separately and distinctly the findings of the court on the issues of competence, treatment, and involuntary confinement.

(d) If neither party contests the report within the time set, the court should independently review the report and:

(i) if the court concurs in the report's conclusions the court should enter an order accepting the report and continuing the defendant's treatment or setting the case for trial, as appropriate;

(ii) if the court does not concur in the report's conclusions the court, if appropriate, should order an independent reevaluation of the defendant and should hold a hearing on the issues addressed in the report.

(e) Notwithstanding the availability of periodic redeterminations by the court, either party should, upon good cause to believe that a defendant has attained competence to proceed, be able to initiate a redetermination of the defendant's competence under Standard 7-4.10.

(i) The prosecutor or defense counsel, upon a showing of good cause, should be able to make a motion for reevaluation of a defendant by independent evaluators or for rehearing by the court of the issue of the defendant's continuing incompetence. For good cause shown, the court should be empowered to order such reevaluation or rehearing at any time.

(ii) Defense counsel should be permitted to have the defendant reevaluated at defense expense at any time, and the treating institution should be mandated to make the defendant available to the evaluator for reexamination. All records necessary for independent evaluation should be available to the prosecutor or defense counsel at any time.

Commentary

Standard 7-4.12 envisions that courts will provide continuing oversight and periodically re-adjudicate cases in which defendants are ordered to undergo treatment

for competency restoration, evaluating not only whether the defendant remains incompetent, but also whether the services the defendant is receiving are appropriate and whether the defendant is making progress and is likely to regain competence in the foreseeable future. As the Supreme Court recognized in *Jackson v. Indiana*,[93] commitment for treatment to restore competence can be justified only by progress toward that goal.[94] By committing a defendant on this basis, a court becomes responsible for monitoring the treatment, which is the sole legal justification for continued commitment. Courts cannot abdicate to treating institutions or professionals their responsibility to monitor the continued commitment of incompetent defendants, nor should they depend on defendant-initiated reviews, given defendants' disabilities and the fact that they often lack continued legal representation.

Thus, paragraph (a) imposes an obligation on treating professionals to furnish periodic treatment reports to the judge, the prosecutor and the defense attorney, with notice to the defendant as well. Reports should be filed when any of three conditions are met: (1) a treating facility or person responsible for the defendant's treatment believes the defendant has attained competence; (2) a treating facility or person providing restoration services believes there is no substantial probability that the defendant will attain competence within the foreseeable future; or (3) a specified interval of time has passed since the previous review. The standard calls for a report to be submitted 30 days after the initial treatment order, 90 days after the first review, and every 180 days thereafter, time frames that reflect the clinical reality that most defendants will respond quickly to treatment,[95] but also recognizing that those who do not are likely to require a protracted course.

Paragraph (b) outlines the contents of the reports treating professionals must provide: a reevaluation of the issues addressed by the initial evaluation; a description of the treatment provided; and, if the evaluator believes the defendant remains incompetent, an assessment of the defendant's progress toward attaining competence in the foreseeable future. If a defendant has been receiving treatment in an inpatient facility and the evaluator believes the defendant has attained competence but that continued use of medications will be necessary for the defendant to remain competent, the report should identify the medications at issue and their effects on the defendant, so that the court, if it wishes, may order continued administration of the medication as a condition of the defendant's release to jail or the community pending further proceedings.

[93] 406 U.S. 715 (1972).
[94] Id. at 738.
[95] See Nicolas Rosinia, How "Reasonable" Has Become Unreasonable: A Proposal for Rewriting the Lasting Legacy of *Jackson v Indiana*, 89 Wash. U. L. Rev. 673, 694-95 (2012) (collecting studies indicating that all or almost all individuals in the samples studied were restored to competence in well under six months).

Paragraph (c) provides that, upon receipt of the report, either party may demand a hearing and present evidence at the hearing, including the results of an independent evaluation. Even if no hearing is requested, subparagraph (d)(i) provides that the court should review the report and, if it concurs with the report's conclusions, enter an order accepting the report and continuing the defendant's treatment (if it finds the defendant still incompetent) or setting the case for trial (if it finds the defendant to have attained competence). If the court does not concur with the report's conclusions, under subparagraph (d)(ii), the court may order an independent evaluation and schedule a hearing on the issues.[96]

Paragraph (e) provides that, in addition to court determinations triggered by the periodic reports required by paragraph (a), either party, upon good cause, may move for an independent evaluation and for a rehearing on the issues. Further, subparagraph (e) (ii) permits defense counsel to have the defendant reexamined at any time, even in the absence of cause (although not at state expense); if such an evaluation is sought, the court should mandate that the treatment facility make the defendant available for the evaluation and provide background records. In any event, the defense should be able to access relevant records upon request.

Standard 7-4.13. Defense motions; proceedings while defendant remains incompetent

The fact that the defendant has been determined to be incompetent to proceed should not preclude further judicial action, defense motions, or discovery proceedings which may fairly be conducted without the personal participation of the defendant.

Commentary

While the Supreme Court's decisions in *Dusky*, *Drope* and *Pate* establish that trial of an incompetent person may not occur, standard 7-4.13 rejects the premise that no proceedings of any kind can take place while the defendant is incompetent. The standard follows the Model Penal Code, which provides that "[t]he fact that the defendant is unfit to proceed does not preclude any legal objection to the prosecution which is susceptible of fair determination prior to trial and without the personal participation of the defendant."[97] Consistent with the Supreme Court's intimation in *Jackson v. Indiana*,[98] the standard recognizes that these pretrial matters can be

[96] Should the court find the defendant unrestorably incompetent, it should proceed in accordance with standard 7-4.14.

[97] American Law Institute, Model Penal Code §4.06.

[98] 406 U.S. 715, 741 (1972) (stating that its decision requiring restoration was not meant "to preclude the States from allowing at a minimum, an incompetent defendant to raise certain defenses such as insufficiency of the indictment, or make certain pretrial motions through counsel.").

disposed of without prejudice to defendants and that a refusal to allow do so might even have the effect of denying fair proceedings.[99]

Proceedings that might validly be permitted include motions attacking an indictment or information on exclusively legal grounds (for example, double jeopardy, denial of speedy trial, or expiration of a statute of limitations), motions to suppress illegally seized evidence, or motions to dismiss a prosecution based on entrapment, if the defendant's personal testimony is not needed to resolve factual issues. Additionally prompt discovery procedures, carried out during a period of treatment to restore a defendant's competence, may enhance the fairness and reliability of subsequent proceedings. For example, a deposition to perpetuate a witness's testimony can assure its availability should the witness become unavailable or his or her memory fade through passage of time. Accordingly, courts should be free to authorize deposition proceedings in a defendant's absence, unless the defendant's participation is necessary to the effectiveness of direct or cross-examination.

Standard 7-4.14. Disposition of unrestorably incompetent defendants

(a) A defendant may be adjudged unrestorably incompetent to proceed (unrestorable) if the defendant has previously been adjudged incompetent and the court finds by a preponderance of evidence that there is no substantial probability that the defendant will become competent to proceed within the foreseeable future.

(b) The court should hold a hearing to determine whether the defendant is unrestorable whenever the issue has been raised by the report of the professional providing treatment, at the expiration of the maximum time of sentence for the crime charged, or [twelve/eighteen] months from the date of adjudication of incompetence to proceed, whichever first occurs.

(c) If the defendant has been found unrestorable then the defendant should be released from any detention or commitment for treatment to attain or restore competence. If the defendant meets the criteria for involuntary civil commitment, the court may order such commitment and may direct that initial commitment take place in a forensic facility.

[99] For an example of why this provision is needed, see States v. Barnes, 175 F. Supp. 60 (S.D. Cal. 1959), in which the indictments against the defendant's co-defendants were dismissed on speedy trial grounds, but the defendant, who was incompetent, was precluded from raising the speedy trial defense.

Commentary

Most defendants who are found incompetent to proceed and then provided treatment respond favorably and attain competence within a relatively short period. One 50-state survey found average lengths-of-stay for defendants committed for inpatient restoration services of 0-60 days in 17% of the 45 states that responded, of 60-120 days in 43% of the states, and of 120-180 days in 23% of the states; in only 16% of the states were average stays of between 180 and 360.[100] Similarly, according to a meta-analysis of 51 independent samples published between 1975-2013 involving 12,781 defendants, the average length of stay for competence restoration ranged from 42.7 to 1,108 days, with a median of 146.9 days.[101] Thus, most defendants can be rendered competent in under six months.[102]

Some defendants, however—as many as 20%, some studies suggest—never become competent.[103] Standard 7-4.14 addresses this situation by operationalizing the Supreme Court's ruling in *Jackson v. Indiana* requiring that defendants who are not restorable to competence either be civilly committed or released.[104] First, a court must confirm that the defendant is in fact unrestorable. Under paragraph (a), the finding of unrestorability must be by a preponderance of the evidence. While civil commitment requires the higher clear and convincing standard, the fact that the defendant has been found to be incompetent and remains so justifies lessening the proof burden.[105]

Under paragraph (b), the court must address the unrestorability issue whenever the professionals attempting competence restoration report that it will not succeed, and in any event by the end of the maximum sentence that would have been imposed upon conviction or at the end of 12 [or 18] months, whichever comes first. Thus, for minor offenses, such a hearing will usually take place within six months of a finding of incompetence, and for more serious offenses it will occur, at the latest, after a year [or a year and a half] has elapsed. Given the typical length of stay periods reported above, defendants who have not been restored within a year will probably never be, and the court should so decide.

Ideally, when the charge is minor, the hearing should not be needed at all. Rather, the defendant will have been diverted out of the system by the time a hearing

[100] Fitch, supra note 1, at 14.
[101] Gianni Pirelli & Patricia A. Zapf, An Attempted Meta-Analysis of the Competency Restoration Research: Important Findings for Future Directions, 20 J. Forensic Psychol. Research & Prac. 134 (2020).
[102] See also supra note 95 (reporting research consistent with this conclusion).
[103] Pirelli & Zapf, supra note 101, at 134. (finding, based on a meta-analysis, "a base-rate for competence restoration" of only 81%).
[104] 406 U.S. 715, 738 (1972).
[105] Cf. Jones v. United States, 463 U.S. 354, 368-369 (1983) (holding that insanity acquittees may be committed on a preponderance of evidence because the insanity finding allows a presumption of mental illness).

is required under this standard. Recall, for instance, that standard 7-4.8(e) encourages the latter resolution by providing that, in cases involving minor charges, earlier diversion out of the system and dismissal of charges (pending completion of a diversion program) should occur if the prosecution, defense counsel and the defendant agree.

However, unrestorable defendants who face very serious charges pose a conundrum for the courts. *Jackson* held that, once it becomes apparent that there is no substantial probability that the defendant will attain competence in the foreseeable future, the only options for the court are civil commitment (pursuant to the standards and procedures that apply where a person has no criminal court involvement) or release. To continue a defendant's indefinite "criminal" commitment when restoration is futile would violate guarantees of both equal protection (because the defendant is not convicted and yet is not afforded protections available to those who are civilly committed) and due process (because no "rational relation" exists between the nature and duration of confinement and the state's purpose for commitment, which is to restore competence).[106] Yet civil commitment standards may be difficult to meet, because they require a finding of "imminent dangerousness" to self or others, which must be proven by clear and convincing evidence.[107] More importantly, the duration of commitment is usually brief, with recent studies finding average lengths of stay in the range of 7-10 days.[108] These scenarios—either no commitment or short-term hospitalization in low security facilities—are not palatable to many judges and most prosecutors, especially when the pending charges are serious. Thus many jurisdictions have been loath to follow *Jackson*, and many appear to be in outright violation of it;[109] for instance, Florida does not require dismissal of charges for an unrestorably incompetent person with mental illness until five years have elapsed (much longer than is needed to determine whether a person is restorable), and even then the dismissal may be without prejudice.[110]

In an effort to reconcile this tension, the original edition of these Standards provided for a special commitment procedure for any nonrestorable defendant charged with a felony causing or seriously threatening serious bodily harm. Under that standard, the court first was required to determine the factual guilt of the defendant at a proceeding at which the defendant would enjoy all the constitutional rights generally afforded trial defendants, other than the right not be tried while

[106] *Jackson*, 406 U.S. at 729, 738.
[107] Addington v. Texas, 441 U.S. 418 (1979).
[108] W. Lawrence Fitch & Jeffrey Swanson, SAMSHA Report—Civil Commitment and the Mental Health Care Continuum: Historical Trends and Principles for Law and Practice 28 (2019), available at https://www.samhsa.gov/ebp-resource-center.
[109] See generally Rosinia, supra note 95, at 689-690 (noting that, as of 2012, 11 states place no upper limit on confinement for competency restoration and 20 states tie the duration of confinement of unrestorable defendants to the sentence connected with the charge, which can amount to life).
[110] See Fla. Stat. § 916.145.

incompetent. Upon a finding beyond a reasonable doubt that the prosecution had established the elements of the offense and disproved any affirmative defenses presented, the court was to invoke the special commitment procedures applicable to defendants found nonresponsible because of a mental disorder [insanity] under Part VII of the Standards; those standards, both in the earlier edition and this one, permit commitment of acquittees on lesser showings of mental disorder and dangerousness than are required by ordinary civil commitment statutes (see standard 7-7.4).

In the intervening thirty years, however, this special commitment proposal gained little traction in the states. Only Ohio and New Mexico enacted similar statutes, and, although both have withstood constitutional scrutiny in their state courts,[111] they have proven controversial.[112] The present standard hews more closely to the Supreme Court's opinion in *Jackson*, but still acknowledges the considerable resistance to it by altering commitment procedures. Paragraph (c) provides that a nonrestorable defendant may be committed only if the criteria for ordinary civil commitment are met. But it also provides that the commitment may take place in a forensic facility, which is typically more secure than a civil hospital. Recall also that, under paragraph (a), unrestorability need only be found by a preponderance of the evidence, not clear and convincing evidence. Allowing commitment to a forensic facility and lowering the standard of proof should allay to some extent concerns about public safety, as well as concerns about co-mingling individuals charged with serious crimes with psychiatric patients in civil hospitals.

Standard 7-4.15. Conducting proceedings when the defendant is taking medication

(a) A defendant should not be considered incompetent to proceed because the defendant's competence is dependent upon continuation of treatment which includes medication, nor should a defendant be prohibited from standing trial or entering a plea solely because that defendant is being provided such services under professional supervision.

(b) If the defendant proceeds to trial with the aid of treatment that may affect demeanor, either party should have the right to introduce evidence regarding the treatment and its effects, and the jury should be instructed accordingly.

[111] State of Ohio v. Williams, 930 N.E.2d 770 (Ohio 2010); State of New Mexico v. Adonis, 145 N.M. 102 (2008).
[112] See Octavio Choi & Kenneth J. Weiss, Adjudicating Dangerous and Incompetent Defendants: Civil or Criminal?, 40 J. Am. Acad. Psychiat. & L. 279 (2012).

Commentary

The discovery, beginning in the 1950s, of effective medications to treat the symptoms of severe mental disorders has changed the course of mental health care, shifting the primary locus of care from large institutions to outpatient settings in the community. Psychoactive medications do not cure mental disorders, but they can be highly effective in alleviating a patient's symptoms, allowing many of those with even the most serious mental disorders to lead full and productive lives in the community. The general mental condition seen most often among defendants found incompetent to proceed is psychosis. The most debilitating symptoms of psychosis, such as delusions and thought disorder, respond particularly well to treatment with psychoactive medications; as a consequence, such treatment has become the primary means of competence restoration in most cases.

Even so, when these medications first appeared, some courts labeled the effects they produced "synthetic sanity" or "chemical competence" and forbade the trial of defendants whose competence depended on their use.[113] The medications' side effects were a particular concern. In more recent years, however, as these medications have become commonplace in the treatment of mental disorder and newer medications have appeared with fewer side effects, the courts' attitudes have changed. Now, most recognize that, at least for defendants with the most serious disorders, these medications are often essential to competence, as long as *Sell's* limitations are followed (see standard 7-4.11 and commentary).[114] Many state statutes echo that view.[115]

This standard follows the trend. Paragraph (a) accepts the premise that defendants whose medicated state is compatible with triability may proceed. The only operative concern is competence, not its source or cause. If the treatment provided affects the defendant's demeanor, as some psychoactive medications can, paragraph (b) allows either party to introduce evidence about the treatments and its effects (and side effects). If there is a jury, it should be instructed about the effects of the medication. These alternatives are particularly likely to be sought when the defendant is raising a mental nonresponsibility [insanity defense], and the effect of medication is to make the defendant appear "sane."[116]

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[113] Thomas G. Gutheil & Paul S. Appelbaum, "Mind Control," "Synthetic Sanity," "Artificial Competence," and Genuine Confusion: Legally Relevant Effects of Anti-Psychotic Medication, 12 Hofstra L. Rev. 77, 78 (1983) ("many of the courts that have been confronted with the issue of a right to refuse treatment have constructed a profile of antipsychotic medications as 'mind-altering' or 'thought-controlling.'").

[114] A leading case is United States v. Weston, 255 F.3d 873 (D.C. Cir. 2001). See generally Melton et al., supra note 22, at 134-135.

[115] See, e.g., Ill. Stat. ch. 725 § 5/104-21 (a) ("A defendant who is receiving psychotropic drugs shall not be presumed to be unfit to stand trial solely by virtue of the receipt of those drugs or medications."); Mich. Stat. § 330.2020 (same); Fla. Stat. § 916.12(2) (same).

[116] See, e.g., People v. Hardesty, 362 N.W.2d 787, 795 (Mich. 1984) (suggesting medication of the defendant is one reason insanity defenses seldom prevail, but ultimately affirming conviction); State v. Hayes, 389 A.2d 1378

Standard 7-4.16. Credit for time served

A defendant who has been detained or committed for examination of competence to proceed or treatment to restore competence to proceed should receive credit against any sentence ultimately imposed for the time of such pretrial confinement.

Commentary

Treatment to restore competence is meant primarily to benefit the judicial system by allowing otherwise untriable cases to proceed; any benefit to defendants is incidental. Consequently, standard 7-4.16 provides that if they have been detained or committed during the pendency of criminal proceedings for the purpose of restoring them to competence, defendants should be given the same credit against a later sentence of imprisonment that they would have had they been detained in jail pending adjudication. The credit embraces both detention for evaluation and compulsory hospitalization.

However, a defendant who is evaluated or treated as an outpatient basis is no more entitled to credit against sentence than a defendant allowed to remain in the community on pretrial release pending completion of criminal proceedings. If a defendant's evaluation or treatment includes both outpatient services and services in confinement (in detention or in a commitment facility), only the time spent in confinement should count toward the credit received.

(N.H. 1978) (holding that if a defendant, while competent, waives the right to be tried while competent, a trial court can consider taking the defendant off medication for trial). *Hayes's* solution is problematic for several reasons, including the harm to the defendant in withdrawing medication, the difficulty of replicating unmedicated mental states at the time of the offense, and the possibility that, given society's interests, defendants should be allowed to waive the right to be tried while competent. A better alternative is showing jurors a video of the defendant being interviewed near the time of the offense.

PART V. COMPETENCE IN SPECIFIC CONTEXTS

INTRODUCTION

As discussed in Part IV, competence to proceed in a criminal case is context dependent. Whether a defendant is competent depends on the nature and extent of the demands that will be placed on the defendant. The criteria for competence may vary accordingly. Part IV focused on competence to stand trial and plead. Part V addresses competence in a variety of other pre-adjudication and adjudication contexts, focusing on situations in which the defendant makes a decision that is likely to conflict with legal advice, including competence to waive a mental nonresponsibility [insanity] defense, to waive counsel, to represent oneself, and to waive *Miranda* rights. Competence in post-adjudication settings is addressed in Parts VIII and IX.

Standard 7-5.1 Competence to proceed in specific contexts and related issues

(a) Legislatures and courts should recognize that special competence issues arise when defense counsel has good faith doubts about the defendant's ability to make significant decisions, when the defendant wants to proceed pro se, when the defendant is subject to police interrogations, and when the proceeding at issue occurs after conviction.

(b) Standard 7-5.2 applies when defense counsel has doubts about the defendant's competence to make decisions about matters within the defendant's sphere of control.

(c) Standard 7-5.3 applies when the defendant elects to proceed without counsel and when, after such election, the defendant proceeds pro se.

(d) Standard 7-5.5 governs the admissibility of statements made by people with mental disorder during interrogation and related issues.

(e) Standards 7-8.7 and 7-8.8 govern competence to proceed of defendants represented by counsel in noncapital sentencing and post-conviction proceedings and Standards 7-9.8 and 9.9 govern competence issues relating to capital sentencing and post-conviction proceedings.

Commentary

Standard 7-5.1 summarizes the variety of circumstances in which special competence issues arise. It provides a roadmap to the standards on point, in Part V and elsewhere.

Standard 7-5.2 Competence to proceed with specific decisions: control and direction of case

(a) Matters that are under the defendant's sphere of control include the decisions to plead guilty, assert a defense of nonresponsibility [insanity defense], and waive the rights to jury trial, testify, and appeal.

(b) The test for determining whether the defendant is competent to make a decision regarding control and direction of the case should be whether the defendant has sufficient present ability to consult with counsel with a reasonable degree of rational understanding and whether the defendant has a rational as well as factual understanding of the nature and consequences of the decision or decisions under consideration.

(c) If the defense attorney has a good faith doubt concerning the defendant's competence to make decisions within the defendant's sphere of control under (a), the defense attorney may make a motion to determine the defendant's competence to proceed under Standard 7-4.3 even if the defendant has previously been found competent to proceed in the case. Upon such motion, the court should order a mental health evaluation, if necessary, according to the procedures set forth in Standard 7-4.4, and indicate the specific decisional issue in question. If, after a hearing, the court finds the defendant competent to proceed, defense counsel should follow the defendant's direction on matters within the defendant's sphere of control. If the defendant is found incompetent, the court should order treatment according to Part IV.

Commentary

Standard 7-5.2 addresses circumstances in which the defendant and defense counsel disagree about control and direction of a case. Paragraph (a) identifies matters that are under the defendant's sphere of control. Consistent with the Standards on the Defense Function,[1] it indicates that the defendant is entitled to make the final decision about whether to plead guilty, assert or waive an insanity defense,

[1] See standard 4-5.2. Note that one area not mentioned in standard 4-5.2 in which the defendant is given some control in these standards is when the defendant does not want defense counsel to raise an incompetency plea. In that situation, standard 7-4.8(b) allows the defendant to proceed represented by special counsel.

and waive the rights to jury, testify and appeal. In contrast to tactical issues involving the selection of witnesses, the manner of presenting evidence, objections and like matters, these are fundamental aspects of the case that the defendant, not the attorney, should dictate.

However, the defendant's control of these matters is contingent on the competence to make decisions about them. As discussed in the commentary to standard 7-4.2, the defendant must not only be competent in the sense governed by Part IV of these Standards, which focuses on adjudicative competence (the ability to understand the process and communicate with counsel), but also must be decisionally competent (i.e., competent to make the specific decision at hand). [2] Paragraph (b) sets out the test for determining competence to make decisions; while this test closely resembles the test for competence to proceed in standard 7-4.1, it recognizes that context matters, and thus focuses attention on whether the defendant has a rational as well as factual understanding of the nature and consequences of the decision or decisions under consideration. A defendant might have a good understanding of how the adjudication process works in the typical case and an adequate ability to disclose relevant facts to counsel, but nonetheless be delusional about the seriousness of the crime, the impact of pleading guilty, the stability of his or her mental state, or the composition of the jury in the defendant's case. Such a defendant may well be competent to proceed in the abstract, but not be competent to make decisions about pleading guilty, waiving the insanity defense, or waiving the right to jury trial.

Accordingly, paragraph (c) provides that when defense counsel has a good faith doubt about a client's ability to make decisions about any of the matters specified in (a), counsel may seek, following the procedures in Part IV of these Standards, evaluations and hearings that address this more particularized focus, even if the defendant has previously been found competent. If after such an evaluation the defendant is found incompetent, treatment aimed at restoring competence should occur, in line with standards 7-4.10 to 7-4.16. If the defendant is found competent, either initially or after treatment, counsel must follow the client's direction on the matters specified in (a).

Standard 7-5.3. Competence to elect to proceed without representation by counsel; competence to proceed pro se

(a) A defendant who is incompetent to elect to proceed without representation by counsel should not be permitted to proceed to trial or enter a plea of guilt or nolo contendere while unrepresented by counsel.

[2] See Richard Bonnie, The Competence of Criminal Defendants: A Theoretical Reformulation, 10 Behav. Sci. & L. 291 (1992).

(b) The test for determining competence to elect to proceed without representation by counsel should be whether the defendant

(i) is competent to proceed under Standard 7-4.1(b),

(ii) 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, and

(iii) has the ability to make a voluntary, knowing, and rational decision to waive representation by counsel.

(c) A defendant who is competent to elect to proceed without representation by counsel may plead guilty if competent to do so under Standard 7-4.2.

(d) 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.

(e) If, after explaining the availability of a lawyer and making sufficient inquiry of a defendant professing a desire to waive representation by counsel and proceed pro se, the trial judge has a good faith doubt about the defendant's competence with respect to either waiver or pro se representation, the judge should order a pretrial evaluation of the defendant according to the procedures set forth in Part IV of this chapter.

(f) After obtaining the report of the evaluators, the court should hold a hearing at which the defendant is represented on the issues raised according to the procedures set forth in Part IV of this chapter.

(i) If the court determines that the defendant is both competent to elect to proceed without representation by counsel and competent to proceed pro se, the court should proceed with the case. The court in any

such case should consider the appointment of standby counsel in accordance with Standard 6-3.7 to assist the defendant or, if it should prove necessary, to assume representation of the defendant.

(ii) If the court determines that the defendant is incompetent to elect to proceed without representation by counsel, the court should proceed to consider treatment in accordance with Part IV of this chapter.

(iii) If the court determines that the defendant is competent to elect to proceed pro se but is not competent to proceed to trial without representation of counsel, the court should appoint counsel to represent the defendant and should proceed to trial of the case.

Commentary

The Sixth Amendment right to counsel is perhaps the single most important constitutional right criminal defendants enjoy. Defendants have the right to counsel whenever subject to confinement, even if indigent.[3] At the same time, in *Faretta v. California*,[4] the U.S. Supreme Court held that defendants have a right to waive counsel and proceed pro se, if they are competent to do so. If, however, they are incompetent to do so, they should not be permitted to waive their Sixth Amendment right. Paragraph (a) recognizes this basic point.

Paragraph (b) sets out the test for determining competency in this context. In *Godinez v. Moran*,[5] the Court ruled that the standard for competence to make this choice is subsumed by the general standard for competence to proceed, stating that "there is no reason to believe that the decision to waive counsel requires an appreciably higher level of mental functioning than the decision to waive other constitutional rights."[6] The Court emphasized that "the competence that is required of a defendant seeking to waive his right to counsel is the competence to *waive the right*, not the competence to represent himself."[7] Subparagraph (b)(i) acknowledges that competence to waive counsel is directly linked to competence to procced generally.

As discussed earlier in these Standards,[8] however, even general trial competence is context dependent. A level of competence sufficient to guarantee fairness where the charges are minimal and the facts simple may not be sufficient in a

[3] Gideon v. Wainwright, 372 U.S. 335 (1963); Argersinger v. Hamlin, 407 U.S. 25, 92 S.Ct. 2006 (1972).
[4] Faretta v. California, 422 U.S. 806 (1975).
[5] 509 U.S. 389 (1993).
[6] Id. at 399.
[7] Id.
[8] See commentary to standards 7-4.2 and 7-5.2.

more serious, more complicated case. Thus, it is important that any competency inquiry focus on the demands a particular type of proceeding will make on the defendant. Moreover, regardless of case complexity, defendants who meet the basic competence requirements of standard 7-4.2 may nonetheless have impairments that compromise the ability to choose to waive counsel. Consider a defendant who understands the charges and their consequences and the way legal proceedings work, but who perseverates under stress, has an attention deficit disorder or suffers from early dementia that causes difficulty staying on track. Is the defendant aware of these deficits and the effect they may have on his or her ability to lawyer the case? Will the defendant take these deficits into account when deciding whether to waive? Or consider a defendant who falsely believes that he or she knows more than any attorney who might be assigned. In *Faretta* the Supreme Court made clear that a defendant need not have legal training or any sophisticated understanding of the law in order to choose self-representation.[9] But can it fairly be said that such a defendant's understanding of the proceedings is rational and factual?

Subparagraph (b)(ii)'s reference to "difficulties the defendant may experience due to his or her mental or emotional condition or lack of knowledge about the legal process" is meant to trigger such inquiries by the court. A second inquiry, found in subparagraph (b)(iii), is mandated by *Moran* itself, which stipulated that a waiver from a competent defendant is not valid unless it is also knowing and voluntary.[10] But, in line with the above reasoning and with *Dusky* test's use of the word (twice), the provision adds that the waiver must also be "rational," to suggest that merely knowing the consequences of waiver of counsel is insufficient if the reasons for doing sound in delusions that ignore reality or clinical depression that eliminates the motivation to consider one's legal predicament.[11]

Furthermore, even competence to make the choice to represent oneself, so defined, does not necessarily connote competence to carry out the task of self-representation. Paragraph (c) makes clear, consistent with the Court's opinion in *Moran*, that any defendant who is competent to elect self-representation may plead guilty if competent to do so under standard 7-4.2. But a defendant who wishes to proceed to trial pro se may require a greater, or more particularized, competence. The Supreme Court so held in *Indiana v. Edwards*,[12] where it recognized that a defendant may have an adequate understanding of the possible consequences of proceeding pro se (and be able to make a voluntary, knowing, and rational decision so to proceed), yet "be unable to carry out the basic tasks needed to present his own

[9] Id. at 836.
[10] *Moran*, 509 U.S. at 400-401.
[11] See Christopher Slobogin, Mental Illness and Self-Representation: *Faretta*, *Godinez* and *Edwards*, 7 Ohio St. J. Crim. L. 391, 402-403 (2009).
[12] 554 U.S. 164 (2008).

defense without [counsel's help]."[13] These tasks, the Court noted, may include "organization of defense, making motions, arguing points of law, participating in voir dire, questioning witnesses, and addressing the court and jury."[14] Quoting from an amicus brief submitted by the American Psychiatric Association, the Court observed that "[d]isorganized thinking, deficits in sustaining attention and concentration, impaired expressive abilities, anxiety, and other common symptoms of severe mental illness can impair the defendant's ability to play the significantly expanded role required for self-representation even if he can play the lesser role of represented defendant."[15]

The Court declined to establish a specific standard for competence to represent self, however. Rather it left to trial courts the duty to weigh the circumstances of the case, the demands trial is likely to place on the defendant, and the degree and significance of the defendant's impairments, as these considerations might affect the "dignity," "fairness" and "appearance of fairness" of trial.[16] In the spirit of this reasoning, subparagraph (d) calls for the court to permit a pro se role for any defendant who is competent to waive counsel *unless*, as a result of a mental disorder, (i) the defendant lacks the capacity to carry out the minimum tasks required for self-representation to such a substantial extent that the dignity or fairness of the proceeding is compromised, or (ii) the defendant will significantly disrupt the decorum of the proceeding.

Making this determination can be a difficult one, not only because it calls for a prediction about complex events but because as *Edwards* recognized,[17] it requires balancing the defendant's right to control the defense case against society's interest in fair and accurate proceedings. In making this determination, understanding the specific deficits of the defendant who has mental disability is important.[18] Accordingly, paragraph (e) provides that a court with a bona fide doubt about the defendant's competence—either competence to waive counsel or competence to proceed pro se—should order a pretrial evaluation of the defendant pursuant to the procedures set forth in Part IV for evaluations of competence to proceed.

Paragraph (f) provides that, upon receipt of the report of the evaluator assigned under (e), the court should conduct a hearing in accordance with procedures set forth in Part IV.[19] Note that, under those provisions, the defendant should be represented by counsel at this hearing. Under subparagraph (f)(i), if the court finds

[13] Id. at 175-176.
[14] Id. at 176 (quoting McKaskle v. Wiggins, 465 U.S. 168, 174 (1984).
[15] Id. (quoting Brief for APA et al. as Amici Curiae 26).
[16] Id. at 176-177.
[17] Id..
[18] For discussion of these points, see E. Lea Johnston, Legal and Clinical Issues Regarding the Pro Se Defendant: Guidance for Practitioners and Policymakers, 25 Psychol., Pub. Pol'y & L. 196 (2019).
[19] Standard 7-4.9.

that the defendant is both competent to waive counsel and competent to proceed pro se, the case may proceed. However, in accordance with standard 6-3.7 in the Standards on Special Functions of the Trial Judge, the court may wish to assign standby counsel to assist the defendant or, if necessary, to assume the defendant's representation should the defendant's competence wane. As the commentary to standard 6-3.7 provides, "the overriding interest in appointing standby counsel, whatever the arrangement with the defendant, is to facilitate the function of the criminal justice process, while protecting the autonomy of the defendant and the principles and policies underlying the right to counsel."

If the court finds instead that the defendant is incompetent to waive counsel, subparagraph (f)(ii) requires the court consider treatment, under the procedures governing treatment for defendants found incompetent to proceed.[20] Another option would be to assign counsel and proceed to trial. However, under *Moran*, a defendant who is incompetent to waive counsel is also incompetent to proceed generally; thus, a defendant who lacks competence to waive counsel probably cannot proceed to trial even with counsel. For all of the reasons that the law strives to restore defendants who are incompetent to proceed, treatment—or, at least consideration of treatment–is the preferred option here.

Finally, the court might find that the defendant is competent to waive counsel under 7-5.2(b) but incompetent to proceed pro se under 7-5.2(d) because of an inability to carry out basic trial tasks, despite an understanding of the trial process and an ability to make rational decisions. In this more likely situation, subparagraph (f)(iii) requires the court to assign counsel and proceed to trial, the remedy the Court approved in *Edwards*. Treatment in an effort to restore competence to proceed pro se in all likelihood would be difficult, frustrating justice unnecessarily.

Standard 7-5.4. Use of statements by people with mental disorder at trial

(a) This Standard addresses competence and admissibility issues that arise when people with mental disorder make incriminating statements to the police that are potentially:

(i) unreliable, as described in (b).

(ii) involuntary, as described in (c),

(iii) obtained in violation of *Miranda v. Arizona,* as described in (d).

[20] See standards 7-4.10 to 7-4.15.

(b) Where the court finds that the reliability of a statement has been significantly impaired by a person's mental disorder, it should exclude the statement from evidence even in the absence of official misconduct. Where the statement has not been excluded, the court should permit evidence to be presented to the trier of fact regarding the effect of the defendant's mental disorder on the reliability of the statement.

(c) Courts should recognize that official conduct that does not constitute impermissible coercion when persons without mental disorder are interrogated may impair the voluntariness of the statements of persons with mental disorder. Where such impairment of voluntariness is significant, the court should exclude the statement from evidence. However, in the absence of any such impermissibly coercive official conduct, such statement should not be excluded from evidence solely because it was the product of the person's mental disorder, unless it is found unreliable pursuant to Standard 7-5.4(b).

(d) Statements made by persons with mental disorder in response to custodial interrogation should be admissible only if the person has a factual and rational understanding of his or her rights and makes a knowing and voluntary waiver of them. A person's mental disability can affect and impair each element of an otherwise valid waiver.

(e) The court should admit into evidence at both pretrial hearings and trial otherwise admissible expert testimony by qualified mental health professionals bearing on the effect of a person's disorder on the reliability and voluntariness of a statement and the validity of any waiver of rights that preceded such a statement.

Commentary

Standard 7-5.4 concerns the use at trial of statements by people with mental disorders. If a criminal suspect makes an incriminating statement to the police, the suspect's mental condition may affect how or whether the statement may be used as evidence in three ways, identified in paragraph (a). First, mental disorder may affect the reliability of the statement, calling into question its evidentiary value. Second, mental disorder may render a suspect vulnerable to forms of persuasion and coercion that would have little or no effect on an individual with no mental disorder, and thus might call for exclusion on due process grounds. Finally, a mental disorder may impair suspects' ability to understand their rights, possibly invalidating any waiver of those rights. Standard 7-5.4 provides guidelines for lawyers, courts, and law enforcement officers in each of these circumstances.

Reliability

The common law has long recognized the potential unreliability inherent in confessions from individuals who are confused, harassed or covering for someone else. Concern about the trustworthiness of self-incriminating statements was the original reason for the long-standing requirement that confessions be corroborated with independent proof of the corpus delicti.[21] The perceived unreliability of coerced statements was also a principal reason for the common-law (and later constitutional) requirement that only "voluntary" confessions be admitted into evidence.[22] As Justice Brennan observed, "Because the admission of a confession so strongly tips the balance against the defendant in the adversarial process, we must be especially careful about a confession's reliability."[23]

The reliability of incriminating statements by persons with mental disorders is particularly suspect. For instance, such a person may make a false or inaccurate confession because an hallucination commanded it,[24] or because of a mistaken understanding of the facts or the nature of criminal responsibility.[25] Given the distorting effects of mental disorder, paragraph (b) recognizes that even in the absence of any coercion or manipulation by the police, admissions and confessions by individuals with mental disorders may be of questionable reliability. While the U.S. Supreme Court, in *Colorado v. Connelly*,[26] held that the Constitution does not require exclusion of unreliable statements in the absence of state coercion, it also recognized that evidentiary rules might do so.[27] Some statements by suspects with mental disorders are so confused or tainted by delusions that, even if not triggered by police conduct, they should be excluded because the prejudicial impact of their introduction would clearly outweigh their negligible probative value.

However, if a court declines to exclude the confession from a mentally impaired individual, the standard would still allow introduction of evidence about

[21] 6 Wayne LaFave et al., Criminal Procedure Vol. 6, § 24.6(c) (4th ed. 2023) (hereafter LaFave et al.).
[22] The King v. Warickshall, 168 Eng. Rep. 234, 1 Leach 263 (1783); Hopt v. Utah, 110 U.S. 574 (1884); Brown v. Mississippi, 297 U.S. 278 (1936); LaFave et al., supra note 21, Vol. 2, § 6.2(b).
[23] Colorado v. Connelly, 479 U.S. 157, 182 (1986) (Brennan, J. dissenting).
[24] In his dissent in *Connelly*, Justice Brennan pointed out that while Connelly did tell the police he murdered a woman sometime during the previous November and took them to the place he claimed the murder happened, at the time he was actively hallucinating that God told him to do so. Brennan further noted that, while police records did show that that an unidentified woman had apparently been killed, that death had occurred the following *April*, and police did not corroborate that the body was the woman Connelly named, that the body was found at the location Connelly indicated, or that a crime occurred there. Brennan concluded that there was "not a shred of competent evidence in this record linking the defendant to the charged homicide." Id. at 182-183.
[25] See, e.g., James Ellis & Ruth Luckasson, Mentally Retarded Criminal Defendants, 53 Geo Wash. L. Rev. 414, 466 n. 286 (1985) (describing a mildly intellectually disabled defendant who entered a guilty plea because he regretted that he had not prevented the commission of a criminal act by another person and therefore believed himself to be "guilty" of the offense).
[26] 479 U.S. 157 (1986).
[27] Id. at 167.

how mental disorder may have affected reliability. Such evidence, which may include the expert testimony of mental health professionals (paragraph (e)), allows the trier of fact to determine how much weight, if any, to assign to the incriminating statements.[28] An admonitory instruction from the court on this issue may also be appropriate.

Voluntariness

Involuntary confessions have long been excluded from evidence by the courts. As the Supreme Court has noted, "a complex of values underlies the stricture against the use by the state of confessions which, by way of convenient shorthand, this Court terms involuntary."[29] These values include not just the possibility that involuntary confessions are factually unreliable but also concerns about the acceptability of police practices used to produce involuntary statements.[30] The increasing focus of the courts on the waiver of rights under *Miranda v. Arizona*[31] has reduced the attention paid to the voluntariness doctrine. But it remains clear that due process forbids the admission of a statement that is coerced by government conduct, and that such conduct does not have to involve physical harm,[32] but rather can consist simply of police taking advantage of a vulnerable suspect.[33] In this context, the Supreme Court has consistently observed that "certain interrogation techniques, either in isolation or as applied to the unique characteristics of a particular suspect, are so offensive to a civilized system of justice that they must be condemned."[34]

Paragraph (c) reflects this rule by providing that interrogation techniques that would not constitute unacceptable coercion in cases involving ordinary suspects may undermine the voluntariness of a confession when the suspect has "unique characteristics" associated with mental disorder. As the Supreme Court has recognized on several occasions,[35] whether because of naivete, ignorance, confusion, suggestibility, delusional beliefs, unusual susceptibility to pressure, or other types of impairments, suspects with mental disorders can be easy prey for law enforcement officers during interrogation. Where a showing is made, typically at a suppression hearing, that a suspect's mental disorder significantly impaired the voluntariness of

[28] The evidence may also describe the circumstances under which the statement was made. As Justice O'Connor observed for a unanimous Court, "evidence about the manner in which a confession was obtained is often highly relevant to its reliability and credibility." Crane v. Kentucky, 106 S.Ct. 2142, 2147 (1986).
[29] Blackburn v. Alabama, 361 U.S. 199 (1960).
[30] LaFave et al., supra note 21, Vol. 2, § 6.2(b). See also Rogers v. Richmond, 365 U.S. 534, 541-542 (1961).
[31] 384 U.S. 486 (1966).
[32] Arizona v. Fulminante, 499 U.S. 279, 287 (1991) ("Our cases have made clear that a finding of coercion need not depend upon actual violence by a government agent").
[33] Mincey v. Arizona, 437 U.S. 385, 398 (1978) (excluding a confession from a person in a hospital being treated for a gunshot wound and in "unbearable pain," because "[i]t is hard to imagine a situation less conducive to the exercise of "a rational intellect and a free will").
[34] Miller v. Fenton, 474 U.S. 104, 109 (1985).
[35] *Connell*y, 479 U.S. at 165 (dictum); Blackburn v. Alabama, 361 U.S. 199 (1960) (mental illness); Columbe v. Connecticut, 367 U.S. 568 (1961) (intellectual disability).

the suspect's statement to the police, the standard provides that the statement should be excluded.[36]

The final sentence of paragraph (c) addresses the admissibility of statements made by individuals with mental disorder who are not in custody and who are not the subjects of official attempts to elicit a confession. As noted above, in *Colorado v. Connelly*,[37] the Supreme Court concluded that a confession could not be considered involuntary as a constitutional matter without some form of coercive police activity. Applying that rule, the Court held that a confession was admissible even though it was a product of "command hallucinations" caused by the defendant's mental illness, because it was unprompted by police interrogation. Consistent with *Connelly*, the standard provides that self-incriminating statements should not be excluded as "involuntary" if they occur outside of police custody and in the absence of any official coercion. While mental disorder might cause, or even "compel" an incriminating statement, so might any number of other personal considerations or traits that have nothing to do with police misconduct, and the latter are clearly admissible as evidence. Further, if the statement is reliable, its exclusion serves no purpose. Thus, "voluntariness" in the context of confessions refers more appropriately to the absence of state coercion. Of course, a voluntary statement may still be inadmissible for other reasons, such as lack of reliability, under paragraph (a), or a violation of *Miranda*, under paragraph (c).

Miranda Violations

In addition to the impact of mental disorder on the reliability and voluntariness of confessions, discussed in paragraphs (b) and (c), statements made in the context of custodial interrogation may be inadmissible if a suspect's mental disorder renders him or her unable to give an effective waiver of the right to remain silent and the right to counsel during interrogation that were recognized in *Miranda v. Arizona*.[38] Paragraph (d) recognizes that the admissibility of any custodial confession requires a valid waiver of the suspect's constitutional rights, and that any waiver must be knowingly and voluntarily made.[39] It is meant to emphasize that the standard *Miranda* warning may not be sufficient to overcome the knowledge deficits some suspects with mental and intellectual disabilities may have.

[36] Defendants are constitutionally entitled to a judicial determination of voluntariness outside of the presence of the jury. Jackson v. Denno, 378 U.S. 368 (1964). The majority of states follow the so-called "orthodox rule," which holds that this determination is not reviewable by the jury. Other states follow the so-called "Massachusetts rule," under which a judge's ruling can be reviewed independently by the jury. LaFave et al., supra note 21, vol. 3, § 10.5(a). The standard expresses a preference for the latter rule.
[37] 470 U.S. 157 (1986).
[38] 384 U.S. 486 (1966).
[39] See Moran v. Burbine, 475 U.S. 412, 421 (1986).

These disabilities can affect both cognition and volition. With respect to cognition, the Supreme Court has held, in cases involving non-disordered defendants, that the suspect need not fully and completely understand and appreciate every aspect of the consequences of a waiver.[40] But suspects must still clearly understand that their rights include the right to counsel, the right to refrain from answering questions, and the fact that the voluntary relinquishment of these rights may produce evidence that can be used to obtain a conviction. Mental disorder may so compromise understanding of these rights that a valid waiver is impossible.[41] For instance, an individual with an intellectual disability may fail to understand the terminology in the standard warning, and may not even grasp the basic concepts of adversarial proceedings or rights.[42] Similarly, suspects with mental illness may misperceive the roles of the police, defense counsel or the fact that they are being interrogated about a crime.

Perhaps even more difficult problems arise from the requirement that a waiver of rights must be voluntary. This rule parallels, but is not identical to, the inquiry into whether a confession is voluntary under paragraph (c). Here the inquiry is whether the suspect's decision to give up the right to counsel and the right to remain silent was voluntarily made. Where that decision was the product of official coercion, the waiver is invalid, and any resulting statement is inadmissible.[43] Just as coercive interrogation techniques may render the statement of a suspect involuntary under the due process clause because of the suspect's exceptional vulnerability, a similar dynamic may invalidate the suspect's waiver of rights under *Miranda*. In particular, the suggestibility of individuals with intellectual disability and their extraordinary susceptibility to the perceived wishes of authority figures have been well documented.[44] Thus, for instance, deception that would not be considered impermissible when directed at a non-disordered person might be unacceptable in a case involving a person who is incapable of separating fact from fiction when it comes from the police.[45]

[40] See, e.g., Oregon v. Elstad, 470 U.S. 298, 316 (1985); North Carolina v. Butler, 441 U.S. 369 (1979).
[41] See, e.g., Smith v. Kemp, 664 F. Supp. 500 (M.D. Ga. 1987).
[42] See, e.g., Morgan Cloud, Words Without Meaning: The Constitution, Confessions, and Mentally Retarded Suspects, 69 U.Chi.L. Rev. 495, 590-91 (2002).
[43] See *Connelly*, 479 U.S. at 170.
[44] Solomon M. Fulero & Carolina Everington, Assessing the Capacity of Persons with Retardation to Waive *Miranda* Rights: A Jurisprudent Therapy Perspective, 28 Psychol. Rev. 53, 56-58 (2004) (describing research indicating that such people usually have "a strong desire to please others, especially those in authority" and often manifest "acquiescence," a tendency to answer "yes" even to absurd questions).
[45] Cf. Connecticut v. Barrett, 479 U.S. 370 (2010) (holding that police failure to clear up a defendant's confusion about whether a confession needed to be in writing did not invalidate the confession); Colorado v. Spring, 479 U.S. 564 (1987) (holding that police deception about the subject of the interrogation did not invalidate the confession); Frazier v. Cupp, 394 U.S. 731 (1969) (admitting statements made by suspect who was told, falsely, that his co-defendant had confessed).

Expert Testimony

Paragraph (e) provides that expert testimony by mental health professionals may be appropriate and necessary in determining the admissibility of a confession given by a suspect with mental disorder. This position is consistent with the overall view expressed in the Standards that courts should make use liberal of the expertise of professionals in the various disciplines that address the problems of mental disorder. Courts may require the assistance of qualified mental health experts both at suppression hearings, in deliberating on the reliability of a statement, its voluntariness, or the validity of a waiver of *Miranda* rights, and at trials, on the issue of the reliability of a defendant's statement. Although the standard does not explicitly so provide, defense counsel should be able to hire such an expert at state expense if the criteria in standard 7-3.3(a) are met. These experts may testify about the confession of a particular person or instead provide general evidence about the causes of false confessions, as a scientific expert (see standard 7-1.3(c)). The qualifications of experts asked to provide such assistance should meet the requirements of Standards 7-3.9 and 7-3.10. At bottom, as provided in standard 7-3.8(a), an expert's testimony should be admissible whenever it "is based on and is within the specialized knowledge of the witness and will assist the trier of fact…."[46]

Paragraph (e) does not address the question of whether mental health experts should be permitted to express an opinion on the "ultimate issue" before the court (i.e., whether the defendant's statement is unreliable, was made involuntarily, or was made during a custodial interrogation without an understanding or knowing and voluntary waiver of Miranda rights). However, standard 7-3.8(c) does deal with this concern, directing the expert who is asked to present such an opinion to "use cautionary language to explain the boundaries of the expert's clinical expertise and the limitations of the opinion."

[46] See Melton Gary Melton et al., Psychological Evaluations for the Courts: A Handbook for Mental Health Professionals and Lawyers (4th ed. 2017), for examples of how experts might assist the factfinder in evaluating the validity of a confession.

PART VI. NONRESPONSIBILITY FOR CRIME

INTRODUCTION

Part VI addresses the defense of mental nonresponsibility, a doctrine that traditionally has been labeled the insanity defense,[*] as well as other defenses that focus on mental state at the time of the offense. In *Kahler v. Kansas*,[1] the U.S. Supreme Court held that the mental nonresponsibility test adopted in these Standards is not constitutionally required. However, for reasons elaborated on below, the American Bar Association's stance in favor of the defense, initially adopted in the original 1986 Standards, is reaffirmed here in the 2016 Standards. That view is shared by a large number of organizations.[2]

Probably no other area of the criminal law has attracted as much professional or public attention as the defense of mental nonresponsibility. The best evidence suggests that the defense is raised in less than 1 percent of all felony cases in the United States and is successful in about a fourth of those.[3] Yet it continues to command a large portion of our attention.

The most famous insanity case as an historical matter came from England. In 1843, Daniel M'Naghten was acquitted "by reason of insanity" on charges of murdering the private secretary of Prime Minister Robert Peel. The verdict caused an uproar in England and moved the House of Lords to scrutinize carefully the grounds on which persons with mental disorder should be excused from crime. A century and a half later, the attempted assassination of President Reagan by John W. Hinckley, Jr. resulted in a new round of controversy over the defense, rivaling the M'Naghten experience. Hinckley's subsequent acquittal by reason of insanity was a major factor in the enactment in 1984 of the Insanity Defense Reform Act's restrictions on the federal insanity defense,[4] as well as legislative changes to mental nonresponsibility

[*] As noted in standard 7-1.1, note ** the term "mental nonresponsibility" replaces "insanity" throughout these Standards, for reasons stated there. However, to ensure no confusion between this defense and other mental state defenses and to remind the reader what it has replaced, this defense will occasionally be referred to as "mental nonresponsibility [insanity]".

[1] 589 U.S. 271 (2020).

[2] See e.g., Am. Psychiatric Ass'n, Statement on the Insanity Defense (2019) ("The APA strongly supports the insanity defense because it offers our criminal justice system a mechanism for recognizing the unfairness of punishing persons who exhibit substantial impairment of mental function at the time of their actions."); Brief of American Psychiatric Association, American Psychological Association, American Academy of Psychiatry and the Judge David L. Bazelon Center for Mental Health, and Mental Health American, Kahler v. Kansas, 2019 WL 2451207.

[3] Gary Melton et al., Psychological Evaluations for the Courts: A Handbook for Mental Health Professionals and Lawyers 200-201 (3d ed. 2017) (summarizing studies).

[4] Comprehensive Crime Control Act of 1984, 18 U.S.C.A. §17(a).

doctrine or its complete elimination in a number of states.[5] The hostile public mood that sparked this flurry of legislative activity echoed the reaction of Queen Victoria (herself once the target of a gunman later acquitted on "insanity" grounds) upon hearing the outcome of the M'Naghten case: "The law may be perfect, but how is it that whenever a case for its application arises, it proves to be of no avail?"[6]

Yet most American jurisdictions as well as most other countries continue to recognize a defense of mental nonresponsibility.[7] Judge Bazelon in 1954 succinctly answered those who would question the purpose of a defense that excuses a person for otherwise criminal conduct: "Our collective conscience does not allow punishment where it cannot impose blame."[8] Many academics have argued that the defense is essential to the moral integrity of the law.[9] The American Bar Association agrees that the basis for the nonresponsibility defense is a moral one; its jurisprudential underpinnings reach back to the origins of Western ethical and legal thought.

The defense has remained controversial, however. Four states (Kansas, Idaho, Montana, and Utah) have abolished the traditional insanity defense.[10] In these states, expert testimony regarding a defendant's mental state at the time of the offense is admissible only on the question of mens rea (i.e., whether the defendant lacked the requisite mental state for the offense charged), a legislative scheme the Supreme Court's decision in *Kahler* upheld against a due process challenge. These Standards endorse the admissibility of mental condition evidence on mens rea, if relevant. But the mens rea defense raises a very different question from that of mental nonresponsibility [insanity]. Mens rea, at least as it is understood today, requires only that a defendant have the requisite intent to commit the act and cause its consequences; why the defendant chooses to act is irrelevant. In contrast, the motivation for the defendant's conduct is the entire focus of the defense of mental nonresponsibility. An intentionally committed crime can nonetheless be blameless if committed for delusional reasons.

[5] See Lisa Callahan, Connie Mayer & Henry Steadman, Insanity Defense Reform in the United States—Post-Hinckley, 11 Mental & Phys. Disability L. Rep. 54 (1987).
[6] Quoted in Loftus T. Becker, *Durham* Revisited: Psychiatry and the Problem of Crime, in Diagnosis and Debate 49 (Richard Bonnie ed. 1977).
[7] See Appendix, Kahler v. Kansas, 589 U.S. at 319 et seq. (setting out the insanity test in 46 states); Rita James Simon & Heather Ahn-Redding, The Insanity Defense, the World Over (2006), at 15 (Canada), 73 (Germany), 83 (Great Britain), 99 (Netherlands), 109 (Sweden), 148 (Israel), 184 (India), 211 (South Africa), 221 (Australia).
[8] Durham v. United States, 214 F.2d 862, 876 (D.C. Cir. 1954), overruled by United States v. Brawner, 471 F.2d 969 (D.C. Cir. 1972).
[9] See, e.g., Brief of Amicus Curiae 290 Criminal Law and Mental Health Law Professors in Support of Petitioner's Request for Reversal and Remand, Kahler v. Kansas, 2019 WL 2418946; Brief of Philosophy Professors as Amici Curiae in Support of Petition, Kahler v. Kansas, 2019 WL 2367190.
[10] Kan. Stat. Ann. § 21-5209 (2018); Idaho Code §18-207 (1982); Mont. Code Ann. §46-14-102 (1981); Utah Code Ann.. §76-2-305(1) (1983).

If one assumes that morally blameless persons should not be punished as criminals, as these Standards posit, it becomes necessary to define the class of persons with a mental disorder who fall in this category, to prescribe procedures to be followed in evaluating and adjudicating defendants who assert a nonresponsibility defense, and to find appropriate dispositions for those determined to lack responsibility. The first issue is discussed in this part; the second is considered both in this part and Part III of this chapter; the third issue is the province of Part VII of this chapter. To grasp the thrust of the ABA's proposals concerning the mental nonresponsibility defense, all three parts must be read together.

Standard 7-6.1. The defense of mental nonresponsibility [insanity]

(a) A person is not responsible for criminal conduct if, at the time of such conduct, and as a result of mental disorder, that person was unable to appreciate the wrongfulness of such conduct.

(b) When used as a legal term in this Standard, mental disorder refers to any disorder that substantially affected the mental or emotional processes of the defendant at the time of the alleged offense, unless it was a disorder manifested primarily by repeated criminal conduct or was attributable solely to the acute effects of voluntary use of alcohol or other drugs.

Commentary

This standard retains a defense resulting in complete acquittal of crime for people whose mental disability at the time of the offense causes significant cognitive impairment. It follows the lead of most states in focusing on cognitive rather than volitional impairment. However, as explained below, it is not meant to eliminate the involuntary act defense, based on the absence of a voluntary act.

The mental nonresponsibility defense has been defined in a variety of ways over the years. Until the Hinckley case, the general trend was toward expansion of the test. Since then, the trend has been toward restriction of the defense. In order to understand why the ABA continues to support the defense despite *Kahler*, and to situate the test set out in standard 7-6.1, this history is briefly described here.

Insanity Formulations Prior to the 1980s

The belief that serious mental disorder should be exculpatory goes back to the ancients.[11] It emerged in Anglo-Saxon law no later than the twelfth century, the

[11] As early as the sixth century B.C, commentary on the Hebrew scriptures distinguished between harmful acts traceable to fault and those that occur without fault. See Anthony M. Piatt & Bernard Diamond, The Origins and

result of the "mutual influences and interaction of Christian theology and Anglo-Saxon law."[12] Writing in the early seventeenth century, Sir Edward Coke commented that the "idiot," "lunatic," and any other person who "wholly loseth his memory and understanding" should be considered among those considered "insane."[13] Later in the same century, Sir Matthew Hale concluded that the "best measure" for determining insanity was whether the accused had "as great understanding as ordinarily a child of fourteen hath."[14] In 1723, Justice Tracey instructed a jury that to be found nonresponsible "a man must be totally deprived of his understanding and memory so as not to know what he is doing, no more than an infant, brute or a wild beast."[15] At about the same time, other English courts were excusing those who lacked the capacity to distinguish "good from evil" or "right from wrong."[16]

This latter approach, in slightly modified form, became the "M'Naghten test of insanity." As announced by the House of Lords in 1843: "[I]t 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 what he was doing was wrong."[17] Although this was the first time an appellate court in either England or the United States had declared a rule for determining mental nonresponsibility, the M'Naghten test became the accepted standard in both countries within a short period of time.

The rule also came under immediate attack. Some of the most strenuous criticism came from the medical community which, far from wanting to do away with the defense, argued that it needed to be recast in light of contemporary understanding about human behavior. Dr. Isaac Ray, an American physician who was one of the most prominent spokesmen for this point of view, felt that the law's emphasis on a defendant's ability to distinguish good from evil failed to recognize "those nice shades of the disease" that could render a person blameless for antisocial conduct. He argued that the defense should turn instead on whether "the mental

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Development of the "Wild Beast" Concept of Mental Illness and Its Relation to Theories of Criminal Responsibility, J. Hist. Behav. Sci. 355, 366 (1965). The Greek moral philosophers, at least as far back as the fifth century B.C, considered the distinction between a culpable and nonculpable act to be among the "unwritten laws of nature supported by the universal moral sense of mankind." John W. Jones, The Law and Legal Theory of the Greeks 264 (1956). The same view pervaded Roman law and appeared in the teaching of the early Christian theologians. Piatt & Diamond, supra, at 356.

[12] Albert Levitt, The Origin of the Doctrine of Mens Rea, 17 Ill. L. Rev. 117, 136 (1922)..

[13] See 2 Edward Coke, the First Part of the Institutes of the Laws of England *247.a. (discussing testamentary capacity).

[14] 1 Matthew Hale, History of Pleas of the Crown *30.

[15] Rex v. Arnold, 16 How. St. Tr. 695, 766 (1723).

[16] See Anthony M. Piatt & Bernard L. Diamond, The Origins of the "Right and Wrong" Test of Criminal Responsibility, 54 Calif. L. Rev.. 1227, 1236- 1237 (1966).

[17] M'Naghten's Case, 10 d & F. 200, 8 Eng. Rep. 718 (H.L. 1843). See generally Barbara Weiner, Mental Disability and the Criminal Law, in The Mentally Disabled and the Law 693, 709-710 (Samuel Brakel, John Parry & Barbara Weiner eds., 3d ed. 1985).

unsoundness . . . embraced the act within the sphere of its influence."[18] In 1870, the New Hampshire Supreme Court, apparently influenced by Ray, adopted a rule commonly known as the "product" test:

> No man shall be held accountable, criminally, for an act which was the offspring and product of mental disease. . . . No argument is needed to show that to hold a man may be punished for what is the offspring of disease would be to hold that he may be punished for disease. Any rule which makes that possible cannot be law."[19]

No other court of the time followed the New Hampshire lead. Toward the end of the nineteenth century, however, several courts, apparently persuaded by the contention that the M'Naghten test was too narrow, supplemented it with a rule focusing on volitional impairment.[20] This so-called irresistible impulse doctrine posited that persons who could not control their actions should not be held criminally responsible for them even if they know the actions were wrong.

By the turn of the century, about one-third of the states had nonresponsibility tests consisting of M'Naghten and the irresistible impulse rule; one state, New Hampshire, had the product rule; and the rest adhered to the M'Naghten test alone. This state of affairs remained essentially unchanged until the 1950s. In that decade, in response to the continuing attacks by psychiatrists and legal academicians against the rigidity of existing formulations, two important events occurred.

The first was *Durham v. United States*,[21] a 1954 decision in which the United States Court of Appeals for the District of Columbia adopted a modernized version of the "product" test. Only two other jurisdictions, besides New Hampshire, adopted the test.[22] But *Durham* stimulated rich judicial and scholarly debates about the complexities of the defense.[23]

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[18] Isaac Ray, A Treatise on the Medical Jurisprudence of Insanity 21 (1838). See also Janet A. Tighe, Francis Wharton and the Nineteenth-Century Insanity Defense: The Origins of a Reform Tradition, 27 Am. J. Leg. Hist. 223 (1983).

[19] State v. Jones, 50 N.H. 369, 394 (1871).

[20] In 1886, the first American court to adopt such a test stated it thus: [A defendant is not] legally responsible if the two following conditions concur: (1) [i]f, by reason of the duress of such mental disease, he had so far lost the power to choose between the right and wrong, and to avoid doing the act in question, as that his free agency was at the time destroyed; (2) and if, at the same time, the alleged crime was so connected with such mental disease, in the relation of cause and effect, as to have been the product of it solely. Parsons v. State, 81 Ala. 577, 596, 2 So. 854, 866-867 (1886). See also 2 James Stephen, A History of the Criminal Law of England 168 (1883).

[21] 214 F.2d 862 (D.C. Cir. 1954).

[22] Me Rev. Stat. Ann. tit. 15, §102 (1964); V.I. Code Ann. tit. 14, §14(4) (1964). The Maine legislature later repealed its "product" statute and adopted a modified version of the ALI test. Me. Rev. Stat. Ann. tit. 17A, §39(1) (1983).

[23] See, e.g., McDonald v. United States, 312 F.2d 847 (D.C. Cir. 1962); Blocker v. United States, 274 F.2d 572 (D.C Cir. 1559); Carter v. United States, 252 F.2d 608 (D.C. Cir. 1957); Alan Stone, Psychiatry and the Law, 1 Psychiat. Ann. 31 (1971).

The second significant event was the American Law Institute's promulgation of the Model Penal Code test for mental nonresponsibility in 1955: "A person is not responsible for criminal conduct if at the time of such conduct as a result of mental disease or defect he lacks substantial capacity either to appreciate the criminality [wrongfulness] of his conduct or to conform his conduct to the requirements of the law."[24] This language combined the notions underlying both the M'Naghten and irresistible impulse formulations, but also made it clear that a defendant's cognitive or volitional impairment at the time of the offense need only be "substantial," rather than total, in order to merit a nonresponsibility defense. The ALI test proved a popular one; over the next two decades a majority of the country's jurisdictions adopted it.[25]

Nonetheless, some critics inveighed against the test because it continued to rely on the so-called medical model of mental nonresponsibility.[26] A final version of the test came from the Rhode Island Supreme Court which, in 1979, held that persons should be excused from criminal liability if they are "so substantially impaired" that they cannot "justly be held responsible."[27] This test marked the most significant expansion of the nonresponsibility defense and no other state adopted it, probably because the 1981 verdict of not guilty by reason of insanity in John Hinckley's case led to significant rethinking about the insanity defense.

Post-Hinckley Developments

Prior to the Hinckley verdict, every federal circuit followed some version of the ALI test. However, in 1984, noting changes in attitude toward that test,[28] and undoubtedly influenced by the Hinckley case, Congress enacted the Insanity Defense Reform Act of 1984, which promulgated the following standard for mental nonresponsibility governing all federal crimes:

> It is an affirmative defense to a prosecution under any Federal statute that, at the time of the commission of the acts constituting the offense, the defendant,

[24] American Law Institute, Model Penal Code §4.01 (hereafter, ALI MPC). See also Weiner, supra note 17, at 710-711.

[25] See John Favole, Mental Disability in the American Criminal Process: A Four Issue Survey, in Mentally Disordered Offenders: Perspectives from Law and Social Science 257-269 (John.Monahan & Henry Steadman eds. 1983).

[26] United States v. Brawner, 471 F.2d 969, 1027-1030 (D.C. Cir. 1972) (Bazelon, J., concurring); Stephen J. Morse, Crazy Behavior, Morals, and Science: An Analysis of Mental Health Law, 51 S. Cal. L. Rev. 527, 640-645 (1978).

[27] State v. Johnson, 121 R.I. 254, 267, 399 A.2d 469, 476 (1979). This test incorporates the position adopted in 1953 by the British Royal Commission on Capital Punishment in Report of the Royal Commission on Capital Punishment 116 (1953)), which took the view that the question of criminal responsibility is not amenable to categorization and should be left entirely to jury discretion.

[28] See Report of the Committee on the Judiciary, U.S. Senate, on the Comprehensive Crime Control Act of 1983, S.1762, Report No. 98-225, 98th Cong., 1st Sess. (1983), at 227-228 (hereafter Judiciary Committee Report).

> as a result of a severe mental disease or defect, was unable to appreciate the nature and quality or the wrongfulness of his acts. Mental disease or defect does not otherwise constitute a defense.[29]

This test eliminated the volitional prong of the ALI test and reduced the scope of the cognitive prong by replacing the phrase "substantial inability to appreciate" with "unable to appreciate." Further, the qualifier "severe" was added to rule out "mere emotional processes" that impair appreciation of the nature and quality or wrongfulness of otherwise criminal activities.[30]

Many states also narrowed their insanity defense tests. Like Congress, several state legislatures eliminated the volitional prong. Some of these states also replaced the ALI test's "appreciation" language with a strict M'Naghten formulation. As mentioned in the introduction to this part, four states went further by limiting defenses based on mental disorder to those that negate mens rea. Anticipating *Kahler*, the appellate courts in these states upheld these statutes against constitutional challenge.[31] Further, in *Clark v. Arizona*,[32] the U.S. Supreme Court rejected a constitutional challenge to an adaptation of the M'Naghten rule that excluded consideration of the defendant's understanding of the nature and quality of the act and permitted acquittal only if the defendant was "afflicted with a mental disease or defect of such severity that he did not know the criminal act was wrong."[33] According to the Court, this formulation–what it called the "moral incapacity" test–did not violate due process.[34] Thus, the Constitution does not require that states provide what has traditionally been called an "insanity defense," nor does it require any particular formulation of that defense in states that retain it.

The Language of Standard 7-6.1's Test

The test for nonresponsibility set out in paragraph (a) of this standard is identical to the first part of the test adopted in the initial version of these Standards, which itself reflected a resolution adopted by the ABA's House of Delegates in 1983 that stated in significant part (see Appendix B): "The ABA approves, in principle, a defense of nonresponsibility for crime which focuses solely on whether the defendant as a result of mental disease or defect was unable to appreciate the wrongfulness of

[29] 18 U.S.C.A. §17(a)).
[30] See Judiciary Committee Report, supra note 28, at 229.
[31] See State v. Korell, 690 P.2d 992 (Mont 1984): State v. Searcy, 798 P.2d 914 (Idaho 1990); State v. Herrera, 895 P.2d 359 (Utah, 1995: State v. Behtel, 66P.3d 840 (Kan. 2003). But see Finger v. State, 27 P.3d 66 (Nev. 2001) (invalidating Nevada's version of the mens rea approach to insanity).
[32] 548 U.S. 735 (2006).
[33] Ariz. Code §. 13-502(C).
[34] 548 U.S. at 747.

his or her conduct at the time of the offense charged."[35] The language in paragraph (a) is also similar to the test approved in *Clark*, the test enacted by Congress in the Insanity Defense Reform Act of 1984, and the proposal advanced by the American Psychiatric Association in 1982.[36]

However, paragraph (b) in standard 7-6.1 makes one significant change to the test adopted in its original Standards. It describes the threshold mental condition as "mental disorder" rather than "mental disease or defect," and further clarifies that the term "mental disorder" in this context does not include disorders that are "manifested primarily by repeated criminal conduct" (e.g., antisocial personality disorder) or "attributable solely to the acute effects of the voluntary use of alcohol or drugs" (e.g., voluntary intoxication).

The Rationale for Rejecting the Mens Rea Alternative

In considering the role of mental disability in determining criminal culpability, the options run the gamut from abolition of the nonresponsibility [insanity] defense (with or without the mens rea alternative) to the product test or Rhode Island's "justly responsible" standard. The introduction to this part has already noted that the ABA considers the abolition option untenable. The moral basis of the mental nonresponsibility defense is compelling and has been reaffirmed throughout the history of western civilization. At the same time, as Judge Kaufman observed after the Hinckley verdict, "[a]cquittals by reason of insanity in highly publicized cases such as the Hinckley affair tend to undermine the public's faith in the courts' ability to respond to crime in a rational fashion."[37] The aim of standard 7-6.1 is to respect the moral basis of the nonresponsibility defense while avoiding the creation of a framework that leaves the public distrustful of its institutions.

As a means of emphasizing this point, more needs to be said about the "mens rea alternative." Again, this approach permits evidence of mental condition at the guilt stage only as it may bear on the requisite mental or culpability element of the crime, and thus eliminates mental nonresponsibility [insanity] as an independent, exculpatory doctrine. Although this approach has been adopted by four states and upheld by the Supreme Court in *Kahler*, the ABA emphatically rejects it.

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[35] ABA, Summary of Action of the House of Delegates, 1983 Midyear Meeting 3 (1983). Many of the ideas expressed in the Standing Committee's report to the ABA House of Delegates in February 1983 and in the commentary to this standard are drawn from Professor Richard Bonnie's testimony before the Senate Judiciary Committee in August 1982, see Judiciary Committee Report, supra note 28, at 226- 227, and from his article, Richard Bonnie, The Moral Basis of the Insanity Defense, 69 A.B.A.J. 194 (1983).

[36] American Psychiatric Ass'n, Statement on the Insanity Defense (Dec. 1982, at 12) (hereafter, APA Statement, 1982). The APA has since revised its position, stating that it "does not favor any particular legal standard for the insanity defense over another, so long as the standard is broad enough to allow meaningful con- sideration of the impact of serious mental disorders on individual culpability." See supra note 1.

[37] Irving R. Kaufman, The Insanity Plea on Trial, N.Y. Times Magazine, Aug. 8,1982, at 16-17.

The majority in *Kahler* reasoned that the mens rea alternative is not unconstitutional as a matter of substantive due process because a version of it existed in English and American law throughout the eighteenth century and much of the nineteenth century; the Court added that, to the extent the mens rea approach leads to conviction of people with mitigating mental disorders, that fact can be taken into account at sentencing.[38] It is true that, in eighteenth century England, a few commentators and cases stated that something approaching a lack of intent was required to be excused by reason of mental disability.[39] But even in the early nineteenth century, and certainly by the time the Fourteenth Amendment's Due Process Clause was ratified in 1868, M'Naghten and its focus on whether the defendant knew the act was wrong held sway.[40] Further, the concept of mens rea, which is Latin for "guilty mind," was long understood to require moral blameworthiness as a condition for criminal liability; only in the last century has mens rea terminology come to refer to the specific state of mind required for the conviction of particular criminal offenses.[41] Thus, while the nineteenth century approach to mens rea usually required delving into a defendant's knowledge of wrongfulness, today, if there were no independent nonresponsibility defense, defendants charged with crimes like murder and aggravated assault who intended to kill or harm another would be convicted regardless of how delusional their reasons were for doing so. For example, a man who intentionally killed his son under the psychotic delusion that he was the biblical Abraham and his son the biblical Isaac would be held criminally responsible. So would individuals who delusionally believe their victims are about to kill them and act in what they perceive to be self-defense. The Montana, Idaho, Utah, and Kansas enactments, on their face, would deny a defense to such defendants. Criminal blameworthiness requires a deeper power of reasoning and understanding that transcends a minimal awareness and intent to act.

In short, as Professor Bonnie has pointed out,[42] the mens rea limitation forces judges and juries confronted with defendants who are incontrovertibly psychotic either to return morally obtuse convictions or to acquit in outright defiance of the law. Neither alternative is palatable. The abolitionist approach as embodied in the mens rea limitation prevents the exercise of humane judgment that has distinguished our criminal law heritage. The Supreme Court's blithe pronouncement in *Kahler* that the impact of serious mental disability can always be considered at sentencing (which

[38] *Kahler*, 589 U.S. at 284-285.
[39] Id. at 288-289.
[40] See Platt & Diamond, supra note 16, at 125-1247 (noting that English courts began using the "knowledge of good and evil" test as early as the sixteenth century, and that the "good and evil test" was regularly used in the eighteenth and nineteenth centuries, with only a few exceptions).
[41] Frances Bowes Sayre, Mens Rea, 45 Harv. L. Rev. 974, 981 (1932)
[42] See Bonnie, supra note 35, at 195-196.

of course only occurs after a finding of guilt that guarantees punishment for the length of the sentence) ignores this heritage.[43]

Selection of a Mental Nonresponsibility Test

Having concluded that a defense of mental nonresponsibility is necessary to the fair administration of criminal justice, the ABA considered carefully the various formulations of the defense to determine which most successfully responds to that moral imperative. The early tests–the M'Naghten and irresistible impulse rules–are couched in arcane language that on its face accepts the outmoded view that a bright line exists between the responsible and the nonresponsible.[44] As Professor Wechsler wrote in explaining the rationale underlying the ALI formulation, "[N]o test is workable that calls for complete impairment of ability to know or to control. . . . Disorientation, we were told, might be extreme and still might not be total; what clinical experience revealed was closer to a graded scale with marks along the way."[45] Many courts appear to recognize that fact. Professor Goldstein demonstrated in his 1967 book that both the M'Naghten and irresistible impulse rules have been liberally construed in many jurisdictions, and seldom have prevented juries from hearing or considering evidence of mental condition,[46] a finding that still rings true today.[47] While that might suggest that, as a practical matter, these tests could be maintained, it makes no sense to depend upon courts or juries to interpret rules against their plain meaning when broader, more sensible language has been devised.

The tests at the other end of the spectrum go too far, however. The "justly responsible" test was first proposed in 1972 by Judge Bazelon, who believed that "the boundary of a legal concept — criminal responsibility — should [not] be marked by medical concepts, especially when the validity of the 'medical model' is seriously questioned by some eminent psychiatrists."[48] He thus rejected a requirement of "mental disease or defect" as a threshold determination on the nonresponsibility issue. But the law has an obligation to structure the responsibility inquiry. The justly responsible test leaves juries with no direction but their own whim in deciding the forms or degree of impairment sufficient to relieve defendants from criminal liability. Reliance on the so-called medical model, whatever its exact scope, permits consideration of a wide panoply of behavior at the same time that it protects

[43] *Kahler*, 589 U.S. at 285 (giving as a second, and "significant" reason for its decision, the fact that any manifestation of mental illness that Kansas's guilt-phase insanity defense disregards—including the moral incapacity Kahler highlights—can come in later to mitigate culpability and lessen punishment.").
[44] Because of its focus on volitional impairment, the irresistible impulse rule is also infirm for other reasons, discussed infra notes 47-53 and accompanying text.
[45] H. Herbert Wechsler, Codification of the Criminal Law in the United States: The Model Penal Code, 68 Colum. L. Rev. 1425, 1443 (1968).
[46] Abraham S Goldstein, The Insanity Defense 45-79 (1967).
[47] E. Lea Johnston & Vincent T. Leahy, The Status and Legitimacy of M'Naghten's Insane Delusion Rule, 54 U.C. Davis 1777, 1791-1793 (2021).
[48] Brawner v. United States, 471 F.2d 969, 1029 (D.C. Cir. 1972) (Bazelon, J., concurring).

the law from unbounded determinism. The product tests suffers from similar problems. While that test adheres to the medical model it still fails to give factfinders adequate guidance about the appropriate limits of criminal responsibility because, in theory, almost every crime can be said to be attributable to some mental dysfunction. The history of the *Durham* decision attests to the problems, at both the trial and appellate levels, generated by the administration of such an ill-defined formulation.[49]

This reasoning process leaves a choice between the ALI test and some variation of it. The eventual selection of the standard 7-6.1(a) test was based on two underlying propositions: first, that the "appreciation of wrongfulness" formula is sufficiently broad to take into account the morally significant effects of severe mental disorder; and second, that any independent volitional inquiry involves a significant risk of "moral mistakes" in the adjudication of criminal responsibility. In short, the standard rests on a policy judgment that morally correct results are likely to be achieved more often under a circumscribed test that does not include a volitional criterion than under a broader test that does.

The principal problem with a continued utilization of the volitional or control test is that it is often combined with vague or broad interpretations of the term mental disease. The mixing of these two imprecise notions results in expert opinions regarding the psychological causes of criminal behavior that strain public credulity and may offend moral sentiments, especially in cases involving defendants with personality disorders, impulse disorders, or some other diagnosable abnormality short of a clinically recognized psychosis. One approach to this problem is to restrict the types of mental disorder that can serve as a basis for a nonresponsibility defense. For instance, the American Psychiatric Association initially proposed that mental disorder be defined, for purposes of the mental nonresponsibility [insanity] defense, as "conditions that grossly and demonstrably impair a person's perception or understanding of reality."[50] While this definition restricts the mental disorder threshold, it also makes the volitional prong unnecessary. Anyone whose mental state grossly impairs perception or understanding at the time of the offense presumably would be found nonresponsible under the appreciation formulation alone. In sum, the control tests cannot be circumscribed so as to avoid moral mistakes without at the same time rendering them irrelevant; the preferable approach is to rely solely on the

[49] See Becker, supra note 6, at 53-73 (recounting the significant rise in insanity verdicts after the product test became law and confusion about the scope of test). As one example of the latter, in McDonald v. United States, 312 F.2d 847,850-851 (D.C. Cir. 1962), the court defined "mental disease or defect" in the product test to mean "any abnormal condition of the mind which substantially affects mental or emotional processes and substantially impairs behavior controls." When inserted in the product test ("an accused is not criminally responsible if his unlawful act was the product of a mental disease or mental defect") the language is not far removed from the ALI test. In United States v. Brawner, 471 F.2d 969 (D.C. Or. 1972), the court of appeals finally declared the product test a failure and replaced it with the ALI test.

[50] APA Statement (1982), supra note 36, at 12..

appreciation or "cognitive-affective" test which, as defined below, should encompass all defendants who merit exculpation because of severe mental disorder.

A second objection to the volitional test for insanity, in addition to the questionable morality of excusing defendants who can convince juries that their acts were significantly "determined" by a mental disorder, is the difficulty of defining the class of defendants who fit a volitional impairment test. The inclusion in the ALI test of a volitional element reflected a wave of clinical optimism that scientific knowledge concerning psychopathology had progressed substantially enough to permit informed judgments about the causes of abnormal behavior. Unfortunately, subsequent experience has not borne out that optimism. Behavioral science has not yielded clinical tools to calibrate impairments of behavior controls. There is, in short, no objective basis to distinguish between offenders who were undeterrable and those who remained undeterred, impulses that were irresistible and those not resisted, "substantial" impairment of capacity and some lesser impairment. Whatever the precise terms of the volitional test, the question is unanswerable, or at best can be answered only by "moral guesses."[51] Consequently, as the American Psychiatric Association has pointed out,[52] testimony under the cognitive test is much more likely to be based on a solid scientific foundation than testimony under a volitional criterion. Clinicians can be more precise and arrive at more reliable conclusions about awareness, perceptions, and understanding of an event than about the causes of a person's behavior, especially when the determinants of behavior are felt to be unconscious.[53]

It should be emphasized that a preference for a narrow test of mental nonresponsibility is not based on the view that the defense is now systematically abused. The empirical evidence is to the contrary: Of those pleas that are successful, most are the result of plea bargain arrangements, and many more are resolved at uncontested bench trials,[54] meaning that agreement on the nonresponsibility issue is

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[51] See Bonnie, supra note 35, at 196; Stephen J. Morse, Uncontrollable Urges and Irrational People, 88 Va. L. Rev. 1025, 1060-62 (2002); Lady Barbara Wooton, Book Review, 77 Yale L.J. 1019, 1026-1027 (1968) (reviewing Goldstein, supra note 44) ("It is indeed apparent that some people, such as sadistic sexual perverts, suffer from temptations from which others are immune. But the fact that an impulse is unusual is no proof that it is irresistible. In short, it is not only difficult to devise a test of volitional competence the validity of which can be objectively established: it is impossible.").

[52] In its December 1982 Statement on the Insanity Defense, the American Psychiatric Association commented on "volition" by stating that:

> Many psychiatrists . . . believe that psychiatric information relevant to determining whether a defendant understood the nature of his act, and whether he appreciated its wrongfulness, is more reliable and has a stronger scientific basis than, for example, does psychiatric information relevant to whether a defendant was able to control his behavior. The line between an irresistible impulse and an impulse not resisted is probably no sharper than that between twilight and dusk.

APA Statement, supra note 36, at 11.

[53] See generally Stephen J. Morse, Failed Explanations and Criminal Responsibility: Experts and the Unconscious, 68 Va. L. Rev. 971 (1982).

[54] See Melton et al., supra note 3, at 203 n. 26 (summarizing research), and at 200 (reporting research showing that, even when an insanity claim gets to the jury, it succeeds only about 25% of the time).

commonplace and that the maligned "battle of the experts" before "impressionable" juries is an extremely rare occurrence. Rather, the rejection of the control prong is based in large part on the observation that there are occasional mistakes, most likely to be associated with the volitional criterion. These observations cannot be documented with findings from systematic empirical investigation. No scientific studies have addressed the issue, and the imposing methodological difficulties of conducting such research are readily apparent. In the absence of empirical investigation, it seems sensible to rely on the informed observation of forensic practitioners and respected authorities, such as the American Psychiatric Association.

By doing away with the volitional inquiry and focusing on the extent to which defendants could "appreciate" the wrongfulness of their conduct, standard 7-6.1(a) is in concert with current clinical expertise, theoretical possibility, and the law in a majority of states.[55] The approach it endorses should help psychiatrists, counsel, and courts focus on the more objective psychiatric factors that should be taken into consideration in determining responsibility for crime. Accordingly, it should reduce expert speculation and offer a more realistic basis to evaluate the exculpatory weight of psychiatric testimony while at the same time preserving the moral imperative of blameworthiness as a predicate for criminal punishment.

The Language of the Standard

The claim has been made that once the issue of mental nonresponsibility [insanity] has been placed in front of a jury, the precise language used to guide its deliberations has little or no effect on the outcome.[56] If one looks merely at the effect of certain phrases on the jury treatment of a given amount and type of evidence, as the principal studies of the issue do,[57] one might reasonably conclude that the impact of variations in the substantive test for mental nonresponsibility is noticeable only in the most marginal cases. But the impact of particular language on decisions made before a jury retires to deliberate also must be considered—the decisions of experts whether or not to testify and, if so, the formulation of their testimony; the strategic decisions by defense counsel relating to the mental nonresponsibility defense, direct and cross-examination, and summation; and trial court rulings on the legal sufficiency of the evidence to raise a jury question. Given this constellation of decision points, the cumulative effect of given normative language on a case from the time a nonresponsibility defense is contemplated to the moment the jury reaches a verdict is probably not insubstantial. This would seem particularly true if the choice is between a volitional and cognitive approach. But even if the alternatives are

[55] See Appendix, Kahler v. Kansas, 589 U.S. at 323 (listing 14 states as having a volitional as well as cognitive test).
[56] See, e.g., Goldstein, supra note 46, at 213-214.
[57] See, e.g., Rita Simon, The Jury and the Defense of Insanity (1967); Norman Finkel & Christopher Slobogin, Insanity Justification and Culpability: Toward a Unifying scheme, 19 L. & Hum Behav. 447 (1995).

M'Naghten and one of the appreciation formulations, the precise phrasing could have a significant influence on the resolution of the issue.

With this in mind, several explanatory comments should be made about the wording in paragraph (a). First, the standard uses the word "appreciation" for the same reason it was included within the cognitive prong of the ALI test. The drafters of the ALI test discarded the term "know," which had been used by the House of Lords in the original formulation of the M'Naghten test, because the focus of the inquiry into criminal responsibility should not be limited, as the term "know" might suggest, to a defendant's superficial intellectual awareness of the law or prevailing social morality.[58] Instead, the nonresponsibility test should take into account all aspects of a defendant's mental and emotional functioning relating to an ability to recognize and understand the significance of personal actions. The language of the standard allows a proper latitude for experts to testify fully concerning the defendant's mental and emotional condition and for juries to consider this testimony in deliberating on the issue of mental nonresponsibility.

A second important feature of the language of paragraph (a) is the use of "wrongfulness" rather than "criminality," both of which are options under the ALI test as originally formulated. Courts have been divided on the appropriate definition of "wrong" under both the M'Naghten and the ALI tests. Some courts hold that mentally disordered defendants should be exculpated only if their misunderstanding of reality disabled them from recognizing the illegality of their conduct. Others recognize a broader, essentially moral, criterion.[59] The standard adopts the latter view. Use of the term "criminality" suggests to triers of fact that they ignore even the most florid effects of delusions and hallucinations in any case in which a defendant's conduct would still be criminal had the delusions been true or the hallucinations real. As Judge Cardozo stated, "there are times and circumstances in which the word 'wrong'. . . ought not to be limited to legal wrong. [If a person has] an insane delusion that God appeared to [him] and ordained the commission of a crime, . . . it cannot be said of the offender that he knows that act to be wrong."[60] The contrary result fails to recognize that, as in the Abraham example given above, severely mentally ill persons may become so detached from reality that they are unable to apprehend why their conduct is wrong, and in fact may feel, because of their disorder, that it is morally justified despite its acknowledged "illegality."[61] The term

[58] Francis Allen, The Rule of the American Law Institute's Model Penal Code, 45 Marq. L. Rev. 494, 501 (1972).
[59] Roughly 19 states use the wrongfulness language. Most others ask whether the defendant knew the act was wrong or use the "criminality" version of the ALI test. Appendix, Kahler v. Kansas, 589 U.S. at 319 et seq.
[60] People v. Schmidt, 216 N.Y. 324, 340, 110 N.E. 945, 494 (1915), reh'g denied, 216 N.Y. 762, 111 N.E. 1075 (1916), (finding insane a defendant who claimed that he killed a woman after hearing the voice of God calling upon him to do so as a sacrifice and atonement). *Schmidt* is considered a leading case on the issue.
[61] On the *Schmidt* facts, supra note 60, for instance, the narrow view would focus on whether religious penance is a legal justification for homicide; since it is not, the defendant should be found, despite his psychosis, to appreciate the "criminality" of his act.

wrongfulness, which focuses on the extent to which the defendant's conviction about the need to carry out the crime was influenced by their mental disorder, is therefore necessary to accommodate adequately the morally significant effects of severe mental illness.

Finally, it should be pointed out that the standard employs the term "unable" to replace the "substantial capacity" language of the ALI test. This modification both simplifies the formulation and reduces the risk that juries will interpret the test too loosely. By using the "substantial capacity" language, the drafters of the ALI standard tried to avoid the rigidity implicit in a M'Naghten formulation.[62] They correctly recognized that it is rarely possible to say that mentally disordered persons were totally unable to "know" what they were doing or to "know" that it was wrong; even psychotic persons typically retain some grasp of reality. However, it is unnecessary to retain the phrase substantial capacity in order to take into account these clinical realities. Sufficient flexibility is provided by the term "appreciate," as defined earlier.

Paragraph (b) of the standard defines "mental disorder." Only if the inability of defendants to appreciate the wrongfulness of their conduct is attributable to mental disorder should they be entitled to exculpation on grounds of mental nonresponsibility. As used in this standard, the phrase mental disorder purposely has been given a legal and not a medical or scientific meaning.[63] It does not refer to and is not coextensive with the usual clinical meaning of "mental disorder" as that term may be used by mental health professionals for diagnostic and therapeutic purposes, and thus intentionally differs from the broader definition of mental disorder found in standard 7-1.1(a). At the same time, the standard does not tie the concept of mental disorder to any narrow collection of diagnostic entities, except to the extent that the exclusionary language regarding disorders manifested primarily by repeated criminal conduct or attributable to the acute effects of intoxication may be read to exclude such disorders as antisocial personality disorder or alcohol use disorders.

Even these exclusions are not meant to be precisely coextensive with particular diagnoses, however. Rather they express the view that when the sole or predominant "symptom" presented by the offender is repeated criminal activity or impairments caused by ingestion of psychoactive substances at the time of the crime, the defendant may justly be held culpable on the ground that any lack of appreciation manifested at the time of the crime was either the result of maliciousness or was self-induced. To impose any other categorical limitations would take insufficient account

[62] ALI MPC, supra note 24, § 4.01 comment ("substantial capacity" is all "that candid witnesses, called on to infer the nature of the situation at a time that they did not observe, can ever confidently say, even when they know that the disorder was extreme.").
[63] ALI Model Penal Code §4.01.

of both the continuing imprecision of the diagnostic process and the unique features of each individual's disorder.[64] Instead, the language of the standard refers to a generic criterion—an abnormal condition that substantially affects mental or emotional processes. It should also be emphasized that the substantial process of functional or organic impairment need not be chronic or enduring; an "acute" psychotic break may be considered a mental disorder even in the absence of an underlying psychotic disorder.

In contrast, mere defects of character or strong passion, if legally relevant in any sense, should be considered only at sentencing. Were it otherwise, the defense would have no threshold at all; every abnormal defendant, and every normal defendant who became abnormally impassioned, could be said to have a "mental disorder." Further, it must be remembered that a mental disorder is without exculpatory significance, no matter how severe, unless it resulted in an inability to appreciate the wrongfulness of the conduct at the time of the offense.

The Involuntary Act and Intoxication Doctrines

This standard relates only to the defense of mental nonresponsibility [insanity]; no position is taken that would modify any other commonly accepted rule dealing with criminal responsibility. For example, elimination of the volitional prong of the nonresponsibility test is not meant to modify the traditional "involuntary act doctrine" codified in the Model Penal Code.[65] Under this doctrine, persons do not commit the actus reus of a criminal offense if they have no conscious physical control over their behavior at the time of the offense. Thus, for instance, courts have held that physical movements during states of impaired consciousness such as sleep, concussion, or epileptic seizures are not "voluntary acts."[66] Elimination of the volitional prong, which deals with conscious behavior that was not consciously willed, would and should have no effect on this doctrine.

Another area of existing law that would remain unchanged concerns the relationship between intoxication and mental nonresponsibility. Under traditional rules (and as recognized in the standard itself), impairments associated with voluntary intoxication, no matter how severe or unanticipated, usually do not have exculpatory significance.[67] The only exceptions concern cases lying on the moral

[64] Thus, this standard rejects the position taken by some jurisdictions that personality disorders may never be a basis for the insanity defense. See Melton et al., supra note 3, at 211.
[65] ALI MPC, supra note 24, § 2.01(2).
[66] See, e.g., Fain v. Comm'r, 78 Ky. 183 (1879) (sleepwalking); United States v. Denny-Shaffer, 2 F.3d 999 (10th Cir. 1993) (dissociative identity/multiple personality disorder). See generally Wayne R. LaFave, Criminal Law 492-493 (5th ed. 2010).
[67] Today most states do not recognize intoxication as a defense even if it negates mens rea, largely on the theory that any resulting impairment is self-induced. See Meghan Paulk Ingle, Law on the Rocks: The Intoxication Defenses are Being Eighty-Sixed, 57 Vand. L. Rev. 606, 631 (2002).

border between risks that are and are not voluntarily assumed, such as when drug use precipitates psychotic deterioration in a predisposed person,[68] chronic alcohol use results in organic brain pathology,[69] or a person has an excessive (or "pathological") reaction to a small amount of alcohol insufficient to induce intoxication in most people.[70] These conditions may result in exculpation either through an interpretation of the nonresponsibility defense or through a parallel interpretation of the involuntary intoxication doctrine. Finally, if a person becomes intoxicated "involuntarily" (e.g., because someone surreptitiously places an intoxicating substance in his or her beverage), it is clear that the resulting impairment can have exculpatory significance, either due to the absence of the *mens rea* required in the definition of the offense or because the intoxication qualifies for an involuntary intoxication defense, by causing functional incapacities similar to those required for the nonresponsibility defense.[71]

Standard 7-6.2. Admissibility of other evidence of mental condition

Evidence, including expert testimony, concerning the defendant's mental condition at the time of alleged offense which tends to show the defendant did or did not have the mental state required for the offense charged should be admissible, consistent with Standard 7-3.8(a) restricting experts to testimony based on their specialized knowledge.

Commentary

Standard 7-6.2 deals with defenses based on lack of mens rea due to mental disorder, a separate and very different defense from mental nonresponsibility [insanity]. Whereas the latter defense examines whether the defendant's motivations for committing crime stemmed from mental disorder, expert testimony on mens rea (hereafter, the "mens rea defense") looks solely at whether the defendant had the requisite mental state (e.g., purpose, knowledge, recklessness or negligence) required by the definition of the crime. As explained in the commentary to standard 7-6.1, most people who are found insane have the mens rea for their offense; for instance, John Hinckley, Andrea Yates and Daniel M'Naghten all intended to kill. They were nonetheless excused because of their lack of appreciation of the wrongfulness of their acts. At the same time, some people who have a valid nonresponsibility [insanity] defense may also have a mens rea defense—for instance, a person who believes he is killing the devil does not have the mens rea for homicide. Further, some people may

[68] People v. Kelly, 516 P.2d 875, 11 Cal. Rptr. 171 (1973).
[69] See State v. Sexton, 904A.2d 1092, 1104 (Vt. 2006) (limiting defense of "settled insanity" due to psychoactive substance abuse "to those cases where the initial choice to abuse alcohol or drugs has become so attenuated over time that it serves little or no purpose to hold the defendant accountable once a permanent mental illness has taken hold through years of chronic substance use.").
[70] LaFave, supra note 66, at 507.
[71] See Minneapolis v. Altimus, 238 N.W. 2d 851 (1976).

not have the serious mental impairment necessary for insanity but nonetheless, due to a mental disorder, lack the requisite intent required to prove the crime. For instance, a nondelusional person may, because of a dependent personality disorder, believe her boyfriend's assertions that forged checks are in fact not forged.[72] If the mens rea for the crime requires proof that the defendant knew the checks were forged, an element of the offense cannot be proven and acquittal should result even though the defendant does not have the type of serious mental disorder contemplated by standard 7-6.1(b).

Accordingly, standard 7-6.2 incorporates a simple evidentiary principle based on a rule of "logical relevance." Evidence, including properly qualified expert testimony, that tends to show a defendant did or did not have the mental state for a charged offense should be admissible. Several state courts have held that principles of fairness require that defendants be permitted to introduce any competent relevant evidence, including psychiatric testimony, in their defense.[73] It has also been argued that since prosecuting attorneys are entitled to a permissive inference that defendants intend the natural consequences of their acts,[74] to deny to defendants an opportunity to present competent clinical evidence that is the only means of overcoming the inference permits the prosecution, in effect, to convict accused persons despite a reasonable doubt as to their guilt.[75]

Despite these considerations, in *Clark v. Arizona*[76] the Supreme Court ruled that the Constitution does not require that states permit defendants to present opinion testimony on lack of mens rea. Rather, the Court held, a jurisdiction may choose to "channel" a defendant's mental health evidence toward a traditional insanity defense.[77] While holding that the defense may rebut the prosecution's assertion of mens rea with "observational" evidence (i.e., the testimony of eyewitnesses or experts that is relevant to a defendant's "tendency to think in a certain way or his behavioral characteristics"), it concluded that states may restrict "opinion testimony going to mental defect or disease, and the cognitive or moral capacities on which sanity depends."[78] In justifying this decision, the Court noted the "controversial character of some categories of mental disease," the "potential of mental-disease

[72] Cf. United States v. Bright, 517 F.2d 584 (2d Cir. 1975).
[73] See Comm. v. Walzack, 360 A.2d 914, 920 (176) (holding that the Pennsylvania due process clause bars prohibition of expert testimony relevant to mens rea); Paul H. Robinson, Abnormal Mental State Mitigations of Murder—The U.S. Perspective, in Loss of Control and Diminished Responsibility: Domestic, Comparative and International Perspectives 291 (A. Reed & M. Bohland eds., 2011 (indicating that 40% of the 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).
[74] See Sandstrom v. Montana, 442 U.S. 510 (1979).
[75] Cf. Hughes v. Mathews, 576 F.2d 1250, 1254-1255 (7th Cir.), cert, dismissed sub nom.Israel v. Hughes, 439 U.S. 801 (1978) (invalidating statutory presumption of intent that could not be rebutted by defense psychiatric evidence because the effect of the provision was to relieve prosecution of burden of persuasion beyond a reasonable doubt on the culpability element of the charged crime).
[76] 548 U.S. 735 (2006).
[77] Id. at 778.
[78] Id.

evidence to mislead," and the "danger of according greater certainty to capacity evidence than experts claim for it."[79] It also suggested that the presentation of a psychiatric diagnosis in testimony on mens rea "may mask vigorous debate within the profession about the very contours of the mental disease itself."[80]

It is true that the various mens rea required for different crimes are not always clear and that an expert may misunderstand the law's requirements when rendering an opinion. But if expert testimony is irrelevant to mens rea–for instance, if the expert admits that the defendant intended to kill but did so delusionally, or if the relevant mens rea is objectively defined–the court should exclude it or limit the evidence to the insanity issue. Judges can also remind the jury through instructions how narrow even subjectively mens rea elements are; usually, if the defendant intended to carry out the conduct and intended harm or was aware that harm would result, mens rea will be proven. If, however, the testimony is relevant and—as required by the rules of evidence and these Standards (see in particular, standards 7-3.8 and 7.6.6)—if the testimony is based on specialized knowledge and avoids the ultimate issue, the probative value of relevant testimony will far outweigh its potential for confusing the factfinder. The *Clark* Court's concerns about speculative or misleading testimony are best addressed through the rules of evidence, not decisions changing the substantive definitions of crime.

Thus, this standard reaffirms that, as expressed in commentary to its 1984 edition of standard 7-6.2, "a defendant should not be convicted if the essential elements of the criminal charge cannot be proven." In taking this position, the ABA allies itself with the Model Penal Code and a substantial number of states,[81] and rejects the position reflected in *Clark*.

Some courts have excluded relevant evidence of mental abnormality if the effect would be an outright acquittal; based on the same concern, other courts have restricted such evidence to cases in which defendants are charged with some form of intentional homicide.[82] However, in the great majority of cases, evidence concerning a defendant's abnormal mental condition as it relates to mens rea will, if believed, do no more than reduce the grade of the offense. Even if defendants lacked the requisite purpose or knowledge (or "specific intent" in common law jurisdictions), they usually remain convictable of lesser included offenses requiring less demanding mens rea, such as recklessness or negligence (or "general intent" in common law

[79] Id. at 774-78.

[80] Id. at 774.

[81] The Model Penal Code provides that evidence concerning a defendant's mental condition should be admissible at a criminal trial whenever it is relevant to prove that a defendant did or did not have the state of mind required for conviction. ALI MPC, supra note 24, §4.01(1). For a state-by-state review of the issue, see Robinson, supra note 73.

[82] See Comm. v. Garcia, 505 Pa. 304, 47 A.2d 473, 477 (1984).

jurisdictions). Evidence concerning a defendant's subjective mental state would not be logically relevant in cases involving general intent crimes, because liability will turn not on what a defendant actually perceived, believed, or intended but on what an ordinary person in the same situation would or should have perceived, believed, or intended.

Moreover, in those rare cases where expert testimony on mens rea could result in complete acquittal, other means of protecting the public are available. The special concerns presented when defendants are acquitted for lack of requisite mens rea because of mental disability are similar to those presented by defendants acquitted on grounds of mental nonresponsibility [insanity]. The commitment procedures presented in Part VII, governing the latter group, could be applied, with some modifications, to defendants acquitted of all charged offenses because a mental disorder negated the requisite mens rea. Of course, general civil commitment procedures are also available to subject such individuals to ongoing noncriminal controls. This standard takes no explicit position on the dispositional issue.

The standard is also silent on the admissibility of expert testimony concerning a defendant's "character". This development is an outgrowth of the traditional rule that opinion evidence of a "pertinent" trait of an accused's character is admissible if proffered for the purpose of proving that the defendant acted in conformity with that trait.[83] This standard takes no position on whether this type of testimony should be limited in any fashion.

One final definitional point should be noted. The term "diminished capacity" has often been employed in discussions about evidence of abnormal mental condition as it relates to mens rea. However, this standard and its commentary have eschewed the use of the phrase because it is misleading. The term diminished capacity connotes the existence of an intermediate criterion of partial culpability—a capacity somewhat impaired but not so fully impaired as to establish a nonresponsibility [insanity] defense. As already noted, mens rea testimony does not bear such a linear relationship to the defense of mental nonresponsibility: Defendants may have had the requisite mens rea in a technical sense, and nonetheless be exculpated under the nonresponsibility defense; conversely, evidence concerning mental condition may be relevant to the mens rea question even though it does not support a nonresponsibility defense. Whether evidence of mental condition should be admitted if it is relevant to

[83] See Fed. R. Evid. 404, 405. In United States v. Staggs, 553 F.2d 1073, 1075 (7th Cir. 1977), for instance, testimony by a psychologist that the defendant was more likely to hurt himself than others was admissible to show he could not have formed the intent to assault another with a deadly weapon. Similarly, the court in O'Kon v. Roland, 247 F. Supp. 743 (S.D.N.Y. 1965), permitted psychiatric testimony that the defendant, charged with murder, was a passive person and unlikely to commit a violent act. The problem with such evidence of "character" is that, as *Staggs* and *O'Kon* demonstrate, it tends to resemble a mere assessment of whether a defendant is "good" or "bad." It is thus much broader in scope than testimony about criminal responsibility or mens rea, and more subject to abuse.

the existence of a state of mind required for conviction is purely an evidentiary question, not an issue of substantive criminal law doctrine.

Standard 7-6.3. Control and notice of defense based on mental condition

(a) The decision whether to raise a defense of mental nonresponsibility under Standard 7-6.1 is the defendant's. The decision whether to introduce evidence of mental condition under Standard 7-6.2 is the defense attorney's.

(b) If the defense intends to rely upon the defense of mental nonresponsibility [insanity] or introduce expert testimony relating to mental condition at the time of the offense charged, it should, within the time provided for the filing of pretrial motions or at such later time as the court may direct, notify the prosecuting attorney in writing of such intention and file a copy of such notice with the clerk. The court may, for cause shown, allow late filing of the notice or grant additional time to the parties to prepare for trial or make such other order as may be appropriate. If notice is not given in compliance with the requirements of this Standard, the court may impose sanctions appropriate to the degree of prejudice to the prosecution.

Commentary

Standard 7-6.3(a) provides that the decision to raise a mental nonresponsibility [insanity] defense belongs to the defendant, but that the decision to introduce evidence of the defendant's mental condition to negate mens rea under standard 7-6.2 should be up to defense counsel. Assigning to the defendant the decision about the nonresponsiblity [insanity] defense is consistent with standard 7-5.2(a) and with the ABA Standards for the Defense Function in Chapter 4. Standard 4-5.2(b) provides in part that "decisions ultimately to be made by a competent client, after full consultation with defense counsel, include… (ii) what pleas to enter….." Because the insanity defense is initiated by a special plea, that language makes the defendant the arbiter of whether it is raised. Of course, as standard 7-4.2 provides, the defendant must be competent to make the decision.

While a majority of courts agree with this position,[84] a few courts have held otherwise.[85] Given the argument in the commentary to standard 7-6.1 that the defense of mental nonresponsibility [insanity] is morally required, convicting and punishing a defendant who chooses to forego a viable insanity defense might seem morally obtuse. Nonetheless, a competent defendant may reasonably prefer the

[84] The leading case is Frendak v.United States, 408 A.2d 364 (D.C. App.1979).
[85] See Whalem v. United States, 346 F.2d 812 (D.C. Cir 1965). *Whalem* was reversed in United States v. Marble, 940 F.2d 1543 (D.C. Cir. 1991).

consequences of conviction over those of an acquittal on mental nonresponsibility grounds. Such an acquittal often involves confinement for indeterminate periods in secure psychiatric hospitals that may exceed the maximum period of any criminal sentence that could have been imposed upon conviction.[86] Further, insanity acquittees may be subject to treatment over objection, including treatment with medications that have undesirable side effects. Finally, some defendants may find the stigma of being found "insane" to be greater than that associated with criminal conviction; they should not be forced to adopt a label that fundamentally repudiates their belief about who they are as a person.

Compared to the mental nonresponsibility [insanity] defense, the mens rea defense is less likely to trigger concerns about disposition or personal stigma. The decision to present evidence about mens rea involves how best to rebut the prosecution's case-in-chief, not whether the defendant lacks fundamental capacities. Consistent with this view is Defense Function Standard 4-5.2(d), which provides that among the strategic and tactical decisions best left to counsel are those involving how evidence should be introduced and what witnesses to call. However, because the introduction of mental state evidence might be objectionable to some defendants, attorneys need to be sensitive to standard 4-5.2(d)'s admonition that attorneys consult with the client where "feasible and appropriate."

Virtually all jurisdictions require defendants to submit a written notice of an intent to assert a defense of mental nonresponsibility [insanity] as a means of avoiding surprise at or delay of trial.[87] Paragraph (b) likewise requires written notice of a decision to rely on evidence about mental disability in support of a defense of mental nonresponsibility "within the time required for filing pretrial motions." It also requires notice of a defense decision to present mental disability evidence negating mens rea, since here too the prosecution may want its own evaluation. Finally, paragraph (b) allows late filing of notice, for cause shown (for instance, if information concerning the defendant's psychiatric history or mental condition at the time of the offense emerges late in discovery). A delayed notice ordinarily should not unduly hinder prosecution efforts in most cases, since, as paragraph (b) states, the court may grant a continuance to provide the prosecution time to seek an evaluation and plan its rebuttal.

Most states impose sanctions if the notice requirement is not met.[88] Paragraph (b) also provides for sanctions, but only those appropriate to the degree of prejudice to the prosecution. Thus, if defense counsel purposely waits until the last moment to initiate an expert evaluation and give notice of the defense or gives no notice at all,

[86] See Melton et al., supra note 3, at 200-201 (summarizing studies comparing acquittee hospitalization periods to potential sentences).
[87] See Fed. R. Crim. Pro. 12.2(a); Wayne R. LaFave et al., Criminal Procedure § 20.5(c) (4th ed. 2023).
[88] See, e.g., Fed. R. Crim. Pro. 12.2(d).

and if a continuance is not feasible or just, harsh sanctions may be justified. But, at most, the sanction in such instances should be exclusion of the defense's expert testimony. Excluding all evidence of mental condition, as some jurisdictions allow,[89] is not appropriate. The principal prejudice to the prosecution from delayed or nonexistent notice is an inability to marshal expert assistance to rebut the defense case. A prosecuting attorney still enjoys an ability, unimpaired by the want of a defense notice, to identify and call lay witnesses and to present other evidence in rebuttal. Thus, a sanctionable defendant also should retain the ability to call lay witnesses.

Standard 7-6.4. Evaluation procedures to determine mental condition at the time of the offense

(a) Prior to the notice required in Standard 7-6.3(b) the defense may seek evaluation of the defendant's mental condition at the time of the offense. Standard 7-3.3(b) governs when the defendant is entitled to funding for this evaluation.

(b) After the defendant's notice as provided in Standard 7-6.3(b) and a finding that the defendant intends to rely upon expert testimony, the court may, on motion of the prosecuting attorney, order the defendant to be examined by an expert designated in the order for the purpose of determining the mental condition that is being put in issue by the defendant. If the court determines that an adequate evaluation of defendant's mental health condition at the time of the alleged crime has been precluded because the defendant has refused to cooperate with the mental health professional, it should adopt remedial measures proportionate to the degree of prejudice to the prosecution and the extent to which the non-cooperation was influenced by the defendant's mental disorder.

(c) The court should not on its own motion order an evaluation of the defendant to determine mental condition at the time of the offense and should not grant such a motion from the prosecution except as provided in (b) of this Standard.

(d) Procedures for conducting evaluations of mental condition at the time of the offense, including the attorneys' duty to provide information, the terms of the court order, the presence of counsel during the evaluation, recording of the evaluation, and the conduct of joint evaluations are governed by Standards 7-3.4 and 7-3.5.

[89] See , e.g., Tex. Code Crim. Proc. Ann. Art. 46C.051(a), (b).

(e) Procedures for preparing reports on the mental condition at the time of the offense are governed by Standards 7-3.6.

Commentary

Standard 7-6.4 addresses procedures for defense and prosecution-initiated evaluations of a defendant's mental state at the time of the offense. Procedures for the conduct of evaluations and preparation of reports are set forth in detail in Part III. Thus this standard consists largely of cross-references to that part. The commentary to cross-referenced provisions appears in Part III.

Paragraph (a), with its cross-reference to standard 7-3.3(b), recognizes that defendants have the right to an exploratory, ex parte evaluation of mental state of the time of the offense, paid for by the state if necessary. The ability to explore potential defenses without fear of prosecution discovery is a crucial aspect of good defense strategy and, as the commentary to standard 7-3.3 discusses, should be guaranteed by both the due process clause and the Sixth Amendment.

Paragraph (b) makes clear that, after the defense gives notice of an intent to rely on an insanity defense and introduce expert testimony under standard 7- 6.3(b), the court may, on motion of the prosecution, order an evaluation of the defendant. The defendant must cooperate with the evaluator assigned. Because, by giving notice, the defendant has signaled an intent to place his or her mental condition at the time of the offense at issue, the defendant may not claim a Fifth Amendment privilege to remain silent in the face of the evaluator's questions on this issue, even those concerning the defendant's thinking and behavior at the time of the offense.[90]

If the court finds that the defendant has failed to cooperate with the prosecution's evaluator, paragraph (b) also allows for the adoption of "remedial measures proportionate to the degree of prejudice to the prosecution and the extent to which the non-cooperation was influenced by the defendant's mental disorder." Similar to the provision in standard 7-6.3(b) dealing with failures to give appropriate notice, this provision recognizes that excluding the defendant's expert might be called for should the court find that the defendant's refusal to cooperate was deliberate and intended to frustrate the prosecution's efforts to develop its case. In some cases, however, a defendant's apparent failure to cooperate may be less strategic, reflecting instead the symptoms of the defendant's mental disorder. Even defendants who are competent to proceed may experience anxiety when questioned

[90] A leading case on this issue is Pope v. United Staes, 372 F.2d 710 (8th Cir. 1967) (so holding on both waiver and fairness to the state grounds). Some courts have held that waiver in this situation is neither voluntary nor intentional, Commonwealth v. Pomponi 284 A.2d 708, 711 (1971), but the standard takes the position that full explication of the insanity issue necessitates allowing the state to obtain its own evaluation.

by a state's expert and stumble in responding. Some experience thought disorder, which may cause difficulty in following questions closely and providing clear, cogent responses. Some may have symptoms of paranoia that, while undermining cooperation, also provide good evidence of serious mental impairment. Under these circumstances, to deny the defense an opportunity to expert testimony may be disproportionately harsh. Other measures a court might take include granting an extension for a re-evaluation, perhaps with defense counsel present,[91] allowing the prosecutor to comment on the defendant's failure to cooperate, or limiting the defense presentation to matters revealed by the defendant to the prosecution's expert.

Paragraph (c) reflects the premise, expressed in standard 7-6.3(a), that only the defense may raise a mental nonresponsibility defense. If the defense has not been raised, or the defense has not yet given notice of an intent to proceed with such a defense and present expert testimony, there can be no grounds for the court to order an evaluation of the defendant's mental condition at the time of the offense. If the defense has given such notice, it is the prerogative of the prosecutor, not the court, to seek an evaluation, in accordance with paragraph (b). In contrast to competence evaluations (see introduction to Part IV), the trial court is not a party to the adversarial process in this setting. This position preserves a maximum scope for defense attorneys to explore, in the course of discharging their Sixth Amendment responsibilities, whether a nonresponsibility defense is viable and strategically sound before having to commit to such a defense and possibly disclose sensitive information that may not otherwise come to light.

Paragraphs (d) and (e) cross-reference the provisions in Part III governing the conduct of evaluations and the preparation of reports on mental nonresponsibility [insanity].

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Standard 7-6.5. Discovery and disclosures

(a) Upon giving notice under Standard 7-6.3(b), the defense should provide the prosecution with the results of its evaluation(s), as provided in Standard 7-3.7(b)(i).

(b) Pursuant to Standard 11-2.1 in the Discovery Standards, the prosecution should timely provide the defense with information bearing on the defendant's mental condition at issue, including expert reports or statements, the results of mental evaluations and tests, and any written or recorded statements and the substance of any oral statements made by the defendant. Additionally, upon receiving notice under Standard 7-6.3(b), the prosecutor should, as soon as reasonably practicable, disclose to defense counsel:

[91] Under standard 7-3.5(c)(ii) defense counsel presence would require the acquiescence of the evaluator.

(i) any information that tends to rebut the factual data upon which the experts called by the defendant are relying, including documents, names and addresses of witnesses and their relevant written or recorded statements, and substance of any oral statements;

(ii) the names, addresses, and statements of any experts whom the prosecutor intends to call for the purpose of discrediting the mental nonresponsibility [insanity] defense or evidence of mental condition.

(c) Admissibility and disclosure of evaluation results are governed by Standard 7-3.2(a)(on the admissibility of defendant's evaluation statements), Standard 7-3.2(b) (on the use of information relevant to competence to proceed or imminent risk), and Standard 7-3.4(c) (on disclosure of evaluation results to the public).

Commentary

Standard 7-6.5 is largely consistent with the Standards on Discovery and Procedures before Trial, in Chapter 11 of the Criminal Justice Standards. However, paragraph (a), which deals with prosecution discovery of defense material, does diverge from the standards of Chapter 11 in one respect. Under standard 11-3.2(a) defendants who have requested and received discovery under standard 11-2.1 must, upon a request by a prosecuting attorney, disclose "any reports or statements (including results of physical or mental examinations and of scientific tests, experiments, or comparison) which were made by experts in connection with the particular case and which the defense intends to use at a hearing or trial." Although paragraph (b) of that standard incorporates an exception governing defense work product, that term is narrowly defined to include only research and opinions by defense legal staff and communications by defendants to counsel. Under standard 11-3.2, therefore, a prosecution request could impel defense counsel to reveal expert psychiatric reports *whenever* a defense request embraced information listed in standard 11-2.1, even if the defense request was submitted well before formal notice of an intent to raise a mental condition defense is required under standard 7-6.3.

Such a result would both discourage early defense discovery and run counter to standard 7-3.8(b), which precludes discovery of defense reports before submission of a standard 7-6.3 notice in order to protect a defendant's Fifth and Sixth Amendment interests and to encourage candor in the evaluation process. Therefore, these latter two standards should be read as creating a narrow exception to standard 11-3.2(a) with respect to expert opinion and expert-generated facts relevant to a defendant's mental condition. As provided in paragraph (a), the prosecution may not

gain access to those data until notice under standard 7-6.3 has been given, even if the defense has relied on standard 11-2.1 to obtain information in the prosecution's possession or control at an earlier time.

A corollary to these procedures is found in standard 11-3.2(c), which opposes introduction in evidence of "the fact that the defendant has indicated an intention to offer specified evidence or to call a specified witness." It also states that "information obtained as a result of disclosure pursuant to this standard is not admissible in evidence at trial except to refute the matter disclosed." These two provisions are designed to prevent the defense from being penalized if it changes strategy and decides not to rely at trial upon disclosures made to the prosecution at some earlier time. This principle should apply in the present context as well. If the defense decides at the last minute to refrain from presenting evidence of mental nonresponsibility, the prosecution should not be able to use information from expert reports on that issue even if they are legitimately obtained through discovery.

Paragraph (b) follows Chapter 11 with respect to the imposition of discovery obligations on the prosecution. Under standard 11-2.1, defendants are entitled upon request to an array of information within prosecution possession or control, including names and addresses of witnesses, statements by defendants, reports or statements of experts, and documents the prosecution intends to use at hearing or trial, at any time before trial. The present standard's treatment of discovery about psychiatric issues is not meant to disturb this aspect of Chapter 11. Indeed, as implied above, much of the data discoverable under standard 11-2.1 should be provided to defense counsel as early as possible, even before notice of an intent to raise a mental condition defense is required under standard 7-6.3, because it can facilitate counsel's decision whether to obtain a mental evaluation of their clients or to assert a defense turning on mental condition. Paragraph (b) simply recognizes that, if information relevant to mental condition has not already been disclosed, the prosecution must disclose it after notice has been given under standard 7-6.3. Of course, because a prosecution evaluation of mental nonresponsibility cannot take place until after such notice (see standard 7-6.4(b)), the results of that evaluation will not be available until sometime after that point. Particularly useful at this stage would be the results of prosecution evaluations that tend to "rebut" the factual assumptions of the defense's expert, because they may help resolve the case short of trial or result in defense experts changing their opinion.

Paragraph (c) cross-references to the standards and commentary in Part III regarding the disclosure and admissibility of information obtained during the evaluation process. In brief, such information should not be proffered by the prosecution except to rebut defense arguments at trial or sentencing or to address competency issues, and otherwise should not be disclosed except to forestall harm to or by the defendant.

Standard 7-6.6. Limitation on opinion testimony concerning mental condition

Expert testimony as to how the development, adaptation, and functioning of the defendant's mental processes may have influenced the defendant's conduct at the time of the offense charged should be admissible. Consistent with Standard 7-3.8(a), expert reports and testimony should be based on specialized knowledge of the expert and the insanity test language should be used only if the expert can explain its clinical relevance. Testimony that a defendant is "sane" or "insane" should not be used unless required by the jurisdiction.

Commentary

Federal Rule of Evidence 704(b) and the evidence rules of several states provide that "an expert must not state an opinion about whether the defendant did or did not have a mental state or condition that constitutes an element of . . . a defense."[92] Standard 7-6.6 similarly discourages expert testimony on the ultimate issue of mental nonresponsibility ("whether a defendant is sane or insane"). However, the standard would permit experts to use "insanity test language" (i.e., the legal language defining mental nonresponsibility) *if*, consistent with standard 7-3.8 (a), which requires that expert opinion be based on specialized knowledge, they can "explain its clinical significance." This standard thus may be somewhat more permissive than the federal rule, which some courts have been construed to prohibit not only ultimate issue testimony but also penultimate testimony that uses or is very similar to the insanity test.[93]

Traditionally neither lay nor expert witnesses have been permitted to address ultimate issues of fact that factfinders must decide. The theoretical rationale for the common law prohibition against ultimate issue testimony was that it usurped the province of the jury. Its practical basis was a fear that jurors would be swayed unduly by the authority of expert witnesses on issues a jury alone was to decide. To these concerns could be added a third—that ultimate issue testimony might tempt witnesses to rely primarily on mere conclusions rather than describe the bases for them, to the detriment of the factfinding process. Finally, to the extent that the question of responsibility calls for a value judgment (i.e., whether the degree of compromise in a defendant's appreciation of wrongfulness is so great as to provide excuse), the ultimate issue can be said to lie outside the special expertise of mental health professionals.

[92] See, e.g., Ariz. R. Evid. 704; Conn. Evid. Code § 7-3; Utah R. Evid. 704.
[93] See, e.g., United States v. Manley, 893 F.2d 1221 (11th Cir. 1990); United States v. Kristiansen, 901 F.2d 1463, 1466 (8th Cir. 1990).

However, several devices can temper these hazards, including cross-examination, testimony by rebuttal witnesses, and arguments of counsel. Courts can always instruct juries that they are the sole judges of credibility, the sole finders of fact, and the sole determiners of inferences properly to be drawn from credible facts. Admonitions of this nature can be reinforced by reminders that jurors can believe the basic facts on which witness testimony rests without sharing a witness's opinions or inferences. A ban on penultimate issue testimony can also be artificial, because clever witnesses, or cleverly coached witnesses, can always find ways to paraphrase forbidden language. That premise no doubt explains the willingness of many courts to allow ultimate opinion evidence.

All of these arguments are unpersuasive, however, with respect to testimony that declares a person sane or insane, and they may also be suspect even with respect to testimony that uses the test language without making clear the clinical content of that language. The gap between legal conclusions and expert opinions may be negligible in the context of some issues, for example, whether a physician charged with malpractice failed to meet a medical standard of care. But the same cannot be said of mental nonresponsibility, which ultimately is entirely a matter of moral blameworthiness, not medical or psychological inquiry. Thus, more so than in other areas, proffered expert conclusions on criminal responsibility are likely to reflect personal conjecture rather than professional judgments based on the specialized knowledge required to qualify witnesses as experts. The legal defect in such purportedly expert opinion evidence is compounded by the aura of authority surrounding persons designated "experts" that may lead jurors to place special credence in their opinions, at least when presented credibly and not vigorously challenged. Shifting the focus of expert testimony from stark conclusions of law toward descriptions of psychological functioning and the data supporting them cannot help but provide triers of fact with enhanced information upon which to reach the ultimate conclusions required of them.

Problems will naturally arise in administering the ban set out in standard 7-6.6. Although, as the standard recognizes, experts have no clinical basis to use terms like "sane" and "insane," other terms like "appreciate" have clinical significance because they refer to mental and emotional phenomena. The proper limits to this penultimate testimony cannot be determined fully in the abstract. In the context of specific testimony, courts must choose between the important principles reflected in this standard and standard 7-3.8(a)'s encouragement of expert opinion testimony based on specialized knowledge that will assist the trier of fact. Thus, an expert certainly could testify that, at the time of the offense, the defendant was suffering from an acute phase of a schizophrenic disorder that led to a hallucination that the victim was an alien bent on destroying the world, and that this belief likely

diminished the defendant's ability to appreciate the wrongfulness of his attack. But a statement that the defendant was "unable" to appreciate the act's wrongfulness might go beyond the expert's specialized knowledge, and a statement that the person was "insane" or mentally nonresponsible certainly would. Note also that, under standard 7-3.8(c), if a court or lawyer insists on ultimate issue language barred by this standard, the expert should explicitly state that the opinion is merely the expert's inexpert take on a legal test, not a clinically-informed judgment.

Although standard 7-6.6 does not address the matter directly, the ultimate issue limitation quite appropriately may also govern expert opinion evidence bearing on mens rea. Terms like "premeditation," "malice," and "provocation" have technical legal meanings about which mental health professionals have no particular expertise. Expert testimony in such cases should focus on facts and the inferences to be drawn from them relating to cognitive impairment and should be expressed in comprehensible, non-legal language. This is also the intent of federal evidence rule 704(b), which states that "an expert witness must not state an opinion about whether the defendant did or did not have a mental state or condition that constitutes an element of the crime charged . . . ."

Standard 7-6.7. A unitary trial

The defense of mental nonresponsibility [insanity] and all other evidence pertaining to the defendant's responsibility for the acts charged should be heard in a unitary trial unless, upon the defendant's request, the court determines that trying the issue of guilt separately from the issue of responsibility is necessary to prevent substantial prejudice to the defendant.

Commentary

Standard 7-6.7 calls for unitary trials in mental nonresponsibility cases, unless the defense requests a bifurcated trial. Jurisdictions that authorize bifurcated trials in cases raising a mental nonresponsibility [insanity] defense usually mandate that the initial proceeding focus on the elements of the crime and that the second stage, if necessary, address insanity issues.[94] By deferring psychiatric testimony on mental nonresponsibility [insanity] until after the first determination, bifurcation promises to (1) avoid jury confusion that might result from superimposing such testimony on other issues arising at trial; (2) eliminate a risk that juries may return verdicts of mental nonresponsibility as a middle ground when they want to grant leniency to a defendant who is not insane; (3) save judicial resources in cases where defendants are acquitted at the first stage; and (4) protect defendants' Fifth Amendment privilege

[94] See, e.g., Morgan v. Krenke, 72 F. Supp. 2d 980 (E.D. Wis. 1999); People v Deason, 670 P2d 792 (Colo. 1983).

against self-incrimination by avoiding disclosures at trial about the offense that the defendant made to evaluators.

In response, it can be argued that to exclude, at the first stage, evidence of mental disorder that tends to negate the requisite state of mind (as evidence of mental nonresponsibility sometimes does) in effect permits convictions in cases in which the prosecution might not be able to meet its burden of persuasion (see commentary to standard 7-6.2). Attempting to reverse the determination at the first stage that all of the elements of a crime have been established at the second stage may present challenges for the defense that are unfair and unrealistic. Thus, one might conclude, persons should never be found "guilty," even provisionally, if in fact they are not criminally responsible.[95]

To conclude that bifurcation can work an injustice in some cases, however, does not mean the procedure is never appropriate. Indeed, there may be circumstances in which a two-stage procedure is preferred. For instance, the defense may want to claim both that the defendant did not commit the crime (because, for instance, a co-defendant pulled the trigger) but that, if the prosecution can show he did, he was insane when the crime occurred. In such cases, if defendants have a colorable defense on the merits, as well as a tenable defense of mental nonresponsibility [insanity], and can show that to permit expert testimony on the latter issue at a unitary trial would jeopardize a defense on the merits (because incriminating or otherwise prejudicial information might be revealed to a jury), courts should be willing to allow bifurcation.

Although standard 7-6.7 expresses a preference for unitary trials, it recognizes the appropriateness of bifurcation in cases of this sort, upon the defendant's request. Defendants should not have to forego their Fifth Amendment interest in protecting against compulsion of information about factual guilt as the price of asserting a mental nonresponsibility defense. The only other option—instructing juries in a unitary trial to consider expert testimony about a defendant's mental state only when deciding the issue of criminal responsibility and to disregard it when deliberating on other issues—would not alleviate the prejudice inherent in such cases.

[95] See generally Necessity or Propriety of Bifurcated Trial on the Issue of the Insanity Defense, 1 Am. L. Rep. 4th 884 (1980-2023).

Standard 7-6.8. Instruction to the jury

Upon motion of either party, the court may instruct the jury as to the dispositional consequences of a verdict of not guilty by reason of mental nonresponsibility [insanity].

Commentary

In most states, persons acquitted by reason of mental nonresponsibility are automatically confined in secure, inpatient mental health facilities for evaluation and observation, after which the large majority are retained (upon court commitment) for an indeterminate period.[96] Similarly, under the standards in Part VII, defendants who are found beyond a reasonable doubt to have committed the actus reus element of felonies involving a victim's death or serious bodily harm may be subject to special commitment procedures for up to the maximum term prescribed for the predicate felony (albeit subject to periodic review).[97] Studies have found that the lengths of stay for persons committed after a finding of mental nonresponsibility are approximately equivalent to the amount of time they would have been imprisoned, had they been convicted of the charges they faced.[98] Some stay much longer.

Standard 7-6.8 permits the court, on motion of either party, to instruct the jury on the dispositional consequences of a verdict of not guilty by reason of mental nonresponsibility. The principal argument against informing juries about the disposition of persons found mentally nonresponsible is that it may distort their deliberations about the verdict. Jurors are not told of possible sentencing alternatives on the ground that their decision about guilt might then be based on irrelevant considerations. Similarly, the argument goes, jurors should not be told that defendants acquitted by reason of mental nonresponsibility will be confined in hospitals; otherwise, they may be inclined to find defendants "insane" as a compromise between prison and a return to the community, rather than focus on the legal standards in question. For these reasons, the U.S. Supreme Court ruled that a federal court is not required to instruct the jury regarding the consequences to the defendant of a mentally nonresponsible verdict.[99] The Court concluded that, even if it is true that some jurors harbor the mistaken belief that a defendant found not guilty by reason of mental nonresponsibility will be released into society immediately, it must be assumed that they will obey the judge's instructions not to consider or discuss punishment, and apply the law regardless of the consequences.[100]

[96] See generally, James Ellis, The Consequences of the Insanity Defense: Proposals to Reform Post-Acquittal Commitment Law, 35 Cath. U. L. Rev. 1961 (1986).
[97] See standard 7-7.7.
[98] See Melton, supra note 3, at 203-204 (summarizing studies).
[99] Shannon v. United States, 512 U.S. 573 (1994).
[100] Id. at 585.

The position taken in standard 7-6.8 reflects the contrary view that despite instructions cautioning jurors to consider only the evidence they have heard, jurors who are not informed about dispositional consequences will naturally speculate about the practical results of a nonresponsibility verdict and, in ignorance of reality, will convict persons who are not criminally responsible in order to protect society.[101] Jurors surely know, without being told, what happens to most convicted offenders, as well as defendants who are acquitted outright; the proposed instruction provides the same level of knowledge with respect to the fate of persons acquitted by reason of mental nonresponsibility. Particularly in cases in which defendants are charged with violent crimes, juries need to be told about the effect of a finding of mental nonresponsibility if the possibility of a serious injustice is to be avoided. The form of a suitable instruction should be left to legislative and rule drafters.

Standard 7-6.9. Burden of production and burden of persuasion

(a) The defense should have the burden of ensuring that evidence of mental nonresponsibility [insanity] is introduced.

(b) Once evidence of mental nonresponsibility [insanity] has been introduced at trial, the party with the burden of persuasion should prevail if it meets the preponderance of the evidence standard of proof.

(c) Nothing contained in paragraph (b) above relieves the prosecution of its burden of proving beyond a reasonable doubt all elements of the offense charged including the mental state required for the offense charged.

Commentary

In virtually all states, criminal defendants are presumed responsible. Therefore, they bear the burden both of pleading the defense of mental nonresponsibility (if a special plea is required by statute or court rule) and of going forward with ("producing") evidence in support of the claim. Paragraph (a) restates this fundamental evidentiary proposition.

The burden of persuasion is a matter separate from the burden of production. Jurisdictions that retain a defense of mental nonresponsibility [insanity] are divided on the question of which party bears the burden of persuasion. Most states place the

[101] Research indicates that, at best, jurors have inconsistent perceptions about disposition. Harold Schwartz, Should Juries Be Informed of the Consequences of the Insanity Verdict?, 8 J. Psychiat. & L. 167, 173-174 (1980): Grant Morris, Wither Though Goest?: An Inquiry into Jurors' Perceptions of the Consequences of a Successful Insanity Defense, 14 San Diego L. Rev. 1058 (1977).

burden on the defendant to prove nonresponsibility by a preponderance of the evidence; a few raise this burden to clear and convincing evidence, as Congress has done for federal jurisdictions.[102] In contrast, in a few states, once the defense has raised the issue and produced evidence in support of the defense, the prosecution must prove beyond a reasonable doubt that the defendant is criminally responsible; otherwise, the defendant is acquitted by reason of mental nonresponsibility.[103]

In the absence of constitutional prerequisites, allocation of the burden of persuasion on mental nonresponsibility issues is exclusively a matter of public policy. The prosecution generally bears the burden of persuading a factfinder beyond a reasonable doubt of all facts necessary to establish the elements of the crime.[104] Whether a defendant meets the test for mental responsibility [insanity], however, is not an element of any crime. Moreover, the parameters of mental nonresponsibility may be less clearly defined than those of the crime's elements. Even when there is agreement on the extent to which a defendant's thinking and behavior at the time of an offense were impaired by mental disorder, there can be vehement disagreement over whether such impairment rendered the defendant nonresponsible. Given these ambiguities, requiring prosecutors to rule out mental nonresponsibility with a high degree of certainty would be unduly burdensome.

Ultimately, however, paragraph (b) avoids designating which party should bear the burden of persuasion. Rather it provides that once the defense has produced evidence of mental nonresponsibility, whichever party bears the burden under the relevant law should prevail if it meets the preponderance of the evidence standard of proof. As noted, most states require the defense to prove mental nonresponsibility by this standard. Should a state assign the burden of persuasion to the prosecution, it would be charged with proving, by the same preponderance standard, that the defendant failed to satisfy the state's nonresponsibility standard. Either way, a defendant who produces evidence in support of a mental nonresponsibility defense (i.e., satisfies the burden of production) should prevail with that defense if the trier of fact finds that it is more likely than not that the defendant meets the applicable legal standard.

Paragraph (c) makes clear that regardless of a state's allocation of the burden of persuasion on the mental nonresponsibility question, the prosecution remains responsible for proving beyond a reasonable doubt all of the elements of the crime charged, including *mens rea.* Thus, in states that have abolished the defense of mental nonresponsibility [insanity] and replaced it with the mens rea approach, the

[102] For a somewhat outdated review of state rules regarding burdens of proof with respect to insanity, see Bureau of Justice Statistics, U.S. Dept. of Justice, State Court Organization 200 (Table 35) (2004).
[103] See Melton et al, supra note 3, at 211-212.
[104] In re Winship, 397 U.S. 358, 364 (1970).

allocation issue should not arise. Similarly, in jurisdictions that permit testimony on both mental nonresponsibility [insanity] and mens rea, the burden of persuasion on the latter issue must rest on the prosecution and not the defense, no matter which side bears the burden on the nonresponsibility issue and irrespective of whether the issues are tried together in a unitary trial or separately in a bifurcated procedure.

Standard 7-6.10. Forms of verdict

(a) When the defense of mental nonresponsibility [insanity] has been properly raised, the verdict returned should be in the form of either guilty, not guilty, or not guilty by reason of mental nonresponsibility [insanity]. The jury should be instructed that it may consider the verdict of not guilty by reason of mental nonresponsibility [insanity] only after finding, beyond a reasonable doubt, that the defendant committed the conduct charged.

(b) Legislatures should not enact statutes that supplant or supplement the verdict of not guilty by reason of mental nonresponsibility [insanity] with a verdict of guilty but mentally ill.

Commentary

Standard 7-6.10 specifies the forms of verdict in mental nonresponsibility cases. Paragraph (a) limits verdicts in such cases to the three forms traditionally provided in criminal cases: guilty, not guilty, and not guilty by reason of mental nonresponsibility [insanity]. The requirement endorsed in paragraph (a) that juries determine beyond a reasonable doubt that defendants committed the actus reus element of charged offenses before determining nonresponsibility is important for the dispositional provisions in standard 7-7.4, which takes the position that the special commitment of persons found nonresponsible must be predicated on such a finding by either a trial judge or a committing judge. In addition, the fact that defendants almost certainly committed otherwise criminal acts will often be material evidence on the question of whether they pose a threat of harm to others if they are not committed, one of the criteria that must be established under standard 7-7.4(b) to authorize involuntary hospitalization.

Paragraph (b) of the standard reinforces paragraph (a) by banning the alternative "quasi-nonresponsibility" verdict of guilty but mentally ill. Since 1975, when Michigan enacted the first such statute, at least eleven other states have enacted guilty-but-mentally-ill legislation.[105] Under the Michigan statute,[106] which is

[105] Carlton A. Palmer and Mark Hazelrigg, The Guilty But Mentally Ill Verdict: A Review and Conceptual Analysis of Intent and Impact, 28 J. Am. Acad. Psychiatry and the Law 47, 47-48 (2000).
[106] Mich. Comp. Laws Ann. §§768.29a(2), 768.36 (1982).

representative of most such formulations, defendants who file a notice of an intent to rely on the insanity defense may be found guilty, not guilty, not guilty by reason of insanity, or guilty but mentally ill (GBMI) at the time of a charged offense. The latter finding is required if a factfinder concludes beyond a reasonable doubt that a defendant committed the act charged, had a mental disorder at the time of the offense, and was not mentally nonresponsible at the time of the offense. If a GBMI verdict is returned, a defendant is sentenced to any term appropriate for the offense, but may be referred for treatment in a psychiatric hospital if such treatment is needed.

The constitutionality of the Michigan statute has been upheld by Michigan state courts on several occasions,[107] and proponents of the GBMI verdict believe it has several advantages. First, and most importantly for many of its proponents, it reduces mental nonresponsibility [insanity] acquittals. Second, it protects the public by ensuring people with mental illness are confined after trial. Third, it gives factfinders a compromise verdict between an unalloyed finding of guilt and complete acquittal, which some research suggests factfinders want.[108]

Nonetheless, paragraph (b) disapproves of the GBMI verdict on the ground that it is unwarranted on both functional and theoretical grounds. As a practical matter, the verdict may not accomplish its primary goal of reducing "insanity" acquittals, and in any event is unlikely to increase protection of the public. Research on the impact of the GBMI verdict indicates that such acquittals have actually increased in some jurisdictions.[109] Apparently, defense attorneys hoping for a GBMI verdict but required to raise the insanity defense to get the issue before the trier of fact occasionally end up with an insanity verdict instead. Further, while it is true that a GBMI verdict results in conviction and sentence rather than acquittal and hospitalization, the length of confinement may not be significantly different from the confinement associated with an insanity verdict. As noted in the commentary to standard 7-6.8, people found mentally nonresponsible sometimes are hospitalized as long as they would have been incarcerated. At the same time, a person found GBMI must be considered for parole just like any other convicted offender. Thus, confinement is likely to be roughly similar under either the traditional system or one that employs the GBMI verdict.[110]

Accepting for the sake of argument that the GBMI verdict tends both to reduce acquittals by reason of mental nonresponsibility and to lead to longer confinement for mentally disordered offenders, the verdict nonetheless is

[107] See, e.g., People v. McLeod, 407 Mich. 632,288 N.W.2d 909 (1980).
[108] Simon, supra note 57, at 18.
[109] Christopher Slobogin, The Guilty But Mentally Ill Verdict: An Idea Whose Time Should Not Have Come, 53 Geo Wash. L. Rev. 494, 506-510 (1985) (summarizing research indicating that the verdict does not reduce insanity acquittals).
[110] Id. at 510-512.

objectionable on conceptual grounds. Under the typical GBMI scheme, jury instructions directing when defendants should be found "insane" as opposed to merely "mentally ill" are at best confusing and at worst prejudicial. There is a strong possibility that jurors, seeing little distinction between these competing terminologies, will choose the GBMI verdict solely because it appears to result in longer confinement (recall from the discussion in connection with standard 7-6.8 that juries are not informed of potential sentences). Persons with a valid nonresponsibility defense may be convicted without serious consideration given to their moral blameworthiness.

Finally, the GBMI verdict is deficient for an important theoretical reason: Because people found GBMI can receive the same sentence as a person found simply guilty, it is not a proper verdict at all. Rather it is an inefficient dispositional mechanism transferred to the guilt determination phase of the criminal process. The hybrid nature of the GBMI inquiry is demonstrated by the fact that it asks the factfinder to make a determination about mental illness at the time of a charged offense that has no bearing on criminal responsibility or culpability (much to the surprise of some defense attorneys, who mistakenly think it will result in a more lenient disposition[111]). Rather, the verdict's only impact, if any, is that it indicates whether the accused should receive treatment after sentencing. Yet that finding is one best made *after* trial, when information about various dispositional alternatives can be obtained and qualified experts consulted. Even if the GBMI verdict accurately identified offenders needing psychiatric treatment (which, again, is unlikely, since it is a determination based solely on mental state at the time of the offense), it would not be a particularly useful innovation. Virtually every state already provides for the hospitalization of prisoners requiring inpatient care. Indeed, the courts have recognized a constitutional right of incarcerated persons to treatment for their serious medical and mental health needs, which should apply regardless of the type of guilty verdict handed down at trial.[112]

If the goal is to reduce acquittals by reason of mental nonresponsibility [insanity], attention should be deflected to the proper scope of the nonresponsibility defense (see standards 7-6.1 and 7-6.2). If it is instituted to prevent premature release of persons found nonresponsible, criteria for committing and releasing them should be reexamined (Part VII of these Standards). If, instead, the concern is the proper treatment of mentally disordered offenders, sentencing and prison transfer provisions should be evaluated (Parts VIII, IX and X). The guilty-but-mentally-ill verdict fails to address any of these problems adequately. Instead, it adds a confusing and conceptually unjustifiable element to the criminal justice system.

[111] See id. at 517-519. See also People v. Crews, 522 N.E.2d 167 (Ill. 1988) (finding that defendants found GBMI may be sentenced to death).
[112] Estelle v. Gamble, 429 U.S. 97 (1976); Bowring v. Godwin, 551 F.2d 44 (1977).

PART VII. COMMITMENT OF NONRESPONSIBILITY ACQUITTEES

INTRODUCTION

Part VII establishes standards for the disposition of defendants found not guilty by reason of mental nonresponsibility (insanity "acquittees"). The willingness of the public to support (or at least tolerate) the mental nonresponsibility defense may depend upon an assurance that persons who have committed acts of violence will not be freed prematurely, to re-offend in the community. At the same time, special statutory provisions that treat acquittees in a substantially different manner from other persons subject to civil commitment raise serious constitutional and public policy questions. To be acceptable, such laws must afford acquittees due process, and differences from ordinary civil commitment must not offend the equal protection clause. The standards in this part try to reconcile this tension. In doing so, they depart to some extent from the leading case on the issue, the U.S. Supreme Court's opinion in *Jones v. United States*.[1] While the standards in this part accept *Jones's* premise that insanity acquittees may be subject to more expansive commitment standards than civil committees, they balance public safety and individual liberty concerns differently than that case did.

Standard 7-7.1. Commitment following mental nonresponsibilty [insanity] acquittal

(a) Mental nonresponsibility acquittees may be involuntarily confined pursuant to special commitment criteria that:

(i) are less demanding in certain respects than the criteria typically required for general involuntary civil commitment of individuals with mental disorder who have not been charged with a crime, and

(ii) if proven, may result in confinement in forensic mental health facilities that are more secure than the civil hospitals relied upon in the general involuntary commitment setting.

(b) If the commitment of a mental nonresponsibility acquittee is not sought, or if the commitment is sought but the court declines to order such commitment, the acquittee should be released.

(c) In jurisdictions that confer authority on an administrative board or a statewide forensic director to make commitment and release decisions about

[1] 463 U.S. 354, 370 (1983).

individuals acquitted by reason of mental nonresponsibility, the provisions of this part referring to the director of the mental health facility should be modified accordingly.

Commentary

Standard 7-7.1(a)(i) acknowledges that mental nonresponsibility acquittees may be confined pursuant to commitment criteria that are less demanding than those governing ordinary civil commitment. Ordinary civil commitment laws provide substantial protection of the liberty interests of respondents. For instance, the Supreme Court has ruled that before a person may be civilly committed, the state must prove by clear and convincing evidence that the person satisfies the criteria for commitment.[2] In most states, these criteria require that the person have a mental disorder and that the person poses an significant and imminent risk of serious bodily harm to self or others in the near future.[3] In *Jones v. United States*,[4] in contrast, the Court upheld automatic commitment of people found nonresponsible for up to 50 days without a hearing, and also held that, upon subsequent review, the burden to prove readiness for release may be placed on the acquittee.[5] The Court rejected Jones' claim that these differences from civil commitment violated equal protection, reasoning that the risk of error in determining an individual's present mental disorder and dangerousness is reduced where the individual has just established, at trial, that he or she committed a crime because of a mental disorder. Subparagraph (a)(i) reflects this reasoning, as do the standards and procedures specified later in this part (although they provide greater protections than those approved in *Jones*).

Subparagraph (a)(ii) recognizes that the facilities that house acquittees will also usually need to be more secure than those that handle people subject to ordinary civil commitment. In the civil setting, psychiatric hospitals treat patients with a range of needs. Many patients admit themselves for treatment voluntarily. Others may be committed, over their objection, on a finding that their mental disorder places them at risk of harm. Rarely, however, is such "civil commitment" precipitated by the individual's commission of a serious criminal act. Accordingly, services in most psychiatric hospitals are provided in settings that have limited security. Individuals with mental disorder who have engaged in criminal activity, in contrast, may present security risks that these civil facilities cannot accommodate. Thus, most states operate dedicated "forensic" facilities for defendants found to be incompetent to proceed, nonresponsible for crime, or in need of psychiatric treatment after conviction (see standard 7-1.1(e)). In

[2] Addington v. Texas, 441 U.S. 418 (1979).
[3] Gary Melton et al., Psychological Evaluations for the Courts: A Handbook for Mental Health Professionals and Lawyers, 335-328 (4th . ed. 2017) (summarizing statutes).
[4] 463 U.S. 354 (1983).
[5] Id at 364-368.

line with this practice, this standard authorizes the use of these facilities for individuals committed after a verdict of mental nonresponsibility. At the same time, as provided in standard 7-7.6, placement of such individuals must be in the least restrictive environment; thus, placement in a civil (non-forensic) facility may be clinically appropriate for some nonresponsibility acquittees.

Paragraph (b) provides that if a person who has been acquitted by reason of mental nonresponsibility is not committed, or such commitment is not sought by the prosecution, he or she should be released. This is another way of saying that detention for purposes other than post-acquittal evaluation, without a hearing to determine committability, is not permitted. While standard 7-7.3 below allows detention for the short period of time needed to evaluate whether commitment criteria are met, the present standard is meant to ban the indefinite automatic commitment that at one time occurred in a number of states.[6] One could try to justify the latter type of automatic commitment by relying on the reasoning found in *Jones*; as noted above, that decision justified a period of commitment without a hearing on the ground that, because an acquittal on a criminal charge by reason of nonresponsibility implies both mental disorder and dangerousness, an acquittee presumptively meets the commitment criteria. However, a nonresponsibility finding only relates to mental state at the time of the offense, and in any event cannot occur unless the individual is competent to proceed; thus, the individual may have few if any symptoms of mental disorder at the time a verdict is reached. Moreover, as in *Jones* itself (where the crime charged involved theft of a jacket), the criminal act may not be probative of a significant risk; even a serious charge does not necessarily indicate the individual poses such a risk.[7] Accordingly, prolonged detention without any post-trial showing of mental disorder and dangerousness authorizing commitment is not justifiable. In *Jones* itself, while the Court did permit automatic commitment, it also emphasized that, under the statute in question, that commitment was of limited duration and designed to permit evaluation of the acquittee.[8]

Paragraph (c) is definitional. In some states, decisions to recommend commitment, authorized leave (as under standard 7-7.11), or conditional release (under standard 7-7.12) rest with the facility's director. In other states, such recommendations may be made by an administrative board or by a statewide forensic director. Paragraph (c) makes clear that provisions in this part referring to the authority of a facility director to make such decisions apply to these other entities in those states that have established

[6] Bruce Sales et al., Disabled Persons and the Law: State Legislative Issues 709-713 (1982) (chart of state statutes).
[7] See Note, Commitment and Release of Persons Found Not Guilty by Reason of Insanity: A Georgia Perspective, 15 Ga. L. Rev. 1065, 1079 (1981) (reporting a study finding that recidivism and the seriousness of the charge against insanity acquittee are not correlated).
[8] *Jones*, 463 U.S. at 366 ("Because a hearing is provided within 50 days of the commitment, there is assurance that every acquittee has prompt opportunity to obtain release if he has recovered.").

them. It should also be noted that in some states (e.g., Oregon and Connecticut), the *ultimate* decisionmaker about disposition, which is most states is a judge, is instead an administrative psychiatric security review board (in Oregon, consisting of mental health professionals with experience in the criminal justice system, an experienced criminal practice attorney, an experienced parole or probation officer, and a member of the general public).[9] These Standards take no position on the advisability of supplanting the court's authority in these cases with that of an administrative board. In states with such a board, however, the standards in Part V describing the responsibility of a court for making decisions concerning the commitment or release of a mental nonresponsibility acquittee should be read to apply to the board.

Standard 7-7.2. Commitment procedures; special and general

(a) Each state should adopt a separate set of special procedures ("special commitment") for seeking the civil commitment of those acquittees who were acquitted by reason of mental nonresponsibility of offenses involving acts causing, threatening, or creating a substantial risk of death or serious bodily harm. These procedures should include the dispositional option of conditional release, consistent with Standard 7-7.12.

(b) States may seek the civil commitment of mental nonresponsibility [insanity] acquittees who were acquitted of offenses that did not involve acts causing, threatening, or creating a substantial risk of death or serious bodily harm only by using those procedures used for the general civil commitment (commitment of persons outside the criminal justice system).

Commentary

Standard 7-7.2 calls for states to adopt special procedures for the commitment of defendants who are acquitted by reason of mental nonresponsibility on offenses involving bodily harm. Individuals acquitted on other charges are to be handled through ordinary civil commitment process.

The Need for Special Commitment Procedures

Designing a system for the commitment of mental nonresponsibility acquittees poses difficult choices. The special commitment procedures recommended in this standard represent a measured approach to the issue. They do not differ radically from general commitment under the law of most jurisdictions. Nevertheless, the differences are substantial enough that they require justification.

[9] Conn. Gen Stat § 17a-581; Or. Rev. Stat. §§ 161.327-161.336.

The justifications given in *Jones* for these differences (i.e., that a finding of insanity allows mental disorder and dangerousness to be presumed) are insufficient, for reasons explained in the commentary to standard 7-7.1. However, there are at least two other justifications for a special commitment process targeted at persons acquitted by reason of mental nonresponsibility. First, it is undisputed that the public feels threatened by the potential release of these individuals. Although some of that fear is undoubtedly exaggerated, agencies responsible for protecting the public must be able to monitor the location and condition of dangerous acquittees. Traditional civil commitment is unlikely to meet that need. Increasingly, general commitment statutes are structured to promote the release of patients as swiftly as possible. This objective is accomplished, among other means, through frequent periodic review and discretionary, liberal release procedures. Though these provisions are appropriate and arguably constitutionally mandated for patients who are not involved in the criminal process or who pose relatively little risk of violence to others, they are unlikely to provide sufficient protection from individuals whose commitment was precipitated by behavior causing, threatening, or creating a substantial risk of death or serious harm to another.

A second justification for adopting special procedures for acquittees is the beneficial impact they have on other parts of the system. Most importantly, they protect the current civil commitment system by separating civil and criminal cases. In a unitary commitment regime, by contrast, reforms that are desirable for the vast majority of civil patients would likely be jeopardized by the public's fear of the small minority of individuals who are violent acquittees.[10] A special commitment system for acquittees could also promote more accurate decisions about mental nonresponsibility [insanity]. If juries know (as they could be instructed under standard 7-6.8) that upon acquittal a defendant found nonresponsible is subject to procedures designed to prevent inappropriate release into the community, they might be less hesitant to return such verdicts.

Scope of Special Commitment

Although *Jones* and the foregoing policy concerns give jurisdictions latitude to devise standards and procedures for committing mental nonresponsibility acquittees that differ from those governing ordinary civil commitment, the standards in this part reflect the view that jurisdictions wishing to do so should proceed with caution. Even if wholesale departures from general commitment practices do not violate equal protection mandates, public policy considerations require that any such deviations be supported by identifiable differences between the classes of general commitment patients and special

[10] See Robert A. Burt, Of Mad Dogs and Scientists: The Perils of the "Criminal-Insane," 123 U. Pa L. Rev. 258, 292 (1974).

commitment acquittees. Further, while the disparity between people subject to general commitment and mental nonresponsibility acquittees is both real and relevant, it should not be exaggerated. General commitment usually covers persons who present some risk of harm to themselves or others. Some of the latter individuals have manifested their potential for harm through earlier violent behavior. The key difference is that rarely will the civil committee's behavior have been proven beyond a reasonable doubt, as is recommended in standard 7-7.4(b)(i) as a prerequisite to special commitment procedures.

In light of these considerations, paragraph (a) makes clear that special commitment procedures should govern only cases involving acquittees who were charged with acts causing, threatening, or creating a substantial risk of death or serious harm. The procedures outlined in the subsequent standards in this part recognize the substantial public apprehension about premature release of violent acquittees and address it through modified periodic review and discharge procedures designed to protect against ill-considered or inadvertent release. In contrast, paragraph (b) assumes that acquittees in nonviolent criminal prosecutions are sufficiently similar in relevant characteristics to general commitment patients that the same procedures for commitment and periodic review hearings and release are appropriate for both.

Standard 7-7.3. Evaluation

(a) After issuance of a verdict of not guilty by reason of mental nonresponsibility in cases governed by 7-7.2(a), the trial court, upon motion by the prosecution, should order an evaluation of whether the acquittee meets the commitment criteria set out in Standard 7-7.4(b). The time allotted for evaluation should not exceed [thirty] calendar days except, when for good cause shown, the court extends the period for up to an additional [thirty] calendar days. This evaluation is for the sole purpose of assisting the court in determining whether the acquittee should be committed.

(b) The court may order that the evaluation be conducted while the mental nonresponsibility acquittee is in the community, in a correctional facility, or in a mental health facility. In choosing the location of the evaluation, the court should be guided by the least restrictive alternative principle and concern for public safety. The evaluation should be conducted by mental health professionals possessing the qualifications required by Standard 7-3.9.

(c) During the evaluation process, mental nonresponsibility acquittees should have the same rights regarding treatment as do persons subject to general civil commitment stem, consistent with the requirements of institutional and public safety.

(d) The evaluation should be completed and an evaluation report should be submitted to the court and to all parties within the time allotted for the evaluation under (a). Upon submission of the evaluation report the prosecuting attorney may move for a commitment hearing. If the prosecuting attorney decides to seek commitment, a motion for a hearing must be filed within [five] days. That hearing must be held within [fifteen] days from the court's receipt of the evaluation report.

(e) If the prosecuting attorney does not file a timely motion seeking commitment, an acquittee in custody should be released.

Commentary

Although the reasoning in *Jones v. United States* does not justify automatic long-term commitment based solely on the verdict, it does justify a mandatory evaluation of an acquittee's current mental condition. An acquittal verdict on mental nonresponsibility grounds not only signals that the acquittee has experienced serious mental difficulties but also should, as provided in standard 7-6.10, contain a finding that a defendant committed the act on which criminal charges rested; those findings, coupled with concern for public safety, warrant an investigation into the appropriateness of commitment. Such an evaluation is indispensable to ensuing civil commitment hearings because a commitment court will need current information about mental disorder and risk that likely was not relevant, and therefore not considered, at the adjudication stage.

Paragraph (a) of the standard recommends that an evaluation order be initiated by a prosecution motion. A trial court should not have discretion on its own either to order an evaluation or to release an acquittee without input from the prosecution. It is likely that an evaluation routinely will be authorized unless it is so clear an acquittee is not currently committable that the prosecution sees no reason for an evaluation.

The duration of a post-acquittal evaluation is a matter on which legislatures and courts have disagreed. Paragraph (a) suggests thirty days. This period substantially exceeds the time generally allowed for evaluation in the civil commitment setting. Further, given the evidence adduced at adjudication, there is likely to be more information about an acquittee than about a person subjected to civil commitment. At the same time, as noted above, additional inquiry about present mental disorder and risk will also be necessary. Moreover, acquittees may pose a greater danger to public safety than respondents in civil commitment proceedings and thus may demand a more thorough examination, requiring an extended period of time. Thirty days should normally be sufficient for this purpose at the same time it ensures that the evaluation

period does not serve as a partial surrogate for the punishment an acquittee has escaped by virtue of a nonreponsibility verdict.

Paragraph (b) provides that the evaluation be performed by mental health professionals possessing the educational, clinical, and forensic knowledge required under the provisions of standard 7-3.9. It also dictates that the choice of location for the evaluation be guided by the least restrictive alternative principle; evaluations should only take place in state hospitals if necessary in light of public safety concerns. Likewise, paragraph (c) adopts the premise that mental nonresponsibility acquittees undergoing evaluation should enjoy the same rights to receive or to refuse treatment services as persons awaiting general civil commitment proceedings, again consistent with institutional and public safety concerns. The traditional rule in the civil setting permitting forcible medication only when serious danger to others or self is imminent would thus apply in this setting. Unlike in the competence restoration setting (see standard 7-4.11), there is no overriding government interest in forcing medication on an individual beyond what is necessary to ensure a safe environment.

After an evaluation report has been submitted, paragraph (d) provides that a commitment hearing should be conducted, if requested by the prosecutor. Setting time limits for such a hearing is a matter of some delicacy. The prosecution must be given adequate time to read the report and consider whether to seek the acquittee's commitment. If the interval between the submission of a report and the convening of a hearing is insufficient to allow proper deliberation and preparation, unnecessary hearings may be held in some cases, counsel on both sides may be poorly prepared for the hearing, and an acquittee whose symptoms are active and whose violence potential is substantial could be released through inadvertence. All this, however, must be weighed against an individual's right to a prompt adjudication. The standard strikes a balance by recommending a period of five days within which the prosecution might move for a hearing and a limit of fifteen days within which a hearing should be held. If the prosecution does not move for a hearing within the time prescribed, paragraph (e) calls for release of the acquittee.

Standard 7-7.4. Special procedures; commitment criteria

(a) Special commitment procedures for mental nonresponsibility acquittees acquitted of offenses involving acts causing or creating a substantial risk of death or threatening serious bodily harm should afford acquittees the right to a commitment hearing which meets the requirements set forth in Standard 7-7.5

(b) At the conclusion of the commitment hearing, the court may order the acquittee committed if it finds:

(i) beyond a reasonable doubt that the acquittee committed the criminal act for which he or she was acquitted by reason of mental nonresponsibility [insanity], unless the trier of fact made such a finding at the acquittee's criminal trial, as provided in Standard 7-6.10(a), and

(ii) by a preponderance of the evidence that, due to mental disorder of the type described in Standard 7-6-1(b), 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.

(c) Commitment should result in confinement in a forensic mental health facility unless the acquittee proves by a preponderance of the evidence that conditions imposed pursuant to Standard 7-7.12 will provide adequate protection of the community.

Commentary

Standard 7-7.4 lays out the criteria that apply at the initial commitment proceeding for mental nonresponsibility acquittees. Paragraph (a) reiterates that these criteria apply only to commitment of those who were charged with crimes involving serious bodily harm. Paragraphs (b) and (c) specify several criteria that must be met with respect to the criminal act that led to the charges, the risk posed by the acquittee and the locus of commitment if it occurs.

The Criminal Act

Subparagraph (b)(i) requires that the criminal actus reus be established beyond a reasonable doubt, either at the criminal trial (as provided in standard 7-6.10(a)), or at a subsequent commitment hearing. Special commitment procedures are acceptable as a matter of constitutional law and public policy only if they rest on a clear finding that the precipitating act occurred.[11] Such a finding also is highly relevant to a determination under subparagraph (b)(ii) regarding an acquittee's risk of bodily harm to others.

Mental Disorder and Risk Criteria

[11] Note, however, that other elements of the crime need not be proven.

Subparagraph (b)(ii) requires that the court find by a preponderance of the evidence that, due to a mental disorder that qualifies for a mental nonresponsibility defense (as defined in standard 7-6.1(b)), the acquittee is at risk for causing a substantial risk of bodily harm to others in the foreseeable future if commitment does not occur. These commitment criteria approximate one of the grounds for commitment now found in most state statutes for the general commitment of persons with a mental disorder.[12] However, there are also several differences between this standard and the typical general commitment standard.

First, the standard makes clear that the mental disorder required for commitment must be a serious one, specifically a disorder that can form the predicate for a nonresponsibility defense. Note that the standard does not require that the acquittee's mental disorder for purposes of commitment be the *identical* disorder diagnosed as the basis for the defendant's nonresponsibility defense, only that it be of the type that could provide such a basis under standard 7-6.1(b). This language reflects the fact that the diagnosis of major mental disorders is not always precise; for instance, what may have appeared to be schizophrenia during an acquittee's initial, pretrial evaluation may subsequently present more reliably as bipolar disorder. Both of these disorders can feature symptoms of psychosis, potentially rendering an individual unable to appreciate the wrongfulness of his or her behavior. Thus, either may qualify as the basis for a mental nonresponsibility defense, and, under standard 7-7.4(b)(ii), either may qualify for the individual's commitment upon acquittal.

The standard also emphasizes that the threat posed by the acquittee must be attributable to this mental disorder, not just co-exist with it, a stipulation that is consistent with the U.S. Supreme Court's opinion in *Foucha v. Louisiana*,[13] which held that dangerousness alone does not justify preventive confinement.[14] This is an important limitation, since dangerousness is often not associated with serious mental disorder. For instance, many committed acquittees are diagnosed with both schizophrenia and antisocial personality disorder. The latter diagnosis would usually not qualify as a disorder that supports a mental nonresponsibility defense under standard 7-6.1(b), given that standard's exclusion of disorders "manifested primarily by repeated criminal conduct."[15] In such a case, if the schizophrenia is successfully treated and

[12] See Melton et al., supra 3, at 337.
[13] 504 U.S. 71 (1992) (holding that there must be proof of both mental disorder and dangerousness to continue commitment of a person found mentally nonresponsible).
[14] Id. at 82-83.
[15] See Am. Psychiat. Assoc'n, Diagnostic and Statistical Manual—Text Revised 748 (5th ed. 2022) (requiring for antisocial personality disorder three of the following symptoms: "failure to conform to social norms;" "deceitfulness," "impulsiveness;" "aggressiveness"; "reckless disregard for safety of self or others"; "consistent irresponsibility"; "lack of remorse [for] having hurt, mistreated or stolen from another.").

continued hospitalization is not needed to ensure continued remission (see subparagraph (c)(i)), commitment could not occur under this provision. The Supreme Court required a similar outcome in *Foucha*, where the acquittee's drug-induced psychosis, the basis for his defense, was successfully treated once he was hospitalized; the fact that he was still considered dangerous did not justify further commitment, because that risk was attributable to his antisocial personality disorder, which the Court assumed did not meet the definition of mental disorder for commitment purposes.[16]

A third difference between the standard in subparagraph (b)(ii) and the typical general commitment statute is that this standard does not define the immediacy of the risk an acquittee must present due to a mental disorder. The usual civil commitment statutes requires that the risk be "imminent," in recognition of two concerns about long-range predictions. The first concern is that the reliability of assessments of violence risk lessens the more remote the event predicted; traits and circumstances relevant to risk can change drastically over time.[17] In addition, the justification for depriving acquittees of liberty weakens if the predicate is an event which, if it occurs at all, does not occur until far in the future. At the same time, a requirement of imminent danger would seldom result in commitment of acquittees, given the intervening treatment since the crime; the resulting early releases would increase hostility toward the mental nonresponsibility defense and make its success less likely. The position articulated in paragraph (b)(ii) reflects these considerations, striking a balance requiring that commitment be based on a finding of substantial risk (of bodily harm to others) within the "foreseeable future."

A final difference between this standard and the typical commitment criteria is found in subparagraph (b)(iii), which addresses what might be described as "treatment-contingent noncommittability." Committing courts should not ignore the possibility that acquittees will cease taking medication or participating in other forms of treatment once released from commitment and thus suffer a deterioration in their mental condition and possibly raise their risk for violence. Accordingly, this standard recommends that if a court finds that an acquittee does not meet commitment criteria because of the effect of treatment being received, the court may deny release, unless the acquittee proves, by a preponderance of the evidence, that he or she will continue to receive such treatment following release for as long as the treatment is required.

Locus of Commitment

[16] 504 U.S. at 82 (assuming that antisocial personality disorder is not a mental disorder justifying criminal commitment, and strongly suggesting it would be unconstitutional "to hold indefinitely any other insanity acquittee not mentally ill who could be shown to have a personality disorder that may lead to criminal conduct.").

[17] See, e.g., James V. Ray & Shayne Jones, Aging Out of Crime and Personality Development: A Review of Research Examining the Role of Impulsiveness on Offending in Middle and Late Adulthood, 16 Psychol. Res. Behav. Manag. 1587 (2023).

Historically, defendants committed following acquittal by reason of mental nonresponsibility have been placed in inpatient facilities. In the last few decades, however, a majority of the states have enacted statutes allowing for an alternative commitment: conditional release to services in the community.[18] Standard 7-7.12 describes the circumstances of conditional release in some detail. Paragraph (c) of this standard allows for conditional release consistent with standard 7-7.12, but only if the acquittee proves, by a preponderance of the evidence, that the conditions imposed will provide adequate protection of the community. Otherwise, paragraph (c) calls for the acquittee's confinement in a forensic mental health facility.

Burden and Standard of Proof

As noted above, subparagraph (b)(i) requires that the actus reus for the crime have been proven beyond a reasonable doubt at trial before special commitment procedures apply. However, it assigns no burden of proof with respect to the primary commitment question: whether the acquittee, because of a mental disorder, is at risk for causing a substantial risk of bodily harm to others in the foreseeable future if not committed. Instead, it states that the court, after hearing the evidence presented, should decide whether the acquittee's committability is established under subparagraph (b)(ii) by a preponderance of the evidence. Although ordinary civil commitment criteria must be proven by clear and convincing evidence,[19] *Jones* held that the preponderance standard suffices in the acquittee commitment setting;[20] this standard endorses this stance, albeit because of the safety concerns identified earlier, not for the reasons given in *Jones* (which allowed a lower standard because of findings at trial). If the court finds the acquittee does not meet the commitment criteria, but that this failure is due to the effect of treatment being received then, as noted above, under subparagraph (b)(iii) the burden falls on the acquittee to prove by a preponderance that he or she will comply with treatment and thus be eligible for release. With respect to placement, paragraph (c) calls for inpatient confinement unless the acquittee proves by a preponderance that the conditions imposed will provide adequate protection of the community.

Standard 7-7.5. Special commitment hearings

(a) A special commitment system for mental nonresponsibility acquittees should provide the procedural protections described in this Standard.

[18] W. Lawrence Fitch, White Paper for NASMHPD: Forensic Mental Health Services in the United States 20-21 (2014) (survey of 45 states showing hundreds of acquittees are on conditional release each year).
[19] Addington v. Texas, 441 U.S. 418, 426-427 (1979).
[20] 463 U.S. at 367.

(b) The acquittee should be represented by counsel at the commitment hearing and is entitled to assistance of counsel during this period. If the acquittee is without counsel, the court should appoint counsel. If the acquittee is unable to afford counsel, the cost should be borne by the state. Representation by counsel cannot be waived except as provided in Standard 7-5.3.

(c) At the hearing, the acquittee is entitled to confront and cross-examine adverse witnesses. The acquittee is also entitled to present witnesses, including an independent expert witness or expert witnesses. For financially eligible acquittees, the reasonable cost of expert witnesses should be borne by the state.

(d) At the hearing, the rules of evidence should apply.

(e) An acquittee's refusal to participate in an evaluation under Standard 7-7.3 may be taken into account by the court in determining whether commitment criteria are met.

(f) The acquittee should have the right to appeal on the record an adverse ruling on the issue of commitment. The appeal should be heard on an expedited basis.

Commentary

Standard 7-7.5 outlines the procedural requirements at commitment hearings and, as standard 7-7.8(b) will make clear, at periodic review hearings as well. This standard's procedural protections, which paragraph (a) recommends be instituted in all jurisdictions, mimic those found in modern civil commitment statutes.[21] There appears to be no persuasive argument for withholding from acquittees the procedures generally afforded to civil commitment patients. For instance, the role of counsel is of paramount importance in cases involving persons with mental disorders, as the symptoms of these disorders often make self-representation infeasible. Thus, paragraph (b) requires representation by counsel, unless waived pursuant to standard 7-5.3. If an acquittee is without counsel, counsel should be appointed, at state expense if the acquittee is financially eligible. Paragraph (c) confirms the right of acquittees to attend hearings and to confront and cross-examine witnesses testifying in support of commitment. Although the Sixth Amendment right of confrontation only applies to criminal prosecutions, the due process clause mandates the same protections where deprivations of liberty are concerned.[22] Expert witnesses are especially important in special commitment

[21] See Melton et al., supra 3, at 343-346.

[22] Cf. Application of Gault, 387 U.S. 1, 30, 42-43 (1967) (holding, in the juvenile delinquency setting, that because of the potential deprivation of liberty "the hearing must measure up to the essentials of due process and fair treatment," including the right of confrontation and cross-examination).

proceedings. Consequently, this provision confirms the right of acquittees to present independent expert witnesses, at government expense if respondents are financially unable.[23] Further, paragraph (d) embodies a policy that the rules of evidence applicable to civil proceedings should govern special commitment hearings. Thus, rules governing the qualifications and form of expert testimony (see standards 7-3.8 and 7-3.9) and the admissibility of hearsay (see standard 7-3.11) apply here.

The standard does not apply all rules of criminal procedure to the special commitment context, however. Paragraph (e) allows the court to take into account any refusal by the defendant to participate in an evaluation to determine committability, a finding that will typically be to the detriment of the defendant. Because this is a commitment hearing, not a criminal adjudication, the Fifth Amendment does not apply.[24] Moreover, this provision is consistent with the rules of civil procedure, which generally allow parties to be examined by their opponents when mental or physical capacity is crucial to the case.[25] Most importantly, without the defendant's cooperation, an adequate evaluation may not be possible and efforts to fairly and reliably determine the acquittee's committability frustrated.

An order for special commitment is a final judicial order that in most if not all jurisdictions will be appealable of right like other civil judgments. Paragraph (f) affirms the acquittee's right to an appeal on the record. If an acquittee appeals, the paragraph further calls for an expedited review. The standard does not address whether the government may appeal an adverse ruling releasing the acquittee.

Standard 7-7.6. Special commitment; conditions of confinement

Consistent with the requirements of institutional and public safety, persons committed to a mental health facility pursuant to special commitment statutes should be confined under comparable conditions and with the same rights of persons committed under general commitment statutes. Placement should be in the least restrictive treatment environment, which can include a civil hospital.

Commentary

Historically, persons acquitted by reason of mental nonresponsibility routinely were confined in special state forensic mental health facilities. Many of these facilities

[23] Cf. In re Gannon, 301 A.2d 493, 494 (N.J. 1973) (holding that due process guarantees the right to a state-paid independent expert at civil commitment proceedings); Ake v. Oklahoma, 470 U.S. 68, 83-84 (1985) (holding that due process requires the state to fund an expert witness for the defense when dangerousness is an issue at capital sentencing proceedings).
[24] Allen v. Illinois, 478 U.S. 364 (1986) (finding that the right to remain silent does not apply in sexually violent predator proceedings).
[25] See Fed. R. Civ. Pro. 35(a).

were maximum security. Most states today continue to operate secure forensic facilities, but not all of their forensic patients are placed there. Indeed, in many states, forensic patients, including those committed after a mental nonresponsibility acquittal, are more likely to be housed in civil mental health facilities than in forensic units.[26]

Taking public and institutional safety concerns into consideration, standard 7-7.6 provides that specially committed acquittees should be confined under comparable conditions and with the same rights as persons committed under general civil commitment statutes. Placement should be in the least restrictive environment, consistent with institutional security and public safety. Of course, some committed acquittees present special security problems, particularly at the time of their admission. These patients may require placement under conditions that are more restrictive than those experienced by other committed persons. However, as many states have recognized, placement in a civil facility rather than one dedicated to the treatment of forensic patients is quite feasible for many acquittees, whether it occurs initially or after a period of treatment in a forensic facility. Individual attributes, not commitment status, should govern the imposition of especially restrictive conditions of confinement.

Standard 7-7.7. Special commitment; maximum duration of commitment order

(a) When, pursuant to Standard 7-7.4, a court hospitalizes or conditionally releases a mental nonresponsibility acquittee, it should also issue an order setting the maximum duration of the acquittee's special commitment. The maximum duration set by the court should not exceed the maximum term of incarceration provided by law for the most serious count in the indictment or information had the acquittee been found responsible for the crime charged. Upon the expiration of the maximum duration of special commitment, the criminal court's jurisdiction over the acquittee should cease, and any confinement or conditional release of the acquittee ordered by such court should terminate.

(b) In setting the maximum duration for special commitment, as in other commitment proceedings under this chapter, the court should consider the acquittee's need for treatment and its concerns for the public's safety, but it may not consider retribution or punitive factors.

Commentary

In *Jones*, the Supreme Court held that mental nonresponsibility acquittees can be subject to special commitment procedure indefinitely, on the ground that their

[26] Fitch, supra note 18, at 12.

disposition should be based on mental disorder and dangerousness, not criminal punishment.[27] In contrast, paragraph (a) calls upon committing courts to establish an outer time limit for each specially committed acquittee, beyond which special commitment may not extend. It also provides that this maximum period applies both to inpatient commitment and to any conditional release period. Most importantly, the standard recommends that this limit be set at the hypothetical maximum prison or jail sentences that acquittees could have received had they been convicted. To permit longer terms of special commitment, as the Supreme Court authorized in *Jones*, creates the temptation to abuse amorphous dangerousness standards and relaxed commitment criteria to ensure indefinite and perhaps lifelong detention. This standard instead provides that, after the hypothetical maximum sentence of imprisonment is reached, acquittees may be detained only through regular civil commitment proceedings.

In determining the maximum commitment period required by paragraph (a), courts should keep in mind the possibility of prosecutorial overcharging; on occasion, prosecuting attorneys might be tempted, in cases in which a successful assertion of the mental nonresponsibility defense is a realistic possibility, to levy a more serious crime than otherwise would be likely, simply to increase the hypothetical sentence and thus extend the period during which the defendant, if acquitted, could be specially committed. Thus, paragraph (a) merely states that the special commitment period should "not exceed" the maximum sentence associated with the "most serious count in the indictment or information." This language does not require that the most serious charge in the charging document dictate its duration.

Linking the duration of special commitment procedures to the hypothetical criminal sentence, as paragraph (a) does, might create the impression that acquittees are being sanctioned commensurate with the punishment they would have received if convicted. The standard explicitly addresses this concern in paragraph (b), which condemns judicial consideration of retributive or punitive criteria in assessing the maximum duration of special commitment. In addition, of course, as provided in standard 7-7.8, if at any time a defendant no longer meets the criteria in standard 7-7.4(b)(ii) or (iii), release must occur.

Standard 7-7.8. Special commitment; periodic review

(a) A specially committed acquittee may petition for a judicial hearing to determine whether the acquittee continues to meet the criteria for special commitment set forth in Standard 7-7.4. The acquittee may petition the court for such a hearing [six months] after the acquittee's original special commitment, and every [year] thereafter. At the original commitment hearing, or at subsequent

[27] *Jones*, 463 U.S. at 368-369.

periodic review hearings under this Standard, the court may issue an order allowing the acquittee to petition for a rehearing sooner than the mandatory period stated herein. The court should issue such an order when it appears that the acquittee's mental condition and other relevant factors warrant a shorter interval between periodic review hearings.

(b) Upon filing of a petition for a review hearing the court should convene a hearing within [thirty] days, which should be conducted in accordance with the procedures set forth in Standard 7-7.5.

(i) At any hearing held within one year of the acquittee's original special commitment, commitment may continue if the criteria in Standard 7-7.4(b)(ii) or (iii) are met.

(ii) At any hearing held a year or more after the original special commitment, commitment may continue if the state proves by clear and convincing evidence that the acquittee meets the criteria in Standard 7-7.4(b)(ii) or (iii).

(iii) If commitment is continued under either (b)(i) or (b)(ii), but the criteria in Standard 7-7.4(c) governing conditional release are met, the acquittee should be placed on conditional release.

(c) Legal assistance should be regularly available to all specially committed acquittees at the location of their confinement. To ensure that each acquittee's right to periodic review as set forth in paragraph (a) of this Standard is effective, each acquittee should have ready access to counsel, including appointed counsel. When the acquittee is entitled to periodic review, counsel should request a hearing on the acquittee's continuing need for commitment or should notify the court in writing that counsel has conferred with the acquittee and that a hearing is not requested at that time. By declining to request a hearing when the acquittee is entitled to review, the acquittee does not waive the right to any subsequent hearing.

(d) Nothing in this Standard should be interpreted as limiting the right of a specially committed acquittee to petition for a writ of habeas corpus at any time.

Commentary

Standard 7-7.8 recognizes the importance of regular judicial review of special commitments of mental nonresponsibility acquittees. Historically, acquittees were confined in forensic mental health facilities for very lengthy periods, often with no

judicial oversight. Even today, lengths of stay are grossly disproportionate to those for persons who are civilly committed. Persons committed under civil commitment laws spend an average of 7-14 days hospitalized before release.[28] Individuals committed after acquittal by reason of mental nonresponsibility remain hospitalized for far longer; some never leave the forensic unit.[29]

These lengthy commitments are often suspect. Most acquittees will be diagnosed with schizophrenia, bipolar disorder, or major depression.[30] These are disorders that generally respond favorably to treatment with psycho-active medications; most individuals see their symptoms improve markedly within days or weeks.[31] Furthermore, at the time of adjudication, all acquittees were competent to proceed. Therefore, by the time of the first judicial review of an acquittee's commitment, the serious symptoms that most likely influenced the acquittee's behavior at the time of the offense should be at least partially in remission. Of course, treatment of acquittees includes much more than medication management; the challenges of preparing for the release of a person acquitted of a violent crime on nonresponsibility grounds can be great, given the need to develop a treatment plan that both helps the individual and protects the community. Nonetheless, the vast disparity between lengths of stay for these patients and ordinary civil patients cannot be ignored.

Thus, in addition to the maximum term for special commitment required by the previous standard, the periodic review described in this standard is an important protective mechanism. Paragraph 7-7.8(a) provides for judicial review upon petition of the acquittee, which the standard recommends be allowed six months after the original commitment and annually thereafter. These review periods mirror provisions for review in many states' civil commitment statutes. Note, however, that the review is not automatic; it is triggered solely on a petition by the acquittee. Automatic review periods for individuals who require prolonged treatment and do not want a hearing waste judicial and treatment staff's resources. Further, acquittees may wish to delay their request for review until a time when their mental condition is stable and the likelihood is greater that facility evaluators will provide a favorable report.

Admittedly, acquittees may have difficulty exercising their right to seek review and thus remain confined longer than necessary. However, paragraph (a) allows the court to issue an order authorizing petitions when the acquittee's mental condition

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[28] Larry Fitch & Jeffrey Swanson, SAMSHA Report—Civil Commitment and the Mental Health Care Continuum: Historical Trends and Principles for Law and Practice 28 (2019), available at https://www.samhsa.gov/ebp-resource-center.
[29] See Melton, supra note 3, at 203-204.
[30] Id. at 233-235. Note that, in contrast, the symptoms of individuals found nonresponsible because of intellectual disability will usually persist throughout the person's life...
[31] Ofer Agid, Phillip Seeman & Shitij Kapur, The "Delayed Onset" of Antipsychotic Action — An Idea Whose Time has Come and Gone, 31 J. Psychiat. Neurosci. 93 (2006).

warrants, and facility directors may also petition for review at any time, under standard 7-7.9. Most importantly, paragraph (c) provides that legal assistance be available regularly for all specially committed acquittees, at the place they are confined. Additionally, it ensures that clients' interests are not ignored by requiring counsel to request periodic review hearings (when a client is eligible) or to notify the committing court in writing that they have conferred with their client and that the client has decided not to seek review. Paragraph (c) also makes clear that the declination does not waive the right to subsequent periodic review, or to seek habeas review, a point confirmed in paragraph (d).

Paragraph (b) requires that, upon receiving a petition, a hearing should take place within 30 days, and sets out the criteria governing the court's periodic review. Under subparagraph (b)(i), the commitment criteria for hearings conducted in the first year after initial commitment are identical to those in standard 7-7.4(b). After a year, however, subparagraph (b)(ii) provides that commitment may continue only if the state proves the acquittee's committability by clear and convincing evidence. Further, subparagraph (b)(iii) provides that, as at the initial commitment hearing, if the acquittee is able to prove by a preponderance of the evidence that conditions imposed pursuant to standard 7-7.12 will provide adequate protection of the community, the court should place the acquittee on conditional release.[32] While *Jones* indicates that the burden may remain on the acquittee throughout commitment,[33] this standard's shifting of the burden to the state is justified by the likelihood—described above—that treatment has had an impact on both the acquittee's mental health and risk level by the end of a year. It also helps to dispel the notion that re-commitment should be automatic. Finally, the heightened proof requirement provides incentive for facility staff to target their services at community re-integration, in keeping with the mandate to serve this population in the least restrictive setting.

Standard 7-7.9. Special commitment; petition for acquittee's release

(a) When the director of the facility in which a specially committed acquittee is confined determines that substantial clinical evidence indicates that the acquittee meets the criteria for release without conditions or, pursuant to Standard 7-7.12, with conditions, the director should petition the court for the acquittee's release.

[32] Note further that standard 7-7.12(b) calls for the development of a conditional release plan before the first periodic review of a mental nonresponsibility acquittee's commitment, providing further incentive for facilities to engage in active release planning at the time of admission.
[33] 463 U.S. at 358 (refusing to invalidate a statute that placed the burden of disproving the commitment criteria on the acquittee by a preponderance of the evidence).

(b) The petitioner should have access to counsel for preparing and presenting the petition to the court.

(c) The petition should set forth the clinical findings supporting the conclusion in favor of release and should contain a summary of all pertinent clinical data.

(d) A hearing should be held no later than [fifteen] days after filing the petition and the acquittee should remain confined pending the hearing.

(e) Following the hearing the court should determine the matter pursuant to Standard 7-7.8(b).

(f) The acquittee should receive a copy of the petition and should have the right to be present at the hearing, to be represented by counsel, and to present evidence.

(g) The prosecuting attorney should receive a copy of the petition and should have the right to be present at the hearing and to present evidence.

Commentary

To facilitate the periodic review process described in the previous standard, paragraph (a) of the present standard permits the superintendent of a facility to file a petition with the court alleging that an acquittee either no longer meets the criteria for special commitment or meets criteria for conditional release. Paragraph (b) recommends that facility administrators have access to counsel for purposes of preparing and presenting the petition. Although the administrators of facilities that serve justice-involved individuals often have a good understanding of the legal system, few are attorneys; having access to counsel should ensure that petitions are properly prepared and presented at hearings. Paragraph (c) sets out requirements for the content of the petition, and paragraph (d) indicates when a hearing on the petition should take place (with a recommendation that it occur no later than 15 days after the petition is filed). Paragraph (e) makes clear that the court is to consider the same periodic review commitment criteria that apply when the acquittee petitions for periodic review under standard 7-7.8, and paragraphs (f) and (g) provide that the acquittee, acquittee's counsel and the prosecutor all are entitled to be present during and present evidence at the hearing.

In the civil commitment setting the staff of a residential facility can usually release a patient without consulting a judge. But the court proceedings mandated by this standard comport with the practice in virtually every jurisdiction that has a mental

nonresponsibility defense.[34] As noted through this part, a history of criminal conduct causing serious bodily harm, which is the distinguishing characteristic of the class of special acquittees in these Standards, justifies more restrictive release procedures than those that govern other committed persons. Judicial review of a superintendent's petition safeguards against premature release of patients presenting too great a risk to public safety. Moreover, a court determination that confinement is no longer necessary can provide "cover" for a facility administrator who believes an acquittee is ready for release but would be hesitant to act for fear of public reaction. Hence, a requirement of judicial approval of recommendations for release may be in the best interest of both the society and the acquittee.

Standard 7-7.10. Special commitment; notification of release

When the release or conditional release of a specially committed acquittee is imminent, the prosecuting attorney should have the authority to notify relevant individuals and agencies.

Commentary

Even with judicial approval, release of mental nonresponsiblity acquittees can be a concern for both officials and the public. This standard endorses a system that allows prosecuting attorneys to notify "relevant" individuals and agencies that release or conditional release of an acquittee is imminent. Appropriate recipients of notice might include persons with whom acquittees have been involved in the past, including victims of violence or threats of violence, law enforcement authorities responsible for crime prevention in the locale to which the acquittee will be released, and community representatives who have indicated concern that persons who have committed or threatened violent acts will be returned to the community.

The power to notify rests in the hands of prosecuting authorities and not with mental health professionals or facility administrators. It thus avoids the legal and ethical problems that may attend release of patient information by treating professionals (although these professionals may still disclose patient information to outpatient treatment facilities as part of a post-detention treatment plan under standard 7-7.12). Most states' laws similarly provide for the notice called for here, as an exception to confidentiality protections that otherwise might apply.[35]

Standard 7-7.11. Special commitment; authorized leave

[34] See, e.g., 18 U.S.C. § 4243(f); see generally, 1 Wharton's Criminal Law § 17.10 (16th ed. 2023).
[35] See, e..g, Ga. Code Ann. § 37-3-148(a); Tex. Crim. Pro. Art. 46C.003.

(a) Authorized leave means a temporary, finite absence from the facility without staff supervision that is part of a treatment program. Authorized leave for specially committed acquittees should be permitted only by an order from court.

(b) When the director of the facility concludes that a specially committed acquittee can be granted authorized leave without posing a danger to the community and that such leave would benefit the acquittee's treatment regimen, the director should provide notice of an intent to authorize the leave to the prosecutor and, if the acquittee is represented, to defense counsel. The notice should indicate the leave's specific conditions and include a summary of all pertinent clinical data. The prosecutor should have the right to challenge the leave authorization in court, which should determine whether the leave is consistent with public safety and whether any additional conditions should be imposed.

(c) If a specially committed acquittee violates any condition of an authorized leave order, or if the leave is no longer appropriate to the acquittee's treatment regimen or is no longer consistent with public safety, the leave may be terminated by the director or by the court.

Commentary

Standard 7-7.11 regulates authorized leave from an inpatient facility, which involves brief furloughs short of conditional release that do not involve supervision by facility staff. The practice exists so that inpatient units can prepare acquittees for transition to the community. It may involve participation in outpatient treatment, occupational therapy, or educational programs. For instance, an acquittee may need to participate in an outpatient program of care on a trial basis to determine suitability for longer term placement in the program as a condition of release.

Consistent with other standards in this part, paragraph (a) provides that authorized leave must be authorized by a court. Paragraph (b) provides that the director of the acquittee's facility should initiate the leave process by providing notice to the prosecutor and defense counsel (if the acquittee is represented) that indicates the director's intent to authorize the leave, describes the specific conditions of the proposed leave, and includes a summary of pertinent clinical data. The prosecutor may challenge the leave in court; no hearing is required, although the implication of paragraph (b) is that one could be held on the basis of a prosecutor's challenge. The court is then to determine whether the leave is consistent with public safety and whether additional conditions should be imposed. Paragraph (c) provides that either the facility director or the authorizing court may terminate the acquittee's leave if any condition is violated, the leave is no longer deemed appropriate for the acquittee's treatment regimen or the leave is no longer consistent with public safety.

Standard 7-7.12 Special commitment; conditional release

(a) Every state should establish procedures for the conditional release of acquittees who can be served in the community without undue risk to public safety. To facilitate conditional release, states should 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 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 24 hours per day, 7 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.

(b) Prior to the first periodic review provided for in Standard 7.8(a), for any person who is committed to a mental health facility, the facility, the CRP or both together should, in cooperation with local mental health providers, prepare a conditional release plan or explain in writing why release planning is not appropriate. The acquittee may also proffer a conditional release plan during any

special commitment or review hearing. Every conditional release plan should specify, at a minimum:

(i) Where the acquittee will reside;

(ii) The names and contact information for all providers who will serve the acquittee, the frequency of services, and the non-confidential nature of services;

(iii) The acquittee's daytime activities; and

(iv) The requirements for drug testing, if applicable.

(c) Conditional release plans should take effect only if approved by the court. Every conditional release order issued by the court should specify, at a minimum:

(i) A plan for services and other conditions of the acquittee's release;

(ii) The responsibilities of the CRP staff, consistent with section (a)(ii-iv) of this Standard; and

(iii) The duration of the order.

(d) If the CRP receives a report alleging that, or otherwise has reason to believe that, an acquittee has failed to comply with the conditions of release or otherwise no longer meets eligibility criteria for conditional release, it should immediately notify the prosecutor. In addition, if the CRP believes that the acquittee requires placement in an inpatient facility without delay, it should initiate proceedings for the acquittee's civil commitment under the jurisdiction's general civil commitment law.

(e) If a prosecutor receives a report under section (d) of this Standard, he or she may petition the court for revocation of the acquittee's conditional release and an order for placement of the acquittee in a facility pending a revocation hearing.

(f) If a court finds probable cause to believe that an acquittee on conditional release has failed to comply with the conditions of release or otherwise no longer meets eligibility criteria for conditional release, it should order the acquittee taken into custody, which can include removing the acquittee from a civil hospital to which he or she was committed under (d), and transported to the

originating mental health facility or such other facility as the state mental health authority designates pending a revocation hearing.

(g) If an acquittee on conditional release is placed in a facility under section (f) of this Standard, a court should conduct a hearing within 10 days of the acquittee's placement. The acquittee should be entitled to the procedural protections described in Standard 7-7.5.

(i) If, at the hearing, the prosecutor proves by clear and convincing evidence that the acquittee no longer meets eligibility requirements for conditional release, the court should revoke the conditional release. Non-compliance with conditions of release may serve as evidence that the acquittee is ineligible for conditional release, but non-compliance alone is not necessarily sufficient.

(ii) If the court finds that the acquittee, although ineligible for conditional release under the existing plan for services, would be eligible with modifications to the plan, it may order such modifications and impose such other conditions as it determines appropriate.

(iii) An acquittee whose conditional release is revoked shall not be precluded from petitioning for release under Standard 7-7.8 or from being released pursuant to Standard 7-7.9.

(h) Before the expiration of an acquittee's term of conditional release, the CRP should provide the court and the attorneys for the acquittee and the state with reports from providers serving the acquittee assessing the likelihood that the acquittee would continue to receive and comply with necessary services without a conditional release order. Upon the request of either attorney, or sua sponte, the court may order additional evaluations of the acquittee. If the prosecutor petitions for extension of the acquittee's conditional release term, the court should hold a hearing with the procedural protections described in Standard 7-7.5.

(i) If, at the hearing, the prosecutor proves, by clear and convincing evidence, that the acquittee is not likely to receive or comply with necessary services without a conditional release order, the court may extend the acquittee's conditional release, consistent with durational limits specified in Standard 7-7.7.

(ii) If the court finds that the acquittee is likely to continue to receive necessary services without a conditional release order in place, it should deny the prosecutor's petition for extension.

Commentary

As noted earlier in this part, historically persons committed after a verdict of mental nonresponsibility were placed in secure state psychiatric hospitals and often stayed for decades, sometimes for life. If they were released, their release was often unconditional. Beginning in the late 1970s, however, three states (Oregon, Connecticut, and Maryland) introduced programs for conditional release (hereafter, CR).[36] Acquittees who were conditionally released remained under the jurisdiction of the court (in Maryland) or an interagency review board with quasi-judicial authority (in Connecticut and Oregon). These authorities established the conditions of release and exercised authority to terminate CR and, if appropriate, rehospitalize an acquittee upon proof of a violation. With the option of CR, these states reasoned, acquittees could be released from hospital level of care to supervised services in the community, at little or no increased risk to public safety.

Today, thirty-one states have programs for CR.[37] Although designed primarily for the transition of forensic patients to services in the community (after a period of inpatient commitment), in some states CR is the initial placement after a nonresponsibility verdict. In at least two states, 40% or more of nonresponsibility acquittees are placed on CR immediately after the verdict,[38] and in these and other states there are often more acquittees on CR than in inpatient facilities.[39] Studies conducted in recent years show that re-offense rates for acquittees on conditional release are low—typically far lower than re-offense rates for offenders released from correctional facilities and, in some states, lower than crime rates for the general population.[40]

Standard 7-7.12 is patterned on CR laws and programs in several states, including Maryland and Virginia.[41] Experience in these states has shown that, although services for individuals on conditional release ordinarily may be provided by the same mental health providers who serve others in the community, some dedicated administrative program is necessary to assure that individuals involved in such programs comply with the terms of their orders and that any failure to comply is addressed promptly, either by modification of the individual's services plan or by proceedings to revoke the conditional release order. Paragraph (a) encourages states to establish such conditional release programs with sufficient staffing and resources to (i) assist facilities in developing conditional release plans for acquittees and orienting

[36] Fitch, supra note 18, at 20-21.
[37] Id. at 20.
[38] Id. at 20.
[39] Id. at 21.
[40] Michael A. Norko, Assessing Insanity Acquitee Recidivism in Connecticut, 34 Beh. Sci. & L. 423, 426-27 (2016) (surveying studies).
[41] See Va. Code Ann. § 19.2-182.7; Md. Code Crim. Proc. §§ 3-114-122.

community providers to their service responsibilities, (ii) monitor acquittees' compliance with conditions of release, (iii) notify authorities when an acquittee is non-compliant or otherwise in need of returning to a facility, and (iv) arrange and perform evaluations of whether individuals nearing the end of their CR term are ready for release without conditions.

In most psychiatric hospitals aftercare planning begins the day a patient is admitted. If the patient is a forensic resident, however, treatment planning may proceed without the expectation that release is imminent. Paragraph (b) calls for the development of a conditional release plan (CRP) within one year of the acquittee's commitment or, if such a plan is not prepared, a written explanation why release planning is not appropriate. The standard specifies the essential elements of every CRP, including housing (i.e., where the individual will live), contact information for all the individual's providers, information about the individual's daytime activities, and a statement that confidentiality cannot be guaranteed in connection with any of these services. The standard also contemplates that acquittees should be involved in development of the CRP and states that they may even propose a plan for consideration by the staff.

Paragraph (c) makes clear that, although CRPs are developed by treatment providers and (perhaps) acquittees, they take effect only when approved by the court or other legal authority. It also describes the minimum contents of the CRP. Of particular note is the requirement that the order indicate the duration of the program. The duration might be indefinite (e.g., "until such time as the court determines the individual can be safely released into the community without supervision"), but ideally would be stated in terms of months or years; in no event should CR be longer than the maximum term limit required by standard 7-7.7(a).

Paragraphs (d) through (g) set out procedures for revocation of conditional release and re-hospitalization if necessary. In some respects, these procedures resemble procedures for the revocation of an offender's probation or parole; an alleged violation of release conditions authorizes taking the individual into custody pending a hearing to determine whether and what type of violations occurred. Note, however, that under paragraph (g) non-compliance with conditions of release does not necessarily require re-institutionalization; if the acquittee still meets criteria for conditional release (perhaps with modifications in the CRP), the conditional release may be extended.

Paragraph (h) provides for termination or extension of an acquittee's term of conditional release. The essential question, about which the court is authorized to obtain evaluations, is whether the acquittee is ready, able, and willing to manage his or her own treatment, without further oversight. The standard provides that conditional release may be extended beyond its court-ordered term only if the prosecution proves by clear and

convincing evidence that the acquittee is not likely to receive or comply with necessary services without a conditional release order in place. Again, if an extension is ordered, it should not last beyond the maximum term specified under standard 7-7(a).

PART VIII. SENTENCING AND POST-CONVICTION IN NON-CAPITAL CASES

INTRODUCTION

Part VIII deals with people with mental disorders who have been convicted of a non-capital offense and are subject to sentencing. It describes the appropriate standards and procedures for obtaining emergency treatment of defendants awaiting sentencing, stresses the need for presentence investigation reports to address defendants' mental health, and recognizes the important role mental health experts can play if a defendant's mental condition is likely to be a significant factor at sentencing. It also points to ways in which mental disorder can diminish culpability, and recognizes that probation, with treatment, may be particularly appropriate for many defendants with mental disorders. At the same time, it cautions against the misuse of pretrial mental health evaluation results at sentencing, given their potential to include irrelevant and prejudicial information. Finally, it addresses concerns about the defendant's competence to proceed at sentencing and appeal.

Standard 7-8.1. Emergency Treatment

If after conviction but prior to sentencing an offender requires emergency treatment, the criteria and procedures of Standard 7-10.3(c) should be followed.

Commentary

This standard—which like all but the last standard in this part—applies only to offenders who are in the process of being sentenced, cross-references standard 7-10.3(c) in Part X, which deals with offenders who have *already* been sentenced. For reasons explained in the associated commentary, the latter standard provides that any sentenced offender confined in a correctional facility who, in the opinion of a mental health professional at the facility, requires immediate transfer to a mental health facility because of a serious and immediate risk to the safety of the individual or others may be so transferred upon the order of the correctional facility's chief executive. It also indicates that a hearing aimed at determining whether the transfer was appropriate must be held within 48 hours. The criteria and procedures for emergency transfer are identical here because the interests of an offender who has been convicted, and of the facility in which the offender is confined, are the same whether the offender has already been sentenced or is awaiting sentence.

Standard 7-8.2 Contents of Presentence Report

Consistent with Standard 18-5.4 in the Sentencing Standards, in cases involving an offender with a mental disorder, a presentence report should be prepared. The report should include:

(a) A summary of the offender's current mental health condition and current and past treatment;

(b) A description of 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;

(c) A description of any condition relating to the offender's likelihood of adhering to treatment;

(d) An indication of 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.

(e) When considered necessary to inform the judge about any of the foregoing factors, a recommendation for a comprehensive mental health evaluation.

Commentary

Standard 7-8.2 draws on standard 18-5.4 in the Sentencing Standards, which describes presentence investigation reports prepared in ordinary cases. Standard 18-5.4 requires that these reports include, in every case, a description of the offender's "personal characteristics and information about programs and services that might be incorporated in an individual offender's sentence." The present standard recognizes the particular importance of presentence reports in cases involving offenders with mental disorders, given the substantial impact evidence of mental impairment can have on post-conviction disposition. For instance, as standard 7-8.5 observes, an offender's mental disorder may serve as a mitigating factor at sentencing, and standard 7-8.6 envisions probation, with mental health treatment as a condition, in a significant number of cases.

The five paragraphs in this standard alert the court and the attorneys to these concerns by providing that, in cases involving offenders with mental disorders, presentence reports should include: a summary of the offender's current mental condition and history of treatment; a description of programs and services that might be

appropriate for the offender; discussion of conditions that may influence the offender's adherence to treatment; an indication whether specialized probation officers or case managers (with training in monitoring mentally disordered offenders) would be appropriate; and a recommendation for a comprehensive mental health evaluation if needed to more fully inform the court about the offender's mental condition and suitability for treatment.

Standard 7-8.3 Expert Assistance in Sentencing

In discharging the duties specified in Standard 18-5.8(a) (requiring notice of an intent to controvert or supplement a presentence report) and Standard 18-5.17(a)(i) (allowing a party to present evidence at sentencing hearings) defense counsel may require the assistance of mental health professionals. Accordingly, each jurisdiction should ensure that this form of assistance is available to indigent defendants who can demonstrate that their mental condition is likely to be a significant factor at sentencing and that expert assistance is needed to evaluate that condition. This provision does not preclude the court or the prosecutor from seeking a mental health evaluation prior to sentencing.

Commentary

Consistent with the Sentencing Standards in Chapter 18, standard 7-8.3 recognizes that defense counsel may need access to mental health experts to interpret, supplement or challenge the presentence report provided for in standard 7-8.2. The presentence report will normally describe the offender's current mental health condition and history of treatment. But to make sense of that information and use it to represent the client's interests, counsel may need to consult with an expert and present the expert's testimony at sentencing. In some cases, the expert will develop additional findings, enhancing its value to the court. In others, the expert's findings may controvert the report.

Consistent with ABA policy in other contexts where experts are needed (see standard 7-3.3), standard 7-8.3 guarantees access to this type of expertise for indigent defendants who can demonstrate that their mental condition is likely to be a "significant factor" at sentencing and that expert assistance is needed to evaluate that condition. This language is identical to the threshold the U.S. Supreme Court adopted in *Ake v Oklahoma*[1] in determining when an indigent defendant's right to a mental health expert in capital trial and sentencing proceedings is triggered.[2] There is no reason not to adopt that threshold in the non-capital sentencing context as well. The state's burden in

[1] 470 U.S. 69 (1986)
[2] Id. at 74.

funding expert assistance for non-capital in addition to capital cases will obviously be greater, but the "significant factor" threshold should eliminate frivolous requests, at the same time it ensures that defendants who need expertise will be able to obtain it. The standard also recognizes that the prosecutor and the court should be able to seek mental health evaluations as well.

Standard 7-8.4 Use of Pretrial Evaluation Results

Testimony of a mental health professional that is based on a competency evaluation conducted prior to trial is admissible at a sentencing hearing only in accordance with Standard 7-4.7. Testimony based on other pretrial evaluations of mental condition are admissible only if the offender puts mental condition in issue at the hearing.

Commentary

Standard 7-8.4 sets limits on the use of pretrial evaluations at sentencing. Many defendants with mental disorder will have undergone one or more pretrial evaluations to address their competence to proceed or mental condition at the time of the offense. Any such evaluation may contain information adverse to a defendant in the context of a sentencing proceeding. This standard references standard 7-4.7, which provides that if the evaluation concerns the defendant's competence, the information obtained may only be used to address the competence question (and related treatment issues), unless the defendant uses the results to address another mental state issue, at which point the door is opened to prosecution rebuttal evidence. This standard extends that rule to other pretrial evaluation results, such as those focused on mental nonresponsibility, and makes clear that it applies at sentencing. Only if the defendant puts mental condition at issue at sentencing are the results of pretrial evaluations admissible there. As the commentary to standard 7-4.7 explains, until that point the Fifth Amendment ought to permit the defense to explore whether it makes sense to raise competence and past mental state issues without concern that the evaluator will become a conduit to the prosecution, and the Sixth Amendment should provide the same protection to facilitate collection of all the information from defendants and third parties necessary to effectively represent the defendant. However, once the defense makes mental condition an issue at sentencing, these constitutional protections are waived. As outlined in the commentary to standard 7-4.7, this approach to the results of pretrial evaluations builds on the U.S. Supreme Court's holding in *Estelle v. Smith*[3]—a capital case—and extends it to noncapital sentencing proceedings.

[3] 451 U.S. 454 (1981).

An issue not addressed in this standard is whether making a mitigation argument based on mental condition at sentencing allows the prosecution to use pretrial evaluation results to not only rebut that argument but also address completely different issues, such as dangerousness. The better practice, also noted in the commentary to standards 7-3.2 and 7-9.7, is to confine prosecution use of pretrial evaluation results to the precise issue raised by the defense. For instance, if mental disorder is advanced by defense counsel as a basis for leniency (for instance, to bolster an argument for probation or a limited term of imprisonment), the results of pretrial evaluations could be used to rebut this contention but not to show the defendant poses a risk of recidivism, unless defense arguments raise that issue.

Standard 7-8.5 Diminished Culpability

Consistent with Standards 18-3.2 and 18-6.3 of the Sentencing Standards, in all non-capital cases evidence of mental disorder at the time of the offense may be a mitigating factor in sentencing a convicted offender. In particular, conditions that should be considered mitigating if they existed at the time of the offense include:

(a) 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.

(b) Severe 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.

Commentary

Standard 18-6.3 of the Sentencing Standards provides that the personal characteristics of an offender should be taken into account at sentencing to the extent they may mitigate the gravity of the offense or the degree of the offender's culpability. The present standard emphasizes that an offender's mental state at the time of the offense is just such a personal characteristic. It notes two conditions in particular that should be considered mitigating if they existed at the time of the offense: intellectual disability or its equivalent, and impairments akin to those contemplated by the insanity defense.

The courts have long recognized the mitigating effects of (non-exculpatory) mental disorder in capital cases. Indeed, the U.S. Supreme Court has granted an exemption from the death penalty for any defendant diagnosed with intellectual

disability in *Atkins v. Virginia*,[4] an exemption expanded upon in standard 7-9.2(a) in the next chapter of these Standards. No defendant with such a significant degree of disability, the Court declared, is sufficiently culpable to warrant a sentence of death. The Court has not established a clear exemption from the death penalty for defendants with mental illnesses. But many of its decisions, especially those in the death penalty setting, recognize that mental illness symptoms may reduce a defendant's blameworthiness,[5] and standard 7-9.2(b) in Part IX of these Standards follows the logic of *Atkins* by precluding execution of individuals with serious mental illness at the time of the offense even if they are not insane at trial.

Standard 7-8.5 recognizes that just as the effects of mental disorder may attenuate responsibility in a capital case, so might they mitigate culpability in a non-capital case. The two conditions that the standard considers mitigating if they existed at the time of the offense are the same conditions that would exempt an offender from the death penalty under standard 7-9.2.[6] However, these conditions are not intended as exclusive. Any evidence of an offender's mental disorder reflects a "personal characteristic" of the offender and might be considered mitigating.

Standard 7-8.6 Sentence of Probation

(a) An offender should not be denied probation solely because the offender requires mental health treatment.

(b) If a court imposes a sentence of probation the court should, to the extent authorized by applicable law, consider the offender's current mental condition, including the presence of mental disorder and the offender's amenability to treatment in the community for the disorder, and the conditions that could ensure the offender's adherence to recommended treatment.

(c) Treatment of an offender with mental disorder who is sentenced to probation should be a condition of probation if necessary to protect the safety of the offender or the public or to assure the offender's successful integration in the community.

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[4] 536 U.S. 304 (2002)),

[5] See Lockett v. Ohio, 438 U.S. 586, 604 (1978) ("The 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 . . .") (emphasis if original); Eddings v. Oklahoma, 455 U.S.104, 115 (1982) (reversing a death sentence of a 16 year-old because the sentencing judge had failed to consider evidence of the defendant's "turbulent family history, of beatings by a harsh father and of severe emotional disturbance."); Zant v. Stephens, 462 U.S. 862, 885 (1983) ("it would be constitutionally impermissible to give aggravating effect to . . . conduct that actually should militate in favor of a lesser penalty, such as perhaps the defendant's mental illness.").

[6] See United States v. McBroom, 124 F.3d 533 (3d Cir. 1997) (recognizing that both volitional and cognitive impairments ought to have mitigating effect at non-capital sentencing).

(d) If probation is imposed with mental health treatment as a condition of probation, the court and the department of corrections should ensure that specialized probation officers trained in working with people with mental disorder are assigned to the offender.

Commentary

Standard 7-8.6(a) prohibits denial of probation simply because a person has a mental disability that requires treatment. Unfortunately, some courts, in an excess of caution, are reluctant to grant probation to a person with mental disability out of an exaggerated fear that their disorder makes them dangerous and that detention with or without treatment is the only option.[7] Paragraph (a) is meant to counter that fear. Even offenders who are perceived to be higher risk may be good candidates for treatment in the community, because such treatment might be the most effective way of reducing recidivism.[8] Indeed, a treatment-oriented disposition in the community, under appropriate supervision, can often be responsive to most of the concerns that judges express when justifying a penal sanction: retribution (by making punishment commensurate with the reduced culpability associated with mental disorder); incapacitation (by providing programs that are more effective at lowering the risk that the offender will re-offend); specific deterrence (by improving the offender's thinking and behavior in ways that discourage re-offense); and rehabilitation (by enabling the offender to lead a safer and more productive life).

At the same time, not every offender with a mental disorder is easily treatable in the community. Most obviously, some offenders may require a structured environment during the treatment process (as Part VII assumed is the case with many mental nonresponsibility acquittees). Even for those who do not need such structure, psychiatric treatment might not be the priority, because only about 10%-15% of crimes committed by people with mental disorder can be said to be directly attributable to the disorder; more direct causes might be homelessness, substance abuse, or peer influence.[9] Further, even when psychiatric treatment is indicated, it might not work; for instance, medication is not effective for at least 25% of those with psychosis,[10] and other therapies also have

[7] See introduction to Part I of these Standards.
[8] A significant amount of research indicates that treatment in the community is more effective than institutional treatment at reducing recidivism, in part because of the criminogenic effects of institutionalization. See Mark W. Lipsey & Francis T. Cullen, The Effectiveness of Correctional Rehabilitation: A Review of Systematic Reviews, 333 Ann. Rev. L. & Soc. Sci. 297, 302 (2008).
[9] Seth J. Prins et al., Criminogenic Factors, Psychotic Symptoms, and Incident Arrests Among People with Serious Mental Illness Under Intensive Outpatient Treatment, 39 L. & Hum. Beh. 177 (2015).
[10] See Stefan Leucht et al., Antipsychotic Drugs Versus Placebo for Relapse Prevention in Schizophrenia: A Systematic Review and Meta-Analysis, 379 Lancet 2063 (2012).

mixed success.[11] Finally, some offenders with mental disorder may be unenthusiastic participants in treatment or refuse it outright.[12]

Thus, paragraph (b) cautions courts to consider carefully the candidate's amenability and willingness to participate in treatment. The court may need to examine the offender's treatment record (what has worked in the past, and what has not), whether the offender will access treatment voluntarily or instead require prodding through a court-ordered condition, and, if the latter, what conditions will best promote adherence, which should usually nclude periodic reporting requirements. If, after consideration of these and related issues, the court determines that the offender is amenable to available treatment that can facilitate the offender's integration into the community and ensure protection of the community, paragraph (c) calls for that treatment to be a condition of any probation plan.

Paragraph (d) recommends that jurisdictions establish probation units that specialize in working with probationers who have mental disabilities, when feasible to do so. Supervising a defendant with a mental disorder present challenges for probation officers. These offenders often have "functional impairments that contribute to unnecessary probation violations and (ultimately) to revocation."[13] They may have poor organizational skills or difficulty negotiating transportation, resulting in missed appointments with probation officers or treatment providers. They may experience side effects from the medications they are prescribed and appear to lack interest or be disengaged. The probation officer who is not familiar with these difficulties may be quick to report a probationer for a technical violation, perhaps unrelated to elevated recidivism risk. Probation units that specialize in working with probationers who have mental disabilities can better meet these challenges.

In current practice, these units tend to have smaller caseloads, typically under 50, compared to caseloads often over 100 for heterogeneous populations.[14] In keeping with principles of "therapeutic jurisprudence,"[15] officers in specialty mental health units emphasize problem-solving over sanctions, on the assumption that offenders in specialty

[11] Jonathan Schedler, The Efficacy of Psychodynamic Psychotherapy, 63 Am. Psychol. 98, 100-107 (2010).
[12] Robert Miller et al., The Right to Refuse Treatment in a Forensic Patient Population: Six-Month Review, 17 Bull. Am. Acad. Psychiat. & L. 107 (1989) (finding that up to 75% of criminal defendants found incompetent to proceed refuse medication at one point or another).
[13] Sarah M. Manchak et al., High Fidelity Specialty Mental Health Probation Improves Officer Practice, Treatment Access, and Rule Compliance, 38 L. & Hum. Beh. 450 (2014).
[14] Jennifer L. Skeem, Sarah M. Manchak & Lina Montoya,. Comparing Public Safety Outcomes for Traditional Probation vs. Specialty Mental Health Probation, 74 JAMA Psychiatry 942 (2017).
[15] See generally, David B. Wexler & Bruce J. Winick, Putting Therapeutic Jurisprudence to Work, 89 A.B.A. J. 54, 55-56 (2003) ("Therapeutic jurisprudence focuses on the law's impact on emotional life and psychological well-being. It is a multidisciplinary approach that seeks to bring insights from the behavioral sciences—psychology, social work, criminology and the like—into the law, the lawyer's office and the courtroom.").

mental health probation experience re-arrest at a substantially lower rate than those in traditional probation. One study that looked at arrest rates within two years of placement on probation found that 28.6% of offenders in specialty probation were arrested compared to 51.8% for those in traditional probation (however, arrests for violent crime were nearly identical between the two groups).[16] Additionally, the overall system costs associated with specialty mental health probation may be lower than under traditional approaches.[17]

Standard 7-8.7. Competence to proceed: noncapital sentencing

(a) A court may not sentence a defendant who is incompetent to proceed at time of sentence.

(i) The test for determining competence to proceed at time of sentence should be whether the defendant has the sufficient present ability to consult with the defendant's attorney with a reasonable degree of rational understanding and whether the defendant has a rational as well as factual understanding of the sentence proceedings.

(ii) If, at the time of sentencing, a good faith doubt is raised as to the defendant's competence to proceed and the defendant's participation is necessary to ensure a fair sentencing proceeding, the court has an obligation to determine the defendant's competence and, before imposing sentence, should order a presentence evaluation of the defendant and determine whether he or she is competent to proceed at the time of sentence according to the procedures set forth in Part IV of these Standards.

(b) If the defendant is found incompetent to proceed at the time of sentence, the court should order treatment to restore competence pursuant to Standards 7-4.10 through 7-4.12 in Part IV of these Standards.

(i) If the defendant is restored to competency, sentencing should proceed.

(ii) If the defendant is found to be non-restorable, and the defendant was convicted of an offense causing, threatening, or creating a substantial risk of death or serious bodily harm, the court should initiate special commitment

[16] Skeem, Manchak & Montoya, supra note 14, at 947.

[17] Jennifer L. Skeem, Lina Montoya & Sarah M. Manchak, Comparing Costs of Traditional and Specialty Probation for People with Serious Mental Illness, 69 Psychiat. Serv. 896 (2018) (finding that the increased cost of supervision in specialty probation was "offset by reduced recidivism [meaning that], for behavioral health care, specialty probation cost an estimated $14,049 . . . less per client than traditional probation," resulting in an overall system savings of 51%").

under Part VII of these Standards. Defendants convicted of other offenses may be subject to general involuntary civil commitment.

Commentary

Standard 7-8.7 requires that defendants be competent before proceeding to sentencing. In defining competence in this context, subparagraph (a)(i) adopts the legal standard applicable to general competence to proceed in standard 7-4.1. As emphasized there and in Part V, competence is context dependent. Arguably, a defendant need not be as competent at sentencing as at trial, at least in non-capital cases. Although defendants have a right to counsel at sentencing, they are not necessarily entitled to all the rights available at trial; for instance, depending on the jurisdiction, they may not have the right to cross examine witnesses, or even to speak.[18] Sentencing proceedings may be more informal, and less may be required of the defendant.

In any event, in the usual case a defendant who was competent to proceed through the trial process will be competent to proceed at sentencing, which usually takes place soon after trial. Occasionally, however, the defendant's mental state may have deteriorated under the stress of trial, and the impact of conviction may have taken a psychological toll as well, particularly if it was unexpected. Subparagraph (a)(ii) provides that if there is a good faith doubt about the defendant's competence to proceed to sentencing, and the defendant's participation is necessary to ensure a fair proceeding, the court should order a presentence evaluation under the procedures specified in Part IV, and then, based on this evaluation, should determine whether the defendant is competent before imposing sentence.

Under paragraph (b), if the court finds the defendant incompetent to proceed with sentencing, it should order treatment to restore the defendant's competence, under the same procedures that apply when a defendant is found incompetent to proceed to trial (see standards 7-4.10 through 7-4.12 in Part IV). If the defendant regains competence, sentencing may proceed. If the defendant is unrestorable (i.e., there is no substantial probability that the defendant will become competent to proceed in the foreseeable future), disposition under these standards depends on the nature of the offense of conviction. If the offense is one that caused, threatened, or created a substantial risk of death or serious bodily harm, subparagraph (b)(ii) provides that the offender be treated as though he or she had been found nonresponsible because of mental disorder [insane], under the standards in Part VII. If the offense is less serious, the court's options under this standard are ordinary civil commitment or release, the same dispositional options prescribed by standard 7-4.14(c) for defendants charged with

[18] Alan Michaels, Trial Rights at Sentencing, 81 N.C. L. Review 1771 (2003).

minor offenses who are found unrestorably incompetent to proceed to trial. Imposition of sentence would not be an option.

These dispositions are consistent with constitutional doctrine. As discussed in the commentary to standard 7-4.14, in *Jackson v. Indiana*,[19] the Supreme Court ruled that defendants who are unrestorably incompetent to proceed to trial must be released from any special commitment intended to restore their competence and either civilly committed or allowed to go free entirely. To continue criminal commitment, the Court reasoned, would violate the defendant's rights to both due process (there being no rational relationship between the nature and duration of such commitment and its purported purpose, which is to restore the defendant's competence) and equal protection (because such commitment, which offers fewer procedural protections than ordinary civil commitment, would treat incompetent defendants differently even though, given the absence of a criminal conviction, they are similarly situated). These principles, applied to sentencing, would prohibit sentencing of an unrestorably incompetent offender. This standard recognizes that point and would not permit criminal punishment of such individuals.

However, in contrast to defendants governed by *Jackson*, defendants who are incompetent to proceed with sentencing have been tried and convicted. Thus, this standard also takes the position that commitment using different standards and procedures than those applicable in pretrial cases is permissible.[20] Where the offense of conviction is one that caused, threatened, or created a substantial risk or death or serious bodily harm, this standard provides that the dispositional rules that govern mental nonresponsibility acquittees are warranted here as well, in the interest of public safety.[21] The disposition subparagraph (b)(ii) would provide—initiation of special commitment proceedings under Part VII—is not punitive in nature because it focuses on mental disorder and dangerousness and contemplates hospitalization and treatment rather than a prison sentence. But it does shift the risk of error from the state to the defendant. Rather than require the state to prove an individual's committability by clear and convincing evidence (a constitutional requirement in ordinary civil commitment cases), commitment under this standard would put the burden on the offender to prove (by a preponderance) suitability for release. Application of these rules to cases involving unrestorable defendants who have been convicted of serious crime strikes an appropriate balance between their interests and the needs of the criminal justice system. In contrast, as provided in subparagraph (b)(ii), commitment under ordinary civil commitment provisions should provide sufficient control of those people with mental disorder who have committed minor crimes but should not be released.

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[19] 406 U.S. 715 (1972).

[20] Cf. Jones v. United States, 463 U.S. 354, 368-369 (1983) (permitting commitment of insanity acquittees under less demanding criteria because they have been found to have committed a crime).

[21] See further discussion of this point in commentary to standard 7-7.2.

Standard 7-8.8. Competence to proceed: appealing from conviction in a noncapital case

(a) Consistent with Standard 7-5.2, the test for determining whether the defendant is competent to make a decision regarding whether to appeal conviction in a noncapital case should be whether the defendant has sufficient present ability to consult with counsel with a reasonable degree of rational understanding and whether the defendant has a rational as well as factual understanding of the nature and consequences of the decision.

(i) If the defense attorney believes the defendant is competent under this Standard, then the defense attorney should abide by the defendant's decision about whether to appeal.

(ii) If the defense attorney believes the defendant is incompetent under this Standard then the attorney may petition the court to permit a next friend acting on the defendant's behalf to initiate or pursue the appeal.

(b) The decision about which issues to raise on appeal is the defense attorney's. However, incompetence of the defendant during the time of appeal should be considered adequate cause, upon a showing of prejudice, to permit the defendant to raise, in a later appeal or action for postconviction relief, any matter not raised on the initial appeal because of the defendant's incompetence.

Commentary

Standard 7-8.8 defines competence to proceed at the time of a non-capital appeal. Mental incompetence rarely affects the fairness or accuracy of appellate decisions because appellate review is based exclusively on trial court records; appellate courts do not re-determine factual issues. Further, to ensure these appellate issues are thoroughly explored, standard 21-3.2 in the Sentencing Standards calls for "every convicted defendant, appellant or appellee," to be represented on appeal. Finally, although, in theory, a trial court may allow a defendant to represent proceed pro se before an appellate court, the U.S. Supreme Court has ruled that no such right exists in the U.S Constitution.[22] Hence, concerns about a defendant's mental competence to proceed to trial or sentencing have no close counterpart in the appellate court proceeding.

[22] Martinez v. California, 528 U.S. 152 (2000).

Nonetheless, the decision whether to lodge an appeal is that of the defendant and not the attorneys (see standard 7-5.2(a) and standard 21-2.2(b) in the Sentencing Standards).[23] Thus, defendants should have at least some ability to discuss with appellate counsel their wishes concerning points to be advanced, even if counsel may not be bound to follow these wishes. Accordingly, the question of competence during appeals cannot be ignored.

Paragraph (a) of the standard sets forth an adapted version of the basic standard for competence to proceed: whether the defendant has sufficient present ability to consult with counsel with a reasonable degree of rational understanding and whether the defendant has a rational as well as factual understanding of the nature and consequences of the decision to appeal. The standard does not call for a mental health evaluation when there is doubt about the defendant's competence, nor does it mandate a court determination of the question, as would be the case if the question were the defendant's competence to proceed to trial or sentencing. Rather, subparagraphs (a)(i) and (ii) place responsibility on defense counsel to handle the matter. If counsel believes the defendant is competent, subparagraph (i) requires counsel to abide by the defendant's decision whether to appeal. If counsel believes the defendant is incompetent, under subparagraph (ii) counsel may petition the court to assign a "next friend, acting on the defendant's behalf" to make the call. The next friend would serve as an agent of the court, duty-bound to protect the rights of the defendant.[24] This remedy best protects the interests of the defendant in this circumstance. The alternative is attempting to restore the defendant's competence through treatment, which would delay the appellate process, in the meantime leaving the defendant's conviction in place with no opportunity to contest it.

Of course, a defendant's incompetence at the time of appeal might prevent counsel from acquiring significant information or learning of concerns that may be important to a proper disposition of the appeal. Paragraph (b) accommodates instances of this sort by recommending the availability of post-conviction review concerning matters that were not raised during an earlier appeal because of the defendant's incompetence. This form of post-conviction review is not automatic; the defendant first must show prejudice. Upon such a showing, however, paragraph (b) would allow the defendant to present any matter not raised on the initial appeal because of the defendant's incompetence.

[23] See also Garza v. Idaho, 586 U.S. 232 (2019) (holding that counsel must file an appeal when requested to do so by a client even when the client has waived the right to appeal at the plea bargaining stage).
[24] This is a common practice in habeas cases. See, e.g., Comm. v. Haag, 809 A.2d 271, 279-281 (Pa. 2002).

PART IX: SENTENCING AND POST-CONVICTION IN CAPITAL CASES

INTRODUCTION

The standards in Part IX, which are new with this edition of the Standards, recognize that mental disorder may play a significant role in determining a defendant's eligibility for the death penalty. Evidence of a defendant's mental disorder is frequently introduced in post-conviction proceedings in capital cases. In some cases, such evidence may categorically exempt a defendant from a sentence of death. In others, it may, together with other mitigating factors, convince the factfinder that the death penalty is not appropriate. A defendant's mental disorder also may affect his or her competence to participate in sentencing or post-sentencing proceedings. The standards in Part IX address all of these issues. Consistent with ABA Criminal Justice Section policy, the Standards take no position on the question whether the death penalty should be prohibited as a sentencing option.

Standard 7-9.1. Mental disorder and capital cases

(a) As stated in Standard 18-1.1 and except as provided in this Part, the American Bar Association Standards for Criminal Justice do not take a position on whether the death penalty should be an available sentencing alternative. The sole purpose of Standards 7-9.1 through 7-9.9 is to address unique issues that arise in connection with mental disorder in those jurisdictions that retain the death penalty. These issues include:

(i) When mental disorder is an exemption from imposition of the death penalty.

(ii) When mental disorder renders an offender incompetent to be executed.

(iii) The effect of mental disorder on post-conviction proceedings in capital cases.

(iv) Evaluation and judicial procedures that should be followed when mental disorder is an issue in a capital trial, at capital sentencing, or during the post-conviction process.

(b) Except as otherwise provided in this Part, procedures governing evaluations, disclosure of evaluation results, and notice of intent to present mental health experts should be consistent with Standards 7-3.2 to 7-3.14 and 7-

6.4 and 7-6.5. The provisions in this Part that address those issues are designed to protect against the prosecution's pretrial access to mental condition evidence that is relevant only after conviction.

Commentary

Standard 7-9.1 provides a roadmap for Part IX. It identifies the different questions concerning a defendant's mental condition that may arise in a capital trial, at sentencing, or in post-sentencing proceedings, and it addresses, by cross-reference to other pertinent standards, the procedures to be followed for mental health evaluations and the use of experts. Finally, it makes clear that, apart from provisions applying specifically to defendants with certain mental conditions, the Standards take no position on whether the death penalty should be an available sentencing alternative in cases that do not involve significant mental disability.

Standard 7-9.2. Prohibition on execution of people with certain mental conditions[1]

(a) Defendants should not be executed or sentenced to death if, at the time of the offense, they had significant limitations in both their intellectual functioning and adaptive behavior, as expressed in conceptual, social, and practical adaptive skills, resulting from intellectual disability, dementia, or a traumatic brain injury.

(b) Defendants should not be executed or sentenced to death if, at the time of the offense, they had a severe mental disorder or disability that significantly impaired their capacity:

(i) to appreciate the nature, consequences or wrongfulness of their conduct,

(ii) to exercise rational judgment in relation to conduct, or

(iii) to conform their conduct to the requirements of the law.

(c) A disorder manifested primarily by repeated criminal conduct or attributable solely to the acute effects of voluntary use of alcohol or other drugs

[1] Sections (a), (b) and (c) of this provision are taken verbatim from paragraphs 1 and 2 of American Bar Association Resolution 122A, which passed the House of Delegates on August 8, 2006. The resolution was also adopted by the American Psychiatric Association, the American Psychological Association, and the National Alliance for the Mentally Ill.

does not, standing alone, constitute a mental disorder or disability for purposes of this provision.

(d) Eligibility for exemption from the death penalty under (a) should be determined at a hearing prior to trial. Eligibility for exemption from the death penalty under (b) should be determined by the judge at the capital sentencing proceeding after the presentation of evidence but before deliberation on a verdict, unless the defense requests a pretrial hearing on the issue. The defendant should bear the burden of proving both exemptions by a preponderance of the evidence.

(e) A finding of criminal responsibility at trial should not bar a finding of eligibility for the exemption in (a) or (b), and a finding of eligibility for the death sentence under (a) or (b) should not preclude finding a mitigating circumstance at sentencing, even if the language defining the relevant criteria is identical.

Commentary

Standard 7-9.2 is taken largely from paragraphs 1 and 2 of American Bar Association Resolution 122A, which passed the House of Delegates on August 8, 2006. The first paragraph of the resolution, reproduced in paragraph (a), builds on the Supreme Court's decision in *Atkins v. Virginia*,[2] which ruled that executing a defendant with mental retardation (now called intellectual disability) violates the cruel and unusual punishment prohibition in the Eighth Amendment. The Court explained that people with intellectual disabilities have "diminished capacities to understand and process information, to communicate, to abstract from mistakes and learn from experience, to engage in logical reasoning, to control impulses, and to understand the reactions of others."[3] No one so diagnosed, the Court declared, acts "with the level of moral culpability that characterizes the most serious adult criminal conduct….If the culpability of the average murderer is insufficient to justify the most extreme sanction available to the state, the lesser culpability of the mentally retarded offender surely does not merit that form of retribution."[4]

In subsequent decisions, the Supreme Court made clear that, for purposes of *Atkins's* exemption from capital punishment, courts are to rely heavily on the definition of intellectual disability adopted by professional organizations, which in turn relies on both scores on intelligence tests and on an individual's "adaptive functioning" in everyday life. In *Hall v. Florida*,[5] the Court held that since, contrary

[2] 536 U.S. 504 (2002),
[3] Id. at 318.
[4] Id. at 306 & 319.
[5] 572 U.S. 701 (2014).

to the practice endorsed by the American Psychiatric Association and other expert organizations, Florida did not take into account the +/- 5 standard error of measurement in IQ test results (which raises the effective cut-off for intellectual disability to 75) and since it limited evidence of adaptive functioning to defendants with an IQ below 71, its definition of intellectual disability violated the Eighth Amendment. In *Moore v. Texas*,[6] the Court again chastised the lower court for failing to take into account the standard error of measurement in evaluating the defendant's IQ scores, and also dismissed that court's "common sense" assessment of Moore's adaptive functioning in prison and elsewhere. It pointed out that the "medical community focuses the adaptive-functioning inquiry on adaptive *deficits*," so that "significant limitations in conceptual, social or practical skills [should not be] outweighed by the potential strengths of some adaptive skills."[7] The Court further noted that experts in the field discount behavior in "controlled settings" like prison, and that "the medical profession has endeavored to counter lay stereotypes" like those referred to by the Texas court.[8]

Paragraph (a) exempts from the death penalty not only those defendants who meet this definition of intellectual disability but also defendants who, at the time of the offense, have essentially the same level of intellectual disorder because of dementia or traumatic brain injury. Like those with intellectual disability, people with dementia—classified as a major neurocognitive disorder in the DSM-5—experience serious deficits in intellectual and adaptive behavior, including disturbances in executive functioning connected with planning, decision making, responding to feedback, and error correction.[9] Traumatic brain injury is also classified as a category of neurocognitive disorder and is characterized by the same kinds of deficits.[10] As ABA Resolution 122A observes, "people with dementia or traumatic head injury severe enough to result in 'significant limitations in both intellectual functioning or adaptive behavior' [as this standard would require] rarely commit capital offenses. If they do, however, the reasoning in *Atkins* should apply and an exemption from the death penalty is warranted…."

Paragraph (b), which reproduces the second paragraph of the resolution, also exempts defendants who, at the time of the offense, had a "severe" mental disorder or disability that significantly impaired their capacity (i) to appreciate the nature, consequences or wrongfulness of their conduct, (ii) to exercise rational judgment in relation to conduct, or (iii) to conform their conduct to the requirements of the law.

[6] 581 U.S. 1 (2017).
[7] Id. at 15-16 (quoting American Association of Mental Retardation: Definition, Classification, and Systems of Supports 8 (10th ed. 2002)).
[8] Id. at 18.
[9] Am. Psychiat. Assoc'n, Diagnostic and Statistical Manual—Text Revised 667-668 (5th ed. 2022) (hereafter DSM).
[10] Id. at 667.

These impairments are grounds for a mental nonresponsibility [insanity] defense in many states (see standard 7-6.1 and commentary). They also are at least as serious as the neurocognitive impairments of intellectual disability and the developmental immaturity of juveniles, both categories of people the Supreme Court has exempted from the death penalty, in *Atkins* and *Roper v. Simmons*,[11] respectively. If, as the Court declared in both *Atkins* and *Roper*, the culpability of the average murderer is insufficient to warrant a sentence of death, defendants with these impairments should also be ineligible for the death penalty.

It is important to emphasize that serious mental illness, alone, is insufficient to meet the exemption in paragraph (b). While an individual with intellectual disability will suffer the same degree of impairment throughout their life,[12] the symptoms of people with a mental illness such as delusional thinking or hallucinations often remit. Thus, in determining whether a defendant with a mental illness deserves leniency in capital (and all other criminal) cases, it is necessary to consider the state of the defendant's thinking and behavior at the time of the offense. Paragraph (b) so requires.

Note also that paragraph (b) requires that the defendant's mental disorder be "severe." As a general rule, only those disorders associated with psychosis will qualify. As ABA Resolution 122A observes, "[t]hese disorders include schizophrenia, … mania, major depressive disorders, and dissociative disorders—with schizophrenia being by far the most common disorder seen in capital defendants." Defendants with less serious mental disorders—or those with severe mental disorders whose symptoms do not cause the significant functional impairments required by paragraph (b) (i-iii)—will not qualify for exemption from a death sentence. Of course, as paragraph (e) and standard 7-9.4(b) recognize, these defendants may still provide evidence of their mental disorders as a mitigating factor at sentencing.

Analogous to the exclusions found in standard 7-6.1 defining the test for mental nonresponsibility, paragraph (c) provides that the phrase "severe mental disorder or disability" does not include disorders manifested primarily by repeated criminal conduct or attributable solely to the acute effects of voluntary alcohol or drug use. The first exclusion is also found in the Model Penal Code's insanity defense formulation and many states' insanity laws.[13] It is meant to refer to antisocial personality disorder, a condition whose features, according to the DSM V,

[11] 543 U.S. 551 (2005) (holding that the Eighth Amendment bars execution of any individual for crimes committed while under 18).
[12] See DSM, supra note 9, at 42.
[13] See, e.g., Texas Penal Code § 8.01(b); Cf. Heidi L. Maibom, The Mad, the Bad, and the Psychopath, 1 Neuroethics 167, 167 (2008) ("Current US legal practice is to regard the psychiatric condition of psychopathy to be irrelevant to a defendant's legal responsibility.")

include "manipulativeness," "deceitfulness," "callousness," and "hostility."[14] People with this disorder tend to show "no regard for right and wrong" or "guilt or remorse for their behavior."[15] Not only will antisocial personality disorder not qualify as a severe mental disorder for purposes of exemption from the death penalty, it "generally does not support leniency or treatment recommendations at the time of sentencing, and in capital sentencing proceedings is often presented as an aggravating factor."[16]

The additional exclusion from the death penalty exemption for impairments caused by the acute effects of voluntary substance use is justified on the grounds that the impairments are both temporary and self-induced. Intoxication may impair a defendant's cognitive or volitional capacities, and some states will allow evidence of voluntary intoxication at the time of an offense to reduce the grade of the crime if its effects were so great as to compromise the defendant's capacity for "specific intent".[17] Additionally, evidence of intoxication may be admissible in mitigation at sentencing.[18] But the effects of intoxication are variable and, even if the choice to abstain may be difficult, it is usually the result of intentional or reckless choices. Thus they will normally not be grounds for an exemption. In contrast, involuntary intoxication may provide the basis for a defense to any charge if its effects at the time of the offense negated the defendant's capacity for independent judgment and volition.[19] Further, as ABA Resolution 122A recognizes, a brain disorder, such as dementia, may have its roots in the long-term use of substances.[20] The language in paragraph (c) is not meant to exclude such free-standing and independently disabling conditions from consideration as severe mental disorders.

Paragraph (d) calls for a defendant's eligibility for exemption from the death penalty under paragraph (a) to be determined prior to trial. Given the condition's permanent nature, nothing about the determination as to whether the person is intellectually disabled requires consideration of the defendant's conduct at the time of the offense or other evidence that may be adduced at trial. Further, resolving the question before trial promotes judicial efficiency. If the defendant is found exempt, there will be no need to hear evidence concerning whether the defendant is also eligible for exemption under standard 7-9.2 (b), or for the involvement of a separate prosecutor, as would be required by standard 7-9.5(b) to handle presentence

[14] See DSM, supra note 9, at 748.
[15] Antisocial Personality Disorder, Mayo Clinic, available at https://www.mayoclinic.org/diseases-conditions/antisocial-personality-disorder/symptoms-causes/syc-20353928.
[16] Sally C. Johnson & Eric B. Elbogen, Personality Disorders at the Interface of Psychiatry and the Law: Legal Use and Clinical Classification 203 (2013).
[17] Wayne R. LaFave, Criminal Law § 9.05(a) (5th ed. 2010).
[18] See Jeffrey.L. Kirchmeier, A Tear in the Eye of the Law: Mitigating Factors and the Progression Toward a Disease Model of Criminal Justice, 83 Oregon L. Rev.631 (2004).
[19] LaFave, supra note 17, § 9.5(g).
[20] See commentary to standard 7-6.2(b) for further discussion of this condition.

evaluation reports that must be shielded from the primary (guilt-stage) prosecutor during the trial. Finally, determinations made prior to trial will be free from any undue influence that incriminating evidence presented at trial may have on the fact-finder.

In contrast, paragraph (d) calls for eligibility for exemption under paragraph (b) to be determined by the judge after the presentation of evidence in the sentencing proceeding but before deliberation on the sentencing verdict, unless the defendant requests a pretrial determination. Defendants seeking an exemption under section (b) effectively must admit that they committed the act underlying the offense charged because the claim is tied to their motivations for committing the offense. Thus, unlike defendants claiming a paragraph (a) exemption, they ordinarily will prefer to avoid making this claim unless and until they have been convicted. Nonetheless, some defendants may wish to make their case for exemption under paragraph (b) pretrial. These defendants may feel that the judge will be less receptive to their arguments after all the evidence has been heard and a conviction has been handed down, particularly if they intend to use a mental nonresponsibility defense at trial and it fails. Another reason a defendant may wish to have the exemption question resolved before trial is strategic. Under standard 7-9.5(b), no report concerning a defendant's eligibility for exemption may be shared with the prosecutor responsible for the guilt stage until after the defendant has been convicted. Thus, a separate prosecutor would have to argue the state's case opposing the exemption when it is raised prior to trial. The defendant may prefer to face this prosecutor.

Paragraph (e) provides that a failed mental nonresponsibility [insanity] defense should not bar exemption under (a) or (b), and further provides that findings of eligibility for the death sentence under (a) or (b) should not preclude findings of mental condition-based mitigation, "even if the language defining the relevant criteria is identical." Many states have adopted nonresponsibility tests that use language similar or identical to that adopted in this standard as an exemption from the death penalty; in particular, 13 states provide that a defendant is "insane" if "the capacity of the defendant to appreciate the criminality of his conduct or to conform his conduct to the requirements of law was significantly impaired."[21] Additionally, virtually every state death penalty statute lists as a mitigating factor a mental condition that impairs the defendant's "capacity . . . to appreciate the criminality [wrongfulness] of his conduct or to conform his conduct to the requirements of the law,"[22] also language very similar to the formulation in paragraph (b). Under paragraph (e), even if a defendant in one of these states unsuccessfully raises the

[21] See Kahler v. Kansas, 589 U.S. 271, 323 Appendix (2020).
[22] Ellen Fels Berkman, Mental Illness as an Aggravating Circumstance in Capital Sentencing, 89 Colum L. Rev. 291, 297 (1989).

defense, they may still argue for an exemption to the death penalty and, if that fails, that they should be spared the death sentence on mitigation grounds.

The language used in these three circumstances may vary slightly. But the greatest difference is the context in which these determinations are made. A factfinder may reasonably conclude, for example, that a defendant's capacity to appreciate the wrongfulness of their conduct at the time of the offense was not so impaired as to negate the defendant's responsibility altogether but also decide that a penalty of death would be incommensurate with the defendant's degree of culpability. Likewise, evidence, standing alone, that a defendant's appreciation of the wrongfulness of the act was impaired to some degree may not compel exempting the defendant from the death penalty, yet the same evidence, presented in a sentencing proceeding in which additional mitigating evidence is adduced, may do so.

Standard 7-9.3. Evaluation of mental condition relevant to capital trials

(a) The court should provide funding for one or more qualified mental health professionals to evaluate a defendant charged with capital murder if, upon motion of the defense attorney, the court finds that (i) the defendant's mental condition is likely to be a significant factor at the guilt or penalty phase of the trial or on issues that would exempt the defendant from the death penalty, and (ii) the defendant is financially unable to pay for expert assistance. Consultative mental health professionals may be appointed consistent with Standard 7-1.3(d) upon similar findings by the court.

(b) Mental health professionals appointed under (a) should satisfy the education, training and experience requirements specified in Standard 7-3.9. If the attorney for the defendant establishes that there is reason to believe that the defendant may have significant limitations in both intellectual functioning and adaptive behavior, as expressed in conceptual, social, and practical adaptive skills, resulting from intellectual disability, dementia, or a traumatic brain injury, at least one of the evaluators should be skilled in the administration, scoring and interpretation of intelligence tests and measures of adaptive behavior.

(c) Evaluators should prepare separate written reports on each of the issues addressed, including, as applicable, a mental condition defense, exemption from the death penalty based on Standard 7-9.2(a), exemption from the death penalty based on Standard 7-9.2(b), and mitigation.

Commentary

Standard 7-9.3 deals with mental health evaluations requested by the defense in capital cases. Paragraph (a) assures indigent defendants state funding for one or more mental health experts, as well as for one or more consultative mental health professionals, upon a showing that the defendant's mental condition "is likely to be a significant factor at the guilt or penalty phase or on issues [regarding exemption]." This language is drawn from the Supreme Court opinion in *Ake v. Oklahoma*,[23] which held that the due process clause guarantees indigent defendants a right to an expert on two questions: (i) the defendant's "sanity," if it is likely to be a significant factor in his or her defense; and (ii) the defendant's "dangerousness," when the prosecution presents evidence of dangerousness as an aggravating factor at sentencing. The Court reasoned that expert consultation is crucial in both of these settings, although it limited the right to one expert, and not necessarily one of the defendant's choosing.

More recently, in *McWilliams v. Dunn*,[24] the Court extended the right to expert assistance in capital cases by emphasizing that due process entitles indigent defendants not only to a state-funded evaluation but also to help in preparing and presenting psychiatric evidence on *any* issues that might be relevant at capital sentencing. Thus the Court held that McWilliams, who had already requested and received an evaluation on his mental state by one psychiatrist (a Dr. Goff), should have been accorded additional expert assistance:

> Neither Dr. Goff nor any other expert helped the defense evaluate Goff's report or McWilliams' extensive medical records and translate these data into a legal strategy. Neither Dr. Goff nor any other expert helped the defense prepare and present arguments that might, for example, have explained that McWilliams' purported malingering was not necessarily inconsistent with mental illness (as an expert later testified in postconviction proceedings). Neither Dr. Goff nor any other expert helped the defense prepare direct or cross-examination of any witnesses, or testified at the judicial sentencing hearing himself.[25]

Paragraph (a)'s provision guaranteeing indigent capital defendants consultants on psychiatric issues that are "significant" recognizes the principle enunciated in *Dunn*.

Paragraph (b), by reference to standards in Part III, specifies the requisite credentials for experts appointed under (a). These Standards, in particular standard 7-3.9(a), make clear that the expert must have both (i) "sufficient education and clinical

[23] 470 U.S. 68 (1986).
[24] 582 U.S 183 (2017))
[25] Id. at 199.

training… as well as sufficient experience, to establish the clinical knowledge required for the specific type(s) of evaluation(s) required, and (ii) sufficient forensic knowledge, gained through specialized training or an acceptable substitute therefor, necessary for understanding the relevant legal matter(s) and for satisfying the specific purpose(s) for which the evaluation is being ordered."

Paragraph (b) also provides that experts called upon to address a defendant's limitations in intellectual functioning and adaptive behavior—conditions that may provide the basis for an exemption from the death penalty under standard 7-9.2(a)—must be skilled in the administration, scoring and interpretation of intelligence tests and measures of adaptive behavior, as these are the key tools experts use to properly assess these conditions. Not all mental health professionals have the training or experience to properly administer and score these tests. After the Supreme Court's decision in *Hall v. Florida* and *Moore v. Texas*, discussed in the commentary to standard 7-9.2(a), it is clear that experts must be able to address the standard error of measurement of such tests and various other issues associated with their use.[26] Moreover, as *Moore* in particular emphasized, a test score alone is inadequate. Experts must also be able to describe an individual's adaptive functioning, which if significantly compromised may require a finding of intellectual disability even for individuals whose IQ scores are well above the traditional cut-off of 70.[27] Drawing these distinctions and explaining them in terms a judge or jury can understand is challenging. The law's enhanced concern for reliability in capital cases demands the use of these types of experts.

In some capital cases an expert may evaluate a person on three separate issues: a mental state defense relevant to trial; an exemption to the death penalty; and mitigation at sentencing. In such cases, paragraph (c) requires experts to write a separate report on each issue, including separate reports on the exemptions recognized in standard 7-9.2(a) and 7-9.2(b). While the information in these reports will frequently overlap, the reason for this admittedly cumbersome requirement is to protect against unnecessary disclosures of sensitive information. Reports addressing mental condition defenses and mitigation are likely to contain statements the defendant makes about his or her thinking and behavior at the time of the offense. But a report addressing the defendant's intellectual functioning for purposes of determining whether an exemption exists under standard 7-9.2(a) will usually not need to include that potentially prejudicial information. Thus, if the defendant claims

[26] For a discussion of some of these difficulties, including the standard error of measurement, the "Flynn Effect" (which posits that if IQ tests are not recalibrated periodically, they will overstate an Individual's IQ vis-à-vis the rest of the population by about three points per decade), and adaptive functioning, see John H. Blume et al., A Tale of Two (and Possibly Three) *Atkins*: Intellectual Disability and Capital Punishment Twelve Years after the Supreme Court's Creation of a Categorical Bar, 23 Wm. & Mary Bill. Rts. J. 393 (2014).

[27] See Moore, 581 U.S. at 15 ("we require that courts . . . consider other evidence of intellectual disability where an individual's IQ score, adjusted for the test's standard error, falls within the clinically established range for intellectual-functioning deficits").

an exemption under standard 7-9.2(a) prior to trial, as provided in standard 7-9.2(d), the supporting report should only include information relevant to that claim, not (possibly incriminating) information relevant to other mental condition claims.

Likewise, should a defendant wish to present a mental condition defense, he or she should not be required to share a report addressing factors in mitigation, which may be wide ranging and include material irrelevant to and possibly prejudicial at trial. Finally, although reports addressing a defendant's mental state at the time of the offense are likely to contain similar information whether prepared in support of a mental condition defense or a death penalty exemption, they may not be identical, particularly if the criteria for the two questions are different (as will be the case in jurisdictions that have narrow nonresponsibility [insanity] tests or no such test at all). Preparing separate reports on each issue may be inefficient. But it is necessary to protect against injection of irrelevant issues into legal determinations.

Standard 7-9.4. Notice of intent to present mental health evidence

(a) If the attorney for the defendant intends to present expert evidence in support of a mental condition defense or an exemption described in Standard 7-9.2, or if the defense anticipates it will present expert mental health evidence in mitigation at the penalty phase of the trial, the attorney should so notify the prosecutor at the time of filing pretrial motions. The notice should also provide:

(i) the names of the mental health professionals who will testify;

(ii) their qualifications;

(iii) the specific nature of any testing the experts have performed or will perform; and

(iv) a brief, general summary of the topics to be addressed that is sufficient to permit the government to identify an appropriate rebuttal expert witness.

(b) If, in the event that the defendant is convicted of capital murder and the issue has not been resolved prior to trial, the attorney for the defendant decides to proceed with presentation of expert mental health evidence in support of an exemption from the death penalty under Standard 9.2(b), or the attorney decides to present such evidence in mitigation, the attorney should confirm his or her intent within 24 hours of the defendant's conviction.

(c) If the defense attorney fails to give the notice required by this Standard, the court may impose sanctions appropriate to the degree of prejudice to the prosecution and the willfulness of the violation.

(d) Evidence of notice given under this Standard, later withdrawn, is not admissible in any civil or criminal proceeding against the defendant who gave notice.

Commentary

Standard 7-9.4 provides for notice to the prosecution in cases where the defense intends to present expert evidence on a mental state defense or to address capital sentencing issues. Like the notice provision in mental nonresponsibility cases (under standard 7-6.3 (b)), paragraph (a) requires notice to be provided at the time for filing of pretrial motions, allowing the prosecution time to retain its own experts.[28] Paragraph (a) additionally requires that the notice include the names and qualifications of the experts to be used, the nature of any testing performed, and a summary of the topics to be addressed. The range of issues a defense expert may be asked to address in these cases is broad, ranging from intellectual disability, dementia, and traumatic brain injury (conditions that may support an exemption under standard 7-9.2(a)) to any mental or emotional disturbance that might be relevant in mitigation. Before obtaining its own evaluation (as provided in standard 7-9.6), the prosecution should have some understanding of the defense's focus in order to know what kinds of experts to retain and what questions to ask their experts to address. As the Federal Rules of Criminal Procedure provide in their discovery provisions, the prosecution is entitled to know "the kind of investigation needed to acquire rebuttal testimony on the defendant's claim[s]."[29]

Defendants who have given pretrial notice of an intent to use expert psychiatric testimony may nonetheless, for various strategic reasons, decide to forego presenting expert evidence. If, after conviction, that remains the case, the prosecution will not need to prepare rebuttal. Accordingly, paragraph (b) requires defendants convicted of capital murder to confirm, within 24 hours of conviction, their intent to present an expert in mitigation or in support of an exemption under standard 9.2(b).

[28] The alternative of not requiring defense notice on the use of experts at capital sentencing until after conviction is both inefficient (because of the delay needed to obtain prosecution experts and the difficulty of reassembling the trial jury for a postponed sentencing hearing), and unfair to the prosecution (whose experts would not have access to the defendant until many months or even years after the offense, when relevant mental condition could be significantly different and third party information stale).

[29] Fed. R. Crim. P. 12.2(b), Advisory Committee Comments.

Paragraph (c) provides that defendants failing to provide the required notice may face sanctions "appropriate to the degree of prejudice to the prosecution and the willfulness of the violation." As discussed in the commentary to standard 7-6.4(b), in non-capital cases failure to give timely notice of intent to present expert evidence may call for exclusion of the defense expert; some states even provide for exclusion of all evidence concerning the defendant's mental condition. In a capital case, however, both of these penalties are too harsh. Whether a defendant convicted of capital murder should be sentenced to death may turn to a significant degree on consideration of the defendant's mental state at the time of the offense. To disallow expert evidence on this question simply because the attorney missed a notice deadline may mean the defendant pays for the attorney's failure with his or her life. An alternative remedy is to grant the prosecution a continuance of the proceedings to allow time for its experts to evaluate the defendant and for the prosecuting attorneys to prepare their rebuttal. Or the court may instruct the jury that the defense attorney's failure to provide timely notice left the prosecution with less time to prepare. Finally, if the court finds that the attorney's failure to provide notice was purposeful, intended to disadvantage the prosecution, it may be appropriate for the court to sanction the attorney for unprofessional behavior.

Paragraph (d) allows defendants to withdraw notice of their intent to present expert evidence without having evidence of that decision admitted against them. Attorneys who represent defendants in capital cases almost always will want to hear from experts about their clients' mental and emotional condition at the time of the offense. To be fully prepared for all possibilities as they prepare their defense, they may give notice of an intent to present these experts in court, even if they are not certain that they will. But, as noted above, the defense strategy may change as the case develops, so that the defense chooses not to present expert evidence. If the jury were to hear that the defense planned to use expert mental health evidence but then chose not to do so, they may draw conclusions that are unwarranted, including that the defendant suffered no mental or emotional impairment, or that if the defendant did have such impairment, there must be more to the story that the defense wishes to hide. Paragraph (d) protects against this possibility.

Standard 7-9.5. Discovery of defense experts' reports and basis of evaluation

(a) Reports of experts identified under Standard 7-9.4(a) that concern a mental condition defense or an exemption under 7-9.2(a) should be subject to discovery by the prosecutor responsible for the guilt phase of the trial prior to trial, consistent with Standard 7-3.7(b).

(b) Reports of experts identified under Standard 7-9.4(a) that concern an exemption from the death penalty under Standard 7-9.2(b) or addressing mitigation should, at the prosecutor's discretion, be provided to either

(i) a separate prosecutor (a "firewalled" prosecutor), who may not share the reports or otherwise communicate about the evaluation with the prosecutor responsible for the guilt phase of the trial unless the defendant is found guilty of a capital offense and the defendant confirms an intent to claim an exemption or offer mitigation during sentencing under Standard 7-9.4(a), or

(ii) the prosecutor responsible for the sentencing phase of the trial once the defendant is convicted of a capital offense and confirms an intent to present mental health evidence at sentencing.

(c) As used in this Standard "reports" include not only the expert's written report but also educational, health care, vocational, social service, military, and mental health records; medical and psychological test data; notes and reports summarizing the experts' work and evaluations; and other materials the experts consulted or relied upon.

(d) The court may impose sanctions appropriate to the degree of prejudice to the prosecution for failure to comply with the discovery requirements of this Standard.

Commentary

Standard 7-9.5 provides that experts' reports concerning a mental condition defense or an exemption under standard 7-9.2(a) (which is based on intellectual disability, dementia, or traumatic brain injury) should be discoverable by the prosecutor responsible for the guilt phase of the trial, in the same way evaluation reports are discoverable in non-capital cases where a mental disorder defense is raised (i.e., at the time the defense gives notice of a intent to present an expert, per Standard 7-3.7(b)). Reports addressing the exemption under 7-9.2(a) must be provided pretrial because, under standard 7-9.2(d), this issue should be resolved prior to trial. Moreover, exemptions under standard 7-9.2(a) turn on diagnosis alone—whether, at the time of the offense, the defendant had an intellectual disability, traumatic brain injury, or dementia. The court need not consider specifically how these conditions affected the defendant's thinking or behavior at the time of the offense. Thus, the evaluator's report ordinarily should not include statements the defendant may have made about the offense, lessening concern about the report's misuse during the guilt phase.

In contrast, under paragraph (b) of this standard reports concerning an exemption under standard 7-9.2(b) (based on the defendant's mental state at the time of the offense) or addressing mitigation would go to a separate prosecutor who would be forbidden from sharing such reports with the prosecutor responsible for the guilt phase until such time as the defendant was convicted and confirmed an intent to claim an exemption or offer mitigation at sentencing under standard 9-4(b). This procedure reflects common practice in federal death penalty cases.[30] It is intended to allow defendants to speak freely with experts about matters that may be relevant in mitigation or to an exemption under standard 7-9.2(b) without risk of having their statements shared with prosecutors who might misuse those statements at the guilt phase; at the same time it provides an independent arm of the prosecution with access to evaluators' reports before trial, to prepare for eventual rebuttal. At the prosecution's discretion, the prosecutor who is authorized to access these reports on mental state at the time of the offense may be a separate prosecutor who will be responsible for the sentencing phase, or a "firewalled" prosecutor who may prepare rebuttal and, when authorized, pass his or her work product to the guilt-stage prosecutor for use in subsequent proceedings. To assure the prosecution an opportunity to prepare rebuttal free from surprise, paragraph (c) would require that any evaluator's report sent to the prosecution include a complete set of records and other materials that the evaluator relied on in conducting the evaluation, whether or not these materials appear in the evaluator's written report.

Section (d) provides that defendants failing to comply with the discovery requirements in this standard may face sanctions "appropriate to the degree of prejudice to the prosecution." As discussed in the commentary to standard 7-9.4(c), exclusion of all evidence concerning the defendant's mental condition would be too harsh. Alternatives are granting the prosecution a continuance, instructions to the jury about how the defense's failure to disclose may have impaired the prosecution's ability to rebut, or direct sanctions on the attorney.

Standard 7-9.6. Prosecution-initiated evaluation of the defendant and defense discovery

(a) If the defendant provides notice under Standard 7-9.4(a), the court should, upon the prosecutor's motion, order the defendant to be evaluated by one or more mental health professionals satisfying qualifications specified in Standard 7-9.3(b). The scope of the evaluation should be limited to issues that are subject of the notice.

[30] See, e.g., LeCroy v. United States, 739 F.3d 1297, 1307 (11th Cir. 2014); United States v. Wilson, 493 F.Supp.2d 480, 482-484 (E.D. N.Y. 2006).

(b) If the notice provided by the defendant under Standard 7-9.4(a) indicates that expert evidence will be used to support a mental condition defense at trial or an exemption under Standard 7-9.2(a), the evaluators should submit written reports on that issue to the prosecution and the defense. If the notice provided by the defendant under Standard 7-9.4(a) indicates that expert evidence will or might be used in support of an exemption under 7-9.2(b) or mitigation at sentencing, the evaluators should submit written reports on that issue to the defense. If the evaluation takes place prior to trial, the reports should also be submitted, at the prosecutor's discretion, either to

(i) the "firewalled" prosecutor described in Standard 7-9.5(b)(i), who should not share the reports or otherwise communicate about the evaluation with the prosecutor responsible for the guilt phase of the trial unless the defendant is found guilty of a capital offense and the defendant confirms an intent to offer mental health evidence during sentencing, or

(ii) the prosecutor responsible for the sentencing phase of the trial once the defendant is found guilty of a capital offense and confirms an intent to offer mental health evidence during sentencing.

(c) If the defendant fails to submit to an evaluation ordered under this Standard or fails to cooperate with the evaluation for reasons unrelated to mental disorder the court may impose sanctions proportionate to the degree of prejudice to the prosecution and the extent to which the failure was influenced by the defendant's mental disorder.

Commentary

If the defense presents expert evidence in support of a mental condition defense, an exemption from the death penalty, or mitigation, the prosecution is entitled to present expert rebuttal evidence. Because these evaluations may elicit otherwise privileged information concerning a defendant's mental condition—information that is material only if the defendant places his or her mental condition at issue—paragraph (a) of this standard provides that these evaluations may take place at the prosecution's behest only after the defense gives notice under standard 7-9.4(a). Paragraph (a) also makes clear that the scope of the prosecution's evaluation should be limited to issues in the defendant's notice.

Under paragraph (b), evaluation reports from prosecution-initiated evaluations would be shared in the same manner as reports resulting from defense-initiated evaluations. That is, evaluators should send the results of prosecution-initiated evaluations to the defense in every instance, to the guilt-stage prosecutor if

limited to a mental condition defense or an exemption under 7-9.2(a), and to the firewalled prosecutor or independent prosecutor if concerning an exemption under 7-9.2(b) or mitigation. Paragraph (c) permits the court to sanction any defendant who refuses to submit to the prosecution-initiated evaluation or fails to cooperate for reasons unrelated to mental disorder. Because these provisions are analogous to the process set out in standard 7-6.4 addressing procedures for prosecution-initiated evaluations of a defendant's mental state at the time of the offense, the commentary to that standard—regarding the timing of report disclosures reports, sanctions on uncooperative defendants, and the need to the sensitive in determining when a defendant is intentionally uncooperative or merely evidencing evidence of mental disability—is relevant here as well.

Standard 7-9.7. Inadmissibility of information obtained during an evaluation

(a) **No statement made by or information obtained from a defendant, or evidence derived from such statement or information during the course of any mental health evaluation, or during treatment that occurs after arrest for the capital offense, and no opinion of a mental health professional based on such statement, information, or evidence is admissible in the prosecution's case-in-chief at the sentencing phase of a capital trial for the purpose of proving the aggravating circumstances provided by law.**

(b) **Such statements, information, or opinion shall be admissible for rebuttal purposes in a capital sentencing proceeding, but only if relevant to (i) an exemption from the death penalty, (ii) mitigation during sentencing, or (iii) statements made by the defendant under oath where the law permits the use of evaluation statements.**

Commentary

Paragraph (a) protects against the prosecution's use, in its case in aggravation, of any information resulting from an evaluation of mental state or from treatment of the defendant occurring after the defendant's arrest. However, paragraph (b) provides that such information may be used by the prosecution in rebuttal of the defendant's evidence, when relevant to an exemption or mitigation claimed by the defendant. That standard also allows the prosecutor to use statements made by the defendant during an evaluation if relevant to impeach statements the defendant makes under oath, in states where the law permits such use (e.g., to impeach the defendant's credibility).

The protection here mirrors the protection provided by standards 7-3.2(a) and 7-8.4 for defendants undergoing pretrial evaluations or treatment. Under those standards, information resulting from a defendant's pretrial evaluation or treatment is admissible only if relevant to the defendant's trial competence or to an issue raised by the defense concerning the defendant's mental condition that is supported by expert testimony, a stance that rests on the premise that the Fifth Amendment privilege against compelled self-incrimination governs pretrial mental health evaluations and treatment. Defendants must be free to explore grounds for a possible mental state defense (by having a mental health evaluation) or to participate in mental health treatment during the pretrial period without giving up this privilege. However, defendants who present expert testimony to support a mental nonresponsibility defense waive the privilege with respect to evaluation results (or statements made during treatment) that bear on that issue. But only that issue. Such information may not be used at trial to support the prosecution's case-in-chief at trial (to show, for example, that the defendant committed the offense charged) or at non-capital sentencing (to show, for example, dangerousness).

This standard applies the same reasoning to the sentencing phase of a capital case, a position that is bolstered by the Supreme Court's decision in *Estelle v. Smith* holding that the Fifth Amendment applies in capital sentencing proceedings despite the fact that the defendant has already been convicted.[31] At capital sentencing, the functional equivalent of the prosecution's case-in-chief at trial is proof of the aggravating circumstances that serve as predicate for imposition of the death penalty. Standard 7-9.7(a) recognizes that the defendant enjoys Fifth Amendment protection against the prosecution's use of evaluation results (or statements the defendant has made in treatment) as evidence of such aggravating circumstances. However, as paragraph (b) provides, the prosecution may use this information to rebut claims the defense may make to support an exemption from the death penalty or to argue for mitigation during sentencing.

Ordinarily, information the defense chooses to present at sentencing is unrelated to the aggravating circumstances the prosecution must prove. For instance, evidence about mental impairment has no relationship to typical aggravating circumstances such as prior offenses or multiple victims. In some cases, however, mitigators and aggravators may overlap. In some states, for example, the relevant state law recognizes a defendant's future dangerousness as an aggravating circumstance;[32] in these states if an offender argues in mitigation that he or she is not dangerous, the prosecution, under paragraph (b), would be able to use evaluation

[31] 451 U.S. 454, 462-463 (1981) ("We can discern no basis to distinguish between the guilt and penalty phases of respondent's capital murder trial so far as the protection of the Fifth Amendment privilege is concerned.").
[32] Roughly 25 states make dangerousness either a statutory or a nonstatutory aggravator. See Mitzi Dorlan & Daniel Krauss, The Danger of Dangerousness in Capital Sentencing, 29 L & Psychol Rev. 63, 64, n.5, 65 n. 12 (2005).

results (or statements the defendant made in treatment) to rebut that argument, in effect, advancing a case for dangerousness because the defendant has opened the door to that issue. But, importantly, this information may be elicited by the prosecution only in rebuttal to arguments the defense has made, not in its case-in-chief.[33]

Finally, paragraph (b) also recognizes that in states where the law allows it the prosecution may use information resulting from a defendant's evaluation or treatment to rebut inconsistent statements the defendant may make under oath. Again, however, the information is used not in the prosecution's case-in-chief (to prove the aggravating circumstances) but rather to challenge the truthfulness of the defendant's testimony.

Standard 7-9.8. Competence to proceed at capital sentencing

(a) The defendant must be competent to proceed with the capital sentencing proceeding.

(i) Absent additional information bearing on a defendant's competence at the time of capital sentencing, a finding that the defendant was competent to proceed at trial should be sufficient to establish the defendant's competence to proceed with sentencing.

(ii) A defendant is competent to proceed at capital sentencing if he or she has sufficient present ability to consult with defendant's lawyer with a reasonable degree of rational understanding and, given the nature and complexity of the sentencing issues, has a rational as well as factual understanding of the proceedings, including the consequences of failing to present mitigation evidence and the possibility that a defendant's attitude toward the death penalty and its alternatives will change over time.

(b) The decisions about whether to challenge the death penalty, present mitigating evidence and present any particular mitigating evidence are defense counsel's, after consultation with the defendant.

[33] Another possible case of overlap is evidence of mental impairment presented in mitigation and heinousness of the crime presented in aggravation, when the alleged "heinousness" results from mental illness. However, in this situation, the Supreme Court has suggested that the evidence of mental illness may only be used in mitigation. See Zant v. Stephens, 462 U.S. 862, 885 (1983) (indicating that it would be impermissible to classify as an aggravator "conduct that actually should militate in favor of a lesser penalty, such as perhaps the defendant's mental illness").

Commentary

Standard 7-9.8 provides that defendants must be competent to proceed at capital sentencing. Subparagraph (a)(i) presumes that most defendants who are competent to proceed at trial will be competent to proceed at capital sentencing, given the fact that capital sentencing proceedings usually occur soon after conviction at trial. However, subparagraph (a)(ii) recognizes that sentencing proceedings in a capital case can be complex. Some defendants may not appreciate the broad range of the inquiry and the potentially mitigating significance of personal information they hold privately. They may be embarrassed to share this information, or they may simply think, because they already have been convicted, it is not important. Other defendants may feel deflated and defeatist when they are convicted; some may even believe they would rather die than spend life in prison. These types of defendants may otherwise be competent to proceed yet fail to provide counsel with the kind of assistance necessary to assure an adequate representation. Furthermore, all of these beliefs and feelings may change in time. For example, the defendant in *Godinez v Moran*,[34] fired his attorneys, pleaded guilty and refused to present evidence in mitigation at sentencing, only to subsequently challenge his conviction after receiving treatment. As emphasized in Parts IV and V of these Standards, this standard recognizes that the competence test is context dependent.

Paragraph (b) provides that the decision whether to present mitigating evidence at sentencing, including an exemption under standard 7-9.2, should be up to defense counsel, after consultation with the defendant. Ordinarily, a defendant who is competent to proceed has substantial control over the direction of the case, including at sentencing. Standard 4-5.2 (b)(vii) of the ABA Standards for the Defense Function, for example, allows the defendant to decide whether to speak at sentencing. Further, standard 7-6.3(a) gives the defendant, not counsel, authority to decide whether to raise a mental nonresponsibility defense, which conceptually is very similar to an argument for preemption or in mitigation. But the consequences of forgoing arguments that might prevent a sentence of death are very different from the consequences of forgoing a mental nonresponsibility defense at trial, even a trial in a capital case. At least in the latter instance, the defense can still present mental disability evidence at sentencing. Furthermore, as the commentary to standard 7-6.3(a) notes, foregoing a mental condition defense at trial avoids indeterminate hospitalization and the stigma of being labeled insane. In contrast, foregoing mitigation in capital cases at the individual's behest, at best, facilitates state-assisted suicide.

At bottom, society's interest in avoiding the execution of person who does not deserve the death penalty is much stronger than its interest in avoiding conviction of

[34] 509 U.S. 389 (1993).

a person who is not mentally responsible [insane], and thus outweighs the individual's traditional entitlement to control fundamental aspects of his or her case; the Supreme Court itself obliquely recognized this point in *Kahler v. Kansas*, a capital case, when it justified its decision allowing abolition of the insanity defense in part on the ground that evidence of mental illness can still be proffered at sentencing.[35] Thus, where after consultation with the defendant defense counsel believes there is evidence of mental disability that mitigates against imposition of the death penalty, counsel should be able to present this information even over the client's objection.

Standard 7-9.9. Mental Disorder or Disability after Sentencing[36]

(a) *Grounds for precluding execution*. A sentence of death should not be carried out if the prisoner has a mental disorder or disability that significantly impairs his or her capacity:

(i) to make a rational decision to forgo or terminate post-conviction proceedings available to challenge the validity of conviction or sentence;

(ii) to understand or communicate pertinent information, or otherwise assist counsel, in relation to specific claims bearing on the validity of the conviction or sentence that cannot be fairly resolved without the prisoner's participation; or

(iii) to understand the nature and purpose of the punishment, or to appreciate the reason for its imposition in the prisoner's own case

Procedures to be followed in each of these categories are specified in (b) through (d) below, and procedures to be followed in all three categories are specified in (e) below.

(b) *Procedure in cases involving prisoners seeking to forgo or terminate post-conviction proceedings.* If a court finds that a prisoner under sentence of death who wishes to forgo or terminate post-conviction proceedings has a mental disorder or disability that significantly impairs his or her capacity to make a rational decision, the court should permit a next friend acting on the prisoner's behalf to initiate or pursue available remedies to set aside the conviction or death sentence.

[35] 589 U.S. 271, 285 (2020).

[36] This provision, through subsection (d), is taken verbatim from paragraph 3 of American Bar Association Resolution 122A, supra note 1. The resolution was also adopted by the American Psychiatric Association, the American Psychological Association, and the National Alliance for the Mentally Ill. The language replaces original standard 7-5.6. Subparagraph (e) revises original standard 7-5.7.

(c) ***Procedure in cases involving prisoners unable to assist counsel in post-conviction proceedings.*** **If a court finds at any time that a prisoner under sentence of death has a mental disorder or disability that significantly impairs his or her capacity to [rationally] understand or communicate pertinent information, or otherwise to assist counsel, in connection with post-conviction proceedings, and that the prisoner's participation is necessary for a fair resolution of specific claims bearing on the validity of the conviction or death sentence, the court should suspend the proceedings and order an evaluation of the prisoner. If the court finds, after evaluation or after treatment as provided in Part IV, that there is no significant likelihood of restoring the prisoner's capacity to participate in post-conviction proceedings in the foreseeable future, it should reduce the prisoner's sentence to the sentence imposed in capital cases when execution is not an option.**

(d) ***Procedure in cases involving prisoners unable to understand the punishment or its purpose.*** **If, after challenges to the validity of the conviction and death sentence have been exhausted and execution has been scheduled, a court finds that a prisoner has a mental disorder or disability that significantly impairs his or her capacity to [rationally] understand the nature and purpose of the punishment, or to appreciate the reason for its imposition in the prisoner's own case, the sentence of death should be reduced to the sentence imposed in capital cases when execution is not an option.**

(e) ***Evaluation and adjudication procedure*****. The evaluation procedure for making the determinations required by this Standard should be as follows:**

(i) Any individual, including a correctional official, other state official, the prosecution, counsel for the prisoner, or the court on its own motion, may raise the issue of whether a prisoner is incompetent on the grounds described in Standard 7-9.9(a). If the court finds that there is reason to believe the prisoner may be incompetent, it should appoint counsel for the prisoner if the prisoner is not represented, and, if the prisoner is indigent, provide counsel with adequate resources to retain a mental health professional to evaluate the prisoner. The state should be permitted to have its own qualified professional or professionals conduct an evaluation as well.

(ii) All evaluations of a prisoner's current mental condition for purpose of determining the issue of competence should be conducted by mental health professionals whose qualifications meet the requirements of Standard 7-3.9 through 7-3.12.

(iii) If, after receiving the reports of the evaluation or evaluations, counsel for the prisoner believes that the prisoner is currently incompetent, counsel should move for a hearing on the issue of competence. Upon receiving such a motion, the court should order a hearing unless it finds, under Standard 7-9.9 (e)(vi), that the attorney's motion is improper.

(iv) Following the hearing, if the court finds, by a preponderance of the evidence, that the prisoner is currently incompetent, it should order the appropriate disposition, consistent with Standards 7-9.9(b) through (d).

(v) If evaluations or proceedings under this Standard cannot be accomplished before the scheduled date of the prisoner's execution, the court should order a stay of execution until the proceedings on the issue of competence are completed.

(vi) In the absence of good faith doubt about the prisoner's current competence, it is improper for an attorney to request resources to retain a mental health professional to evaluate the prisoner or move for a hearing to determine the prisoner's competence. It is improper to use proceedings on the issue of current mental condition solely for the purpose of delay.

Commentary

Standard 7-9.9 concerns post-sentence circumstances that may call for precluding the execution of defendants who have been sentenced to death. Paragraph (a) recognizes three such situations: (i) where the mental disorder significantly impairs the defendant's capacity to make a rational decision to forgo or terminate post-conviction proceedings; (ii) where the mental disorder significantly impairs the defendant's capacity to assist counsel in challenging the validity of the conviction or sentence; and (iii) where the mental disorder significantly impairs the defendant's capacity to understand the nature and purpose of the punishment, or to appreciate the reason for its imposition in the offender's own case. Paragraphs (b) through (d) establish procedures to be followed upon a finding of each incapacity. In the case of offenders found to be incapable of seeking to forgo or terminate post-conviction proceedings, paragraph (b) provides that the court should permit a "next friend" to act on the offender's behalf. In the case of offenders found to be unable to assist in post-conviction proceedings, paragraph (c) indicates that if efforts to restore competency pursuant to Part IV fail or are likely to do so, the sentence should be reduced to the sentence imposed when execution is not an option. Paragraph (d)

states that if an offender is found to be unable to rationally understand the punishment or its purpose —a standard taken from the Supreme Court's decisions in *Ford v Wainwright*[37] and *Panetti v Quarterman*[38]—the sentence should be reduced to the sentence imposed when execution is not an option.

This standard, through subsection (d), is taken verbatim from paragraph 3 of American Bar Association Resolution 122A. The bulk of the commentary that follows comes from the report that accompanied that resolution, edited only as necessary to account for subsequent developments in law and practice and to fit the Standards' format. Paragraph (e) is added to provide a procedure for evaluation and adjudication when any of the issues addressed in Resolution 122A arise.

Prisoners Seeking to Forgo or Terminate Post-Conviction Proceedings

The U.S. Supreme Court has ruled that a competent prisoner is entitled to forgo available appeals.[39] If the prisoner is not competent, the standard procedure is to allow a so-called "next friend" (including the attorney) to pursue direct appeal and collateral proceedings aiming to set aside the conviction or sentence. Paragraph (b) addresses the definition of competence in such cases, providing that a next friend petition should be allowed when the prisoner has a mental disorder or disability "that significantly impairs his or her capacity to make a rational decision."

Research has found that a sizeable percentage of prisoners executed in the modern era have been so-called "volunteers"—prisoners choosing not to contest their execution.[40] As emphasized in the analogous circumstances discussed in the commentary to standard 7-5.2, any meaningful competence inquiry in this context must focus not only on the prisoner's understanding of the consequences of the decision, but also on their *reasons* for wanting to surrender their right pursue collateral relief, and on the rationality of the prisoner's thinking and reasoning. In *Rees v. Peyton*,[41] the U.S. Supreme Court instructed the lower court to determine whether the prisoner had the "capacity to appreciate his position and make a rational choice with respect to continuing or abandoning further litigation or on the other hand whether the prisoner is suffering from a mental disease, disorder or defect which may substantially affect his capacity in the premises."[42] The lower courts have integrated the *Rees* formula into a three-step test: (1) does the prisoner have a mental disorder? (2) if so, does this condition prevent the prisoner from

[37] 477 U.S. 399 (1986)
[38] 551 U.S. 930 (2007)
[39] See, e.g., Gilmore v. Utah, 429 U.S.1012 (1977).
[40] John Blume, Killing the Willing: "Volunteers, Suicide and Competency, 103 Mich. L. Rev. 939, 959 (2005).
[41] 384 U.S. 312 (1966) (remanding the case for a competency determination after condemned prisoner directed attorney to withdraw petition for certiorari).
[42] Id. at 314..

understanding his or her legal position and the options available to the prisoner? (3) even if understanding is unimpaired, does the condition nonetheless prevent the prisoner from making a rational choice among the options?[43] Because the courts have adopted a fairly broad conception of mental disorder (the first step) and because the prisoner's understanding of his or her "legal position" (the second step) is hardly ever in doubt in these cases, virtually all the work under the *Rees* test is done by the third step.[44] Conceptually, the question is relatively straightforward – is the prisoner's decision attributable to "rational choice"?

Unequivocal cases of irrationality rarely arise. If an offender suffering from schizophrenia tells his or her attorney to forgo appeals because the future of civilization depends upon the offender's death,[45] the "reason" for the prisoner's choice can comfortably be attributed to the psychotic symptom. However, decisions rooted in gross delusions of this sort are atypical in these cases. The usual case involves articulated reasons that may seem "rational" under the circumstances. For instance, offenders may state a desire to take responsibility for their actions and pronounce that they deserve the death penalty or they might indicate a preference for the death penalty over life imprisonment. The cases that give the courts the most trouble are those in which such apparently rational reasons are intertwined with emotional distress, feelings of guilt and remorse, and hopelessness. Assuming, for example, that the prisoner is depressed and suicidal but has a genuine desire to take responsibility, how is one to say which motivation "predominates"?

John Blume studied the prevalence of significant mental disorder among a group of 106 prisoners who "volunteered" for execution.[46] According to Blume, 15 of these volunteers had recorded diagnoses of schizophrenia, 23 had diagnoses of depression or bipolar disorder, 10 had records of PTSD, four had diagnoses of borderline personality disorder, and two had been diagnosed with multiple personality disorder. Another 12 had unspecified histories of "mental illness."[47] Given this high prevalence of mental disorder, the courts should be more willing than they are now to attribute suicidal motivations to mental disorder when the clinical evidence of such a link is convincing. The third step of the *Rees* test would then amount to the following: Is the prisoner who seeks execution able to give plausible reasons for doing so that are clearly *not* grounded in symptoms of mental disorder?[48]

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[43] See, e.g., Hauser v. Moore, 223 F.3d 1316, 1322 (11th Cir. 2000); Rumbaugh v. Procunier, 753 F.2d 395 (5th Cir 1985).

[44] See id.

[45] Cf. Illinois v. Haynes, 737 N.E.2d 169, 178 (Ill. 2000); In re Heidnick, 720 A. 2d 1016 (Pa 1998).

[46] Blume, supra note 40, Appendix B, at 989-96.

[47] The text refers only to significant mental disorders that could have distorted the prisoner's reasoning process and impaired capacity for rational choice. In addition to these cases, Blume reports that 20 of these prisoners had histories of substance abuse unaccompanied by any other mental disorder diagnosis, another 6 had personality disorders (with or without substance abuse) and 4 had sexual impulse disorders.

[48] See Richard J. Bonnie, Mentally Ill Prisoners on Death Row: Unsolved Puzzles for Courts and Legislatures, 54

Given the stakes of the decision, a relatively high degree of rationality ought to be required in order to find people competent to make decisions to abandon proceedings concerning the validity of a death sentence.[49]

Prisoners Unable to Assist Counsel in Post-Conviction Proceedings

Paragraph (c) addresses the circumstances under which impaired competence to participate in adjudication should affect the initiation or continuation of post-conviction proceedings. Under the laws of many states and the federal Anti-Terrorism and Effective Death Penalty Act (AEDPA), collateral proceedings are barred if they are not initiated within a specified period of time.[50] However, it is undisputed that a prisoner's failure to file within the specified time must be excused if such failure was attributable to a mental disorder that impaired the prisoner's ability to recognize the basis for possible collateral remedies. Similarly, the prisoner should be able to lodge new claims, or re-litigate previously raised claims, if the newly available evidence upon which the claim would have been based, or that would have been presented during the earlier proceeding relating to the claim, was unavailable to counsel due to the prisoner's mental disorder.[51]

Assuming, however, that collateral proceedings have been initiated in a timely fashion, the more difficult question is whether, and under what circumstances, a prisoner's mental disability should require suspension of the proceedings. In *Ryan v. Gonzalez*,[52] the Supreme Court held that there is no federal statutory right to be competent during habeas proceedings. But it avoided squarely addressing whether the due process clause or the right to counsel is inapplicable in this setting. Rather, it held that, on the facts before it, most or all of the asserted claims were "record based or resolvable as a matter of law," and thus could be addressed without the petitioner's involvement.[53] At the same time, it concluded by stating that "where there is no reasonable hope of competence, a stay is inappropriate and merely frustrates the State's attempts to defend its presumptively valid judgment."[54] To the contrary, paragraph (c) of this standard provides that courts should suspend post-conviction proceedings upon proof both that a prisoner is incompetent to assist counsel in such

Cath. U. L. Rev. 1169, 1187-88 (2005) (arguing that a more demanding approach would ask whether the prisoner is able to give plausible reasons that reflect authentic values and enduring preferences).

[49] See Richard J. Bonnie, The Dignity of the Condemned, 74 Va. L. Rev. 1363, 1388-89 (1988); Cf. Richard J. Bonnie, The Competence of Criminal Defendants: Beyond *Dusky* and *Drope*, 47 U. Miami L. Rev. 539, 579-80 (1993).

[50] 28 U.S.C. § 2244(d).

[51] See, e.g., Council v. Catoe, 359 S.C. 120, 597 S.E.2d 782, 787 (2004) ("For issues requiring the petitioner's competence to assist his [post-conviction] counsel, such as a fact-based challenge to his defense counsel's conduct at trial, the [post-conviction] judge may grant a continuance, staying review of these issues until petitioner regains his competence."); Commonwealth v. Haag, 809 A.2d 271, 285 (PA, 2001).

[52] 568 U.S. 57 (2013)

[53] Id. at 74-75.

[54] Id. at 77.

proceedings and that the prisoner's participation is necessary for fair resolution of a specific claim; it further provides that, if the prisoner is not restorable to competence, the suspension should be made permanent.

Thorough post-conviction review of the legality of death sentences has become an integral component of modern death penalty law, analogous in some respects to direct review. Any impediment to this review undermines the integrity of the review process and therefore of the death sentence itself. As *Ryan* recognized, many issues raised in collateral proceedings can be adjudicated without the prisoner's participation, and these matters should be litigated according to customary practice. However, when the prisoner's counsel makes a substantial and particularized showing that the prisoner's impairment would prevent a fair and accurate resolution of specific claims, suspension of the proceedings is necessary to prevent miscarriages of justice. Scores of people on death row have been exonerated based on claims of factual innocence, and many more offenders have been removed from death row and given sentences less than death because of subsequent discovery of mitigating evidence.[55] The possibility, however slim, that incompetent individuals may not be able to assist counsel in reconstructing a viable factual or legal claim requires that executions be barred under these circumstances.

Further, once the post-conviction proceedings have been suspended on grounds of the prisoner's incompetence to assist counsel, the death sentence should remain under an indefinite stay. The situation is analogous to the suspension of criminal proceedings before trial under *Jackson v. Indiana*;[56] in that context, as provided in standard 7-4.14(c), the proceedings are typically terminated (and charges are dismissed) after a specified period if a court has found that competence for adjudication is not likely to be restored in the foreseeable future. In the present context, it would be unfair to hold the death sentence in perpetual suspension. A judicial finding that the prisoner's competence to assist counsel is not likely to be restored in the foreseeable future should trigger an automatic reduction of the sentence to the disposition the relevant law imposes on capital offenders when execution is not an option (usually life without parole).

Prisoners Unable to Understand the Punishment or its Purpose

In *Ford v. Wainwright*,[57] the U.S. Supreme Court held that execution of an incompetent prisoner constitutes cruel and unusual punishment proscribed by the Eighth Amendment. The Court failed, however, to specify a constitutional definition

[55] See Death Penalty Information Center, Innocence (2024), available at https://deathpenaltyinfo.org/policy-issues/innocence (indicating that 190 people have been exonerated on capital charges for various reasons).
[56] 406 U.S. 715 (1972).
[57] 477 U.S. 399 (1986).

of incompetence for lower courts to follow. Rather the Court recited various rationales to support its opinion. These included the need to ensure that offenders are able to provide counsel with information that might lead to vacation of sentence; the view that, in the words of Lord Coke, execution of "mad" people is a "miserable spectacle . . . of extream inhumanity and cruelty [that] can be no example to others"; and the notion that retribution cannot be exacted from people who do not understand why they are being executed.[58] Apparently based on the latter rationale, Justice Powell, in his concurring opinion in *Ford*, stated: "I would hold that the Eighth Amendment forbids the execution only of those who are unaware of the punishment they are about to suffer and why they are to suffer it."[59] Justice Powell pointed out that states are free to preclude execution on other grounds, but most courts and commentators have assumed that the Eighth Amendment requirement is limited to the test offered by Justice Powell.[60]

In *Panetti v Quarterman*,[61] the Court clarified that competence in this context requires more than a simple "awareness" of the punishment and its purpose; rather, the Court declared, the prisoner's awareness must reflect a "*rational* understanding" of the reasons for execution, and should not be undermined by psychosis.[62] As the Court stated, "Gross delusions stemming from a severe mental disorder may put an awareness of a link between a crime and its punishment in a context so far removed from reality that the punishment can serve no proper purpose."[63] Still, the standard for competence to be executed remains ambiguous.

In order to emphasize the need for a deeper understanding of the state's justifying purpose for the execution, paragraph (d) requires that an offender not only "rationally understand" the nature and purpose of punishment but also "appreciate" its personal application in the offender's own case – that is, why it is being imposed *on the offender*. If, as is generally assumed, the primary purpose of the competence-to-be-executed requirement is to vindicate the retributive aim of punishment, then offenders should have more than a shallow understanding of why they are being executed. Thus, for instance, in *Madison v. Alabama*,[64] where the offender allegedly could not remember the offense, the Court stated that, while the memory loss, by itself, did not render the offender incompetent to be executed, "if that loss combines and interacts with other mental shortfalls to deprive a person of the capacity to

[58] *Id.* at 406-08.
[59] Id. at 42 (Powell, J. concurring).
[60] See, e.g., Ferguson v. Sec'y, Fla. Dep't Corrections, 716 F.2d 1513 (11th Cir. 2013); Richard Bonnnie, *Panetti v. Quarterman*: Mental Illness, the Death Penalty, and Human Dignity, 5 Ohio St. J. Crim. L. 257, 276-277 (2007).
[61] 551 U.S. 930 (2007).
[62] Id. at 959-960.
[63] Id. at 960.
[64] 586 U.S. 265 (2019).

comprehend why the State is exacting death as punishment, then the *Panetti* standard will be satisfied."[65]

Whether a person found incompetent to be executed should be treated to restore competence implicates not only the prisoner's constitutional right to refuse treatment but also the ethical integrity of the mental health professions.[66] Some courts have decided that the government may forcibly medicate incompetent individuals if necessary to render them competent to be executed, on the ground that once an individual is fairly convicted and sentenced to death, the state's interest in carrying out the sentence outweighs any individual interest in avoiding medication.[67] However, treating a condemned prisoner, especially over his or her objection, for the purpose of enabling the state to execute the prisoner strikes many observers as barbaric and also violates fundamental ethical norms of the mental health professions. For instance, mental health professionals are nearly unanimous in the view that treatment with the purpose or likely effect of enabling the state to carry out an execution of a person who has been found incompetent for execution is unethical except in two highly restricted circumstances: an advance directive by the prisoner while competent that requests such treatment, or a compelling need to alleviate extreme suffering.[68] These will both be rare events. Because treatment aimed at restoring execution competency is therefore nearly always unethical, it is not "medically appropriate" and should be considered constitutionally impermissible under the criteria enunciated by the Supreme Court in *Sell v. United States*[69] and *Washington v. Harper*,[70] even when the prisoner does not object.[71] As the Louisiana Supreme Court observed in *Perry v. Louisiana*,[72] medical treatment to restore execution competence "is antithetical to the basic principles of the healing arts," fails to "measurably contribute to the social goals of capital punishment," and "is apt to be administered erroneously, arbitrarily or capriciously."[73]

There is only one sensible policy in this situation: a death sentence should be automatically commuted to a lesser punishment (the precise nature of which will be governed by the jurisdiction's death penalty jurisprudence) after a prisoner has been

[65] Id. at 727-728.
[66] Kirk S. Heilbrun, Michael L. Radelet & Joel A. Dvoskin, The Debate on Treating Individuals Incompetent for Execution, 149 Am. J. Psychiat 596 (1992); Richard J. Bonnie, Dilemmas in Administering the Death Penalty: Conscientious Abstention, Professional Ethics and the Needs of the Legal System, 14 L. & Hum. Beh. 67 (1990).
[67] Singleton v. Norris, 319 F.3d 1018 (8th Cir.) (en banc), cert denied, 540 U.S. 832 74 (2003).
[68] See Council on Ethical and Judicial Affairs, American Medical Association, Physician Participation in Capital Punishment, 270 JAMA365 (1993); American Psychiatric Association and American Medical Association, Amicus Brief in Support of Petitioner in Perry v. Louisiana, 498 U.S. 38 (1990); Richard J. Bonnie, Medical Ethics and the Death Penalty, 20 Hastings Ctr. Rep., 12, 15-17 (May/June, 1990).
[69] 539 U.S. 166 (2003).
[70] 494 U.S. 210 (1990).
[71] For further discussion of these cases, see commentary to standard 7-4.11.
[72] 610 So.2d 746 (La. 1992).
[73] Id. at 751.

found incompetent for execution.[74] Maryland has so prescribed,[75] and section (d) embraces this view. Once an offender is found incompetent to be executed, execution should no longer be a permissible punishment.

The current judicial practice is to entertain *Ford/Panetti* claims only when execution is genuinely imminent. Assuming that a judicial finding of incompetence–whenever rendered–would permanently bar execution, paragraph (d) likewise provides that *Ford* adjudications should be available only when legal challenges to the validity of the conviction and sentence have been exhausted and execution has been scheduled.[76]

Procedures

The procedures currently employed by the states for determining whether a condemned prisoner is incompetent to be executed vary widely. In *Ford*, the Court invalidated a Florida statute that left discretion to the governor to decide whether a prisoner is incompetent to be executed and that failed to ensure prisoners could prevent material suggesting incompetence.[77] But procedures that provide more than this bare minimum remain constitutional.

Paragraph (e) reflects the view that executing a prisoner who is irrationally waiving post-conviction claims, incapable of providing necessary information for post-conviction proceedings, or incompetent to be executed would violate principles of fundamental fairness. Procedures must be in place to ensure that does not occur. As Justice Marshall stated for the plurality in *Ford*, "[A]ny procedure that precludes the prisoner or his counsel from presenting material relevant to his sanity or bars consideration of that material by the fact finder is necessarily inadequate"[78]

Subparagraph (e)(i) provides that any interested individual may raise any issues addressed in standard 7-9.9. If, as the Constitution may demand,[79] all condemned prisoners are afforded counsel, the petition will often be brought by the

[74] A state could try to restore a prisoner's competence without medical treatment, but the prospects of an enduring change in the prisoner's condition are slight.

[75] Md. Code of Correctional Services, 3-904(a)(2), (d)(1).

[76] Given the many procedural barriers to successive petitions for collateral review, an execution date set after the completion of the initial round may be a "real" date, even if a successive petition has been filed or is being planned.

[77] 477 U.S. at 416 ("Perhaps the most striking defect in the procedures . . . is the State's placement of the decision wholly within the executive branch").

[78] Id. at 414..

[79] Due process may also require the appointment of counsel under such circumstances. In the terms of the balancing test announced in Mathews v. Eldridge, 424 U.S. 319 (1976), the individual interest in an accurate determination of his or her current mental condition is extremely high, while the state's interest in avoiding the appointment of counsel is relatively small. Equally importantly, the risk of erroneous determination when the inmate is not represented is very high, and the likelihood that counsel will reduce the risk of error is substantial.

defense. But correctional officials and other state officials have an obligation to do so as well if they have reason to believe that a condemned prisoner is currently incompetent. Because of the importance of the issue, it is unacceptable to allow these officials to decline to convey to the court relevant information on the convict's mental condition which might indicate incompetence. While the standard does not specify the procedures by which correctional officials should monitor the mental condition of condemned prisoners, one appropriate mechanism would be regular periodic review by qualified mental health professionals. But whether it comes from such reviews or any other source, information that indicates current incompetence must be communicated to the court. Although judges and attorneys for the state are less likely than correctional officials to be aware of the current mental condition of death row inmates, the same principle requires that these entities also raise the issue if they have reason to believe that the convict may be currently incompetent.[80]

Finally, subparagraph (e)(i) provides that, if sufficient doubt is raised as to competence, both the defense and the prosecution may seek evaluation of the issue. The standard adopts the adversarial model of *Ake v. Oklahoma*.[81] Although *Ake* only guarantees the defendant expert assistance on past mental state and future dangerousness issues, the stakes in the competence context are equally high in the competence context and the adversarial positions of the parties are clearly established.

Subparagraph (e)(ii) provides that all evaluations should be conducted by mental health professionals whose qualifications meet the requirements of standards 7-3.9 through 7-3.12,[82] and subparagraph (e)(v) provides that the court should stay execution if necessary for these professionals to carry out the relevant evaluations. Subparagraph (e)(iii) requires defense counsel to motion for a hearing on competence if, after the evaluation reports are received, counsel believes the prisoner's competence to be impaired in any of the three ways addressed in this standard, a motion the court should grant unless, as provided in subparagraph (e)(vi), the court believes counsel is acting solely to delay execution or some other improper purpose.[83] Subparagraph (e)(iv) assumes, following *Ford's* lead, that the hearing will be conducted by a judge, not an

[80] Cf. standard 7-4.3(a): "The court has a continuing obligation, separate and apart from that of counsel for each of the parties, to raise the issue of incompetence to stand trial at any time the court has a good faith doubt as to the defendant's competence, and may raise the issue at any stage of the proceedings on its own motion."; standard 7-4.3(b), requiring prosecutors to initiate an evaluation "whenever the prosecutor has a good faith doubt as to the defendant's competence" to stand trial.

[81] 470 U.S. 68 (1985).

[82] The other general evaluation requirements in Part III of Chapter 7 of the Standards should also be satisfied, such as the requirement of a personal interview specified in standard 7-3.9(b)(iii).

[83] Cf. standard 7-4.3(e): "In the absence of good faith doubt that the defendant is competent to stand trial it is improper for either party to move for evaluation. It is improper for either party to use the incompetence process for purposes unrelated to incompetence to stand trial such as to obtain information for mitigation of sentence, to obtain favorable plea negotiation or to delay the proceedings against the defendant."

executive official, and that the hearing will be adversarial in nature.[84] This procedure is also in accord with policies recommended by the American Psychological Association and the American Psychiatric Association, both of which have concluded that the decision on competence should be made by the court and that an adversarial presentation of expert witnesses is essential to fundamental fairness.[85]

Subparagraph (e)(iv) provides that the standard of proof on the competence issue is by a preponderance of the evidence, as it is under standard 7-4.9(c) when competence to proceed at other stages of the criminal process is at issue, for the reasons set out in that commentary. Thus there is a presumption of competence, and the burden of demonstrating incompetence must be carried by counsel for the inmate. If, after the hearing, the court finds by a preponderance of the evidence that the prisoner is incompetent, it should order the appropriate disposition, as set out in paragraphs 7-9.7(b), (c), and (d). The court's finding on the issue of competence is a final, appealable order. States may wish to consider providing for expedited hearings for appeals from such orders.

[84] The standard does not take a position on which court should be given jurisdiction over these cases. Somes states may choose to assign the task to the trial court that heard the criminal trial. Others may prefer that venue in which the inmate's prison is located. Logistical considerations, especially in large states, may favor the latter approach.

[85] Amici Curiae Brief of American Psychological Association and Florida Psychological Association, Ford v. Wainwright, U.S. Sup. Ct. No. 85-5542 (filed January 1986); Amicus Curiae Brief of American Psychiatric Association, id.

PART X. SENTENCED PRISONERS WITH MENTAL DISORDER

INTRODUCTION

Part X provides the procedural framework for voluntary and involuntary transfers of prisoners with mental disorders from correctional facilities to facilities that provide treatment, and for their later return to correctional control. It borrows heavily from Chapter 23's Standards on Treatment of Prisoners. Both there and in these Standards the basic principle is that correctional facilities should provide mental health treatment for prisoners who need it. Where a prisoner's needs cannot be met in the correctional facility, prisoners with severe mental disorder should be transferred for treatment or habilitation services to appropriate facilities, preferably under the jurisdiction of a state department of mental health or intellectual disability. Prisoners with sufficient mental capacity are allowed to seek voluntary transfer with the approval of correctional administrators, but otherwise judicial approval is required for transfers to treatment-centered administrative control and for contested returns to correctional administrative control. Transferred prisoners should be returned to prison whenever they no longer require special mental health treatment services; however, they should also continue to receive good-time credits and to be eligible for parole as if they had remained in adult correctional institutions. They also should have the correlative rights to receive treatment or to refuse it to the same extent civilly committed patients can. If they are in treatment facilities when their sentence of imprisonment expires, they must be either released immediately or committed through regular civil commitment proceedings, using either voluntary or involuntary processes. Finally, this part firmly rejects special post-sentence commitment procedures of the type currently in use for sexually violent predators and other "dangerous" offenders.

Standard 7-10.1 Services for people with mental disorder

(a) Pursuant to Standards 23-6.11 and 23-8.2 in the Standards on Treatment of Prisoners, a correctional facility should provide appropriate and individualized mental health treatment to prisoners with mental disorder.

(b) Correctional officers should receive appropriate training on how to deal with prisoners who have a mental disorder.

(c) Segregated housing of persons with mental disorder should only occur under the circumstances defined in Standard 23-2.8.

(d) Prisoners who require mental health treatment not available in the correctional facility should be transferred to a forensic mental health facility, pursuant to procedures set forth in the following Standards.

Commentary

Standard 7-10.1 follows Chapter 23 in establishing the general responsibility of correctional facilities to assure "appropriate and individualized mental health treatment to prisoners with mental disorder." The Supreme Court has recognized a constitutional right of prisoners to adequate medical diagnosis and treatment, including psychiatric care.[1] Paragraph (a) of this standard repeats the endorsement of that principle in standards 23-6.11 and 23-8.2 by stating that prisoners with mental disabilities are entitled to "appropriate and individualized" treatment. As standard 23-6.11 goes on to provide, this principle requires the development of "a protocol for identifying and managing prisoners whose behavior is indicative of mental illness, [intellectual disability] or other cognitive impairments," prompt referral to a qualified mental health professional under appropriate circumstances, and "appropriate housing assignments and programming opportunities in accordance with [prisoners'] diagnoses, vulnerabilities, functional impairments and treatment and habilitation plans."

Paragraph (b) of this standard endorses the correlative principle that prisons and jails must ensure they have staff members who are qualified to offer appropriate mental health treatment.[2] An issue not directly addressed in this standard is the nature of the treatment staff/prisoner-patient relationship. Despite the fact that treating professionals in prisons are employed by state governmental departments, they generally be governed by therapist-patient rules, which require a supportive, protective attitude. However, as recognized in standard 23-7.7, legitimate institutional needs relating to security and order may require a modification of usual confidentiality principles with respect to prisoner communications and records ;[3] if so, prisoners should be told in advance of disclosure obligations to correctional authorities.[4]

[1] Estelle v Gamble, 429 U.S. 97, 104 (1976) (describing, under the Eighth Amendment "the government's obligation to provide medical care for those whom it is punishing by incarceration"); *Bowring v. Godwin*, 551 F.2d 44, 47 (4th Cir., 1977) (finding "no underlying distinction between the right to medical care for physical ills and its psychological or psychiatric counterpart")..

[2] 3. Cf. standard 23-7.4 and commentary (noting the legislature's responsibility to provide sufficient resources to implement the legal rights of prisoners).

[3] Paragraph (a) of standard 23-7.7 requires prisoner consent for release of most information unless "a government official specifies in writing the particular information desired, the official's agency is authorized by law to request that information, and the disclosure of the information is appropriately limited to protect the prisoner's privacy" or "a valid court order authorizes disclosure."

[4] See Emil Pinta, Decisions to Breach Confidentiality When Prisoners Report Violations of Prison Institutional Rules, 37 J. Am. Acad. Psychiat. & L.1590 (2009) (summarizing the APA's Guidelines on Psychiatric Services in Jails and Prisons (2002), as providing that "confidentiality can be breached when inmates are at risk of serious

Paragraph (c) adopts by reference standard 23-2.8's rules regarding segregated housing and mental health. That standard prohibits "long-term segregated housing" for people with mental disorder, and requires immediate mental health screening of segregated prisoners, as well as daily monitoring, weekly sessions with a qualified mental health professional, and other treatment services as needed. If placement in the segregated setting leads to decompensation, the prisoner is to be removed to "an environment where appropriate treatment can occur."[5]

Standard 7-10.2. Voluntary transfer to mental health facility

(a) A prisoner desiring treatment in a mental health facility may make an application for voluntary admission to such a facility.

(b) If the application is endorsed by the chief executive officer of the correctional institution and accompanied by the report of an evaluation conducted by a mental health professional that explains why the prisoner should be transferred to a mental health facility, and the mental health facility accepts the endorsed application, the prisoner should be admitted to the facility.

(c) If the mental health facility does not accept the application, then the correctional facility may petition a court to order the transfer. The petition should be accompanied by the prisoner's application and the evaluation report, all of which should also be sent to the mental health facility. The court should set the matter for a prompt hearing. If the court finds, by clear and convincing evidence, that the prisoner has a mental disorder and is in need of treatment for the disorder in a mental health facility, the prisoner should be transferred.

Commentary

Standard 7-10.2 provides procedures for the voluntary admission of a prisoner to a mental health facility. All generally-applicable state civil commitment statutes

harm to themselves or others, . . . when an inmate presents a clear and present risk of escape" or when the inmate is responsible for "the creation of disorder within the facility" and describing analogous positions of various other organizations).

[5] Standard 23-2.8 (b). See also Am. Psychiat. Ass'n, Position Statement on Restrictive Housing of Incarcerated Adults with Serious Mental Illness (2023):
Restrictive housing of incarcerated adults with serious mental illness, with rare exceptions that involve significant danger to others, should be avoided due to the potential for harm to such individuals. If an individual with serious mental illness is placed in restrictive housing, in which one is confined to a cell for 22 or more hours per day, out-of-cell structured therapeutic activities (e.g., mental health/ psychiatric treatment) in appropriate programming space and regular unstructured out-of-cell time should be provided to maximize access to clinically indicated programming, treatment, recreation and transfer to a more therapeutic settings.

permit and encourage voluntary commitment.[6] By authorizing applications for voluntary care, standard 7-10.3(a) affords a like opportunity for prisoners with mental disorders, as a means of avoiding the time, expense, and trauma inherent in the judicially approved transfers governed by standard 7-10.3. Treatment that is administered voluntarily tends to be more successful.[7] And transfer of prisoners whose treatment needs cannot be met in prison will benefit both the prisoner and prison security.

However, the standard does not accord prisoners an absolute right to a transfer from correctional to hospital custody. Under paragraph (b), the chief executive officer must concur in a prisoner application for voluntary transfer and may do so only if an evaluation report supports the claim that mental health treatment outside the correctional system is needed. Under paragraph (c), even if the application is endorsed by correctional officials, the administrators of the treatment facility to which the prisoner will be transferred may, based on legitimate security concerns, refuse to accept a prisoner/patient. In that instance, voluntary transfer may occur only if a court finds by clear and convincing evidence that the transfer is warranted under a need for treatment standard.[8] Courts will have to make the difficult decision about whether the administrator's decision may be overridden, and under what conditions.

Standard 7-10.3. Involuntary transfer

(a) If the prisoner disagrees with the correctional facility's determination that transfer is needed, the facility may petition a court for involuntary transfer. The decision-maker must find by clear and convincing evidence that the prisoner has a mental disorder and is in need of treatment for the disorder in a mental health facility rather than in the correctional facility. Expert testimony as to whether a prisoner has a mental disorder and requires treatment in a mental health facility should be admissible.

(b) Prior to involuntary transfer of a prisoner with a mental disorder to a mental health facility, the prisoner should be afforded, at a minimum, the following procedural protections:

[6] See Christopher Slobogin, Thomas L. Hafemeister & Douglas Mossman, Law and the Mental Health System: Civil and Criminal Aspects 974-975 (7th ed. 2020).

[7] Henning Hachtel, Tobias Vogel & Chistian Huber, Mandated Treatment and Its Impact on Therapeutic Process and Outcome Factors, 10 Frontiers in Psychiat. 219 (2019) (stating that "[e]vidence suggests that perceived coercion in treatment is linked to an impaired therapeutic process and outcome compared to voluntary treatment" but also finding that court-ordered treatment does not always produce perceptions of coercion).

[8] The intent of the standard is that a hearing must be held and that petitions cannot be disposed of on the basis of written evaluation reports.

(i) at least [3 days] in advance of the hearing, written and effective notice of the fact that involuntary transfer is being proposed, the basis for the transfer, and the prisoner's rights under this Standard;

(ii) decision-making by a judicial or administrative hearing officer independent of the correctional facility, or by an independent committee that does not include any correctional staff but that does include at least one qualified mental health professional, who cannot be responsible for treating or referring the prisoner for transfer;

(iii) a hearing at which the prisoner may be heard in person and, absent an individualized determination of good cause, present testimony of available witnesses, including the prisoner's treating mental health professional, and documentary and physical evidence;

(iv) absent an individualized determination of good cause, opportunity for the prisoner to confront and cross-examine witnesses or, if good cause to limit such confrontation is found, to propound questions to be relayed to the witnesses;

(v) an interpreter, if necessary for the prisoner to understand or participate in the proceedings;

(vi) counsel, or some other advocate with appropriate mental health care training;

(vii) a written statement setting forth in detail the evidence relied on and the reasons for a decision to transfer;

(viii) an opportunity for the prisoner to appeal to a mental health care review panel or to a judicial officer; and

(ix) a de novo hearing held every [6 months], with the same procedural protections as here provided, to decide if involuntary placement in the mental health facility remains necessary.

(c) If a mental health professional at the correctional facility concludes that a prisoner with mental disorder requires immediate transfer to a dedicated mental health facility because of a serious and imminent risk to the safety of the prisoner or others, the chief executive of a correctional facility should be authorized to order such a transfer. However, with 48 hours of admission an involuntary transfer hearing should be conducted pursuant to this Standard.

Commentary

Standard 7-10.3 addresses the involuntary hospitalization of prisoners. It reproduces standards 23-6.15(a) and (b) verbatim, with one significant exception. Standard 23-6.15(a) allows involuntary treatment and transfer to a hospital only if failing to treat the prisoner's "serious mental illness" would pose "a significant risk of serious harm to the prisoner or others…." Paragraph (a) of this standard instead permits involuntary hospitalization upon a judicial finding, by clear and convincing evidence, that a prisoner "has a mental disorder and is in need of treatment for the disorder in a mental health facility rather than the correctional facility." The latter, broader standard, with its focus on need for treatment rather than dangerousness, is more consistent with the U.S Supreme Court's opinion in *Vitek v. Jones*.[9] While *Vitek* only directly addressed the appropriate *procedures* for involuntarily transferring prisoners to other facilities, it strongly suggested that dangerousness is not required for the involuntary hospitalization of prisoners, and the process it upheld involved a need for treatment standard.[10] Given the restrictions prison imposes on behavior, a dangerousness standard might also be difficult to meet in this setting. Most importantly, it might prevent a prisoner who is in need of treatment from obtaining it.

The need for treatment standard also calls for the expertise that mental health professionals are most likely to have. Paragraph (a) encourages their participation in this setting, consistent with the rest of these standards. Expert witnesses should have the necessary qualifications,[11] should offer opinions only if they have conducted a personal interview with the prisoner,[12] and should present their expert testimony in acceptable form.[13]

The rest of the standard sets out procedures for involuntary transfer, following standard 23-6.15. Notably, these procedures do not provide prisoners with the full complement of rights available at trial or even at civil commitment proceedings. As the Supreme Court pointed out in *Vitek*, prisoners' liberty interests are diminished by virtue of their conviction and imprisonment, whereas the state's interest in ensuring security and the prisoner's treatment are strong.[14] At the same

[9] 445 U.S. 480 (1980).
[10] Id. at 495 (recognizing that "the inquiry involved in determining whether or not to transfer an inmate to a mental hospital for treatment involves a question that is essentially medical. The question whether an individual is mentally ill and cannot be treated in prison 'turns on the meaning of the facts which must be interpreted by expert psychiatrists and psychologists.'") (quoting Addington v. Texas, 441 U.S. 418, 429 (1979)).
[11] See standards 7-3.9 & 7-3.10.
[12] See standard 7-3-9(b)(iii).
[13] See standard 7-3.8.
[14] 445 U.S. at 492 ("The loss of liberty produced by an involuntary commitment is more than a loss of freedom from confinement. It is indisputable that commitment to a mental hospital "can engender adverse social consequences to the individual" and that "[w]hether we label this phenomena 'stigma' or choose to call it

time, transfer to a mental health or habilitation facility can also implicate important liberty interests. Prisoners may be subject to treatment over objection, increased stigmatization, and delayed parole opportunities.[15] Thus, the procedure for involuntary transfer must ensure a reliable determination. As *Vitek* stated, "the medical nature of the inquiry . . . does not justify dispensing with due process requirements."[16]

Accordingly, paragraph (b) guarantees the rights recognized in *Vitek*: the rights to notice; a hearing at which the prisoner may present evidence and cross-examine the state's witnesses; an independent decisionmaker; and a written statement explaining a decision to transfer. It also provides a right to an interpreter in appropriate cases, a right to appeal, and de novo hearings on the necessity of continued transfer. Consistent with *Vitek*, however, it does not require counsel,[17] although it does bar counsel either.[18] Rather, it permits, in lieu of counsel, other advocates who have "appropriate mental health care training." This provision, at a minimum, ensures prisoners have assistance in making their case and may, given the need for treatment transfer criterion, be a better fit with the proceeding. Finally, paragraph (a) requires that the requisites for transfer be proven by clear and convincing evidence, the standard of proof required for civil commitment; while one might argue that a lower standard is permissible, given the fact that civil commitment involves people who, unlike prisoners, are not subject to custody, civil committees are typically confined for much shorter periods of time than prisoners, which justifies adoption of the clear and convincing threshold in this context.[19]

Paragraph (c) allows for emergency transfer of a prisoner to a mental health facility upon order of the correctional facility's chief executive officer. As is the case under standard 23-6.15(c), such transfer may only occur if the prisoner presents "a serious and imminent risk to the safety of the prisoner or others." However, this standard departs from standard 23-6.15(c) by providing that a judicial finding that these criteria are met must take place within 48 hours of admission, a shorter period of time than allowed under the latter standard, which calls for review after 7 days. Correctional institutions must be able to provide timely emergency medical care for

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something else . . . we recognize that it can occur and that it can have a very significant impact on the individual.").

[15] Id. at 491-492.

[16] Id. at 495.

[17] Four justices concluded that a right to counsel does not exist in this setting, four justices held to the contrary view, and Justice Powell concluded that "qualified and independent assistance must be provided to an inmate who is threatened with involuntary transfer to a state mental hospital" but that provision of legal counsel was not required. Id. at 497 (Powell, J., concurring).

[18] Cf. Gagnon v. Scarpelli, 411 U.S. 778, 790 (1973) (holding that, even though there is no constitutional right to counsel in every parole or probation revocation proceeding, one must be provided when "the reasons [for rejecting the government's action] are complex or otherwise difficult to develop or present.").

[19] Alexander D. Tulloch, Paul Fearon P & Anthony S. David, Length of Stay of General Psychiatric Inpatients in the United States: Systematic Review, 38 Adm Policy Ment Health 155 (2001) (reporting a maximum length of stay of 24.9 days).

prisoners consistent with accepted medical practice and standards. Nonetheless, prompt review of this decision is necessary to prevent abuse. The 48-hour period in this standard has its counterpart in most civil commitment statutes.[20]

Standard 7-10.4. Right of prisoner to refuse treatment

(a) Involuntary medication of a prisoner should be permitted 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.

(b) Prior to involuntary mental health treatment of a prisoner with a mental disorder, the prisoner should be afforded, at a minimum, the procedural protections specified in Standard 10.3(b) for involuntary mental health transfers, except that:

(i) the decision-making body in the first instance and on appeal may include appropriate correctional agency staff;

(ii) the notice should set forth the mental health staff's diagnosis and basis for the proposed treatment, a description of the proposed treatment, including, where relevant, the medication name and dosage, and the less-intrusive alternatives considered and rejected; and

(iii) the de novo hearing should determine whether to continue or modify any involuntary treatment, and in reaching that decision should consider, in addition to other relevant evidence, evidence of side effects.

(c) In an emergency situation requiring the immediate involuntary medication of a prisoner with mental disorder, an exception to the procedural requirements described in subdivision (b) of this Standard should be permitted, provided that the medication is administered by a qualified health care professional and that it is discontinued within 72 hours unless the requirements in subdivision (b) of this Standard are met.

(d) Notwithstanding a finding pursuant to subdivision (b) of this Standard that involuntary treatment is appropriate, mental health staff should continue attempting to elicit the prisoner's consent to treatment.

Commentary

[20] See Gary Melton et al., Psychological Evaluations for the Courts: A Handbook for Mental Health Professionals and Lawyers 344 (3d ed. 2017).

Standard 7-10.4 addresses the right of a prisoner to refuse treatment—specifically, psychotropic medication, which, as the Supreme Court has recognized, is powerful and can have significant negative side effects.[21] This provision borrows from Part 23 as well, in particular standard 23-6.15.

Paragraph (a) follows standard 23-6.15(a) by permitting treatment with medications over the prisoner's objection only if the prisoner is "suffering from a serious mental disorder, non-treatment poses a significant risk of serious harm…, and no less intrusive alternative is reasonably available." This language provides more protection than afforded prisoners by the Supreme Court's decision in *Washington v. Harper*.[22] But it is consistent with the Court's subsequent decision in *Riggins v. Nevada*,[23] where, in a case involving persons subjected to trial, the Court emphasized that, given their powerful effects, psychotropic drugs should be a treatment of last resort.

Paragraph (b) requires adjudication of the involuntary treatment issue pursuant to the same procedure that governs involuntary hospitalization under standard 7-10.3(b), except the decision-making body may be composed of the appropriate correctional agency staff and the notice and decision-making requirements should be specific to medication issues. Paragraph (c) permits emergency treatment with medication by a qualified health care professional for up to 72 hours without adjudication under (b). And paragraph (d) incorporates good clinical practice by imposing an ongoing duty to elicit consent to treatment, which sometimes is more forthcoming once the medication takes effect.

Standard 7-10.5. Good time credits and parole

(a) A prisoner transferred to a mental health facility should earn good time credits on the same terms as prisoners in adult correctional facilities.

(b) A prisoner transferred to a mental health facility should be eligible for parole release consideration on the same terms as prisoners in correctional facilities.

[21] See Washington v. Harper, 494 U.S. 210, 229 (1990) ("The forcible injection of medication into a nonconsenting person's body . . . represents a substantial interference with that person's liberty.").
[22] Id. at 227 (holding that the decision to override a prisoner's refusal of medication is permissible if prison staff conclude " the inmate is dangerous to himself or others and the treatment is in the inmate's medical interest")..
[23] 504 U.S. 127, 135 (1992) (holding that imposing psychotropic medication over the objection of a defendant for the purpose of restoring competence should occur only if the medication is medically appropriate and, considering less intrusive alternatives, essential for the individual's own safety or the safety of others).

(c) If otherwise qualified for parole, a prisoner should not be denied parole solely because the prisoner had or is receiving treatment in a mental health facility.

(d) Parole may be conditioned on outpatient treatment if the prisoner would benefit from such treatment and if treatment is necessary to protect the safety of the offender or the public or to assure the offender's successful integration in the community parole may be conditioned on such treatment.

Commentary

Standard 7-10.5 provides that good time credits and parole should not be denied or restricted simply because a prisoner had or is receiving treatment in a mental health facility or in the community. Prisoners continue in the legal control of a department of prisons or corrections even when transferred to a department of mental health. Therefore, they should be treated like other prisoners with respect to the accrual of good time and other credits against sentence.

Paragraph (a), which is consonant with standard 23-7.2(d), makes this clear with respect to good time credits. Paragraph (b) similarly confirms that prisoners in a mental health facility must be evaluated for parole release whenever they would have been given a parole review had they been retained continuously in an adult correctional institute. Paragraph (c) expresses the corollary principle, namely, that prisoners found to be eligible for parole cannot be denied parole solely because they have received or currently are receiving treatment in a mental health facility.

Paragraph (d) indicates the appropriate resolution of cases involving prisoners who remain in custody of a department of mental health when they become parole-eligible. If they cannot be released safely into the community as outpatients, they should not be paroled from prison. Conversely, however, if they can be furloughed from a mental health facility as outpatients, and otherwise are eligible for parole release, they should be paroled. Parole should be conditioned on compliance with treatment regimes of the type prescribed for civilly committed patients allowed to leave hospital confines on outpatient or furlough status (compare standard 7-7.12, which governs conditional release of mental nonresponsibility [insanity] acquittees).

Standard 7-10.6. Return to correctional facility

(a) When a transferred prisoner seeks return to a correctional facility and the prisoner was transferred voluntarily under Standard 7-10.2, the prisoner should be returned to the correctional facility unless the mental health facility believes that the prisoner still meets transfer criteria and it is

determined, pursuant to a hearing conducted under Standard 7-10.3(b), that continued treatment in the mental health facility is necessary. If the prisoner seeking return to the correctional facility was transferred involuntarily, the prisoner is entitled to a hearing within [six months], consistent with Standard 7-10.3(b)(ix).

(b) When the mental health facility determines that the prisoner no longer meets the transfer criteria and decides to return the prisoner, the prisoner, the correctional facility, and the court should receive written notice of this decision at least [fifteen] days prior to the return. The notice should include the factual basis for the return decision and confirmation that the prisoner has been advised of the right to object.

(i) When the prisoner, the mental health facility, and the correctional facility agree that the prisoner no longer meets the transfer criteria in Standard 7-10.3(a), the prisoner should be returned promptly to the correctional facility.

(ii) If the prisoner objects to being returned, that objection must be included in the notice sent to the court. The court should determine, at a hearing if necessary, whether the return decision reflects deliberate indifference to the offender's reasonable mental health needs. If the court so finds, the prisoner should remain in the mental health treatment facility.

Commentary

Standard 7-10.6 addresses the circumstances under which a hospitalized prisoner may be returned to a correctional facility. As recognized in standards 7-10.3 and 7-10.4 prisoners can be transferred voluntarily or involuntarily to the custody of a mental health department only if they are severely mentally disordered and are in need of treatment that can only be provided outside the correctional setting. If their condition improves to the point that they no longer need treatment, or treatment can be provided within corrections, they should be returned promptly to the control of the latter to serve out their prison term. That is the objective of standard 7-10.6.

Paragraph (a) deals with prisoners who *want* to return to the correctional facility. They should be allowed to do so, unless the mental health facility can show, at a hearing, that the prisoner still meets transfer criteria. The standard also restates the requirement in standard 7-10.3(b)(ix) that such a hearing is in any event required within six months of transfer if the prisoner was initially transferred to the treatment facility involuntarily.

If instead the mental health facility wishes to return a prisoner who prefers staying there, paragraph (b) requires that the facility provide notice to the prisoner, the correctional facility, and the court at least [15] days in advance. If all parties agree that the prisoner does not meet criteria in 7-10.3(a), subparagraph (b)(i) requires a "prompt" return of the prisoner. Otherwise, subparagraph (b)(ii) calls for a hearing at which the court determines whether the return decision reflects a "disregard of the offender's reasonable mental health needs;" if so, the return to prison should be denied. This provision also makes clear that this decision should be made by a court. While release decisions in the civil commitment setting are usually made by the mental health facility rather than the court, in the correctional setting the mediation of a judge is necessary to prevent correctional departments and mental health departments from transferring, against their wishes, prisoners perceived as difficult to manage or treat to the other entity.

Standard 7-10.7. Civil commitment at expiration of sentence

(a) A prisoner who has been hospitalized pursuant to Standard 7-10.3 must either be released or civilly committed pursuant to the state's general civil commitment statute when the sentence expires.

(b) Statutes that provide for post-sentence commitment of offenders using criteria that differ from the general civil commitment criteria should be repealed.

Commentary

Standard 7-10.7 provides, in paragraph (a), that prisoners who have been hospitalized must be released or civilly committed when their sentences expire. Paragraph (b) calls for the repeal of statutes for the special, post-sentence commitment of sex offenders or other types of offenders using criteria different from ordinary civil commitment criteria. Despite the Supreme Court's decision in *Kansas v Hendricks*[24] upholding such statutes, the ABA continues to firmly oppose them, in line with the first edition of these Standards and virtually every professional organization that has addressed the matter.[25]

Part VIII of the first edition of these Standards contained a single provision, standard 7-8.1. That standard called for the repeal of statutes enacted during the

[24] 521 U.S. 346 (1997).
[25] See Brief of the American Psychiatric Association as Amicus Curiae in Support of Leroy Hendricks, 1996 WL 469200; Brief for the National Mental Health Association as Amicus Curia in Support of Respondent, 1996 WL 471077.

1930s through the 1960s authorizing the special indeterminate sentencing or treatment of "sexual psychopaths," "psychopaths," and "defective delinquents."[26] Today, almost all of these old statutes have been repealed. However, beginning in the 1990s a second generation of "sexual predator" statutes appeared that provided for the indeterminate "civil commitment" of sex offenders who have completed a criminal sentence but who are considered likely to reoffend due to "mental abnormality."[27] Approximately twenty states and the federal government have what are now known as sexually violent predator (SVP) laws.[28]

These special commitment laws have aroused serious concerns in both the psychiatric and legal communities. In 1994, when legislatures throughout the country were considering sex offender commitment bills, the American Psychiatric Association established a Task Force to study them. In 1996, the Task Force released an interim report concluding that SVP laws use psychiatric commitment as a "pretext for extended confinement that would otherwise be impermissible," and thus "distort the traditional meanings of civil commitment, misallocate psychiatric facilities and resources, and constitute an abuse of psychiatry."[29] The APA had used the characterization "abuse of psychiatry" only once before—in describing psychiatry in the former Soviet Union. Three years after releasing its preliminary report, the APA published the Task Force's Final Report. Employing slightly less sensational language, the report concluded: "[S]exual Predator Commitment Laws represent a serious assault on the integrity of psychiatry . . . . [B]y bending civil commitment to serve essentially non-medical purposes, sexual predator commitment statutes threaten to undermine the legitimacy of the medical model of commitment. . . .[T]his represents an unacceptable misuse of psychiatry."[30]

The National Association of State Mental Health Program Directors (NASMHPD) has studied these statutes as well. In a 1997 Position Statement that organization concluded that SVP laws threatened to "disrupt the state's ability to provide services for people with treatable psychiatric illnesses, . . . undermine the mission and integrity of the public mental health system, . . . divert scarce resources away from people who both need and desire treatment, . . . and endanger the safety of others in those facilities who have treatable psychiatric illnesses."[31] Recognizing

[26] ABA Criminal Justice Mental Health Standards, standard 7-8.1 (1st ed. 1986).
[27] Isaac D. Buck, An Indefinite Quarantine: A Public Health Review of Chronic Inconsistencies in Sexually Violent Predator Statutes, 87 St. John's L. Rev. 847 (2013) (describing and critiquing the statutes). These statutes also often permit indeterminate commitment of people who are about to be released from commitment as incompetent to stand trial or not guilty by reason of mental nonresponsibility.
[28] Id. at 849-854.
[29] American Psychiatric Association. Dangerous Sex Offenders: A Task Force Interim Report 106 (1996).
[30] American Psychiatric Association. Dangerous Sex Offenders: A Task Force Report 173-174 (1999).
[31] National Association of State Mental Health Program Directors Position Statement on Laws Providing for the Civil Commitment of Sexually Violent Criminal Offenders (1997), available at https://www.nasmhpd.org/content/position-statement-laws-providing-civil-committment-sexually-violent-criminal-offenders/.

that, despite this warning, SVP legislation was likely to remain on the books, NASMHPD included in its statement "guidelines" for implementing it. The guidelines provided, among other things, that people committed under these laws should "not be committable to facilities with mentally ill patients (for the protection of [those] patients);" and "should be administered and funded outside the state mental health authority (to maintain the mission and integrity of the public mental health system and guard against the depletion of resources allocated for traditional mental health services)."[32]

Several legal challenges have been mounted against SVP laws. Foremost among them is the argument that the "mental abnormalities" that form the basis for SVP commitment do not constitute the kind of mental disorder that justifies commitment to a mental health facility; concomitantly, the argument continues, the states have failed to provide meaningful services for committed offenders. After conflicting decisions in the lower courts, the Supreme Court took on the issue in *Hendricks* and rejected these contentions. A four-member plurality concluded that the Constitution does not require that civil commitment be based on psychotic-like symptoms (or any other condition recognized by organized psychiatry), stating "we have never required State legislatures to adopt any particular nomenclature in drafting civil commitment statutes. Rather, we have traditionally left to legislators the task of defining terms of a medical nature that have legal significance."[33] Further, the plurality concluded, treatability is not a precondition of preventive detention; rather incapacitation may be its "overriding" goal as long as some attempt at treatment is made.[34] The Court also rejected arguments that, by imposing confinement after completion of sentence, SVP laws violate the double jeopardy and ex post facto clauses; instead, it concluded, these laws are civil or regulatory in intent and therefore do not constitute "punishment."[35] Finally, the Court was unmoved by the fact that Leroy Hendricks, the prisoner in the case, had received "essentially no treatment during this period of commitment." The majority attributed that apparent shortcoming to the novelty of the treatment program and stressed that treatment was a stated purpose of the commitment.[36]

In a concurring opinion—an opinion essential to a holding joined by only five members of the Court—Justice Kennedy made clear his view that the availability of treatment was prerequisite to the law's constitutionality: "If the object or purpose of the Kansas law had been to provide treatment but the treatment provisions were adopted as a sham or mere pretext, there would have been an indication of the

[32] Id.
[33] 521 U.S. at 359.
[34] Id. at 365-366.
[35] Id. at 370-371.
[36] Id. at 367-368.

forbidden purpose to punish."[37] Justice Kennedy went on to question the legitimacy of "mental abnormality" as the predicate condition for commitment: "If it were shown that mental abnormality is too imprecise a category to offer a solid basis for concluding that civil detention is justified, our precedents would not suffice to validate it. . . . In this case, the mental abnormality—pedophilia—is at least described in the DSM-IV."[38]

In a dissenting opinion, Justice Breyer identified several aspects of the statute that made it more punitive than civil. In addition to the apparent lack of treatment for individuals once they were committed, he noted that Kansas had provided no treatment for those subjected to SVP law while they had been in prison, suggesting that the real motivation for the commitment was not to rehabilitate but to ensure continued confinement.[39] He also noted the state's failure to provide for alternative, less restrictive forms of treatment, which are routinely available for individuals subject to ordinary civil commitment.[40]

Important to the opinion in *Hendricks* is the Court's declaration that "[t]he pre-commitment requirement of a 'mental abnormality' or 'personality disorder' [in the Kansas law] is consistent with the requirements of . . . other statutes that we have upheld in that it narrows the class of persons eligible for confinement to those who are *unable to control their dangerousness*" (emphasis added).[41] Although nothing in the Kansas statute required a showing of lack of control, *Hendricks* held that this showing is now constitutionally required. That surmise was confirmed in *Kansas v. Crane*,[42] where the Court stated that, before commitment may occur under these statutes,

> there must be proof of serious difficulty in controlling behavior. And this, when viewed in light of such features of the case as the nature of the psychiatric diagnosis, and the severity of mental abnormality itself, must be sufficient to distinguish the dangerous sexual offender whose serious mental illness, abnormality, or disorder, subjects him to civil commitment from the dangerous but typical recidivist convicted in an ordinary case.[43]

The Court observed that 40-60 percent of male prison inmates have antisocial personality disorder and suggested that a law that would allow these inmates to be kept confined (after serving their sentences) might invite use of SVP laws as "a

[37] Id. at 371 (Kennedy, J., concurring).
[38] Id. at 372.
[39] Id. at 385-386 (Breyer, J., dissenting).
[40] Id. at 387.
[41] Id. at 357.
[42] 534 U.S. 407 (2002)
[43] Id. at 412.

mechanism for retribution or general deterrence—functions properly those of criminal law, not civil commitment."[44]

This brief recounting of the Court's caselaw in this area makes clear why the ABA objects to preventive detention statutes of the type at issue in *Hendricks* and why this standard permits post-sentence confinement only under traditional civil commitment statutes that require proof of serious mental disorder and dangerousness. The mental condition predicate under sexual predator laws and similar statutes is more often than not a personality disorder that is more consistent with criminal liability than the cognitive or volitional impairment typically associated with preventive detention.[45] Even if, as *Hendricks* and *Crane* seem to dictate, the states require an additional showing of an "inability to control," several problems remain. First, as the commentary to standard 7-6.1 explained, the ability of mental health professionals to evaluate volitionality (as opposed to cognitive impairment) is quite weak. Second, because the perceived difference between "inability to control" criminal conduct and repeated criminal conduct is likely to be minimal, these statutes, as applied, are usually simply a means of prolonging the confinement of "ordinary recidivists." The Supreme Court itself has declared that a statute allowing preventive detention of the latter group would be unconstitutional, both in *Crane* (where even the dissenters defending the sex offender statute distinguished between offenders who "choose" to reoffend and those who, "because their mental illness is an affliction and not a choice, are unlikely to be deterred"),[46] and in *Foucha v. Louisiana*, where a plurality disapproved preventive confinement of any individual "shown [only] to have a personality disorder that may lead to criminal conduct."[47] Third, because the predicate mental condition under SVP statutes is likely to be just such a personality disorder, it is either untreatable or very difficult to treat,[48] which, as the dissenters in *Hendricks* emphasized, makes the statutes punitive in effect. Additionally, as already noted, under these statutes mental health facilities are saddled with individuals they are ill-equipped to handle.

Preferable to the hybrid approach approved in *Hendricks*, the criminal and civil commitment systems should be kept separate. Convicted offenders should be able to know that their confinement in prison ends when their sentence ends. Once they have served their time, they should be treated like everyone else, subject to preventive detention only if serious mental disorder renders them dangerous to self or

[44] Id.
[45] See W. Lawrence Fitch, Sex Offender Commitment in the United States: Legislative and Policy Concerns, in Sexually Coercive Behavior: Understanding and Management 489, 492 (Robert Prentky et al., eds. 2003 (Table 1).
[46] 534 U.S. at 420 (Scalia, J. dissenting).
[47] 504 U.S. 71, 82 (1992).
[48] For one of the more optimistic, but still unenthusiastic, positions on this issue, see R. Karl Hanson et al., The Principles of Effective Correctional Treatment Also Apply to Sexual Offenders: A Meta-Analysis, 26 Crim. Just Behav. 865 (2009).

others as defined in general civil commitment statutes. That is what this standard provides.

Standard 7-10.8 Re-entry

Provisions for ensuring a smooth transition to the community for prisoners with mental disorder are found in Standard 23-8.9 of the Standards on Treatment of Prisoners, which govern re-entry of prisoners.

Commentary

Standard 7-10.8 references several provisions in standard 23-8.9 that provide for community re-entry of released prisoners with mental disorder, all of which are meant to ensure "a smooth transition to the community." Paragraph (a) of the latter standard requires government officials to "ensure that each sentenced prisoner confined for more than [6 months] spends a reasonable part of the final portion of the term of imprisonment under conditions that afford the prisoner a reasonable opportunity to adjust to and prepare for re-entry into the community." Paragraph (b) calls for a "individualized re-entry plans" for each prisoner, which are to include assistance in locating housing, identifying and finding job opportunities, developing a resume and interview skills, and similar assistance. Most importantly for present purposes, standard 23-8.9(c) states that each prisoner released to the community should be provided "a written health care discharge plan that identifies medical and mental health services available to the prisoner in the community," describes "the course of treatment," and identifies and arranges for community-based health care services. Paragraph (d) of that standard provides that any health care provided in prison should "continue uninterrupted, including, if necessary, providing prescription medication." Finally, paragraph (e) requires correctional authorities to provide released prisoners, inter alia, information about how to contact relevant agencies.

Every state recognizes the importance of continuity of care, and many go to great lengths to link released prisoners with programs and services in the community.[49] Standard 7-10.8, with its cross-reference to standard 23-8.9, is included to underscore the importance of transition planning for mentally disordered offenders approaching release.

[49] See Edward E. Rhine & Anthony C. Thompson, The Reentry Movement in Corrections: Fragility, Resiliency and Prospects, 47 Crim. L. Bull. 177 (2009) (reporting a resurgence of a "reentry movement in corrections"); see also Francis Cullen, Prisoner Reentry Programs, 44 Crime & Justice 517 (2015).

APPENDIX A
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