THE ETHICS OF REPRESENTING CLIENTS WITH LIMITED COMPETENCY IN GUARDIANSHIP PROCEEDINGS

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I. INTRODUCTION

A substantial body of literature has cropped up in the past twenty years addressing the role of and practical and ethical challenges facing attorneys representing individuals with mental disabilities,[1] both in general practice and in proceedings (such as competency determinations in criminal cases and civil commitments) where mental disability is the central issue.[2] Some of this literature overlaps with the larger body of literature from the past few decades on "client-centered" lawyering.[3] Though we are indebted to these resources, few articles have addressed at length the specific ethical

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1. In this article, we use the term "mental disability" broadly to refer to a range of intellectual disabilities such as schizophrenia that are often characterized as "illnesses," to progressive syndromes such as dementia that often accompany old age, and to developmental disabilities that remain relatively constant over life. When we discuss "mental illness" specifically, we are primarily referring to mental illnesses thought of as serious and persistent, such as schizophrenia, bipolar disorder, or schizoaffective disorders which are often amenable to treatment and will typically have a fluctuating course of time.

2. *See, e.g.*, Michael L. Perlin, *Pretexts and Mental Disability Law: The Case of Competency*, 47 U. MIAMI L. REV. 625 (1993) [hereinafter Perlin, *Pretexts*]; Jan Ellen Rein, *Ethics and the Questionably Competent Client: What the Model Rules Say & Don't Say*, 9 STAN. L. & POL'Y REV. 241 (1988); Leslie Salzman, *Rethinking Guardianship (Again): Substituted Decision Making as a Violation of the Integration Mandate of Title II of the Americans with Disabilities Act*, 81 U. COLO. L. REV. 157 (2010).

3. For early examples of this work, see, e.g., DAVID A. BINDER & SUSAN C. PRICE, LEGAL INTERVIEWING AND COUNSELING: A CLIENT-CENTERED APPROACH (1977); Richard Wasserstrom, *Lawyers as Professionals: Some Moral Issues*, 5 HUM. RTS. 1, 4-6 (1975); Marcy Strauss, *Toward a Revised Model of Attorney-Client Relationship: The Argument for Autonomy*, 65 N.C. L. REV. 315 (1986-1987). For more recent works, see, e.g., DAVID A. BINDER, PAUL B. BERGMAN & SUSAN C. PRICE, LAWYERS AS COUNSELORS: A CLIENT-CENTERED APPROACH (2d ed. 2004); Katherine R. Kruse, *Fortress in the Sand: The Plural Values of Client-Centered Representation*, 12 CLINICAL L. REV. 369 (2006).

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challenges facing an attorney representing a person with limited competency who is the subject of a guardianship[4] petition.

The attorney representing a client with limited competency works in an ethical minefield. The paramount value guiding the attorney-client representation is client autonomy – the exercise of self-determination. Yet the client with limited competency, by definition, has some degree of difficulty making the decisions that constitute self-determination. The attorney representing such a client must determine how best to vindicate client autonomy in the long term without unduly compromising it in the short term. These questions are particularly nettlesome for the attorney representing a client who is the subject of a guardianship petition because he must simultaneously protect the information he has concerning the client's condition in order to preserve the ability to contest the petition, zealously represent the client's interests, and ensure that the client's long-term autonomy is not being sacrificed in the name of "beating" the petition.[5] The spectrum of limitations experienced by clients and the unique demands of each representation make categorical answers impossible and attorney judgments inevitable. Our goal throughout this article is to offer a practical framework, and some concrete suggestions, for attorneys operating in an ethically muddy area. Where we are unable to do this, we hope to at least frame the question clearly so that debate concerning an insufficiently discussed topic can be generated.

Part II of this article describes the case of a representative hypothetical client facing a guardianship petition. Part III sets out the normative framework of our approach to client representation. Part IV discusses the ethical challenges facing the attorney representing a client with a mental disability. Part V provides some context about guardianship proceedings and applies the issues discussed in earlier sections to those proceedings. Part VI considers a scattering of related issues.

II. A HYPOTHETICAL: MS. X

Ms. X is a 68-year-old woman living in a one-bedroom apartment in a large metropolitan area.[6] She is not married and never had children. Long

4. We use the term "guardianship," though some states term the proceedings for the appointment of a person to supervise the affairs of a person with severe mental disabilities a "conservatorship." *See, e.g.*, CAL. PROB. CODE §§ 1800-04 (West 2002).

5. Unless, of course, the client makes an informed decision to do this and has the capacity to understand the consequences.

6. This hypothetical is a hybrid drawn from one of the author's (HD) experiences in hundreds of legal proceedings involving people with mental disabilities as well as otherwise working with individuals with mental illness in various capacities. Another hypothetical, and an effective attempt to work through some of these issues, was presented at the May 2003

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ago, she lost track of a half-brother, her mother's son, and she leads an isolated life. That brother, who is three years her junior, recently located Ms. X on Facebook, seeking to rekindle contact, but to date, Ms. X has declined to respond to his overture.

While in her 20s, Ms. X worked regularly as a supervisor in a factory and achieved a Bachelor's degree going to school at night. She was injured in an explosion of a poorly maintained pipe and, while not permanently disabled, she secured a rather large settlement from a personal injury suit brought in connection with that incident. Her overall functioning deteriorated as she stayed home recuperating, and she never returned to full-time employment again. She also began to experience feelings of paranoia, thinking that her phone was tapped. Her doctor mentioned schizophrenia and prescribed Thorazine. This helped with her feelings of paranoia, but Ms. X developed involuntary twitches from the medication. She became increasingly self-conscious of them and continued her isolative behavior. She has never executed a living will, health care proxy, last will and testament, or power of attorney.

Over time, the state of Ms. X's apartment has deteriorated, and occasionally her electricity is cut off. Neighbors have brought this to the attention of building management, who has involved the city's Adult Protective Services ("APS"). APS has considered bringing guardianship petitions in the past but, when faced with this prospect, Ms. X has agreed to engage in intensified psychiatric treatment and has been willing to tap into her still adequate financial resources to restore her apartment to a more livable state. Recently, though, she has appeared less amenable to intervention and her treatment providers wonder if she is showing early signs of dementia in addition to her long-standing mental illness. Ms. X has begun to horde artifacts in her apartment – refusing, for example, to discard old newspapers, which now are stacked halfway to the ceiling in some portions of her apartment. Her adherence to her prescribed medication regime has likewise become less steady as she is reluctant to leave the apartment for appointments with her psychiatrist. Ms. X does not shop, but orders in Chinese takeout. She does not do laundry; instead, she relies on a service that picks up her soiled clothing and cleans it. There is concern that she may spend all of her savings on these types of services.

APS has now moved forward with a guardianship petition seeking to have a community agency appointed guardian of Ms. X's person and

annual meeting of the National Association of Protection and Advocacy Systems, and is available online. *See* Robert D. Fleischner, *Selected Materials on Ethical Issues in the Representation of People with Disabilities*, CTR. FOR PUB. REPRESENTATION (May 2003), www.centerforpublicrep.org/litigation-and-major-cases/litigation-issues/78-selected-materials-on-ethical-issues-in-the-representation-of-people-with-disabilities.

property. You have been appointed to represent Ms. X, who is steadfastly opposed to the guardianship petition. Her current belief is that she does not require psychotropic medications, as she no longer believes that she suffers from a mental disability. She correctly recites the potentially dangerous side effects of these medications, some of which she has experienced, but also believes that the psychiatrist might be working in conjunction with her brother to "get their hands" on her bank account.[7] She thinks that the medication is an attempt to cloud her mind so that they may achieve this goal. She acknowledges that her apartment is cluttered, but says that she prefers it that way. With respect to the concern that she may burn through her remaining money, Ms. X states the belief that it is better for her to spend her money as she sees fit than let it fall into the hands of her brother and psychiatrist. To further complicate matters, Ms. X., a chain smoker, has developed a persistent cough. She so far has declined efforts by her treatment team for an MRI, stating that she would rather not know what is "going on inside."

We will return to the case of Ms. X periodically in this article.

III. OUR NORMATIVE FRAMEWORK

It is impossible to identify and resolve ethical issues in a reasoned way without first setting out a normative framework. Articulating values forces the writer to identify his commitments and motivations, and makes it possible to test actions against stated values and identify which values are being given primacy and which are being sacrificed. At the same time, a theoretical framework cannot resolve practical real-world problems on its own. One can agree with the thesis we set out below and still come to completely different conclusions about how to handle any dilemma in actual practice. What can be achieved is a sensitizing of the ethical compass: By considering the values at stake, and how various practical solutions do or do not serve those values, we become better judges of the options available to us when presented with actual clients and their desires and constraints.

With that caveat, our normative thesis is this: (1) Autonomy is the paramount value in client representation. (2) Whenever the attorney believes the client is competent, the attorney should respect her choice.[8] (3) Whenever the attorney believes the client's competency is limited, the attorney should intrude on the client's autonomy in the short term only to the extent necessary to achieve ends that facilitate the client's autonomy in the

7. For a recent, vivid portrayal of the complications created by an individual with some mental illness who resists treatment, see Rachel Aviv, *God Knows Where I Am: A Patient Rejects Her Diagnosis*, THE NEW YORKER, May 30, 2011, at 57.

8. For sake of clarity, we have arbitrarily used masculine pronouns to refer to the attorney and feminine pronouns to refer to the client.

long term. (4) All of this should be undertaken with a healthy dose of self-doubt. We attempt to unpack, justify, and qualify this thesis below.

(1) *Autonomy is the paramount value in client representation*.

We, as most others who have considered the issue, believe that there are two overarching values governing the lawyer-client relationship. The first is client autonomy. The client, as any other human actor, is entitled to the unrestrained exercise of her will whenever it does not harm others.[9] In this regard, the attorney's role is to apply his specialized skills to realize the client's goals. The second principle is beneficence. The attorney, as a professional with privileged status and significant powers of action and persuasion, is obligated to act in a way that benefits the client.[10] To that extent, the attorney's role is to apply his specialized skills to better the client's situation or prevent it from deteriorating.

It is not difficult to see how these principles can and do come into conflict in both theory and practice. First, they focus on two separate actors. Autonomy begins from the perspective of the client; beneficence begins from the perspective of the attorney. This sets up an inevitable conflict based on the subjectivity of experience and the different goals and motivations of the actors. Second, even from the attorney's perspective, the two values require the attorney to evaluate two different metrics to see whether the representation has "succeeded." To evaluate whether he has served client autonomy, the attorney must look to his conduct in the course of the representation and his interactions with the client: Did the client understand that she was in control of the representation and was she permitted to exercise that control within the wide bounds given to her?[11] To evaluate whether he has served beneficence, the attorney looks to whether he achieved a "good" result for the client: Is she better off than she was at the beginning of the representation, or than she would have been without the attorney's assistance?

In our view, the value which must prevail, whenever possible, is client autonomy. Our conclusion is based on two rationales. First, because beneficence depends on a value judgment imposed by the attorney, it is suspect. Even if the attorney is able to set aside the lenses of race, class, gender, or other elements of subjectivity that color his judgments, the judgments will still be his rather than the client's. Since the attorney is being

9. MODEL RULES OF PROF'L CONDUCT R. 1.2 (2010).

10. *Id.*

11. The discretion is bound, of course, by the attorney's ethical and moral obligations not to assist the client in victimization of others (codified as the crime/fraud exception to attorney duties of loyalty and confidentiality) or, in sufficiently extreme cases, in harming herself. *See* MODEL RULES OF PROF'L CONDUCT R. 1.6, 1.14 (2010).

retained by the client,[12] he should act as an agent, not as a principal. Second, in the context of the attorney-client relationship, client autonomy is by definition the "best" result.[13] The attorney is engaged not for the purpose of guiding the client in her life decisions, but to resolve a particular problem that has brought into play the legal system and that threatens the client's autonomy – to defeat an indictment, prevent eviction, secure public benefits, or (as in the case of a guardianship petition) protect her right to be recognized as a legally competent actor.[14] Replacing the client's judgment with that of the attorney, even where the attorney acts with the best of intentions, replaces one threat to autonomy with another.

This is an especially critical issue for attorneys representing marginalized populations.[15] For those attorneys working in these fields who practice "client-centered" lawyering, the aim is to empower the client by helping her attain her goals through the legal process, rather than further subjugating her desires to the interests and convenience of the other parties, the legal system, or her attorney.[16] In general, this means ensuring that the client's objectives are pursued rather than those of the attorney, and that the attorney does not project his values onto the client and allow that projection to taint the representation. As Foucault observed, for most individuals, their interactions with individual officers of government agencies are their most tangible interactions with power.[17] The courts are a branch of government, and the attorney is an officer of the court. Even if the attorney views himself as a "free radical" within this system, the reality is that he is an institutional actor – a repeat player – and he will very frequently be perceived as a part of the institution by the client.[18] Thus, how attorney-client interactions play

12. This holds true even where the attorney is being paid by a state actor or some other disinterested third party; the attorney is the client's, rather than the payor's agent. *See* i*nfra* Part III.D.

13. *See, e.g.*, William H. Simon, *Lawyer Advice and Client Autonomy: Mrs. Jones's Case*, 50 MD. L. REV. 213, 225 (1991) ("[T]he most notable theory of 'the good' to come out of the law schools in recent years defines the good in terms of the 'choices' people make when not under 'domination.' This sounds very much like a theory of autonomous choice.").

14. As we discuss elsewhere, *see infra* Part V., the client may – but may not – choose to contest the proceeding or attempt to limit the scope of any subsequent guardianship order.

15. For a review of some of the vibrant literature in this area, *see* Paul R. Tremblay, *Critical Legal Ethics*, 20 GEORGETOWN J. LEGAL ETHICS 133 (2007) (reviewing *Lawyers' Ethics and the Pursuit of Social Justice: A Critical Reader* (Susan D. Carle ed., 2005)).

16. Robert D. Dinerstein, *Client-Centered Counseling: Reappraisal and Refinement*, 32 ARIZ. L. REV. 501, 507 (1990).

17. *See generally* MICHEL FOUCAULT, "SOCIETY MUST BE DEFENDED": LECTURES AT THE COLLÈGE DE FRANCE, 1975-1976 (Arnold I. Davidson et al. eds., David Macey trans., Picador 1997) (2003).

18. MODEL RULES OF PROF'L CONDUCT, pmbl. ¶ 1 (2010) (referring to lawyers as "officer[s] of the legal system").

out is critical to the client's assessment of her position in society, the respect she has been accorded, and her relationship to that power. Put simply, the person who is able to exert her will in an interaction with her attorney is "empowered"; the person who is rebuffed is "disempowered."[19] Because empowerment is the goal of client-centered lawyering, when in conflict, beneficence should give way to autonomy.[20]

(2) *Whenever the attorney believes the client is competent, the attorney should respect her choice*.

If autonomy is the paramount value, then the attorney should not allow his views to interfere with the client's choice when the attorney believes the client is acting competently – that is, when the attorney believes that the client is capable of exercising her autonomy.

Several issues need to be unpacked here. First, is the question of competency. We have in mind here the model of competency developed in the case law and mental health literature regarding informed consent[21] and described by the authors of the Macarthur Treatment Competence Study, a landmark empirical study into health care decision-making by individuals with mental illness.[22] That study highlighted four decision-making abilities.[23] One is the ability to understand the information provided.[24] A second is the ability to rationally manipulate the information provided (*e.g.*, comparing

19. As we discuss *infra* Part IV.C.3, this notion is complicated by the reality that "autonomy" – the right and responsibility for making one's own decisions – may not be what every client wants.

20. As we discuss *passim* below, the real-life interaction between these two values can be exceedingly complex.

21. MODEL RULES OF PROF'L CONDUCT R. 1.0(e) (2005). Informed consent is "the agreement by a person to a proposed course of conduct after the lawyer has *communicated* adequate information and explanation about the material risks of and reasonably available alternatives to the proposed course of conduct." *Id.* (Emphasis added to underscore that communicating with another person involves a dyadic process whereby information is provided by one party (in this case, the attorney) and is received, clarified if necessary, and ultimately comprehended by the other (in this case, the client).)

22. *See* Paul S. Appelbaum & Thomas Grisso, *The MacArthur Treatment Competence Study. I: Mental Illness and Competence to Consent to Treatment*, 19 L. & HUM. BEHAV. 105 (1995) [hereinafter Appelbaum & Grisso, *The MacArthur Treatment Competency Study. I*]; Thomas Grisso et al., *The MacArthur Treatment Competence Study. II: Measures of Abilities Related to Competence to Consent to Treatment*, 19 L. & HUM. BEHAV. 127 (1995); Thomas Grisso & Paul S. Appelbaum, *The MacArthur Treatment Competence Study. III: Abilities of Patients to Consent to Psychiatric and Medical Treatments*, 19 L. & HUM. BEHAV. 149 (1995) [hereinafter Grisso & Appelbaum, *The MacArthur Treatment Competence Study. III*].

23. Appelbaum & Grisso, *The MacArthur Treatment Competence Study. I*, *supra* note 22, at 109-11.

24. *Id.* at 109-10.

benefits and risks of various options).[25] A third is the ability to appreciate the situation and its consequences for decision-makers in the concrete, rather than merely in the abstract.[26] A fourth is the ability to communicate choices.[27] Limitations in any of these capacities interfere with client autonomy because they hinder the client's ability to make choices that reflect her genuine preferences.[28] Put another way, the attorney would believe the client is competent when she is making decisions under her own reason, and not under the influence of mistakes about facts, their interactions, or consequences, and is unable to communicate her choices accurately.

A second issue is what it means for the attorney to "respect" a client's choice – or, conversely, what it means to not "interfere" with a client's choice. It should not mean being a mere vessel for the client's decisions. Providing the client with the attorney's subjective views is not an intrusion on her autonomy, but rather a necessary precondition to her exercise of autonomy in the face of legal difficulties. The attorney has superior knowledge of the legal system, the judge, and opposing counsel, and – if operating in a field where he has sufficient experience – possibly the practical consequences of resolving a dispute in a particular way. Attorneys are retained or appointed not to be ticket-takers, but to bring their expertise and experience to bear on the problems of their clients. They also serve an important role as an ally who can provide perspective on the facts at issue and the arguments the client is likely to face from the other parties to the matter. An attorney's opinion is important to most clients, and they are entitled to it. The "choice" that should be respected is the one that the client makes after receiving from the attorney the information and counseling required to understand the options available and the consequences of choosing a specific course of action. On the other hand, as detailed elsewhere,[29] how the attorney elects to communicate his views is important. The attorney should not overbear the client's will by presenting his opinions with much force or argue them as he would to a court. For example, he may choose to communicate what he believes to be the "best" choice, but he should identify the assumptions he has made, the reasons for his conclusion, and the weaknesses in his approach.

25. *Id.* at 110-11.

26. *Id.* at 110.

27. *Id.* at 109.

28. Appelbaum & Grisso, *The MacArthur Treatment Competence Study. I, supra* note 22, at 109-11. We acknowledge that this assumes that there is a "healthy" viewpoint for any individual.

29. *See infra* Part III.B.

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A third issue is that we have phrased this precept from the perspective of what the "attorney believes." This is deliberate. We are addressing how the attorney should conduct himself. In actual practice, except in extreme cases, the attorney will never know with certainty whether (or to what degree) one or more of the client's decision-making abilities is limited in some way. He will necessarily have to depend on his perception of the client's functioning. This puts into play issues of subjectivity, preconceptions, and prejudice regarding mental disability discussed elsewhere in this article,[30] but there is no avoiding it. The attorney representing a client who may have limited competency has little choice but to make judgments about the client's functioning. In the specific context of guardianship petitions, there will very frequently be some limitation on the client's decision-making abilities; were there not some significant deficiency in functioning, a petition would not likely have been brought in the first place.[31] Thus, the attorney will necessarily have to make judgments about how severe those limitations are, and whether they are interfering with the client's rational thought, day-to-day functioning, and ability to exercise her autonomy.[32] There are bases on which to make an informed judgment. For example, an examination of specific areas of day-to-day functioning is useful. Can the client manage a checking account? Is she sufficiently nourished? Does she attend medical appointments and have the ability to follow through with treatment? But, in the end, there is no escaping the dilemma of subjectivity and the attorney's limited understanding of the mind of another – there can only be awareness of it.[33]

30. *See infra* Part III.A.

31. This is not to say that every person who is the subject of a guardianship petition ought to be found incompetent. Quite the contrary. As we discuss elsewhere, one can have some limitations on decision-making capacity and still be able to function very well with appropriate supports and limited intervention. The point is that, setting aside a bad faith petition, the person who is the subject of the petition was likely demonstrating some characteristics that led someone in close contact with her to believe that she was unable to care for her own needs. However, particularly where the petitioner stands to gain (economically or otherwise) from the appointment of a guardian, the possibility of self interest on the part of the petitioner should be considered by the attorney representing the person alleged to be incapacitated. *See infra* Part IV.

32. Stanley S. Herr, *Representation of Clients with Disabilities: Issues of Ethics and Control*, 17 N.Y.U. REV. L. & SOC. CHANGE 609, 621-23 (1989-1990).

33. For an excellent fictional treatment of this dilemma, *see, e.g.*, PAUL AUSTER, THE NEW YORK TRILOGY (Per Bregne ed., Green Integer 2008) (1987).

(3) *Whenever the attorney believes the client's competency is limited, the attorney should intrude on the client's autonomy in the short term only to the extent necessary to achieve ends that facilitate the client's autonomy in the long term.*

We believe that intrusions on client autonomy are permissible when the client is, because of mental disability or other limitation, unable to act autonomously.[34] We believe intrusion is permissible in these situations because, if the client is limited in a material way in her ability to understand facts, their interactions, or their consequences, or in her ability to communicate her choices, then her ability to act autonomously is already impaired.[35] The American Bar Association's (ABA) model rule on the topic is consistent with this approach. Model Rule 1.14 provides that, if the attorney reasonably believes the client is unable to act in her own best interests and is at risk of harm as a consequence, the attorney can take what the rule terms "protective action."[36]

It is important to distinguish, however, between a situation in which the attorney believes in a general sense that something is "not right" with the client, but can pinpoint no deficit in decision-making, and situations in which the client is showing difficulties with one of the four components of decision-making. In the former situation, no intervention is warranted. This approach is consistent with both Model Rule 1.14 and the Americans with Disabilities Act (ADA).[37] Under the ABA rule, the representation should be kept, "as far as reasonably possible, . . . normal."[38] Under the ADA, individuals with disabilities are to be provided, whenever possible, the same

34. We do not subscribe to the school of thought that holds that all human action is autonomous, regardless of its origin. We do believe there is such a thing as mental disability, and that those suffering from the acute manifestations of such a disability may, over the long run, recover, and in the short run, through treatment and support, may return to rational thought and the conditions of autonomy. What is critical to remember, and this is recognized by modern guardianship statutes at least in theory, is that mental disability is not synonymous with lack of capacity.

35. Appelbaum & Grisso, *The MacArthur Treatment Competence Study. I*, *supra* note 22, at 109-11. As with the second precept, this depends on the attorney making a judgment about the client's competence based on his experience with her.

36. MODEL RULES OF PROF'L CONDUCT R 1.14(b) (2010). The commentary notes that such action might include "consulting with family members, using a reconsideration period to permit clarification or improvement of circumstances, using voluntary surrogate decision-making tools such as durable powers of attorney or consulting with support groups, professional services, adult-protective agencies or other individuals or entities that have the ability to protect the client" or seeking appointment of a guardian. MODEL RULES OF PROF'L CONDUCT R 1.14 cmt. 5 (2010).

37. MODEL RULES OF PROF'L CONDUCT R. 1.14 (2010); Americans with Disabilities Act, 42 U.S.C. § 12102 (2008).

38. MODEL RULES OF PROF'L CONDUCT R. 1.14(a) (2010).

services that others receive.[39] Those with a "disability" are entitled to enjoyment of the same "services" of a "public accommodation" as those without a disability, unless the difference in service is "necessary to provide the individual . . . with a . . . service . . . that is as effective as that provided to others," and attorney's offices are defined under the ADA as "public accommodations."[40] As reflected in the ABA commentary and in the Macarthur Study, a person with mental disability or illness "often has the ability to understand, deliberate upon, and reach conclusions about matters affecting the client's own well-being."[41] That is, the attorney should not intrude upon the autonomy of a client with mental disability who is not showing deficits in decision-making simply because the client shows other symptoms of mental disability.

We also believe that the primary permissible intrusion on client autonomy is one that invades short-term autonomy in order to foster long-term autonomy. The attorney should not be acting for his own convenience. For example, we would say that an attorney who unilaterally decides to rely on a client's family member to gain information about a client simply because the client has become difficult to work with has acted inappropriately. He has intruded on short-term autonomy by breaching the duties of client confidentiality,[42] client communication,[43] and possibly client loyalty,[44] but is not helping to support the client to maintain long-term autonomy.[45] By contrast, we would say that an attorney who pursues a meritorious appeal for a criminal defendant who, solely because of manifestations of mental illness, wishes to drop the appeal, has acted appropriately. He has intruded on the defendant's short-term autonomy by overriding his request to drop the appeal. However, he has kept options open for the defendant rather than foreclosing them, and has made it less likely that the defendant will suffer criminal punishment (including

39. 42 U.S.C. §§ 12131-65 (2008) (prohibiting discrimination by public entities, including public transportation services); Title III, 42 U.S.C. §§ 12181-89 (2006) (prohibiting discrimination by private entities in public accommodations and services). *See also* Salzman, *supra* note 2, at 183-87.

40. RONALD M. HAGER, NAT'L DISABILITY RTS. NETWORK (NDRN), PRACTICAL ETHICS: SERVING CLIENTS WITH LIMITED COGNITIVE ABILITY AND LIMITED COMMUNICATION ABILITY 10-11 (2009). *See also* Americans with Disabilities Act, 42 U.S.C. §§ 12181(7)(F), 12182(b)(1)(A)(iii) (2008).

41. MODEL RULES OF PROF'L CONDUCT R. 1.14 cmt. 1 (2010); Grisso & Appelbaum, *The MacArthur Treatment Competence Study. III*, *supra* note 22, at 173.

42. MODEL RULES OF PROF'L CONDUCT R. 1.6 (2010).

43. MODEL RULES OF PROF'L CONDUCT R. 1.4 (2010).

44. *See infra* Part III.D.

45. There are cases in which it may be appropriate to include family members, but this should be with the client's knowledge and consent and for the specific purpose of achieving the client's goals in the representation. *See infra* Part IV.C.

incarceration, which can be especially harsh on those with mental illness),[46] which is a much more serious intrusion on autonomy. Many decisions are not so easy. As detailed below,[47] determining what intrusions will foster long-term autonomy is especially thorny in the guardianship context.

Finally, any intrusion on short-term autonomy should be the least restrictive necessary to deal with the problems created by the client's limited competency. This approach is consistent with the ABA commentary to Model Rule 1.14 and an ABA formal opinion.[48] The commentary highlights that, in taking "protective action," the attorney should "intrud[e] into the client's decisionmaking autonomy to the least extent feasible . . . ."[49] The opinion similarly states that "the principle of respecting the client's autonomy dictates that the action taken by a lawyer who believes the client can no longer adequately act in his or her own interest should be the action that is reasonably viewed as the least restrictive action under the circumstances."[50]

(4) *All of this should be undertaken with a healthy dose of self-doubt*.

A final key element of our normative framework is self-doubt. We believe that none of us is free from misconceptions and prejudices, making it critical that we monitor our reactions to our clients and how they may be affecting our judgments. If we are prone to viewing those with mental illness as helpless and disenfranchised, we may resolve ethical dilemmas too much in favor of paternalism. If we emphasize personal responsibility, we may be too harsh in thinking that the client's views should conform to generally accepted norms or that the client should be made to "learn" from her "mistakes." If we are excessively rights-oriented, in the sense that we believe that all people must seek to vindicate their rights to the greatest extent possible in all situations, we may push the client to aggressively litigate where she might wish to settle or acquiesce.[51] But a "healthy" dose of self-doubt is not a paralyzing dose. Self-doubt does not mean handwringing. It

46. Jamie Fellner, *Special Comment: A Human Rights Perspective on Segregating the Mentally Ill*, CORRECTIONAL MENTAL HEALTH REP., May/June 2009, at 1079, 1080, *available at* http://www.hrw.org/en/news/2009/05/18/special-comment-human-rights-perspective-segregating-mentally-ill; Jamie Fellner, *Afterwords: A Few Reflections*, 35 CRIM. JUST. & BEHAV. 1079, 1082 (2008); David Lovell, L. Clark Johnson, & Kevin C. Cain, *Recidivism of Supermax Prisoners in Washington State*, 53 CRIME & DELINQ. 633, 634-35 (2007).

47. *See infra* Part IV.

48. MODEL RULES OF PROF'L CONDUCT R. 1.14 cmt. 5 (2010). *See also* ABA Comm. On Prof'l Ethics, Formal Op. 96-404 (1996).

49. MODEL RULES OF PROF'L CONDUCT R. 1.14 cmt. 5 (2010).

50. ABA Comm. On Ethics and Prof'l Responsibility, Formal Op. 96-404 (1996).

51. The specific correlate in the guardianship context is that having a guardian appointed is a relief to some people who have struggled to function daily but whose sense of pride or lack of insight into their disabilities has thwarted their ability to accept assistance through less intrusive means.

means skepticism about one's first reactions and a willingness to engage in ongoing self monitoring.

Stating this normative framework does not resolve the many ethical issues that can arise in the course of a representation of an individual with a mental disability, as the balance of this article will show. We cannot resolve individual, concrete dilemmas by reference to abstract principles. Yet it does provide a backdrop against which to assess the conduct of the attorney taking on such representations.

IV. ETHICAL ISSUES IN REPRESENTATIONS OF CLIENTS WITH LIMITED COMPETENCY

There are four key ethical issues that arise in the representation of any client – (1) preservation of client authority, (2) adequate communication with the client, (3) preservation of confidential information, and (4) avoidance of conflicts of interest.[52] Each of these is underpinned by autonomy concerns. The key decisions are the client's to make. To make those decisions, the client needs to be adequately informed. To communicate the key information to the attorney necessary for the client to be informed about the legal consequences of the facts and her options, the client needs to know that her information will be kept confidential. To rely on the attorney to carry out her desires, and so trust that she is receiving accurate information and can rely on the attorney in certain tactical areas, the client needs to know that she has the attorney's undivided loyalty.

Carrying out each of the four core ethical duties becomes more complicated when dealing with a client who has limited competency because of mental disability. The client may have a limited ability to communicate desires and information. The client may have a limited ability to understand information communicated by the attorney or a limited ability to understand choices. The client may voice desires that do not appear to be in her best interests, raising the possibility— but not proving— that she is not acting rationally. The interests of the attorney may conflict with the client, or the client may believe they do.

We consider each of these duties in turn, relying in the first instance on the formulation of them in the ABA's Model Rules of Professional Responsibility[53] and amplifying this with a discussion of how these duties fit into our normative framework, and then applying them to the representation of the client with limited competency. To return to a theme: The ABA Model

52. *See* MODEL RULES OF PROF'L CONDUCT, pmbl. (2010).

53. Though each jurisdiction has its own rules governing attorney practice, we focus on the ABA Model Rules of Professional Responsibility because they are the most influential and serve as the pattern for most states' rules.

Rules are permissive, and provide limited guidance in practice.[54] A normative framework, even if carefully developed, also cannot determine the correct answer to any dilemma. The attorney must still decide how to act on a case-by-case basis.

A. Client Authority

The attorney is the client's agent. The representation is the client's, and the life affected is the client's. In our hypothetical, it will be Ms. X, not the attorney, who loses some of her right to self-determination if the guardianship petition is granted – and it will be Ms. X, not the attorney, who may continue to live in a state of continuing decline if it is denied. The attorney ought to bring the full breadth of his knowledge, insight, experience, and judgment to bear on the client's issues, but the key decisions that define the representation are the client's to make.

The ABA has a Model Rule that deals with this issue.[55] It distinguishes between the ends of the representation – which it states are the client's to determine – and the means of achieving those ends – about which it states the attorney must consult with the client.[56] Model Rule 1.2 provides that "a lawyer shall abide by a client's decisions concerning the objectives of the representation and . . . shall consult with the client as to the means by which they are to be pursued."[57]

The official commentary to the rule reiterates this basic division: The client has "the ultimate authority to determine the purposes to be served by legal representation."[58] The attorney "shall consult" with the client about strategic matters.[59] The commentary acknowledges that, as a matter of practice, "[c]lients normally defer to the special knowledge and skill of their lawyer with respect to the means to be used to accomplish their objectives, particularly with respect to technical, legal and tactical matters."[60] Neither the rule nor commentary, however, provides a mechanism for determining how to resolve conflicts over strategy, except to note that, at the outer limits, the attorney may withdraw and the client may discharge the attorney.[61]

This rule requires modification to fit within our framework. Its basic division between "ends" and "means" does not acknowledge that how an

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54. Herr, *supra* note 32, at 620 (noting "the professional codes do not provide much aid to effective, client-centered lawyering"). *See also* MODEL RULES OF PROF'L CONDUCT, SCOPE ¶ 14 (2010).

55. *See* MODEL RULES OF PROF'L CONDUCT R. 1.2 (2010).

56. MODEL RULES OF PROF'L CONDUCT R. 1.2 cmt. 1 (2010).

57. MODEL RULES OF PROF'L CONDUCT R. 1.2(a) (2010).

58. MODEL RULES OF PROF'L CONDUCT R. 1.2 cmt. 1 (2010).

59. MODEL RULES OF PROF'L CONDUCT R. 1.2(a) (2010).

60. MODEL RULES OF PROF'L CONDUCT R. 1.2 cmt. 2 (2010).

61. *Id.*

end is pursued may be as important to the client as achievement of the goal, and that, for the client whose goal is not simply to vindicate her legal rights to the maximum extent possible, there may not be a clear "means" and "ends" distinction. For example, a client in a commercial dispute with an important business partner may be willing to write aggressive letters and even file a complaint to bring the dispute to a head, but may not be willing to notice the depositions of particular witnesses because to do so would be inflammatory. Conversely, it may be important to such a client to notice particular depositions as quickly as possible and not grant any continuances or extensions. In the family law or guardianship context, how arguments are presented can have a critical impact on ongoing relationships that the client may depend upon on a day-to-day basis. That a client has chosen to take recourse to available legal protections in her dispute with a friend or family member does not mean that she is prepared to (or can) sever all connections to that person. Yet the rule directs only that the attorney "consult" with the client on these "technical, legal and tactical" matters, suggesting that the final decisions about these matters rest with the attorney.[62] Further, while the rule accurately notes that clients often defer to their attorneys on these matters,[63] it does not consider why that is so or whether it is appropriate. There is also reason to question whether this claim is accurate as a descriptive matter. Aside from the concerns described above, most clients bearing some or all of the costs of representation will be interested in the costs and benefits of "tactical" or "technical" decisions. Finally, the rule also provides no guidance on how to resolve any conflicts that may arise between the client and the attorney on "means" other than to note that, at the outer edges, the attorney may withdraw.[64]

We would clarify that, as a starting point, the attorney should give the client the opportunity to approve every significant action in a representation. Each practice will have its own set of "significant actions," but we would include classic "tactical" decisions such as whether to serve discovery requests, whether to seek depositions of any individual, and whether and whom to call as witnesses at any hearing. This approach serves client autonomy by ensuring that the client maintains authority over every aspect of the representation, and by reinforcing the agent-principal nature of the attorney-client relationship. For related reasons, it also protects the attorney-client relationship. For example, Ms. X, who already suspects that her brother and psychiatrist are scheming against her, may begin to suspect her attorney, as well, if he makes decisions without her. This approach also

62. *Id.*

63. *Id.*

64. *Id.* As discussed *infra* Part IV.C.5, withdrawal is generally an unsatisfactory solution for both the attorney and the client.

offers considerable benefits to the attorney. In general, clients who are more involved with a representation are more responsive to requests for information and answer questions more effectively. The client who is aware of the many technical and tactical decisions that an attorney must make during the course of the representation will better appreciate the need for the attorney's expertise. The client who is kept abreast of even minor developments and who approves tactical decisions is also less likely to be surprised by an adverse result, and so less likely to pursue or succeed on a malpractice claim at the end of the representation.

There are a number of factors that may affect whether and how an attorney preserves client authority when the client has limited competency. Because attorneys, like everyone else, may harbor misconceptions concerning people with mental disabilities,[65] they may tend to discount or ignore the opinions of clients with mental disabilities. For example, the attorney who treasures neatness, order, and the company of others may discount Ms. X's claim that she prefers to live a more isolated existence amongst piles of newspapers and other clutter. This may lead the attorney to override, either explicitly or by excessively forceful persuasion, the view of such a client on matters that the attorney regards as "technical, legal and tactical,"[66] or in the extreme case, override the client's choices about end goals. Attorneys often have a tendency to combat the "opponent" in any representation in order to "win" for themselves or the client, and may seek this result without regard to its impact on the client or to whether the client shares this goal.[67] When a judge has observed a client with symptoms of limited competency, he or she may look to the attorney to act as a decision-maker, either in the hopes of reaching a favorable result, or out of a desire to smooth the processing of the client's case. The client may not be used to exercising her autonomy without interference, and so may be hesitant to voice her opinion. The client may also be so overwhelmed by the prospect of a negative outcome to the representation that she automatically defers to the attorney, or actively requests that he make all decisions for her, in the

65. Michael L. Perlin, *"You Have Discussed Lepers and Crooks": Sanism in Clinical Teaching*, 9 CLINICAL L. REV. 683, 684, 689-90 (2003) [hereinafter Perlin, *Sanism*]. *Cf.* Wal-Mart Stores, Inc. v. Dukes, 2011 WL 2437013, at *19 (June 20, 2011) (Ginsberg, J., dissenting) ("Managers, like all humankind, may be prey to the biases of which they are unaware.").

66. As noted above, ABA Model Rule 1.2 provides cover for this tendency. MODEL RULES OF PROF'L CONDUCT R. 1.2 cmt. 2 (2010).

67. *See* Sandra Day O'Conner, Assoc. Justice, Sup. Ct. of the U.S., Professionalism, *in* 78 OR. L. REV. 385, 387 (1999). This tendency can be born of competitiveness, of the belief that every client should seek the full vindication of her legal rights to the maximum extent possible, or of a tendency to see the client as a metonym for a class of similarly situated individuals.

belief that doing so will best protect her. The client may also have difficulty making choices – either failing to decide or vacillating. In an extreme circumstance, the client may stake out a position based upon a false belief which is not amenable to modification based upon contravening information. Ms. X may believe that, if the guardianship petition is granted, her brother will immediately have her committed "forever" – and may refuse to believe the attorney's explanations of the procedural safeguards designed to prevent such an abuse. Any of these problems can result in a representation where the client is unable or not permitted to exercise self-determination.

B. Communication With the Client

The client cannot exercise her authority unless adequately informed. The ABA has a Model Rule that deals with this issue, as well.[68] In general terms, it requires the attorney to keep the client abreast of the representation so that she can make informed decisions.[69] ABA Model Rule 1.4 provides that the attorney shall keep the client informed of key facts and developments in the representation, consult with the client on the means by which objectives are pursued, comply with reasonable requests for information, and "explain a matter to the extent reasonably necessary to permit the client to make informed decisions regarding the representation."[70] The commentary sums up the purpose of this rule pithily: "Reasonable communication between the lawyer and the client is necessary for the client effectively to participate in the representation."[71]

Neither the commentary nor the rule, however, provides much guidance as to what is "reasonable communication" or how much information is "reasonably necessary" for the client to make an "informed decision."[72] The answer cannot simply be to provide "all the information." No attorney can provide a client with every possible fact that could affect the client's decision. In addition, flooding a client with information that may not be relevant to her decision does not facilitate autonomy – it may just paralyze her decision-making process, making her more reliant on the attorney. Happily, there is a well-developed body of case law in a highly analogous area that provides some guidance.[73]

The doctrine of "informed consent" to medical procedures arose from concerns similar to those which resulted in the client-centered lawyering

68. MODEL RULES OF PROF'L CONDUCT R. 1.4 (2010).
69. *See id.*
70. *Id.*
71. MODEL RULES OF PROF'L CONDUCT R. 1.4 cmt. 1 (2010).
72. MODEL RULES OF PROF'L CONDUCT R. 1.4 cmt. 1-4 (2010).
73. *See infra* notes 74-79.

model – the recognition of the right of patients to control what is done to their bodies – and can be justified on similar normative (autonomy) and practical (the need for them to be active partners in their own care for effective results) grounds.[74] In its modern formulation, the informed consent doctrine generally requires that a physician disclose to a patient "what is reasonably necessary for a reasonable person to make an intelligent decision with respect to the choices of treatment or diagnosis."[75] The states are split over whether the scope of disclosure is determined from the physician's[76] or patient's[77] viewpoint, but disclosures normally must include "the nature of the pertinent ailment or condition, the general nature of the proposed treatment or procedure, the prospects of success, the risks of failing to undergo any treatment or procedure at all, and the risks of any alternate methods of treatment. A physician must also inform the patient of any alternatives that exist to a surgical procedure."[78] The physician generally need not disclose "alternative treatments or procedures which are not accepted as feasible,"[79] and "need not disclose absolutely every fact or remote possibility that could theoretically accompany a procedure."[80]

74. *See* Mark Spiegel, *Lawyering and Client Decisionmaking: Informed Consent and the Legal Profession*, 128 U. PA. L. REV. 41, 44-49 (1979-80). *See also* Stouffer v. Reid, 965 A.2d 96, 101 (Md. Ct. Spec. App. 2009) ("The fountainhead of the doctrine . . . is the patient's right to exercise control over his own body . . . .") (internal citations, quotations, and alteration omitted).

75. Jandre v. Physicians Ins. Co. of Wis., 792 N.W.2d 558, 564 (Wis. Ct. App. 2010) (internal citations and quotations omitted).

76. *See, e.g.*, Willis v. Bender, 596 F.3d 1244, 1254 (10th Cir. 2010) (under Wyoming law, "[a] physician is required to disclose only such risks that a reasonable practitioner of like training would have disclosed in the same or similar circumstances.") (internal citations, quotations, and alteration omitted); Melton v. Medtronic, Inc., 698 S.E.2d 886, 894 (S.C. Ct. App. 2010) ("The scope of a physician's duty to disclose is measured by those communications a reasonable medical practitioner in the same branch of medicine would make under the same or similar circumstances.") (internal citations, quotations, and alteration omitted).

77. *See, e.g.*, Wyszomierski v. Siracusa, 963 A.2d 943, 952 n.14 (Conn. 2009) ("The lay standard requires a physician to provide the patient with the information which a reasonable patient would have found material for making a decision whether to embark upon a contemplated course of therapy.") (internal citations, quotations, and alteration omitted); Univ. of Md. Medical Sys. Corp. v. Waldt, 983 A.2d 112, 127 (Md. 2009) ("[T]he scope of the physician's duty to inform is to be measured by the materiality of the information to the decision of the patient. A material risk is one which a physician knows or ought to know would be significant to a reasonable person in the patient's position.") (internal citation, quotation, and alteration omitted).

78. Pertuit v. Tenant Louisiana Health Systems, 49 So.3d 932, 936 (La. Ct. App. 2010).

79. *Id.* at 937.

80. Hageny v. Bodensteiner, 762 N.W.2d 452, 455 (Wis. Ct. App. 2008) (citation omitted).

However, the physician may be required to make more specific or detailed disclosures if "the physician knows or should know of a patient's unique concern or lack of familiarity with medical procedures . . . ."[81]

These formulations provide a fair guide to attorneys. The attorney should disclose to the client the basic nature of her matter and the general legal standards governing it, the material facts about the representation, the risks inherent in staking out contemplated positions and taking contemplated tactical decisions, and the availability of alternatives to any of these. The attorney need not disclose infeasible approaches (*e.g.*, seeking a declaration of unconstitutionality in a case where such a ruling is clearly foreclosed). He should disclose particular facts or issues if he knows that the client will be interested in them. For example, some clients may be interested in asserting the unconstitutionality of a practice, even if such a ruling is foreclosed, or may be particularly sensitive to anyone becoming aware of their mental disability (*e.g.*, someone who generally functions very well and is aware of the negative social consequences which disclosure might involve),[82] and so may want to avoid any disclosure whatsoever, even if it might benefit her in the representation. Ms. X's experience of suffering severe injuries due to poorly maintained facilities may have galvanized her desire for justice, making her willing to stake out aggressive positions in the interest of advancing the cause of those similarly situated to her. Or, her sense of loss due to the explosion may drive her to reveal as little as possible about her condition. Finally, though, the informed consent doctrine does not answer the problem. It is a malpractice standard; beyond its limits, one is open to civil suit. While malpractice is a concern for attorneys,[83] we should hold ourselves to a higher standard. The question should be not simply, "What can I do without being sued?" but "What is the best action to take within the range of permissible actions?"

In assessing the scope of disclosures to make, the attorney should also be mindful of the impact of heuristic biases such as salience. Outlier possibilities with severe negative impacts – such as death for one considering undergoing a minor medical procedure, or imprisonment for

81. Hernandez *ex rel*. Telles-Hernandez v. United States, 665 F. Supp. 2d 1064, 1077 (N.D. Cal. 2009) (internal citation and quotations omitted).

82. For a poignant description of a leading psychologist's struggle with these issues in her personal and professional life, see Benedict Carey, *Expert of Mental Illness Reveals Her Own Fight*, N.Y. TIMES, June 23, 2011, http://www.nytimes.com/2011/06/23/health/23lives.html

83. Though we are unaware of any particular malpractice lawsuits in this context, it would not be hard to imagine a disappointed client, or family member of a client, filing suit against an attorney based on the attorney's failure to prevent the client from making a clearly "bad" decision when the attorney believed he was serving short-term autonomy, or failing to zealously contest guardianship when the attorney believed he was protecting the client's well-being.

one facing a very minor criminal charge – become outsized possibilities in the mind of the person faced with them, and can distort rational decision-making. Overwhelming the client with information that will frighten or upset her to an extreme degree, although extremely unlikely to occur, does not serve autonomy.[84] The order in which information is presented (primacy and recency) can also play a significant role in determining decisions, and the attorney should be conscious of what he chooses to emphasize by placing them first and last. For example, the attorney who believes that Ms. X should be under some sort of supervision may find himself discussing the benefits of the proposed guardianship first, then acknowledging the loss of rights, and finally returning again to the benefits. If he does not reflect on this inclination, the attorney risks unnecessarily supervening the client's will.

Putting together the issues of informed consent, individuality, existence of heuristics, and self-monitoring: The attorney needs to be aware, in the process of communicating information, what he chooses to include and what he chooses to exclude; needs to consider the manner and order in which information is presented; and should remain mindful of the client's individual characteristics by including everything she would be interested in knowing and being wary of how he addresses outlier possibilities that may be especially alarming to the client. As in other facets of the representation, there is no way to avoid attorney judgments in this regard. Self-monitoring and consulting with other attorneys is the best way to ensure that the client receives all the information she needs in a way that facilitates, rather than guides or determines, her decisions.

In the representation of a client with limited competency, a number of factors may complicate the execution of the duty of communication.[85] The attorney accustomed to quick interactions with clients may lack the patience required to communicate with someone who has trouble understanding or remembering key facts. Even a patient attorney may simply be too busy with other matters to give the client the time she needs to understand case developments. The communication strategies that the attorney usually employs without reflection in other representations may not be effective. The risk is that, out of a desire to reach the "best" result for the client, the attorney may be over-selective in the information he provides. At the opposite end of the spectrum, the attorney may overwhelm the client with

84. This is an area for the exercise of great caution. It can be difficult to distinguish withholding information in service of long-term autonomy from doing so out of paternalism.

85. The commentary to Model Rule 1.4 notes this issue. "Ordinarily, the information to be provided is that appropriate for a client who is a comprehending and responsible adult. However, fully informing the client according to this standard may be impracticable, for example, where the client is a child or suffers from diminished capacity." MODEL RULES OF PROF'L CONDUCT 1.4 cmt. 6 (2010).

too much information, or with information to which the client may be extremely sensitive even if it is of little practical import.

C. Confidentiality of Client Information

The client cannot provide the attorney with all the material information about a representation unless she can rest assured that the attorney will not disclose the information to anyone unless it is required to achieve the goals of the representation.[86] This is of special concern where the information might be embarrassing if brought to light, or might undermine the client's goals in the representation if revealed to the court or to any other party.

ABA Model Rule 1.6 bars disclosure of information relating to the representation absent consent or exigency.[87] The consent can be actual "informed consent" or implied, as when the disclosure is "impliedly authorized in order to carry out the representation."[88] The exigencies include prevention of bodily or property harm and seeking ethical guidance about the representation, among others.[89]

This is an area where any compromise must be very carefully considered. The loss of trust that can result from inappropriate disclosure of confidential information can be very detrimental to the representation, and the sense of betrayal and exposure can be traumatic for the client. For example, Ms. X has a history of paranoia and distrust of those close to her. If she learns that her attorney has revealed information to her psychiatrist or her brother without her consent, the representation may be irremediably damaged. Workarounds are available to avoid disclosing client confidences when the attorney needs to consult with someone outside the protection of attorney-client privilege without seeking the client's consent.[90] The most commonly employed workaround, and perhaps the most effective, is to describe the client and her issue in sufficiently general terms to prevent identification, but specific enough terms to permit comment on the client's situation.[91]

86. *See* MODEL RULES OF PROF'L CONDUCT R. 1.6 (2010).

87. MODEL RULES OF PROF'L CONDUCT R. 1.6 (2010).

88. *Id.* The rule's commentary offers as an example attorneys within a firm discussing a case. MODEL RULES OF PROF'L CONDUCT R. 1.6 cmt. (2010).

89. MODEL RULES OF PROF'L CONDUCT R. 1.6 (2010).

90. Consultants and others retained to assist in a litigation are frequently covered by the attorney-client privilege. Some courts recognize an even broader category of individuals to whom information may be disclosed – those to whom disclosure was beneficial to the representation and who could be expected to keep the information disclosed confidential.

91. This approach can be justified because it is not the pure disclosure of the facts of the client's situation that are harmful, but the disclosure of those facts in a way that would associate them with the particular client.

Issues of confidentiality are more likely to arise and more difficult to navigate in the representation of a client with mental disability. The issues are more likely to arise because the attorney may feel a greater need to seek assistance from other attorneys, physicians, mental health experts, or friends and family without formal client consent (*e.g.*, in order to determine whether the client is suffering from limited competency or to determine appropriate techniques for working with a client who is). Confidentiality issues are more difficult to navigate with mentally ill clients because the disclosure can be extremely harmful to the client's interests and to the representation. For example, the attorney who consults with a physician about the client's competency without client consent risks making the conversation available for discovery by other parties.[92] The impact of such a disclosure can range from embarrassment and adverse cross-examination material in a matter where mental health is not the central concern, to frustration of the very purpose of the representation in matters where mental health is squarely at issue.

It is no surprise that this is the only area that the ABA Model Rule on clients with diminished capacity treats explicitly. It states that client information must still be kept confidential, even when the attorney is taking protective action.[93] Implied disclosure should not be interpreted as an exception that swallows the rule. In particular, "the lawyer is impliedly authorized . . . to reveal information about the client, but only to the extent reasonably necessary to protect the client's interests."[94] This can make any disclosure of the client's condition forbidden in some circumstances. As the commentary notes, "[d]isclosure of the client's diminished capacity could adversely affect the client's interests. For example, raising the question of diminished capacity could, in some circumstances, lead to proceedings for involuntary commitment."[95]

One example of when disclosure might be appropriate and permissible is when a lawyer consults with a physician about a client who is having difficulty communicating or making decisions about the representation. ABA Informal Opinion 89-1530 permits such disclosures, even absent client consent,[96] so that the attorney may determine whether the client remains capable of acting in her own best interest and may understand whether

92. If the attorney consults with a treating physician, the physician-patient privilege would likely prevent the physician from testifying against the client in the guardianship proceeding if it were a contested matter. *See In re* Guardian of Derek, 12 Misc. 3d 1132 (N.Y. Surr. Ct. 2006). *Cf. In re* Guardian of Linda Tian, 10/15/2007 N.Y.L.J. 30 (col. 4) (ordering release of medical records in uncontested matter).

93. MODEL RULES OF PROF'L CONDUCT R. 1.14(c) (2010).

94. *Id.*

95. MODEL RULES OF PROF'L CONDUCT R. 1.14 cmt. 8 (2010).

96. ABA Comm. On Ethics and Prof'l Responsibility, Informal Op. 1530 (1989).

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further protective action is necessary. For example, if Ms. X's condition deteriorates to the point of incoherence, the attorney may seek specific advice from a physician in order to ensure that her health is not at immediate risk and that she remains capable of making decisions.

D. Attorney Loyalty

Each client is entitled to the undivided loyalty of her attorney. This means that, with respect to the representation, the attorney is beholden to no one besides the client. ABA Model Rules 1.7 and 1.8 identify several types of conflict of interest.[97] We highlight two in particular for this article: (1) unless the attorney gets the informed written consent of the client, she must not take on a representation if doing so creates a "significant risk" that the representation will be "materially limited by the lawyer's responsibilities to, [among others], a third person,"[98] and (2) the attorney cannot be paid by someone other than the client unless "the client gives informed consent; there is no interference with the lawyer's independence of professional judgment or with the client-lawyer relationship; and information relating to representation of a client" is kept confidential.[99]

It is not reasonable to expect a client to repose trust in an attorney unless she is confident that he is acting in accordance with her wishes. The client with mental illness may already doubt the attorney's loyalty. This risk is exacerbated when the attorney is appointed by the court. The client may wonder whether the attorney has been assigned in order to zealously represent her, or instead to facilitate her processing through the legal system. Ms. X already believes her APS-appointed psychiatrist is working against her; she may expect the same of her court-appointed attorney. Some of this is unjustified. An attorney who appears regularly in the probate and mental health courts may have relationships with opposing counsel, judges, and court personnel, and familiarity with the procedures employed by courts or judges hearing mental disability matters that are constructive in furthering the client's goals. Appointed counsel who specialize in a particular area often have specialized knowledge which can assist the client in decision-making. But, some of this concern is rational: Both civil and criminal appointed attorneys may be poorly paid, and their compensation is often structured on a "per case" or "per motion" basis. There are thus strong personal disincentives to thorough preparation, even for the committed attorney. If the appointed attorney spends too much time on any one case, he cannot tend to his other cases, and if he does not handle

97. MODEL RULES PROF'L CONDUCT 1.7, 1.8 (2002).
98. MODEL RULES PROF'L CONDUCT 1.7 (2002).
99. MODEL RULES PROF'L CONDUCT 1.8(f) (2002).

enough cases to make a living, then he will be forced to seek better-paying work elsewhere, preventing him from taking on any appointed cases. There are also institutional pressures: The attorney who depends on the goodwill of others in the system (*e.g.*, judges, state attorneys, or prosecutors) may pull his punches, even unwittingly, in order to retain credibility for future interactions (which he would put to use for his future clients). Judges want cases resolved.

The stigma of mental disability, abetted by cultural myths and negative media portrayals, creates additional problems. The client with some form of mental disability or illness may have learned not to trust her own instincts, and may tend to be overly reliant on the advice of others. "The client with mental disabilities may be uniquely in need of skills and assertiveness training to function as a participatory, and not nominal, client."[100] Conversely, the client may seek to maintain a sense of pride and dignity by minimizing her difficulties in functioning, and so display confidence when she is, in fact, confused. Ms. X might present such a scenario: She worked her way into a supervisory position and put herself through night school to earn a college degree, and so is likely possessed of a strong will and sense of personal accomplishment. Her fear of loss of control over her life might trump any worries she has for her health – remember that she began to isolate herself more when she developed involuntary twitches from her medication. An additional problem is that the client may project the stigma she feels as one diagnosed with mental illness onto her attorney. As we have seen from our work in the criminal justice system, the client who has been told she is worthless for much of her life may have trouble believing that anyone competent would willingly take up her cause, and so may distrust the appointed attorney's motives or abilities. "It is almost a truism that a criminal defendant would rather have the most inept private counsel than the most skilled and capable public defender."[101]

V. APPLICATION TO GUARDIANSHIP PROCEEDINGS

A. *Context*

Every state provides proceedings by which an adult may have her rights to act on her behalf partially or totally placed in the hands of another, who is charged with the responsibility to act as a guardian (or, in some states, conservator) of that person's best interests. This deprivation of legal capacity to act and placement in the hands of another is "an extraordinary exercise of governmental authority," and a "broad and very restrictive form of

100. Herr, *supra* note 32, at 639.
101. People v. Huffman, 139 Cal. Rptr. 264, 267 n.2 (Cal. Ct. App. 1977).

substitute decision making . . . ."[102] The need for a guardian does not grow out of a specific (or indeed any) diagnosis, but rather out of functional impairments which may be manifestations of an illness or condition at any given point in time. Modern guardianship statutes recognize this and seek, at least in principle, to minimize the intrusion by "afford[ing] the person the greatest amount of independence and self-determination and participation in all the decisions affecting such person's life."[103]

Accordingly, courts are directed to employ "the least restrictive form of intervention" possible,[104] meaning only granting the guardian "those powers which are *necessary* to provide for that person's personal needs and/or property management and which are consistent with affording that person the greatest amount of independence and self-determination in light of that person's understanding and appreciation of the nature and consequences of his or her functional limitations."[105] Whether courts in fact do so, because of the structure of the guardianship statutes[106] or out of an institutional tendency towards paternalism is another matter – as is whether this failure makes court practices subject to challenge under the ADA.[107] Finding the nexus between mental illness and lack of capacity can be tricky and also may be contextually and temporally bound. Having first found lack of capacity, many judges are reluctant to tie the hands of the guardian both out of a sense of paternalism and to avoid the need for further proceedings.[108]

B. General Considerations

The attorney representing someone who is the subject of a guardianship petition should employ the same least restrictive approach in her dealings with her client. As the ABA has observed, "protective action should be

102. ROBERT D. FLEISCHNER, CTR. FOR PUB. REPRESENTATION, GUARDIANSHIP, EXTRAORDINARY TREATMENT AND SUBSTITUTED JUDGMENT 1 (2000).

103. N.Y. MENTAL HYG. LAW § 81.01 (McKinney 2006). *See also, e.g.*, CAL. PROB. CODE § 1800 (West 2011) (expressing legislative intent, *inter alia*, to "increas[e] the conservatee's functional abilities to whatever extent possible" and "allow the conservatee to remain as independent and in the least restrictive setting as possible").

104. N.Y. MENTAL HYG. LAW § 81.03(d).

105. *Id.* §§ 81.03(d), 81.02(a)(2). *See also, e.g.*, CAL. PROB. CODE § 1800.

106. The finding of incapacity acts as an "on/off" switch triggering the loss of certain rights. Only after this finding does the court consider whether any restrictions should be placed on the guardianship. This finding may act as an anchor and may prompt judges to be overrestrictive.

107. Salzman, *supra* note 2, at 173-82.

108. Henry A. Dlugacz, *Involuntary Outpatient Commitment: Some Thoughts on Promoting a Meaningful Dialogue Between Mental Health Advocates and Lawmakers*, 53 N.Y.L. SCH. L. REV. 79, 89 (2008-09).

exercised with caution in a limited manner *consistent with the nature of the particular lawyer/client relationship* and the client's needs . . . ."[109] This means that, in the particular context of guardianship proceedings, the attorney must be very cautious about taking any action that would reveal to the party petitioning for guardianship, the court, or anyone else not protected by attorney-client privilege the attorney's concerns about client competence. "Incapacity," *i.e.*, that "the person is unable to provide for personal needs and/or property management" and "cannot adequately understand and appreciate the nature and consequences of such inability" is the very thing that the petitioner is seeking to establish. Effectively conceding the issue would result in serious long-term deprivations of client autonomy (*i.e.*, by appointment of a guardian).[110]

The guardianship attorney must take a nuanced view of how to promote self-determination. One option would be to focus on the immediate result, and always advocate for the least intrusion on the client's short-term autonomy. However, where the client is not presently equipped to exercise her autonomy, this may be setting her up to fail. The client may find herself the subject of a further petition, or may simply fail to provide for her own needs. If Ms. X is left completely to her own devices, her physical and mental condition may deteriorate to the point of dangerouness A short-term intervention (such as treatment, supported decision-making, or negotiating a resolution involving a guardian with power limited in scope, duration, or both) may promote her long-term autonomy by restoring her to competence or providing her with the resources she needs to move towards greater independence.

Many questions are raised in such circumstances. Is it ethical to pursue such a course? How is the right to self-determination vindicated in the extreme case where the client may be responding to hallucinations? Should Ms. X's attorney vigorously contest the petition and oppose any involvement by her psychiatrist or brother, despite clear evidence that she suffers greatly in the absence of treatment and indications that her brother has her best interests at heart? Is doing what the client wishes at that point promoting self-determination in the highest tradition of putting aside one's preconceived notions, or does simply following the client's direction in such circumstances make a farce of that ethical precept? Is helping her avoid a guardianship in the moment the best way to promote self-determination when long-term functioning will decline without intervention, leading to more restrictive interventions such as involuntary civil commitment?

109. ABA Comm. on Ethics and Prof'l Responsibility, Formal Op. 96-404 (1996).
110. N.Y. MENTAL HYG. LAW § 81.02 (McKinney 2006).

While states have developed different approaches, a goal of modern guardianship statutes is "preserving the autonomy of [alleged incapacitated persons] to the extent possible while providing necessary support for matters beyond the [incapacitated person's] competency."[111] One specific manifestation of this least intrusive alternative approach is the imperative to consider the sufficiency of community resources which might obviate the need for a guardian.[112] What is the lawyer's duty to attempt to secure those resources – *e.g.*, a case manager, housing, psychiatric treatment – which would make a guardian unneeded? Is it permissible to breach confidentiality on the basis of client need without making a simultaneous effort to assist with procuring needed services? To repeat, these questions can only be answered in the individual case, not in the abstract. The next section proposes some concrete approaches to these dilemmas.

C. Concrete Solutions

1. Involvement of Family or Friends

Clients with mental disabilities may rely to varying degrees on the assistance of family and friends in their everyday lives. Consequently, the client may want or expect them to be involved in her legal representation, as well. Friends and family can be valuable resources to the attorney, but can also present thorny ethical problems.

Family and friend involvement can be beneficial for a number of reasons. They are most likely to know the client's premorbid desires and values. The client may trust family and friends, and prefer their involvement. If the family and friends are trustworthy, this approach mimics the supported decision-making model (discussed below) that can encourage client participation and autonomy.[113] Yet there are also risks to the duties of confidentiality and client loyalty. "Even though a family may appear united when initially meeting with the attorney, the possibilities of conflicts are staggering."[114] Friends and family may have interests that diverge from the client's in subtle ways; if the client is the individual who is the subject of the

111. *See also* MICHAEL L. PERLIN, PAMELA R. CHAMPINE, HENRY A. DLUGACZ & MARY CONNELL, COMPETENCE IN THE LAW: FROM LEGAL THEORY TO CLINICAL APPLICATION 248 (2008), *citing, e.g.*, N.Y. M.H.L., at § 81.01.

112. See, e.g., N.Y. M.H.L.§81.02 ("In deciding whether the appointment is necessary, the court shall consider the report of the court evaluator . . . and the sufficiency and reliability of available resources . . . to provide for personal needs or property management without the appointment of a guardian.").

113. *See infra* Part D.1.

114. Barbara Carlin, *Ethical Considerations and the Client with Diminished Capacity*, TOOLE, CARLIN & POWERS, P.A., at 1, 6, http://www.elderlawinme.com/ethical.pdf (last visited June 10, 2011).

guardianship petition (as opposed to the family members, who might also seek representation in connection with the petition), it is critical to track where direction is coming from and ensure that the family is assisting the client in making decisions, not making decisions for her. Even if both Ms. X and the attorney trust Ms. X's brother, it is Ms. X who should be making decisions about the representation to the greatest extent possible. This approach may also create privilege problems, especially if the family members' or friends' interests might later be found to diverge from that of the client. Frequently, the very people who bring the petition for guardianship may be family or friends,[115] or those who stand to benefit from distributions of estate or trust property if the person is judged to be in need of guardianship.[116]

Monetary issues rear their head particularly in this context. In one of the author's (HD) experience, guardianship may be employed with the poor, because the alternatives that can prevent it – such as health care proxies, powers of attorney, living wills – require access to legal counseling or knowledge which may require the ability to pay attorney's fees. Ms. X has never put in place any of these protective measures, and her dwindling resources may not be enough to cover the cost of them now. At the same time, the wealthy may find themselves targets of a guardianship petition when a family member or friend seeks to use the process as a means to control the disposition of property prior to death and disposition by probate or to preserve future inheritance—which is Ms. X's fear.[117]

2. Appointment of a Guardian Ad Litem

In the hopes of getting clear direction and reducing the complexity of the representation, the attorney confronted with a client with diminished competency may wish to have a guardian ad litem appointed to make decisions for the client. The Model Rules permit this approach.[118]

The fundamental benefit to this approach is that the attorney receives clear direction from a person appointed by a court to so act, eliminating questions about the attorney's legal and ethical authority to carry out the directions he is given. In the case of a severely incapacitated client, or one who is extremely reliant on family members who may not have the client's best interests at heart, a guardian ad litem may protect the client from advertent or inadvertent overreaching by family or friends, and can protect the attorney from similar accusations. The cost to this approach is extremely

115. *See, e.g.*, N.Y. MENTAL HYG. LAW § 81.06 (McKinney 2006).

116. *See, e.g.*, *id.*

117. Rein, *supra* note 2, at 243. *See also* PERLIN, CHAMPINE, DLUGACZ & CONNELL, *supra* note 111.

118. MODEL RULES OF PROF'L CONDUCT R. 1.14(b) (2010).

high, however. It completely supplants client decision-making, and can be alienating and traumatizing for the client, who may not trust the guardian ad litem.[119] Further, the attorney is not absolved of his responsibilities. He cannot rely blindly on the guardian ad litem's direction, but still must make "an independent determination of the client's interests."[120] In the guardianship context, it is difficult to see how an attorney could carry out his duties to the client and seek appointment of a guardian ad litem. If the client's disability is slight or moderate, the other accommodations and support techniques discussed elsewhere here should suffice. If the client's disability is so severe as to make some form of guardianship a forgone conclusion, cooperative participation from those involved in the client's life is probably the appropriate approach, and the appointment of a guardian ad litem would only seem to add an unnecessary, uninformed party to the mix.

3. Following the Client's Directions Literally

One option available to the attorney who suspects the client may have diminished competency would be to follow the client's directions literally and unquestioningly. From one perspective, this seems to serve autonomy by eliminating the risk of the attorney overbearing the client's will. Indeed, some have contended that "[d]irect representation of the client's expressed wishes is clearly the optimal approach from ethical and pragmatic perspectives."[121]

We would question that approach, even for fully competent clients, for reasons outlined in Section II above. The attorney cannot know whether the client is making an informed decision until he has tested the client's decision against her stated values and rationales. The client is entitled to the benefit of the attorney's opinion, and is not well served unless she receives it.

In the guardianship context, this may manifest in the client who indicates she wishes to resist the petition. Even though this direction may accord with the attorney's own views – he may have difficulty imagining being under anyone's guardianship, as well – he should engage in a firm and clear exploration of the client's wishes. The client may not understand the many nuanced outcomes that may be available to her, including a guardianship limited in scope or duration. It is as disparaging of individual choice to assume that all clients wish to engage in adversarial proceedings as it is to assume that all clients with a mental disability lack decisional capacity. It may be perfectly rational to be relieved at the prospect of having assistance

119. Rein, *supra* note 2, at 245.

120. Martha Matthews, *Ten Thousand Tiny Clients: The Ethical Duty of Representation in Children's Class Action Cases*, 64 FORDHAM L. REV. 1435, 1446 (1996).

121. Herr, *supra* note 32, at 641.

with the daily struggles of life. Do not many of us want to give up this responsibility? It is likewise perfectly human to deny, particularly to a stranger, that assistance is required. Further, it can be tremendously stressful and destructive to litigate these proceedings, and a client who initially indicates her desire to resist the petition may not wish to pursue aggressive litigation once she understands what is involved. It is paternalistic to attempt to force a person to pursue all of their "rights," whether it is driven by cause-oriented lawyering or a failure to explore with the client her options and the basis for her stated preferences.

In failing to explore all possibilities, including settlement of the proceeding with appointment of a guardian, the attorney would be acting as an advocate for the client's presently stated interests – which benefits short-term autonomy – but with possibly poor outcomes for the client in the long run. Some states endorse this "advocate" role explicitly by requiring attorneys to pursue a client's opposition to the provision of mental health services whenever the client expresses opposition to them.[122] These states do not appear to take into consideration the possibility that the client's presently expressed desires may not reflect her considered opinion, and may undermine her long-term prospects of independence. Further, while we strongly support the overriding value of self-determination, there are real-life circumstances where blindly following the client's wishes without critical exploration, or permitting the client to express herself in court on the record, can lead to almost farcical situations where the client becomes the subject of demeaning ridicule in a public forum. Ms. X's desire for independence and dignity may not be advanced by allowing her to testify at length about the people tapping her phone and the scheming of her brother and psychiatrist. We offer no bright line rule for handling these situations but suggest that just as the lawyer's proper role as advocate should be tempered by some humility and self-exploration, the right to self-determination should not prevent the attorney from attempting to aid the client in preserving dignity. In all instances, the client has the right to our clearly articulated opinion regarding the likelihood of success and the consequences of certain actions.

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122. *See, e.g.*, TEX. HEALTH & SAFETY CODE ANN. § 574.004 (Vernon 2009) ("[r]egardless of an attorney's personal opinion, the attorney shall use all reasonable efforts within the bounds of law to advocate the proposed patient's right to avoid court-ordered mental health services if the proposed patient expresses a desire to avoid the services"); *In re* Mental Health of K.G.F., 29 P.3d 485, 500 (Mont. 2001) ("the proper role of the attorney is to 'represent the perspective of the respondent and to serve as a vigorous advocate for the respondent's wishes'") (quoting NAT'L CTR. FOR STATE COURTS, GUIDELINES FOR INVOLUNTARY CIVIL COMMITMENT, 10 MENTAL & PHYSICAL DISABILITY L. REP. 410, 465 (1986)).

4. Accommodations in Court Proceedings

Contested proceedings can be very stressful, because the client may already be uncomfortable in the foreign environment, and because the need to testify can be destructive to the client's family and professional relationships. Assuming the client is able to understand the risks involved, the attorney should not seek to avoid such proceedings if the client has given her informed consent. Instead, when indicated, he may consider seeking accommodations within the proceeding. Frequent breaks or transitional objects[123] may help keep the client comfortable and engaged. Adjournments to seek support and treatment might obviate the need for guardianship, or at least improve the client's ability to meaningfully participate in the proceeding. However, in the guardianship context, seeking these accommodations tacitly concedes that the person may not be competent. This area is fraught with complexities and no categorical solution applies. In practical terms, however, an attorney can work on these issues with the client – to identify what accommodations may be needed, or find some way to provide them *sub rosa* – before bringing them to the attention of the court.

5. Withdrawal

A final option is for the attorney to withdraw from the representation. Given the difficulty of navigating the demands of autonomy for a client with diminished competency, withdrawal may be appealing to some. (One hopes that the attorney who agrees to represent the subject of a guardianship petition is already prepared for these sorts of dilemmas, however.) The benefit to withdrawing is that it eliminates the dilemma for the attorney. It is certain that he will not supplant the client's decision-making authority.[124] That is the only benefit. Withdrawal does not solve the underlying dilemma for the next attorney, and can be extremely prejudicial for the client. It "only solves the lawyer's problem and may belittle the client's interest."[125] It often signals to the court and opposition that something is wrong. The ABA discourages withdrawal,[126] noting that it may be impossible to withdraw without prejudicing the client's interests, particularly where the client's disability has worsened over the course of the representation, making it more difficult for any new counsel to serve the

123. A transitional object is a possession that carries special meaning for the individual, and can provide a source of comfort in unfamiliar surroundings.

124. ABA Comm. on Ethics and Prof'l Responsibility, Formal Op. 96-404 (1996).

125. ABA Comm. on Ethics and Prof'l Responsibility, Formal Op. 96-404 (1996) (quoting CHARLES W. WOLFRAM, MODERN LEGAL ETHICS 162 (1986)).

126. ABA Comm. on Ethics and Prof'l Responsibility, Formal Op. 96-404 (1996).

client effectively.[127] We do not regard withdrawal as a genuine option in the guardianship context, except in the most extreme circumstances, but include it for the sake of discussion.

D. Possible Alternatives to Guardianship

There are a number of alternatives to guardianship of which an attorney practicing in this context should be aware. Some require advance planning, while others can be brought into play after a guardianship petition has been filed as a means to effectuate legislative intent to employ the least restrictive means possible in ensuring that the basic needs of individuals with mental disability are met.

1. Supported Decision-making

Supported decision-making occurs when an individual "receives support from a trusted individual, network of individuals, or entity to make personal, financial, and legal decisions that must be followed by third parties . . . ."[128] It differs from substituted decision-making (such as occurs in guardianship or when an attorney acts contrary to her client's stated preferences) in that the person receives help in understanding her choices and articulating them, but final authority over the decisions rests with her. This can ameliorate the downward spiral in functioning which can flow from a determination of incapacity – once you are thought of as incapacitated, your opinion is not sought, you lose the decision-making skills you have, and you become dependent on others. "[P]erceived loss of control causes people to suffer mental and physical decline."[129] Access to supported decision-making is now the preferred norm by international treaty. The Convention on the Rights of Persons with Disabilities (CRPD), to which the United States is a signatory but which it has yet to ratify, requires states to "take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity."[130] Other nations have begun to provide for supported decision-making by statute or practice.[131] In the guardianship context, it is worth noting the point made by Surrogate Booth in a New York guardianship matter: Although the United States has not ratified the CRPD, "a state's obligations under it are controlled by the

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127. ABA Comm. on Ethics and Prof'l Responsibility, Formal Op. 96-404 (1996).

128. Salzman, *supra* note 2, at 180.

129. Rein, *supra* note 2, at 243.

130. Convention on the Rights of Persons with Disabilities, opened for signature Mar. 30, 2007, G.A. Res. 61/106, art.12(3), U.N. Doc. A/RES/61/106, (Dec. 6, 2006). *See also* Salzman, *supra* note 2, at 231-32.

131. Doug Surtees, *The Evolution of Co-Decision-Making in Saskatchewan*, 73 SASK. L. REV. 75, 83-84 (2010).

Vienna Convention of the Law of Treaties[,] which requires signatories 'to refrain from acts which would defeat [the Disability Convention's] object and purpose.'"[132]

2. Enhanced Community Services That Could Obviate the Need for Guardianship

While the manifestations of a mental disability may wax and wane,[133] leading to the oft-described "lucid intervals,"[134] a growing body of literature describes evidence-based practices which can lead to recovery from, or prolonged periods of remission from, serious mental illnesses.[135] As noted, the modern trend in guardianship law is towards a functional approach that examines the alleged incapacitated person's ability to handle the activities of daily living without any diagnostic predicate.[136] In contrast, earlier statutes required a certain "status" such as diagnosis of dementia or mental illness as a predicate for guardianship.[137] Some statutes combine elements of both

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132. *In re* SCPA Article 17-A Guardianship Proceeding for Mark C.H., Ward*,* 906 N.Y.S.2d 419, 433 (Sur. 2010) (citing Vienna Convention on the Law of Treatises art. 18, May 23, 1969, 1155 U.N.T.S. 331).

133. Another issue to consider is the extent to which symptoms and their attendant reductions in social functioning are iatrogenic – that is, caused by medications or combinations of medications – and thus subject to reversal. *See* EDMUND H. DUTHIE, JR. & PAUL R. KATZ, PRACTICE OF GERIATRICS 65-6 (3rd ed. 1998) (1986) (defining iatrogenic illness as "any illness that results from a diagnostic procedure or therapeutic intervention or any harmful occurrence that is not a natural consequence of the patient's underlying illness"). The same is true of disturbances in mental status caused by treatable medical conditions. While it may seem obvious, it bears emphasis that mental illness is not protective of medical illness; quite the contrary, people with severe mental illnesses have elevated rates of many major medical conditions. *See generally* Marc De Hert et al., *Physical Illness in Patients with Severe Mental Disorders. I. Prevalence, Impact of Medications and Disparities in Health Care*, 10 WORLD PSYCHIATRY 52, 52-53 (2011). That is to say, these areas of inquiry are not categorical, but rather form the component parts of a full bio-psycho-social-legal assessment of the situation.

134. BLACK'S LAW DICTIONARY 1033 (9th ed. 2009).

135. *See, e.g.*, EVIDENCE BASED PRACTICES IN MENTAL HEALTH CARE (Robert E. Drake & Howard H. Goldman eds., 2003) (noting the collection of articles on evidence-based research within this book).

136. PERLIN, CHAMPINE, DLUGACZ & CONNELL, *supra* note 111, at 249-50. *See, e.g.*, FLA. STAT. § 744.102(12) (2010).

137. PERLIN , CHAMPINE, DLUGACZ & CONNELL, *supra* note 111, at 249-50. *See, e.g.*, UNIF. GUARDIANSHIP & PROTECTIVE PROCEEDINGS ACT § 1-201(7) (1982, amended 1997), 8A U.L.A. 429 (2003).

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approaches,[138] both of which have been criticized as having arbitrary elements.[139]

To the extent a jurisdiction errs toward a functional threshold, supports and treatment for people with severe mental illnesses may avoid or limit the unwanted intrusion on their autonomy that guardianship signifies. Each situation and individual are different, but, aside from the efficacy of properly prescribed and monitored medications, there are five widely accepted evidence-based practices that have been found effective in the treatment of severe mental illness.[140] First, assertive community treatment provides a multi-disciplinary approach to care, where teams with very low caseloads (10:1 ratio) provide 24-hour-a-day access to crises care and other forms of treatment.[141] Services are provided in vivo, or where the person resides, rather than requiring the person to attend appointments in a clinic or hospital.[142] Second, family psychoeducation provides education for family members and others providing support for consumers of mental health services.[143] It encourages collaboration between family, the person with a mental disability, and clinicians to improve outcomes and has been shown to enhance the quality of life for participants.[144] Third, illness management and recovery centers on the person with a mental disability taking responsibility for her own life and fosters collaboration between caregiver and participants.[145] Fourth, where applicable, integrated dual diagnosis treatment for those with substance abuse difficulties as well as mental illness emphasizes motivational interventions and cognitive-behavioral treatments, provided in an integrated manner rather than treating the two issues separately.[146] Finally, supported employment, where vocational services are

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138. PERLIN, CHAMPINE, DLUGACZ & CONNELL, *supra* note 111, at 251.

139. *Id.* at 250. The status approach relies heavily on the vagaries of psychiatric diagnosis, while the functional approach does not distinguish between illness and eccentricity. *Id.* at 249-50.

140. Robert E. Drake et al., *Implementing Evidence-Based Practices in Routine Mental Health Service Settings*, *in* EVIDENCE BASED PRACTICES IN MENTAL HEALTH CARE, *supra* note 136, at 1.

141. Susan D. Phillips et al., *Moving Assertive Community Treatment into Standard Practice*, *in* EVIDENCE BASED PRACTICES IN MENTAL HEALTH CARE, *supra* note 135, at 47, 48.

142. *Id.*

143. Lisa Dixon et al., *Evidence-Based Practices for Services to Families of People With Psychiatric Disabilities*, *in* EVIDENCE BASED PRACTICES IN MENTAL HEALTH CARE, *supra* note 135, at 57, 58.

144. *Id.*

145. Frederick J. Frese III et al., *Integrating Evidence-Based Practices and the Recovery Model*, *in* EVIDENCE BASED PRACTICES IN MENTAL HEALTH CARE, *supra* note 135, at 21, 22.

146. Robert E. Drake et al., *Implementing Dual Diagnosis Services for Clients With Severe Mental Illness*, *in* EVIDENCE BASED PRACTICES IN MENTAL HEALTH CARE, *supra* note 135, at 39, 39-41.

integrated with mental health treatment, has been found to be successful in leading to competitive employment.[147]

3. Legal Planning That Can Obviate the Need for Guardianship

Anyone with sufficient foresight, means, and mental capacity can greatly reduce the likelihood that she will require a guardian.[148] The execution of a durable power of attorney or irrevocable trust while the person is competent are two ways people with access to legal advice make prior arrangements so that they (or a proxy of their choosing) can continue to enter into financial arrangements before they become incompetent.[149] Likewise, execution of a health care proxy or living will (in jurisdictions where they are given force of law) may permit a person to avoid the expense and humiliation of a guardianship proceeding with respect to personal decision-making.[150] Had Ms. X established any of these protections when she was first injured, she could have set boundaries on the type of assistance she wanted from others, avoided invasive questioning from APS and the court about her mental state, and ensured that her financial resources were managed by someone trustworthy. There is an emphasis on the need for advance planning, which in part is reliant on access to legal advice.

VI. ADDITIONAL CONSIDERATIONS

A. Attorney Competence

Representation of persons with mental disabilities is routinely not of the highest caliber.[151] Attorneys may lack the expertise necessary to competently handle the delicate issues raised by mental disabilities.[152] The limitations of time and expense imposed on appointed attorneys may be crippling.[153] Whether owing to personal discomfort, ingrained prejudices, or a lack of expertise, judges sometimes fail to hold counsel to the highest standards of the profession in proceedings involving mental disability

147. Gary R. Bond et al., *Implementing Supported Employment as an Evidence-Based Practice*, *in* EVIDENCE BASED PRACTICES IN MENTAL HEALTH CARE, *supra* note 135, at 29, 29.

148. PERLIN, CHAMPINE, DLUGACZ & CONNELL, *supra* note 111, at 245.

149. *Id.* at 245-46.

150. *Id.* at 245.

151. Michael L. Perlin, *Fatal Assumption: A Critical Evaluation of the Role of Counsel in Mental Disability Cases*, 16 L. & HUM. BEHAV. 39, 43-45 (1992).

152. *See, e.g.*, *In re* Mental Health of K.G.F., 29 P.3d 485, 492 (Mont. 2001) ("'[R]easonable professional assistance' cannot be presumed in a proceeding that routinely accepts – and even requires – an unreasonably low standard of legal assistance and generally disdains zealous, adversarial confrontation.").

153. *Id.* (noting that in "an involuntary commitment proceeding . . . counsel typically has less than 24 hours to prepare for a hearing on a State petition . . . .").

issues.[154] Because one plays to the level of one's competition, this may result in sloppy lawyering, with insufficient attention to the applicable legal standards or the client's goals.

An attorney has an obligation to provide competent representation to her client.[155] Since most attorneys do not have experience dealing with clients with mental disabilities and are not trained as mental health professionals, they are often ill-equipped to accurately identify or develop responses to a client's disability. Reading a few articles on mental disability and ethics will not prepare the attorney to deal with the complexities of a client manifesting symptoms of a disability. Yet such judgments are unavoidable. An attorney confronted with a client of questionable capacity is already making a determination of that client's capacity, even if only preliminarily and for the purpose of determining whether intervention or additional guidance from others is warranted.[156] To comply with his ethical obligations, an attorney who is likely to come into contact with clients with limited competency must make efforts to educate himself about the symptoms of mental disability and illness so that he can recognize them.[157] In the event of a client showing significant symptoms, he should either seek guidance from an attorney experienced with such clients, or support from a medical professional, support network, or similar organization with the appropriate background.

Beyond the question of assessment, the attorney must also ensure that he is equipped to understand the substantive mental health issues at play. He must be able to analyze medical records and effectively interview and question physicians and mental health professionals.[158] He must also understand the "range of alternative, less-restrictive treatment and care options available . . . ." in the client's community.[159]

Specialized interview skills may also be required.[160] People with mental disabilities may have difficulty presenting material in a linear fashion. It is important to use the right mixture of open-ended questions to allow the person time to tell her story (narrative truth) in her own way, but move to closed-ended (yes or no) questions when preparing for trial or to get very

154. Perlin, *Pretexts*, *supra* note 2, at 669-71.

155. MODEL RULES OF PROF'L CONDUCT R. 1.1 (2011); MODEL CODE OF PROF'L RESPONSIBILITY DR 6-101 (1980).

156. A.B.A. COMM'N ON L. & AGING & AMER. PSYCH. ASS'N, ASSESSMENT OF OLDER ADULTS WITH DIMINISHED CAPACITY: A HANDBOOK FOR LAWYERS 1 (2005) [hereinafter DIMINISHED CAPACITY HANDBOOK].

157. *Id.* at 8. Such clients are likely to be encountered in criminal defense, poverty law, probate, and, of course, guardianship practices.

158. Perlin, *Sanism*, *supra* note 65, at 702-03.

159. *In re* Mental Health of K.G.F., 29 P.3d 485, 498 (Mont. 2001).

160. Perlin, *Sanism*, *supra* note 65, at 703.

specific required information. Though it may be particularly tempting (and sometimes necessary)[161] to try to correct factual misunderstandings, this may result in the attorney arguing with the client – which is disruptive to the relationship. It may be impossible to convince Ms. X that her phone was never tapped and that her psychiatrist and brother are not conspiring against her, and efforts to convince her otherwise may lead her to a rupture in the attorney-client relationship. It is important to recall that much of what we think of as objective truth is really subjective. For example, the temperature in a room may be viewed as an empirical inquiry, but whether it feels hot or cold is not. Whether Ms. X's apartment has stacks of newspapers in it is empirical, but whether these stacks suggest mental illness or just an individual taste is not. Recalling this simple example can help the attorney avoid getting involved in counter-productive arguments with the client. Looking for themes in the client's communications and listening to her sufficiently to understand the nuances of what she wants with regard to the proceeding can be a sophisticated undertaking, but both good lawyering and truly ethical practice may require just such an endeavor. The Honorable Jack B. Weinstein once said, "We are responsible not only for the rule of law. We are also accountable for the principle of empathy and humanity."[162] In describing the fundamental difference between the approach employed by social workers and that of the legal profession, Judge Weinstein went on to say: "As I sometimes tell my law clerks, 'As judges, we must learn to be superficial.' This fundamental difference between the two professions may be summed up as 'tell me more' versus 'get to the point.'"[163]

B. Use of Experts

Experts may serve distinct purposes at different stages. An attorney whose client seeks to avoid future challenges to advance directives and financial planning methods, which may obviate the need for guardianship later in life, may have a neutral expert evaluate and document the client's capacity at the time that the instruments are executed. At other times, an expert may be employed following the filing of petition.

The attorney must be careful not to place complete reliance on a mental health expert for several reasons. The attorney is ethically required to

161. An attorney should accept the client's view to the extent possible. But, from time to time, the attorney may be required to confront factual issues that may be bound up with poor reality testing.

162. Jack B. Weinstein, *When is a Social Worker as Well as a Lawyer Needed?*, 2 J. INST. STUD. LEG. ETH. 391, 391 (1999).

163. *Id.*

exercise his own professional judgment.[164] The legal standards for capacity are not identical with those of the mental health professions,[165] though they are intertwined. Finally, mental health professions may have a bias towards intervention and treatment – expertise seeks its own use.[166]

C. Danger of Outcome-Oriented Assessments

Implicit in our discussion of the need for self-evaluation, but still meriting separate mention, is that the attorney must be careful not to make judgments about whether the client is demonstrating competence based primarily on whether the client's decisions accord with his own. "[A] client's decision that accords with the professional's judgment may be seen as a well-considered decision."[167] As the National Association of Criminal Defense Lawyers has observed in the context of criminal defense, the "ambiguous ethical norm related to an attorney's obligation to facilitate client participation and an attorney's paternalistic attitude relevant to decision making in cases involving defendants with mental health histories" makes it "tempting for a defense lawyer to usurp a client's authority, especially if the client is difficult to work with, mentally ill, or lacks insight into his mental illness."[168] The ABA made a similar observation in its formal opinion on clients with disabilities. "A client who is making decisions that the lawyer considers to be ill-considered is not necessarily unable to act in his own interest, and the lawyer should not seek protective action merely to protect the client from what the lawyer believes are errors in judgment."[169] The attorney must be certain, when evaluating his client's competence, that he is asking not whether the client is acting in a way that makes sense to the attorney, but whether she is acting in a way that accords with her own demonstrated premorbid preferences. The question must remain the same even where the client's decision accords with the attorney's. For example, the attorney who favors aggressive litigation may believe his client is acting competently when she chooses a similar tack, even though she is, in fact, simply relying on the attorney, or operating under a misconception about what the consequences will be for her everyday life. "In other words, the client's capacity must be judged against the standard set by that person's own habitual or considered standards of behavior and values, rather than

164. MODEL CODE OF PROF'L RESPONSIBILITY EC 3-2 (1980).

165. *See* DIMINISHED CAPACITY HANDBOOK, *supra* note 156, at 5-12 (2005).

166. *See* Perlin, *Pretexts*, *supra* note 2, at 641-59.

167. Herr, *supra* note 32, at 621.

168. John M. Fabian, *How to Deal With Difficult Clients from a Mental Health Perspective*, THE CHAMPION, June 2007, at 25, 27.

169. ABA Comm. on Ethics and Prof'l Responsibility, Formal Op. 96-404 (1996).

against conventional standards held by others."[170] Ms. X may have made an unusual set of choices about how to live her life, and those choices may weigh on Ms. X's physical health and finances, but the attorney cannot assume that they are the product of mental illness simply because they deviate widely from his own choices.

VII. CONCLUSION

The root principle is hard to take issue with: Humans are entitled to autonomy, and those who have mental disabilities and need attorneys are entitled to no less presumption of autonomy than anyone else. As we hope this article has shown, however, putting this principle into practice in the representation of a person who is the subject of a guardianship petition forces the attorney to make difficult decisions that often compromise one or another aspect of the client's autonomy based on limited knowledge and expertise. There is no avoiding these dilemmas, at least not as a society. Whether any individual attorney chooses to participate or not, the guardianship system will continue to process petitions, and individuals will have significant decisions made about their capacity to act on their own behalves. There are also no categorical solutions. The attorney who fights a petition too ferociously may do as much harm as the attorney who raises little defense at all. Each case demands that the attorney employ his skills to communicate effectively, listen carefully, evaluate the client's competency based on his own experience and the resources available to him, and work with the client to protect her long-term autonomy at minimal cost to her short-term autonomy. We are hopeful that this article has provided some context on these issues, some practical suggestions, and a framework for debate in a frequently ignored area.

170. ABA Comm. on Ethics and Prof'l Responsibility, Formal Op. 96-404 (1996) (quoting MICHEL SILBERFIELD & ARTHUR FISH, WHEN THE MIND FAILS: A GUIDE TO DEALING WITH INCOMPETENCY 6 (1994)).

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