Representing Clients with Mental Health and/or Cognitive Impairments in Treatment Courts

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Introduction

A client's mental health and cognitive impairment matter at every stage of the lawyer client relationship, from the first meeting to case strategizing to the plea/trial decision to the sentencing process and beyond. At each juncture, there are different legal issues and behavioral issues that must be taken seriously by defense counsel.[i]

Persons with mental disabilities in the criminal justice system

A statistical overview

It is a truism that the nation's largest urban jails are the largest mental health facilities.[1] Consider these statistics gleaned from a Bureau of Justice Statistics study:

- 64% of individuals in county jails and 56% of those in state prisons were characterized as having "mental health problems;"
- 76% in county jails and 74% in state prisons met the criteria for substance abuse disorders;
- 75% of females in county jails and 73% in state prisons reported mental health problems;[2] and
- 66% of prisoners and 40% of jail inmates with a current chronic condition reported taking prescription medication.[3]

Recent estimates calculate that 40% of inmates at Rikers Island (the main New York City jail) have some sort of mental illness.[4] Of those in prisons, the American Psychiatric Association has estimated that 20% were seriously mentally ill.[5] Also, we know that persons with intellectual disabilities represent 4% to 10% of the prison population, with an even greater number of those in juvenile facilities and in jails.[6]

It is impossible for defense counsel to do their jobs without taking into account the prevalence of mental disabilities in persons they represent.[7] In this context, these factors are of special importance to defense counsel representing defendants in drug courts:

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- Although in the aggregate persons with mental disabilities are less violent than other citizens, in those instances in which such individuals are abusing alcohol and/or cocaine, the risk of violence increases.[8]
- Persons with mental disabilities who are addicted to or abusing alcohol or other drugs – and thus, most likely to appear in drug court – have likely suffered significant traumas (physical and/or psychological) in their lives. We know that drug courts will increase the probability of participants' success by providing a wide array of ancillary services such as mental health treatment, trauma and family therapy, job skills training, and many other life-skill enhancement services.[9]
- Many of those being represented may seek to mask their mental illness or cognitive disability for a number of reasons; it is absolutely essential for lawyers to "get" this if they are to provide effective counsel.

Common mental and developmental disabilities

It is important that defense counsel have at least a basic understanding of some of the specific disabilities that their clients may have. Below is a list of the more frequently diagnosed disorders.

Schizophrenia affects how people think, feel, and perceive the world. The hallmark symptom of schizophrenia is psychosis, such as experiencing auditory hallucinations (voices) and delusions (fixed false beliefs). There are four major "domains" of this illness:

- Positive symptoms: Psychotic symptoms, such as hallucinations, which are usually auditory; delusions; and disorganized speech and behavior.
- Negative symptoms: Decrease in emotional range, poverty of speech, and loss of interests and drive; the person with schizophrenia has tremendous inertia.
- Cognitive symptoms: Neurocognitive deficits (e.g., deficits in working memory, attention, and in executive functions, such as the ability to organize and abstract); patients

[i] Defense counsel may include public defenders, private attorneys, contract attorneys, and court-appointed attorneys.

also find it difficult to understand nuances and subtleties of interpersonal cues and relationships.

- Mood symptoms: Patients often seem cheerful or sad in a way that is difficult to understand; they often are depressed.

To meet the diagnostic criteria, the patient must have experienced at least two of the following symptoms, at least one of which must be among the first three listed: delusions; hallucinations; disorganized speech; disorganized or catatonic behavior; negative symptoms.[10]

Bipolar disorder creates unusual shifts in mood, energy, activity levels, and the ability to carry out day-to-day tasks. People with bipolar disorder experience moods ranging from periods of extremely "up," elated, and energized behavior (known as manic episodes) to very sad, "down," or hopeless periods (known as depressive episodes). DSM-5 divides bipolar disorder into multiple subcategories, all of them involve clear changes in mood, energy, and activity levels:

- Bipolar I disorder: This diagnosis requires (1) manic or mixed episodes that last at least seven days, or (2) manic symptoms requiring immediate hospital care. Depressive episodes can also occur and typically last at least two weeks.
- Bipolar II disorder: This diagnosis requires (1) at least one major depressive episode lasting at least two weeks, and (2) at least one hypomanic episode lasting at least four days. Bipolar II disorders do not apply if there was a manic episode.
- Cyclothymic disorder: This diagnosis requires (1) repeated episodes of some of the symptoms of hypomania (traits) but without actual hypomania, and (2) repeated episodes of some of the symptoms of depression (traits) but without actual depression. These symptoms have continued for (3) at least two years (adults) or one year (children and teenagers), with (4) symptoms occurring half the time or more, and that are never absent for more than two months at a time.[11]

Anxiety Disorders For a person with an anxiety disorder, the anxiety does not go away and can get worse over time. The feelings can interfere with daily activities such as job performance, school work, and relationships. There are several different types of anxiety disorders. Examples include generalized anxiety disorder, panic disorder, social anxiety disorder, and Post-Traumatic Stress Disorder (PTSD), which is described below in greater detail because of its prevalence among treatment court participants.[12]

PTSD may develop after exposure to a terrifying event or ordeal in which severe physical harm occurred or was threatened. Traumatic events that may trigger PTSD include violent personal assaults, natural or unnatural disasters, accidents, or military combat. Symptoms usually begin early, within 3 months of the traumatic incident, but sometimes begin years afterward. The following are categories of symptoms often experienced by people with PTSD:

- Re-experiencing symptoms may cause problems in a person's everyday routine. The symptoms can start from the person's own thoughts and feelings. Words, objects, or situations that are reminders of the event can also trigger re-experiencing symptoms. Re-experiencing symptoms include: (1) flashbacks — reliving the trauma over and over, including physical symptoms like a racing heart or sweating, (2) bad dreams, and (3) frightening thoughts.
- Avoiding thoughts or feelings related to the traumatic event. Avoidance symptoms include: (1) staying away from places, events, or objects that are reminders of the traumatic experience. Things that remind a person of the traumatic event can trigger avoidance symptoms and may cause a person to change his or her personal routine. For example, after a bad car accident, a person who usually drives may avoid driving or riding in a car; and (2) avoiding thoughts or feelings related to the traumatic event.
- Arousal symptoms are usually constant, instead of being triggered by things that remind one of the traumatic events. These symptoms can make the person feel stressed and angry. They may make it hard to do daily tasks, such as sleeping, eating, or concentrating. Arousal and reactivity symptoms include: (1) being easily startled, (2) feeling tense or "on edge," (3) having difficulty sleeping, and (4) having angry outbursts.
- Cognition and mood symptoms can begin or worsen after the traumatic event but are not due to injury or substance use. These symptoms can make the person feel alienated or detached from friends or family members. These can include: (1) trouble remembering key features of the traumatic event, (2) negative thoughts about oneself or the world, (3) distorted feelings like guilt or blame, and (4) loss of interest in enjoyable activities.

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Intellectual disability This classification includes three criteria: (1) significant limitations in general intellectual functioning; (2) significant limitations in adaptive functioning; and (3) age of onset.[13] The US Supreme Court has made it clear that an IQ score is not dispositive of a determination of intellectual disability.[14]

Autism spectrum disorder This disorder is characterized by "persistent deficits in social communication and social interaction across multiple contexts, including deficits in social reciprocity, nonverbal communication behaviors, and skills in developing, maintaining and understanding relationships."[15] Asperger's Disorder has now been subsumed under this category.[16]

Judges, jurors, and lawyers frequently confuse these diagnoses. This is not new; over thirty years ago, James Ellis and Ruth Luckasson wrote about this, and clearly laid out the differences in these disorders,[17] yet this confusion continues to the present day.[18] It is impossible to provide effective and ade-

quate representation to this population otherwise.[ii]

It should be noted that mental illness is not "all or nothing at all."[19] Perhaps because the legal system is dyadic – a person either is competent or is not; a person either is insane or is not[20] – lawyers often fail to see the gradations of mental illness[21] and the reality that a person may be, say, competent for some purposes and not for others. Consider the Supreme Court's language in *Indiana v. Edwards*: "[m]ental illness itself is not a unitary concept. It varies in degree. It can vary over time. It interferes with an individual's functioning at different times in different ways."[22] It is especially critical that defense lawyers do not fall into this trap.

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>
> *— Indiana v. Edwards*

Issues in providing effective counsel for people with mental or cognitive disabilities

Fear of "Faking" The fear of "faking" – that is, that a client would pretend to have a disability in order to get out of responsibility for a crime – has bedeviled the legal system for centuries.[23] A striking example is Justice Antonin Scalia's dissent in *Atkins v. Virginia*, charging that "nothing has changed" in over 300 years since Lord Hale discussed "the easiness of counterfeiting [mental] disability."[24] Sadly, criminal defense lawyers often parrot these views as well. The reality is the opposite. More often, persons with mental disabilities will feign wellness as it is more consonant with their self- view.[25] Drug court lawyers must understand this.

Undiagnosed or Misdiagnosed Disability Sometimes a person's contact with law enforcement may be the first indicator of a mental illness. Because of the stigma attendant to a mental health diagnosis[26] – coupled with the lack of access to mental health services in many communities, either as a result of geographic isolation, sparse population, and/or economic impoverishment[27] – many individuals who have a mental disability have not been so diagnosed or treated. And many persons who are diagnosed as mentally ill have never had a full evaluation or screening. Thus, many clients appear in drug court without ever having their condition previously evaluated.[28]

Impact of Prescribed Medications A significant percentage of defendants with mental disabilities are likely taking prescribed antipsychotic medications.[29] The side effects of these – the centerpiece of decades of "right to refuse" litigation – may not be known or adequately considered by defense attorneys. It is essential that lawyers be familiar with this case law – much of which is civil[30] – when they meet with clients, not so much for the holdings of the cases but for the discussion of the toxic impact of the side effects.[31] This may be especially important when a client is also addicted to or abusing "street drugs," as the interactions between these drugs and prescribed drugs can be particularly toxic.

Collateral Issues If a client has a major mental disability, the range of issues that that mental disability might affect is far greater than the disposition of the criminal case. Some clients may not understand or be able to follow through with a simple request ("Please be in my office Thursday at 3 pm."), or their illness may make a seemingly straightforward task impossible (needing to take a bus if the client is afraid of crowds or if use of such public transportation triggers their PTSD). Others may be unable to cooperate with their lawyers in ways not covered by the rubric of *Dusky v. United States*.[32] Many will have other issues – facing eviction, facing loss of child custody, etc. – that may be far more important to them than the criminal charge they face.

How these issues manifest in practice

It is important that defense lawyers understand the differences between these disorders, and how these differences may be critical in the representational process, whether the case in-

[ii] Consider some of the salient differences between mental illness and cognitive impairments:

Mental Illness	Cognitive Impairments
Disturbances in thought processes, mood, perception or memory. May experience hallucinations and delusions. May be caused by chemical imbalances	Difficulty with certain mental tasks such as thinking and understanding, usually with a basis in the biology or physiology of the individual
May be temporary, cyclical or episodic	Generally lifelong and will not dissipate
Onset can occur at any stage of life (though onset is typically in teen or early adult years)	For ASD (autism spectrum disorder) and ID (intellectual disability), onset must occur before a specific age
Medication can be prescribed to control and ameliorate the symptoms	Medication cannot restore cognitive ability
Assessed and treated by a psychiatrist	Assessed by a psychologist or neuropsychologist

Adapted from Eleanore Fritze, *Guide to Cognitive and Neurological Disabilities for Lawyers* (2015) (unpublished).

volves the incompetency status, insanity defense, mitigation in a death penalty case, mitigation at sentencing, diversion to a problem-solving court, or, simply, as part of the entire "toolkit" that a lawyer brings to the representation of a "regular" criminal case in the context of plea negotiations or trial.

Consider some of the questions that the competent defense lawyer will have to ask her/himself (and be able to answer) in these contexts:

- Assuming that the client is competent to stand trial, can s/he follow the conversation with counsel? Can s/he meaningfully involve her/himself in strategic decision-making? Is the client so disorganized or impaired that simple tasks ("be in my office at 3 pm") become insurmountable?
- If the client is in jail awaiting trial, what impact will the conditions of pre-trial confinement have on her/his ability to communicate with you (or affect her/his mental health)?
- Is the client currently taking any prescription psychotropic medications? Has s/he complained of any side-effects?
- If this is not the client's first interaction with the criminal justice system, what were the dispositions of prior involvements? Was s/he ever diverted to a problem-solving court before? If so, what was the outcome? Was s/he ever placed on probation with the requirement that s/he enter a treatment program? If so, what was the outcome?
- Has the client ever been institutionalized in a psychiatric hospital or a "state school" for persons with intellectual disabilities? If so, for how long?

These are just a few of the wide range of questions that an attorney must take seriously in the representational process. But there are other questions that must be considered in the specific context of drug court representation:

- Has the client been adequately assessed? By whom? What are the qualifications of the assessor?
- After the assessment, has an individualized treatment plan been crafted?[33]
- Are sanctions for noncompliance with the treatment plan or other terms of drug court participation appropriate for someone with a mental or cognitive disability?
- If drug courts are not appropriate for the defendant, how can the attorney best provide representation in a "traditional" criminal court for such a defendant?[34]
- Will the attorney be able to assist in the monitoring of treatment and compliance after an initial drug court disposition is made?[35]
- Are there gender-responsive drug treatment services available?[36]
- Are drug courts providing simply drug counseling, or are they able to provide the participant other ancillary social and/or legal services s/he may need? If not, do they make referrals to services that are accessible?[37]
- In cases in which defendants have cognitive impairments, has the court taken appropriate steps to accommodate his or her intellectual disability?[38]

A client's mental health and cognitive impairment matter at every stage of the lawyer-client relationship.

The task of improving the skills level of defense counsel in the representation of persons with mental disabilities in drug courts has to be approached on two parallel, interlocking tracks:

1. Education about mental disabilities and their impact on defendants in the criminal justice system, especially those in drug courts, and
2. Education about factors that contaminate the entire criminal justice process: sanism, pretextuality, heuristics, and the use of false "ordinary common sense."[iii]

We know that education is not enough. Unless the second track is included, education – standing alone – is not a sufficient predicate for systemic meaningful change.

It is not enough that lawyers and judges learn about mental illness, diagnoses, etc.; it is essential that they learn also about attitudes.[39] Consider the disappointing results reported nearly 40 years ago by Dr. Norman Poythress – that merely training lawyers about psychiatric techniques and psychological nomenclature made little difference in ultimate case outcomes, unless they were also trained about *attitudes*.[40] As indicated above,[41] it is also critical that lawyers understand those factors that poison the entire criminal justice system in the context of the representation of persons with mental disabilities to be able to do an effective job of representing drug court defendants.

End Notes

[1] See e.g., Gregory L. Acquaviva, *Mental Health Courts: No Longer Experimental*, 36 SETON HALL L. REV. 971, 978 (2006) (observing that, "in 1992, the Los Angeles County jail became the nation's largest mental institution, with Cook County Jail, Illinois, and Riker's Island, New York, as second and third respectively."). On the overrepresentation of persons with mental illness in the justice system in general, see e.g., Linda A. Teplin, *Psychiatric and Substance Abuse Disorders among Male Urban Jail Detainees*, 84 AM. J. PUBLIC

[iii] Because of space limitations, I am discussing these latter factors cursorily. For full discussions, see e.g., Michael L. Perlin, *A Half-Wracked Prejudice Leaped Forth: Sanism, Pretextuality, and Why and How Mental Disability Law Developed As It Did*, 10 J. CONTEMP. LEG. Iss. 3 (1999), and Michael L. Perlin, "*Infinity Goes Up on Trial": Sanism, Pretextuality, and the Representation of Defendants with Mental Disabilities*, accessible at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2734762. I have also passed over the critical issue of how lawyers in such courts need to embrace therapeutic jurisprudence in their work. See e.g., Michael L. Perlin, *"Too Stubborn To Ever Be Governed By Enforced Insanity": Some Therapeutic Jurisprudence Dilemmas in the Representation of Criminal Defendants in Incompetency and Insanity Cases*, 33 INT'L J. L. & PSYCHIATRY 475, 477-78 (2010); see generally, REHABILITATING LAWYERS: PRINCIPLES OF THERAPEUTIC JURISPRUDENCE FOR CRIMINAL LAW PRACTICE (David B. Wexler ed., 2008).

HEALTH 290 (1994); Sarah McCormick, Michele Peterson-Badali & Tracey A. Skilling, *Mental Health and Justice System Involvement: A Conceptual Analysis of the Literature*, 21 PSYCHOL. PUB. POL'Y & L. 213 (2015).

[2] Doris J. James & Lauren E. Glaze, *U.S. Dep't of Justice, Office of Justice Programs, Bureau of Justice Statistics Special Report: Mental Health Problems of Prison and Jail Inmates* (2006), accessible at http:// www.ojp.usdoj.gov/bjs/pub/pdf/mhppji.pdf.

[3] Jennifer Bronson, Laura M. Maruschak & Marcus Berzofsky, *U.S. Department of Justice and the Bureau of Justice Statistics: Medical Problems of State and Federal Prisoners and Jail Inmates,* 2011–12, Washington, DC (2015), accessible at http://www.bjs.gov/index.cfm?ty=pbdetail&iid=5219.

[4] See e.g., Bandy X. Lee & Maya Prabhu, *A Reflection on the Madness In Prisons,* 26 STAN. L. & POL'Y REV. 253, 254 (2015).

[5] AM. PSYCHIATRIC ASSOC., PSYCHIATRIC SERVICES IN JAILS AND PRISONS, at xix (2d ed. 2000).

[6] Leigh Ann Davis, *People with Intellectual Disability in the Criminal Justice System: Victims & Suspects*, accessible at http:// www.thearc.org/what-we-do/resources/fact-sheets/criminal-justice, citing, in part, Joan Petersilia, *Doing Justice? Criminal Offenders with Developmental Disabilities*, CPRC Brief, 12 (4) (2000).

[7] See generally, Michael L. Perlin & Alison J. Lynch, *"Had to be Held down by Big Police": A Therapeutic Jurisprudence Perspective on Interactions between Police and Persons with Mental Disabilities*, -- Fordham Urban L.J. – (2016) (forthcoming), accessible at http:// papers.ssrn.com/sol3/papers.cfm?abstract_id=2676909.

[8] John Monahan & Jean Arnold, *Violence by People with Mental Illness: A Consensus Statement by Advocates and Researchers*, 19 PSYCHIATRIC REHABILITATION J. 67, 70 (1996): "Serious violence by people with major mental disorders appears concentrated in a small fraction of the total number, and especially in those who use alcohol and other drugs."

[9] C. WEST HUDDLESTON, III ET AL., NAT'L DRUG COURT INST., BUREAU OF JUSTICE ASSISTANCE, PAINTING THE CURRENT PICTURE: A NATIONAL REPORT CARD ON DRUG COURTS AND OTHER PROBLEM-SOLVING COURT PROGRAMS IN THE UNITED STATES 2 (2008), available at http://www.ojp.usdoj.gov/BJA/pdf/12902_PCP_fnl.pdf

[10] Frances R Frankenburg, *Schizophrenia*, accessible at http:// emedicine.medscape.com/article/288259-overview, relying in part on AM. PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL-5 (2015) (DSM-5). ; see also, Rajiv Tandon et al, *Definition and Description Sf schizophrenia in the DSM-5*, 150 SCHIZOPHRENIA RESEARCH 3 (2013). Relevant portions of this manual are discussed in the context of the legal process in Perlin & Cucolo, supra note 12, at § 3-3.1.

[11] DAN J. TENNENHOUSE, 2 ATTORNEYS MEDICAL DESKBOOK § 25:84 (2015).

[12]https://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd/index.shtml#part_145371

[13] DSM-5, *supra* note 10, at 33.

[14] See Hall v. Florida, 134 S.Ct. 1986 (2014), discussed in this context in MICHAEL L. PERLIN & HEATHER ELLIS CUCOLO, MENTAL DISABILITY LAW: CIVIL AND CRIMINAL§ 17-4.2.3 (3d ed. 2016)..

[15] DSM-5, *supra* note 10, at 31,

[16] *Id.* at 51. *See generally*, Rebecca Johnson, *Does the DSM-5 Threaten Autism Service Access?*, 2015 UTAH L. REV. 803.

[17] See James Ellis & Ruth Luckasson, *Mentally Retarded Criminal Defendants*, 53 GEO. WASH. L. REV. 414 (1985).

[18] See e.g., See Michael L. Perlin, *A Life Is In Mirrors, Death Disappears: Giving Life to* Atkins*,* 33 N. MEX. L. REV. 315 (2003).

[19] Michael L. Perlin, *AI Ain't Gonna Work on Maggie's Farm No More: Institutional Segregation, Community Treatment, the ADA, and the Promise of* Olmstead v. L.C., 17 T.M. COOLEY L. REV. 53, 54 (2000).

[20] Michael L. Perlin, *"The Borderline Which Separated You From Me": The Insanity Defense, the Authoritarian Spirit, the Fear of Faking, and the Culture of Punishment*, 82 IOWA L. REV. 1375, 1397 (1997).

[21] See e.g., Stamper v. Commonwealth, 324 S.E.2d 682, 688 (Va. 1985): ("The classifications and gradations applied to mental illnesses, disorders, and defects are frequently revised").

[22] 554 U.S 164, 175-76 (2008). Compare Peeples v. Commonwealth, 519 S.E. 2d 382 (Va. Ct. App. 1999) ("we hold that evidence of a criminal defendant's mental state at the time of the offense is, in the absence of an insanity defense, irrelevant to the issue of guilt").

[23] See Perlin, *supra* note 20, at 1380, characterizing it as "perhaps the most compelling and dominating myth in all of criminal procedure."

[24] 536 U.S. 304, 354 (2002) (execution of person with mental retardation violates the Eighth and Fourteenth Amendments). See Perlin, *supra* note 18, at 344, criticizing Justice Scalia's dissent as a "pathetic recapitulation of [a] dreary myth."

[25] See id. at 341-42, citing, in part Dorothy Lewis et al., *Neuropsychiatric, Psychoeducational, and Family Characteristics of 14 Juveniles Condemned to Death in the United States*, 145 AM. J. PSYCHIATRY 584, 588 (1988:,

Criminal defendants will mask their retardation from their counsel (and often from themselves). Dr. Dorothy Lewis documented that juveniles imprisoned on death row were quick to tell her and her associates, "I'm not crazy," or "I'm not a retard." See also BRUCE D. SALES & DANIEL W. SHUMAN, LAW, MENTAL HEALTH, AND MENTAL DISORDER 348-49 (1997), noting that the mentally ill offender is actually more likely to lie in order to *hide* symptoms of mental illness to avoid the stigma, even at the cost of losing the protections a mental illness diagnosis can provide.

[26] Mark Olfson et al., *National Trends in the Office-Based Treatment of Children, Adolescents, and Adults with Antipsychotics,* 69 ARCHIVES GEN. PSYCHIATRY 1247, 1253 (2012).

[27] See e.g., Yael Zakai Cannon*, There's No Place Like Home: Realizing the Vision of Community-Based Mental Health Treatment for Children,* 61 DEPAUL L. REV. 1049 (2012).

[28] It is also necessary to consider the reality that many individuals who are ethnic minorities are distrustful of and suspicious of mental health professionals, an attitude, in likelihood, dating back to the infamous Tuskegee Study that used economically impoverished African-American men to study the untreated course of syphilis. See e.g, Bernice Roberts Kennedy, Christopher Clomus Mathis & Angela K. Woods. *African Americans and Their Distrust of the Health Care System: Healthcare for Diverse Populations*, 14 J. CULT. DIVERSITY. 56 (2007); Javier Boyas & Tanya L. Sharpe. *Racial and Ethnic Determinants of Interracial and Ethnic Trust,* 20 J. HUM. BEHAV. SOC'L ENVIRON. 618 (2010).

[29] E.g., Haleigh Reisman, *Competency of the Mentally Ill and Intellectually Disabled in the Courts,* , 11 J. HEALTH & BIOMEDICAL L. 199 (2015).

[30] E.g., Rennie v. Klein, 476 F. Supp. 1294 (D.N.J. 1979), stay denied in part, granted in part, 481 F. Supp. 552 (D.N.J. 1979), modified and remanded, 653 F. 2d 836 (3d Cir. 1981) (en banc), vacated and remanded, 458 U.S. 1119 (1982), and Rogers v. Okin, 478 F. Supp. 1342 (D. Mass. 1979), modified, 634 F. 2d 650 (1st Cir. 1980) (en banc), vacated sub nom Mills v. Rogers, 457 U.S. 291 (1982), as discussed in Michael L. Perlin & Deborah A. Dorfman, *AIs It More Than Dodging Lions and Wastin' Time"?: Adequacy of Counsel, Questions of Competence, and the Judicial Process in Individual Right to Refuse Treatment Cases*, 2 PSYCHOLOGY, PUB. POL'Y & L.114 (1996).

[31] See PERLIN & CUCOLO, *supra* note 14, § 8-2.

[32] 362 U.S. 402, 402 (1960), asking whether the defendant "has sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding" and whether he has a "rational as well as factual understanding of the proceedings against him."

[33] Beyond the scope of this paper is a discussion of the contours of such individualized treatment plans. One issue to consider, though, is that raised by Professor Evan Seamone: "Treatment courts have

learned through experience that individualized treatment plans may exceed ideal timeframes for program completion." See *Reclaiming the Rehabilitative Ethic in Military Justice: The Suspended Punitive Discharge as a Method to Treat Military Offenders with PTSD and TBI and Reduce Recidivism,* 208 MIL. L. REV. 1, 156 (2011), From the perspective of a drug court judge, see Mary Muehlen Maring, *North Dakota Juvenile Drug Courts*, 82 N.D. L. REV. 1397 (2006).

[34] I have written frequently criticizing the pallid effectiveness-of-counsel standard established by the Supreme Court in Strickland v. Washington, 466 U.S. 668, 689 (1984) "whether counsel's conduct so undermined the proper function of the adversarial process that the trial court cannot be relied on as having produced a just result"), see e.g., MICHAEL L. PERLIN, MENTAL DISABILITY & THE DEATH PENALTY: THE SHAME OF THE STATES 123-28(2013). I do not believe there have been any challenges to quality of representation in this specific context.

[35] The answer to this question depends on the staffing and funding of the local public defender's office, whether counsel is part of an organized, dedicated office, or simply appointed for the case in question.

[36] For a pointed criticism of drug courts that do not have such specialized services, see Richard Boldt, *The "Tomahawk" and the "Healing Balm": Drug Treatment Courts in Theory and Practice,* 10 U. MD. L.J. RACE, RELIGION, GENDER & CLASS 45, 59 (2010).

[37] "A public health model of drug court emphasizes both the treatment resources available to defendants admitted to drug court and the ancillary services available in the communities in which defendants live: employment, housing, religious institutions, and other social resources." Stephen Hunter et al, *New Jersey's Drug Courts: A Fundamental Shift from the War on Drugs to a Public Health Approach for Drug Addiction and Drug-Related Crime*, 64 RUTGERS L. REV. 795, 825 (2012).

[38] I discuss the issues attendant to counsel's special responsibilities in, inter alia, Michael L. Perlin & John Douard, *Equality, I Spoke That Word/As If a Wedding Vow: Mental Disability Law and How We Treat Marginalized Persons,* 53 N.Y.L. SCH. L. REV. 9, 22-23 (2008-09); Michael L. Perlin, *And My Best Friend, My Doctor/ Won't Even Say What It Is I've Got : The Role and Significance of Counsel in Right to Refuse Treatment Cases*, 42 SAN DIEGO L. REV. 735, 738-51 (2005) (Perlin, *Best Friend*).

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