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The Conflict Between **Advocacy** and “**Best Interests**” for Individuals in Psychiatric Institutions



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Mr. X has been involuntarily committed to a psychiatric institution for three years.¹ He is 65 years old, has a diagnosis of schizoaffective disorder, and uses a walker. His speech is often slurred, and he has trouble modulating his voice and tone. With some patience, listeners can understand him; he raises his voice to express anger, and he cries when he is upset. The clinical team treating Mr. X plans to discharge him to a nursing home.

Mr. X has repeatedly told his attorney that he is opposed to living in a nursing home. At a meeting with the clinical team the attorney raised Mr. X's desire to live in his own apartment with the appropriate support services. The team members refused to consider such an idea; Mr. X had to live in a nursing home for his own safety. The attorney objected to the team's unilateral decision and questioned whether anyone had asked Mr. X what he wanted. Members of the team, including a psychiatrist, psychologist, and nurse, grew exasperated with the attorney. "Have you met Mr. X? Have you seen him?" they questioned. A social worker tried to put the situation into perspective for her colleagues, "Oh, this is University Legal Services. They're his attorney, so they have to say what he wants no matter what. If he wanted to go live on an island by himself they would have to fight for that, too." "Well," a nurse responded, "you can express what he wants, but we are concerned with what is best for him."

¹All individuals' names have been changed to protect client confidentiality.

University Legal Services, where I work, is a private, nonprofit organization that serves as the District of Columbia’s federally mandated protection and advocacy system for people with disabilities.² We strive to protect our clients’ right to maintain their personal autonomy, which implies the right to take an active role in their mental health treatment.³ This is a challenge when representing individuals in psychiatric institutions because often the clinical treatment team presumes that individuals with mental illness are incapable of making a “good decision” on their own health care and mental health treatment. Clinical treatment teams can be dismissive, irritated, or even hostile to our efforts to include our clients in their own treatment. As Mr. X’s treatment team demonstrated, we are perceived as lawyers who are obligated to support our client’s position, whereas the treatment team protects the patient from harm.⁴

In our work there is an inherent tension between legal services providers and clinicians. As advocates, we strive to protect our clients’ autonomy and preserve their right to make independent decisions and take an active role in their own treatment. We find that clinicians typically favor a “best-interests” model where the mental health professional has the primary decision-making authority on treatment. As legal advocates who file complaints and demand better care on behalf of our clients, we naturally often take an adversarial position against clinical staff. Moreover, the very culture of psychiatric

institutions inherently limits patients’ basic liberties.⁵ This fundamental difference in approach to patient autonomy is the primary source of our conflict with mental health providers.⁶

Here, in examining our conflict with mental health professionals when we advocate our clients’ rights to preserve their personal autonomy, I draw on the experiences of University Legal Services attorneys, social workers, and advocates representing individuals with mental illness in psychiatric institutions. First, I discuss the legal and ethical implications of advocating on behalf of individuals whose ability to make decisions may have diminished due to their mental illness. Second, I describe the approach of mental health professionals treating the same clients and examine why the difference in our approaches leads to so much conflict.⁷ Third, I examine this conflict in the context of discharge planning, the process that allows institutionalized individuals to return to the community. And, fourth, I recommend strategies for legal advocates who find themselves in conflict with mental health professionals.

I. Our Approach to Representing Clients Who May Have Diminished Decision-Making Capacity

In our jurisdiction, individuals in psychiatric institutions are either (1) civilly committed individuals, (2) individuals who have voluntarily entered the institution, or (3) individuals who are await-

²Protection and Advocacy for Mentally Ill Individuals, 42 U.S.C §§ 10801–10851, 10805, establishes the authority of protection and advocacy systems to advocate for individuals with mental illness and to investigate abuse and neglect.

³See generally Mental Health Consumers’ Rights Protection Act, D.C. CODE §§ 7-1231 *et seq.* (2011).

⁴See William A. Wood, *Mental Health and the Law: Where Necessity Is the Mother of Invention (Patent Pending)*, 29 NORTHERN ILLINOIS UNIVERSITY LAW REVIEW 469 (2009), for an excellent summary of the conflict between attorneys and psychiatrists from the perspective of an experienced psychiatrist and assistant medical director at a state-operated inpatient psychiatric facility.

⁵Race and class disparities contribute to the suppression of our clients’ autonomy. Most of our clients in urban psychiatric institutions are poor and African American. Here I do not explore the complex intersections among disability, race, and class, but I must acknowledge that they are inextricably intertwined.

⁶“The field of capacity is dominated by a fundamental tension between two core ethical principles: autonomy (self-determination) and protection (beneficence)” (Jennifer Moye & David Marson, *Assessment of Decision-Making Capacity in Older Adults: An Emerging Area of Practice and Research*, 62B No. 1 JOURNAL GERONTOLOGY: PSYCHOLOGICAL SCIENCES P3 (2007).

⁷I do not purport to provide a comprehensive or expert explanation of the psychiatric approach to treating individuals with diminished decision-making capacity.

ing criminal competency proceedings or have been declared not guilty by reason of insanity in criminal court. Our advocacy consists in assisting clients in filing formal complaints of abuse and neglect, preserving their right to take an active role in developing a treatment plan, and transitioning them to less restrictive living environments.

Representing individuals with mental illness from a client-centered perspective becomes a complex ethical and legal challenge when the individuals have difficulty articulating their position due to their mental illness.⁸ For a variety of reasons, clients may not be able to express clearly what they want. Their medication may interfere with their decision-making faculties or make them too drowsy to communicate. Mental illness can cause someone to express unrealistic or unattainable goals.⁹ Individuals who have prolonged or repeated stays in institutions often become “institutionalized” and lose their desire and ability to express independent thought.¹⁰

As attorneys, we have an ethical obligation to maintain a normal lawyer-client relationship to the extent reasonably possible. Our clients, just like any other clients, have the right to make a bad decision.¹¹ According to the American Bar Association’s Model Rule 1.14(a), adapted with some minor modifications by the

District of Columbia Bar, “when a client’s capacity to make adequately considered decisions in connection with a representation is diminished, whether because of minority, mental impairment or for some other reason, the lawyer shall, as far as reasonably possible, maintain a normal client-lawyer relationship with the client.” A “normal” relationship entails explaining all of the client’s legal options to him, and then allowing him to make his own reasoned decision.¹² As every new attorney quickly learns, a client’s decision is not necessarily the one his attorney would have made in the same position.

A. Personal Autonomy: Client-Centered Advocacy

Many attorneys representing individuals with diminished capacity employ a model based on preserving the client’s “personal autonomy.” Under this approach, the lawyer’s responsibility is to advise the client sufficiently so that the client can make an informed decision.¹³ The goal of this method is to enable clients to come to their own decisions rather than adopt what the lawyer believes is in their best interests.¹⁴ This model primarily applies to clients with some decision-making ability since supporting a client’s autonomy presupposes that the client is competent to consider various choices and make a reasoned decision.¹⁵

⁸See Nancy Knauer, *Defining Capacity: Balancing the Competing Interests of Autonomy and Need*, 12 *TEMPLE POLICY AND CIVIL RIGHTS LAW REVIEW*, 321, 325 (2003); Client with Diminished Capacity, MODEL RULES OF PROFESSIONAL CONDUCT RULE 1.14 cmt. 1 (2011) (maintaining ordinary client-lawyer relationship may not be possible in all respects, but client may still be able to “understand, deliberate upon, and reach conclusions” about client’s own well-being).

⁹Robert D. Fleischner & Dara L. Schur, *Representing Clients Who Have or May Have “Diminished Capacity”: Ethics Issues*, 41 *CLEARINGHOUSE REVIEW* 346 (Sept.–Oct. 2007).

¹⁰Prolonged institutionalization leads to individuals losing their ties to their family, friends, and communities and the essential skills they would need to function in the community (Mental Disability Rights International & Center for Legal and Social Studies, *Ruined Lives: Segregation from Society in Argentina’s Psychiatric Asylums ii* (2007), <http://bit.ly/wTrWbR>).

¹¹See Fleischner & Schur, *supra* note 9, at 353–54 for a discussion of the available options when representing an “incapable client.” Here I do not take up that scenario since such individuals often have guardians and thus University Legal Services rarely represents them.

¹²Most attorneys’ decisions are based objectively on the client’s ability to express a position and subjectively on the attorney’s assessment of whether the position is “reasoned” (*id.* at 352 (quoting comments 1.2–1.6 of Model Rule 1.14)).

¹³David Green, “I’m OK–You’re OK”: *Educating Lawyers to “Maintain a Normal Client-Lawyer Relationship” with a Client with a Mental Disability*, 28 *JOURNAL OF THE LEGAL PROFESSION* 65, 82 (2003–2004).

¹⁴See Robert Dinerstein, *Client-Centered Counseling: Reappraisal and Refinement*, 32 *ARIZONA LAW REVIEW* 501, 507 (1990), for a thorough explanation of client-centered counseling and its centrality to client-centered lawyering.

¹⁵Katherine Hunt Federle, *The Ethics of Empowerment: Rethinking the Role of Lawyers in Interviewing and Counseling the Child Client*, 64 *FORDHAM LAW REVIEW* 1655, 1661 (1996) (cautioning that lawyer’s role in ascertaining when decision is competent leads to greater opportunities for lawyer manipulation; thus lawyer may think that poor decision is incompetent decision).

A strict version of the personal autonomy or client-centered approach favors the attorney giving minimal to no advice at all.¹⁶ However, many attorneys who favor a client-centered approach consider advice a potential middle ground on a continuum of attorney-client interaction, from attorneys refraining to communicate with their clients to attorneys simply telling their clients what to do. On this continuum, advice is “more interventionist than suggestion but less so than persuasion.”¹⁷

For disability rights advocates, focusing on clients’ personal autonomy is particularly significant. The disability rights movement was founded on the principle that individuals with disabilities have the right to live independently and enjoy the same personal liberties as their fellow citizens.¹⁸ While the movement succeeded in achieving equal rights on many levels for individuals with disabilities, individuals who have mental illness and have been institutionalized continue to face great resistance when they attempt to assert their independence.¹⁹

B. The Best-Interests Approach: Not Necessarily a Threat to Personal Autonomy

As in the personal autonomy model, under a best-interests approach, attorneys

give their clients the necessary information to make an informed decision. This approach also allows the attorney to consider what is in the best interests of the client and, if possible, steer the client toward such a decision.²⁰ This position has received much criticism in the academic literature concerning representation of clients with disabilities.²¹ Critics fear that an attorney might interfere with the client’s liberty in the interests of what the lawyer believes would benefit the client.²² If attorneys strongly believe that they know what is right for their clients, they may advocate a certain position whether or not it is their clients’ expressed interest.²³

Despite these extreme scenarios, favoring a best-interests approach when representing individuals with diminished decision-making capacity is often natural. When the client’s articulated goal does not meet a minimal degree of reasonableness, we may intuitively rely on our own best-interests analysis to steer the client toward a certain decision.²⁴ Moreover, even when attorneys believe that they are simply providing information, they may influence their clients in the way they present the information, emphasizing or deemphasizing certain facts, or taking a particular tone.²⁵

At University Legal Services we often struggle with how best to represent cli-

¹⁶Not all client-centered advocates adhere to this position (Dinerstein, *supra* note 14, at 569 (referring to the Bender and Price model)).

¹⁷*Id.*

¹⁸This fundamental concept within the disability rights movement traces its origins to the women’s rights movement, which reclaimed bodily autonomy (JOSEPH P. SHAPIRO, *NO CITY* 47 (1993)).

¹⁹Robert M. Levy & Leonard S. Rubenstein, *THE RIGHTS OF PEOPLE WITH MENTAL DISABILITIES* 104 (rev. ed. 1996) (choices of individual with mental illness are rarely questioned as long as they are the same choices his doctor would make).

²⁰William H. Simon, *Lawyer Advice and Client Autonomy: Mrs. Jones’s Case*, 50 *MARYLAND LAW REVIEW* 213 (1991); see also Paul R. Tremblay, *Impromptu Lawyering and De Facto Guardians*, 62 *FORDHAM LAW REVIEW* 1429, 1442–43 (1994).

²¹Simon, *supra* note 20, at 226 n.1.

²²David Luban, *Lawyers as Upholders of Human Dignity (When They Aren’t Busy Assaulting It)*, 2005 *UNIVERSITY OF ILLINOIS LAW REVIEW* 815, 825 (2005) (what offends contemporary American legal values about best-interests approach is that it violates autonomy).

²³E.g., when commitment attorneys put on a deliberately feeble defense, going through the motions of their duty to represent their client at a commitment hearing but covertly informing the judge that they do not believe the patient is ready for discharge. (Fleischner & Schur, *supra* note 11, at 350–51).

²⁴Simon, *supra* note 20, at 223–24 (defending two kinds of “refined paternalism” based on David Luban, *Paternalism and the Legal Profession*, 1981 *WISCONSIN LAW REVIEW* 454, and Duncan Kennedy, *Distributive and Paternalistic Motives in Contract and Tort Law, with Special Reference to Compulsory Terms and Unequal Bargaining Power*, 41 *MARYLAND LAW REVIEW* 563 (1982)).

²⁵*Id.* at 217.

ents in institutions. Our primary role as advocates for institutionalized individuals is to fight for our clients’ rights to preserve their autonomy. Yet we caution clients against making certain choices that would adversely affect their chances for discharge.²⁶ For example, when patients seek advice about refusing to take their prescribed medication, we counsel them that they have the legal right to refuse, but we also caution that refusal will likely be perceived as noncompliance and prolong their stay in the institution. Once we have explained all of their options and potential consequences, we strive to support them in making an informed, independent decision.

II. The Conflict Between Lawyers and Mental Health Treatment Professionals

Both attorneys and clinical professionals who work with individuals with mental illness share a grave responsibility; more than other service providers, we must assess a client or patient’s capacity for decision making.²⁷ When we are in this position, we ask ourselves as legal advocates whether we truly believe a client cannot make a decision or whether we are concerned that the client has articulated a position that is not in the client’s best interests.²⁸ In our experience, mental health treatment professionals do not go through a parallel deliberation before determining a patient is incapable of making a reasoned decision.

This is of great concern because clinicians, and not legal decision makers, make most assessments on an individual’s ability to make a decision.²⁹ Yet in our experience the applicable legal framework does not inform the clinician’s assessment. In the District of Columbia a court’s finding that an individual should be involuntarily committed to a psychiatric institution is not paramount to a finding of incompetence.³⁰ Nor does involuntary commitment preclude an individual from the right to make decisions about the individual’s treatment.³¹ State laws have increasingly favored a strict standard for involuntary commitment when individuals are at risk of harm to themselves or others. Despite these legal provisions, the capacity assessments that occur both formally and informally in institutions are rarely subject to judicial review.³² We seek to remind and instruct clinical staff about these laws, which we view as safeguards against psychiatric discretion.³³

Paul S. Appelbaum, a psychiatrist and leading author on this subject, cautions physicians that they must support their jurisdiction’s legal standards in assessing competency. He argues that modern democracy values the individual’s right to make independent decisions and that right should be infringed upon only in the most serious circumstances: “Only patients with impairment that places them at the very bottom of the performance curve should be considered in-

²⁶Peter Margulies, *Access, Connection, and Voice: A Contextual Approach to Representing Senior Citizens of Questionable Capacity*, 62 *FORDHAM LAW REVIEW* 1073 (1994) (in context of elder law, any sensitive lawyer who represents clients with diminished capacity “will endure some lost sleep, no matter what they choose”).

²⁷While individuals’ capacity to make decisions concerning their health care, mental health care, and other legal matters is protected by the law, in practice most determinations on diminished capacity occur outside the courtroom and are made by mental health treatment professionals, attorneys, and other social service providers (Moye & Marson, *supra* note 6, at P3).

²⁸Federle, *supra* note 15, at 1661.

²⁹Moye & Marson, *supra* note 6, at P5.

³⁰Fiduciary Relations and the Mentally Ill: Presumption of Capacity, D.C. CODE § 21-2203 (2011).

³¹*Id.* § 21-2203(1); Mental Health Consumers’ Rights Protection Act, Consent to Mental Health Services and Mental Health Supports, D.C. CODE § 7-1231.07(a) (2011). Unless the court finds an involuntarily committed individual legally incompetent, the individual has the right to vote, execute legal instruments, enter into contractual relationships, and maintain a driver’s license (Exercise of Property and Other Rights: Notice of Inability: Persons Hospitalized Before September 15, 1964, D.C. CODE § 21-564(a)).

³²Moye & Marson, *supra* note 6, at P5 (citing Thomas Grisso, *EVALUATING COMPETENCES* (2d ed. 2003)).

³³Paul S. Appelbaum, *Can Mental Patients Say No to Drugs?*, *NEW YORK TIMES MAGAZINE*, March 21, 1982, at 46, <http://nyti.ms/wmOAP7>.

competent. In practice, the stringency of the test applied varies directly with the likely consequences of the patients’ decisions.”³⁴

Psychiatrists see an inherent contradiction between the legal system’s charge to treat involuntarily committed individuals and the legal restrictions on psychiatrists’ freedom to treat these individuals.³⁵ In the words of an experienced assistant medical director and staff psychiatrist at a state institution, “[f]requently, clinicians feel frustrated by the impression that these laws are never concerned with the many vagaries of treatment and its outcome.”³⁶ Or more bluntly stated, “I’m a clinician, not a lawyer. All I want to do is help people. Why doesn’t the law just let me do my job?”³⁷ As one psychiatrist summarized, there is a concern in the professional community that the law prevents them from providing the appropriate care to patients: “for some patients, the state hospital is converted into a prison; they can’t be treated and they can’t be freed.”³⁸

We experience the same level of frustration with clinicians, often condoning their practices as oppressive, illegal, and nontherapeutic.³⁹ Yet we must remember when we come into conflict with hospital staff members that they do not always intentionally deprive patients of their rights

to autonomy. The very culture of institutions inherently limits our clients’ rights to liberty, freedom of association, travel, freedom from unreasonable searches and seizures, and bodily autonomy.⁴⁰ The institutional routine dictates virtually all aspects of patients’ lives, from the smallest minutiae to major decisions. Institutionalized mental health consumers eat, sleep, bathe, and go outside according to a highly regulated daily schedule.⁴¹ They can choose their social partners only from the limited selection of individuals they meet on their unit or in treatment. Recreational activities, holiday celebrations, and religious worship are privileges offered at the staff’s discretion.⁴² Practicing in such an environment reinforces the clinicians’ frequent disregard for patient autonomy.

III. Discharge Planning

Assisting individuals with mental illness in leaving institutions for community placements is one of the targets of our advocacy. Our efforts often provoke conflict with hospital staff members because we challenge their professional authority and the legal basis they offer for keeping individuals in institutions.⁴³ Both legally and practically, whether and when a committed individual may leave an institution is at the discretion of the treatment team.⁴⁴

³⁴Paul S. Appelbaum, *Assessment of Patients’ Competence to Consent to Treatment*, 357 *NEW ENGLAND JOURNAL OF MEDICINE* 1834, 1836 (2007); see also Federle, *supra* note 15, at 1661 (concept of autonomous and competent client is consistent with Western notion of right to individual liberty).

³⁵Appelbaum, *supra* note 33 (describing psychiatrists’ frustrations over treating patients who have legal right to treatment).

³⁶See Wood, *supra* note 4, at 470–71.

³⁷*Id.* at 470 (quoting PAUL S. APPELBAUM & THOMAS G. GUTHEIL, *CLINICAL HANDBOOK OF PSYCHIATRY AND THE LAW*, at viii (4th ed. 2007)).

³⁸Appelbaum, *supra* note 33.

³⁹Involuntary commitment to an institution is a major deprivation of one’s liberty interest (*Humphrey v. Cady*, 405 U.S. 504, 509 (1972)). Individuals are presumed legally competent and maintain all their civil rights unless limited by court order (Mental Health Consumers’ Rights Protection Act: Retention of Civil Rights, D.C. CODE § 7-1231.13 (2011)).

⁴⁰Levy & Rubenstein, *supra* note 19, at 15 (acknowledging that nature of involuntary commitment to an institution poses conflict between individual’s liberty interests and government’s authority to protect citizens from harm and danger).

⁴¹Changes in routine day-to-day care, routine or periodic changes in a drug regimen, or changes relating to minor medical care needs are not “substantial changes” and do not warrant the same legal protections (Definitions, D.C. CODE § 7-1231.02(26) (2011)).

⁴²Under the District of Columbia Code, institutionalized individuals have the right to practice religion freely, but institutional programming provides the forum and access to clergy for organized worship (Conditions of Mental Health Service Delivery, D.C. CODE § 7-1231.04(e)(7) (2011)).

⁴³Congress identifies the unnecessary institutionalization of individuals with disabilities as a form of discrimination (*Olmstead v. L.C.*, 527 U.S. 581, 600 (1999)); see also Barry C. Taylor, *Integrating People with Disabilities in the Community Through Innovative Collaboration*, in this issue.

⁴⁴Hospitalization of the Mentally Ill: Periodic Examinations of Committed Patients: Procedure for Examination and Detention or Release: Petition to Court, D.C. CODE § 21-546(a) (2011).

Even if individuals with mental illness enter the institution voluntarily, they rely upon the team to assist them in arranging essential social services—such as public benefits, a place to live, and mental health treatment—for reentering the community.

Our clients have the right to receive their mental health services in the least restrictive, most integrated setting appropriate to their individual needs.⁴⁵ Statutory safeguards are meant to protect individuals from unnecessarily prolonged hospitalizations. Furthermore, according to local policy, discharge planning should be taking place from the moment an individual enters an institution.⁴⁶ For example, under District of Columbia regulations, a qualified psychologist or psychiatrist is required to examine the mental health of committed individuals every ninety days and report to their chief clinical officer. If the report indicates that they are no longer mentally ill to the extent that, if not committed, they would injure themselves or others, the chief clinical officer shall order their immediate release.⁴⁷

Moreover, individuals with mental illness have the right to “meaningful participation in the development of their service plans, as well as the opportunity to participate in planning for their transition from one provider to another.”⁴⁸ In an institution this entails developing a treatment plan on medication, health care, behavioral supports, therapeutic activities, and discharge. The individuals and their treatment team, which can include a psychiatrist, psychologist, social worker, and medical staff, should meet regularly to discuss and update the

plan. The individuals also have the right to have an advocate or family member present at these meetings.⁴⁹

Despite the patient’s legal right to play a central role in the patient’s own discharge planning, clinical staff members typically make important decisions without seeking the patient’s input. A common practice is for the treatment team to meet without the patient and discuss the treatment plan. Concerning the patient, the team makes most major decisions, such as whether the patient is ready for discharge and what the plan should be for housing and services.

Consider our first example, Mr. X, a committed individual who is vehemently opposed to his team’s recommendation of discharge to a nursing home. Our confrontation with his treatment team occurred during a meeting without Mr. X (we participated with his consent).⁵⁰ Much of the discussion centered on why Mr. X had not earned the right to live independently. His psychologist complained that he behaved poorly at a treatment group that she led, even embarrassing her in front of her supervisor. Another staff member pointed out that he would use his walker to signify anger and hostility, brushing past other patients and banging the walker on the ground. The team reacted defensively, even angrily, when we pointed out that Mr. X did not have to earn the right to live in the community and that the team’s job was to identify the supports he would require to live in a less restrictive environment. The medical, psychiatric, and social work professionals were concerned that there were simply not enough available supports for Mr. X and reiter-

⁴⁵Conditions of Mental Health Service Delivery, *id.* § 7-1231.04(d).

⁴⁶Washington, D.C., Department of Mental Health, Transmittal Letter, Continuity of Care Practice Guidelines for Adult Mental Health Providers § 2.6.d, Policy 200.2A (Jan. 17, 2012), <http://1.usa.gov/xHWtCf>.

⁴⁷Commitment Under Court Order: Periodic Examinations of Committed Patients: Procedure for Examination and Detention or Release: Petition to Court, D.C. CODE §21-546(a) (2011). See also D.C. CODE § 21-546(d)(1) (if psychiatrist or psychologist’s report indicates that individual can live in less restrictive environment, individual may directly petition director of institution for release and, if denied, petition court for order directing person’s release).

⁴⁸Service Planning, D.C. CODE § 7-1231.05(a) (2011).

⁴⁹*Id.* § 7-1231.05(c).

⁵⁰We have debated whether to attend these meetings, even with our client’s consent. Attending allows us to be a voice for our client and learn what the team is planning, but refusing to attend meetings to which our clients have not been invited demonstrates our solidarity with the client and our commitment to ensuring that our advocacy is client-centered.

ated their concerns that Mr. X would hurt himself without constant supervision. At no point did the team discuss what services Mr. X might actually require to live in a less restrictive environment than a nursing home. Instead the conversation turned to the necessity of appointing a guardian to ensure that Mr. X would go to a nursing home upon discharge.

Tensions escalated as we continued to challenge the team and asked team members whether they had discussed their concerns with Mr. X. What became clear was that the team members felt we doubted their commitment to Mr. X’s well-being. A social worker reassured us that he was actually one of the most “well-liked” patients in the institution, and the staff was very committed to protecting him. We tried to explain that we were not concerned about the team’s dedication to Mr. X. What we objected to was their focus on what they believed was in Mr. X’s best interests, rather than considering his expressed wishes. A nurse exclaimed, “Well, you can express what he wants, but we are concerned with what is best for him.”

When Mr. X was finally invited to join the meeting, he entered the small meeting room and literally stood outside the circle of his seated clinical team. The visual metaphor could not be clearer. Mr. X was the outsider, and the team was a unified, powerful force. Mr. X sat down, and the team members went over an edited, simplified version of what they had discussed earlier, not even broaching the subject of a guardian. When we met with Mr. X after the meeting and related what, in his absence, was discussed, such as appointing a guardian, he became very upset.

At a subsequent meeting, the team did talk to Mr. X about the nursing home option and the idea of appointing a guardian. Mr. X strongly objected to both

proposals. Despite the team’s consensus that Mr. X’s behavior had recently improved, his psychiatrist insisted that Mr. X needed a guardian. Mr. X’s cognitive functioning was likely to deteriorate, the psychologist explained, and then Mr. X would not be able to make “good” decisions. The team was so sure of its role as protector and arbiter of what was in Mr. X’s best interests that it was invested in limiting not only his current but also his future decision-making autonomy. We tried to educate the team that such a plan was illegal. The legal standard for appointing a guardian involves a finding of current incapacitation, not the possibility of future incapacitation.⁵¹

Institutions often seek appointment of a guardian for an individual when the individual does not agree with the treatment team, particularly on the topic of discharge.⁵² The appointment of a guardian is a permanent and life-changing event for an individual; it seriously diminishes the individual’s ability to make any independent decisions.⁵³ The guardian’s authority is so great that we cannot continue representing individuals after the appointment of a guardian unless the guardian consents to working with us and supporting our advocacy.

Ms. L’s treatment team proposed appointing a guardian and placement in a nursing home because Ms. L was not capable of making “good decisions.” Such a plan was particularly outrageous because, before our involvement with her case, the team had clearly never truly communicated with Ms. L to ascertain her decision-making ability. Ms. L is deaf and communicates in sign language, but clinical staff had not consistently arranged for an interpreter to attend treatment plan meetings and consultations. Moreover, the team viewed her refusal to participate in treatment groups and go

⁵¹Health-Care Decisions: Certification of Incapacity, D.C. CODE § 21-2204(b).

⁵²D.C. CODE § 21-2041 provides the legal framework for petitioning the court for a guardian (Guardians of Incapacitated Individuals: Procedure for Court-Appointment of a Guardian of an Incapacitated Individual, D.C. CODE § 21-2041 (2011)).

⁵³Absent a durable power of attorney for health care and assuming an individual has been declared incapacitated, a court-appointed guardian has primary authority to make decisions on the patient’s health care treatment, service, or procedure (Health-Care Decisions: Substituted Consent, D.C. CODE § 21-2210(a) (2011)).

to medical appointments as noncompliance with treatment; the team failed to consider that the absence of an interpreter might have had some influence on her decision not to attend.

The team was gravely concerned that Ms. L would not quit smoking. Due to a health condition, Ms. L was at a serious risk of imminent death if she smoked. Without arranging for an interpreter to accompany Ms. L to an on-site smoking cessation group or provide any other kind of therapy, the team insisted that her smoking habit was sufficient to warrant a guardian appointment and placement in a nursing home. We argued that Ms. L had the right to receive therapy for this addiction. Furthermore, like any adult in this country, she had the right to make the self-destructive decision to smoke even if the team did not believe that her decision was a “good” decision.

Communicating with Ms. L requires more resources and effort than communicating with most clients. We would never have been able to develop a relationship with her without the interpreter we brought to every client meeting. Even with an interpreter, understanding Ms. L was often difficult. However, Ms. L was consistently clear that she wanted to live in a place of her own. The treatment team strongly opposed Ms. L’s desire to live independently. The team claimed that Ms. L did not have the ability to understand that living alone was not in her best interests; the team believed that the best placement for this woman in her early 50s was a nursing home.

After months of acrimonious discussions with Ms. L’s treatment team, we assisted her in filing a formal complaint against the institution through its internal process. The complaint outlined Ms. L’s legal right to participate in her own treatment and discharge planning. With hospital counsel and agency involvement, we were able to settle the complaint; we agreed that the team would begin discharge planning that considered Ms. L’s desire to live independently.

The formal settlement changed the goal of the treatment team’s discharge planning from a nursing home to securing the services that would allow Ms. L to live in an apartment. However, the settlement did not change the team’s disregard for Ms. L’s personal autonomy since the team continued to question Ms. L’s decision-making capacity at every stage. When she rejected several different apartments, a team member wrote an e-mail questioning whether her decision-making capacity prevented her from making a choice. Members of the team often began statements with “the team feels,” or the “the team thinks,” reinforcing the dynamic of Ms. L against her treatment team. We challenged every doubt that team members expressed and reminded them of their own settlement agreement and Ms. L’s right to participate in the proceedings. Ultimately a University Legal Services social worker identified a voucher for an appropriate housing arrangement. Four years after we met Ms. L, she is finally living in her own apartment.

IV. Recommendations

The conflict between mental health professionals who favor a best-interests approach and our focus on personal autonomy is usually the primary obstacle in assisting our clients in achieving their goals, whether they seek discharge or wish to assert their right to participate in their own mental health treatment in another way.⁵⁴ Clinicians perceive our efforts as being in a legal vacuum without respect or consideration for therapy, while we feel that they ignore and disparage the laws that should govern their practice.

Despite our differences, mental health professionals and legal advocates share the challenge of serving individuals who often have diminished decision-making capacity. Clinical treatment does not always enable individuals to lead more independent lives. We find that prolonged stays in institutions, where our clients should be receiving treatment,

⁵⁴Although our discussion uses District of Columbia law as a starting point, the conflicts and challenges we analyze are recognizable to mental health advocates in any jurisdiction (see, e.g., Jeanette Zehlf & Sara J. Fulton, *MFY Legal Services’ Mental Health—Legal Partnership*, 44 CLEARINGHOUSE REVIEW 535 (2011); Appelbaum, *supra* note 33).

often serve to diminish decision-making capacity further. The prevailing best-interests approach to treatment, coupled with an institutional culture of regulation and subordination, leaves little to no room for personal autonomy.

The following recommendations outline our strategies for overcoming the divide between mental health professionals and advocates:

- If institutional staff members are unresponsive to your attempts to engage them in a discussion about discharge for your client, file a formal complaint. To prepare for this possibility, document all communication with staff—discussions at meetings, time, dates, and substance of phone calls and e-mails, informal consultations, and any interactions you observe between your client and staff. Report your concerns through the supervisory chain of the institution or monitoring agency or both. Had we not filed a complaint that resulted in the involvement of hospital legal counsel and the District of Columbia Department of Mental Health, Ms. L’s treatment team might never have agreed to work on a plan for independent living.
- Despite our first recommendation, if possible, try to build congenial relationships with institutional players. Remember that hospital employees are much more constrained by protocol, bureaucracy, and threat of employment termination than legal advocates at a nonprofit organization. You may be able to accomplish more for your client if the treatment team sees you as a source of legal expertise and a resource for discharge planning.
- Be aware that your own values, or the values of your organization, may conflict with your client’s goals. As a protection and advocacy agency, we provide individual, client-centered representation, and we are working toward a larger mission of advancing the rights of all people with disabilities. On rare occasions, clients express their desire to remain in an institution, and we have to make a difficult decision as to whether to continue representing them. More frequently but equally problematic, our clients’ actions can subvert their articulated goals of discharge from an institution to a less restrictive living environment. When facing a conflict between your client’s and your employer’s goals, talk to your supervisor or colleagues or both. This is an excellent way for organizations to reflect, reassess, or reaffirm their mission.



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